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A combination that has to fail: new patients, old therapists

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About 30 years ago I saw my first patient. My classic education and training meant that the following clinical characteristics were to be expected: a patient would have symptoms that can be interpreted; these symptoms are meaningful constructions, although the patient is unaware of this meaning due to defence mechanisms; the patient would be aware that these symptoms were connected with a life history. The aim of the talking cure is to uncover this connection so that the underlying conflicts may find another and better solution. Furthermore, a relatively positive transference was forthcoming. These were the basic criteria put forward by Freud in 1905 for a successful psychoanalytic treatment (Freud, 1905a). In short: a classic psychoanalytic treatment is intended for the classic psychoneurosis, and I must stress the prefix “psycho.”

Today, a hundred years after Freud, we are confronted with totally different symptoms. Instead of phobic constructions, we meet with panic disorders; instead of conversion symptoms, we find somatization and eating disorders. Instead of acting-out we are confronted with aggressive and sexual enactments, often combined with self-mutilation and drug abuse. Furthermore, the aspect of “historization” is missing: i.e., the elaboration of a personal life history in which these symptoms find a place, a reason and a meaning. Finally, the development of a useful therapeutic alliance is not forthcoming. Instead, we meet with an absent-minded, indifferent attitude, together with distrust and a generally negative transference. Indeed, such a patient would have been refused by Freud. I can say, with some exaggeration, that the well-behaved psychoneurotic patient of the past has almost disappeared. Hence the contemporary conviction that you will find everywhere in

clinical practice: we are meeting with new kinds of symptoms and, especially, with a new and difficult kind of patient.

New and difficult.

The idea that these symptoms are “new” is of course relative. They have always been there; the novelty is that we see them more often in our consulting room. A non-exhaustive list runs as follows: panic disorder, ADHD, somatization, eating disorders, difficulties in impulse control, self-mutilation, drug abuse, sexual and aggressive acting-out, an always vague combination of anxiety and depression. From a scientific perspective, it is debatable whether these new symptoms can be put under one heading. At first sight, they are quite diverse. The question is whether these new symptoms have a common denominator, and if so what this might be.

An initial answer is that most of them can be understood as more or less forming part of the personality disorders via co-morbidity. However from a psychoanalytic perspective we can't do anything with this description. If we want to bring them together under one diagnostic heading, this should have therapeutic implications, otherwise it is pointless.

A second possible answer is that these symptoms can be assigned to the attachment disorders (Mills, 2005). This implies a hypothesis about aetiology (attachment), and thus has implications for treatment. The disadvantage, however, is that the classic psychoneuroses can also be considered as attachment pathology. The question then is, what are the differences with the new kind of attachment disorders?

If we consider three common characteristics of these new symptoms, which are simultaneously three differences from classic psychopathology, it is possible to put them into one diagnostic group. The similarities run as follows. Firstly, the new symptoms have mainly to do with the body, and moreover with the somatic. Secondly, they are usually of a performative nature. Thirdly, they lack the different layers of signification together with the aspect of historization. Moreover, these three characteristics are

combined with a typical therapeutic alliance that is everything but positive and cooperative. We will now go more deeply into their differences from classic psychopathology.

Concerning the importance of the body, it is quite obvious that in the new symptoms the somatic aspect is central in a direct, unmediated way. In the classic symptoms, the reality of the body is kept outside the psychopathology; insofar as it enters the neurotic game, it is always in an imaginary fantasising manner. For example, conversion symptoms do not concern the real body in a permanent way. In contrast to this, the new symptoms imply it directly: self-mutilation and eating disorders are the most spectacular examples of putting the body in the centre, as is the case with aggressive and/or sexual enactments.

Secondly, the new symptoms are usually performative: they imply action. With the exception of obsessive-compulsive actions, the classic symptoms remain almost always within the field of the imaginary (see phobic complaints, hallucinations, obsessive thoughts, delusions), and don't give rise to actions. In cases where they do, our term for them, acting-out, implies that this action has a meaning, usually taking place at the limit of symbolisation. The classic patient has to be driven to a certain point before he crosses the threshold and acts. In cases of the new enactment, it is exactly the other way around; this form of enactment is one of the reasons why these are difficult patients, their demand from us is more coercive.

