The Social of the Psychoanalytic Act, The Child, and his Symptom

Introduction

By way of tribute to the work of this Special Interest Group of ICLO-NLS, I borrow from J-A Miller….. "*what is expected…..is not to elaborate, to isolate child psychoanalysis as a speciality it is on the contrary to contribute to the analytic discourse as such".* [1] This is precisely what you Joanne and the SIG offer to the work with young people but also to the greater body of psychoanalysis.

In this evenings presentation, I'd like to raise some questions about four of the junctures which the Child/Adolescent and his knowledge encounters in the domain of Public Mental Health Services (PMHS) here in Ireland. These include; the insertion of psychoanalysis in PMHS for young people; secondly I'd like to make some comments on capitalist discourse, its implications and effects followed by a question about the child/adolescent and his symptom finding a place in the social domain; fourthly I will discuss psychiatric disorder and dilemmas posed by DSM classifications. In conclusion I'd also like to make a proposal for consideration of the insertion or re-insertion of psychoanalysis in PMHS

1. **The Insertion of Psychoanalytic Discourse in Child and Adolescent Public Mental Health Services, is it possible?**

Psychoanalysis is a portable installation whose effects do not depend on the setting, but on the discourse…*"that is on the installation of the symbolic co-ordinates by someone who is an analyst and whose quality as an analyst does not depend on the location of his consulting room, nor the nature of his clients, but rather on the experience he is engaged in".*[2] And in that experience he is engaged in, whether it is applied psychoanalysis or pure psychoanalysis, the truly essential element at stake, Miller says, is to ensure that it is psychoanalysis when it is applied. When the distinction is not made it leads to confusion, to false solutions, to

[1] Miller. J-A., *The Child and his Knowledge*. Orientation for Journée of the Institute of the Child. 2011
[2] Miller. J-A., *Psychoanalysis in Close Touch with the Social*. 2007 p.1, www.Lacan.com and Psychoanalytical Notebooks. Issue 31.

complications of what we do in our practice.[3] Analytic practice is a discourse. It doesn't provide precise solutions. It is not a form of social control and does not try to adapt people to fit a social order.

Over a hundred years ago, Freud's September 1918 address in Budapest to the