Thirdly, unlike the classic symptoms, the new ones seem to lack meaning, together with a clear-cut connection to the life history of the patient. This comes as a surprise because usually when someone consults a therapist, he or she will talk about his problems in such a way that these problems form part of his or her history, with the parents and the siblings playing important roles. By and large, this is not typical for the new clinical situation. For example, while most of these patients suffer from a combination of anxiety and depression, what in the DSM-dialect is called "mood disorders," there is a lack of significant content. Classic depression, as described by Freud (1917e), goes back to the loss of a significant object and the ensuing (partial) loss of identity. It is not too difficult

to find both losses in clinical practice, the classic ones being the loss of a love partner or a conflict in the work-place. In both cases, there is a significant loss of identity for the subject. Again, this is not the case with the new type of patient. It seems as if the depression has always been there and there is no obvious link with the loss of an object. In these times of genetics, the aetiology of such a depression will be considered as biological, something to do with “chemical imbalances,” although there is no clear-cut scientific proof for such an assumption. Clinical evidence shows that such a depression arises against a background of a general meaninglessness, where the most insignificant drawback is enough to trigger the depression that is already there. The same reasoning can be applied to the anxiety that is ever ready to materialise without the need for a specific object or situation. Finally, this group of characteristics can be linked to something also present in the idea of personality disorders. It seems as if these patients are different in matters of identity and because of this difference their way of relating to others is unusual.

Based on my contemporary reading of Freud, I believe it is possible to bring these new symptoms together under one heading, and to put forward a common diagnostic difference from the classic group. The best label for the first group is psychopathology; the name for the new group is actual-pathology. Psychopathology means that the psychological part is in the foreground, i.e., *psychological* symptoms, with a *meaning* and with a *history*. Actual-pathology means that the actual - the here and now - fills the scene, together with the body, and apparently without a link to the life history. These two groups should be understood as two poles of the same continuum. This is what Freud discovered quite early in his clinical practice.

From actual-pathology to psychopathology.

When Freud began to concentrate on the diagnostic process it became obvious that, for patients, speaking about their problems is not always that easy. There seemed to be a resistance to it, a kind of defence that either makes it hard to find the right words or even

to find any words. While Freud assumes that this defence is caused by an underlying trauma that the patient does not want to talk about, he soon discovers that it has more to do with “not being able to.” He sees that there are at least two abnormal forms of elaboration. Initially, he will describe the first group as the neuropsychoses of defence (Freud, 1894a, 1896b). Their pathological aspect lies in a defensive elaboration of an original tension that has gone awry: i.e., the elaboration can be based on a number of signifiers that contain an internal contradiction. A timeless example concerns the identification with the signifier “woman” versus the identification with the signifier “mother” – in a number of cases, this ends e.g. in a hysterical phobia. Such a pathological solution fixes the tension on a certain meaningful construction. This is simply the symptom, as a concrete lid on top of the conflict. The pathological result is that the tension cannot be abreacted via further displacements, and that the subject is confronted via the symptom time and again with the tension. This tension has taken the appearance of anxiety: the classic illustration of a symptom being a phobic construction. The same reasoning applies to every symptom in the psychoanalytic sense of the word. That is, a symbolic construction that is idiosyncratic for a particular patient, contains several meaningful layers and is linked to a certain affect; the latter is obvious for the patient, whilst the meanings may remain unconscious. This is what classic psychopathology is about, and Freud will develop his psychoanalytic treatment for the neurotic part of such classic psychopathology.

The typical characteristics of this first group become especially obvious when compared to the second one (Freud, 1895b). In a case of psychopathology, the tension arising from the body has already passed the somatic-psychological boundary and has established a connection with signifiers, so that a representational-associative processing of the arousal has taken place. This is not the case in the second group. Here the tension remains under that threshold, with the result that the normal defensive elaboration via representations, which aims at “abreaction,” cannot take place. Put in a larger perspective, this means that the defensive elaboration and the discharge cannot be processed in a psychological way. According to Freud, this is the general aetiology of actual-pathology: the failure to master an endogenic source of excitation in a psychological way and to abreact it via associated

representations. He will describe three different forms: anxiety neurosis, neurasthenia and the psychotic hypochondria (Verhaeghe et al., 2007). He will provide us with a very detailed description of anxiety neurosis, explaining how the discharge of tension takes place via anxiety attacks and via somatic anxiety equivalents. Freud stresses the fact that both forms of anxiety are devoid of meaning, in contrast to their psychoneurotic counterparts. The same reasoning goes for the somatic symptoms of neurasthenia. He will add hypochondria in 1914, as the actual-pathological starting-point of psychosis, where the patient fails to assign meaning to the strange sensations arising from his body.

The common denominator of actual-pathology is the fact that the arousal or tension cannot be processed in a psychological-representational way. For Freud, this means that the psychoanalytic treatment of his time is out of the question. As there is no verbal or even symbolic material, there is nothing to analyse. In Freud's reasoning, psychopathological development is the normal continuation on top of the actual-pathological kernel as the starting-point of every development, and these two have to be considered as the two extremes of a single continuum. Every psychopathology contains an actual-pathological kernel, and every actual-pathology may potentially evolve into psychopathology.

In my reading, this classic Freudian differentiation can be used to understand the difference between the new and the classic symptoms, provided that we enlarge his theory both at the descriptive and the aetiological level. Concerning the latter, from a Lacanian point of view, the typical failure to put the arousal into representations implies that there is something wrong in the relationship between subject and Other, especially during the process of subject-formation or identity development. Consequently, we meet with problems on the level of identity. The necessary expansion concerns the clinical variants. Freud describes only the anxiety neurosis and neurasthenia (our contemporary panic disorder and somatization), but these are not the only possible forms of actual-neurosis. In my reading, we have to add the whole borderline spectrum as well as most of the traumatic neuroses (Verhaeghe, 2002). This impossibility of representation puts us in

a very difficult situation, because it means that we cannot apply our usual psychoanalytical approach.

Classic psychoanalysis does not work.

It is no surprise that a number of therapists have put forward the idea that they need a kind of pre-therapy to prepare these patients for the normal therapeutic procedures. In my opinion, we don't need pre-therapy. On the contrary, it is the treatment itself that needs to be reconsidered in the light of the psychodynamic history of these patients, and this goes for every classic approach. First we must consider what the operative factors in psychotherapy are and why they don't work with these patients.

Research has demonstrated that among the common factors in therapeutic efficacy the relationship is the most important, and this independently of specific techniques or treatment models. In this therapeutic relationship, there are a number of client-related variables that will determine the outcome, especially the degree to which the patient himself can participate actively in the therapeutic process (Miller et al., 1997, pp. 24-33). The failure of classic psychotherapy in the treatment of actual-pathology has probably to do with the failure of the therapeutic relationship. We expect a positive working alliance, instead of which we meet with indifference or even with a negative stance. This experience is confirmed almost everywhere in the contemporary literature. In classic psychotherapy, the active participation required will be almost nil because the activity expected from the patient comes down to verbalisation – and this is precisely what is impossible in a case of actual-pathology. Psychotherapy for patients with addiction, self-mutilation, eating disorders, and personality disorders does not work because the patient does not cooperate, does not trust us, and does not want the kind of help that we are willing to offer. It is no wonder that many disappointed psychotherapists talk about “therapy-resistant” clients who do not have a genuine demand for help. That is: they don't present the kind of demand that we would like to hear, the one locating us in the

comfortable position of the benevolent helper. As Lacan said, the only resistance is the one coming from the analyst – in this case, from the therapist.

By and large we can categorise therapeutic techniques into verbal and behavioural. In spite of their differences, it is possible to isolate one common characteristic, namely deconstruction. The moment traditional therapists try to use these techniques with the new patients it becomes obvious that they don't work. In my reading this means that deconstruction doesn't work, because, quite simply, there is nothing to deconstruct. Their symptoms are not so much new as different.

In conclusion I will put forward three theses. First of all, the so-called new symptoms do not consist of different meaningful layers so characteristic of classic symptoms; on the contrary, it is the body that takes centre stage. This is the most important difference from classic psychopathology, and why it is better to give the new symptoms a different name. For historical terminological reasons, actual-pathology seems the best choice.

Secondly, this deficit in meaning and, from a larger perspective, this failure in the capacity to represent the real, has to do with the double process of subject-formation and drive-regulation in relation to the Other. The basic relationship to this Other is completely different from the one at work in classic psychoneurosis.

Thirdly, the psychodynamic history of these new patients, along with their typical relationship towards the Other, obliges us to redefine the aim of the treatment and the accompanying techniques. Whatever the approach might be, the central focus should be on the original relationship between the actual-pathological subject and the Other. Only when this relationship has been established in an operational manner, will it become possible to think about the actual symptoms.

Elsewhere I have elaborated the first two theses by combining Freud's classic differentiation with Lacan's theory on the mirror stage and on subject-formation and with contemporary attachment theory (Verhaeghe, 2002). A clinical diagnosis should contain

implications for treatment. Such a diagnosis has to present a perspective on the aetiology of the problem and on the developmental history of the patient. The question as to how the identity of a certain client was formed within their relation towards the Other must be central. It is this relationship that will be repeated later on towards other Others, and towards the therapist as well. This is of course the transference. The final aim of the treatment will be to change precisely this relationship. This can only happen when we have coherence between aetiology, diagnostics and treatment.

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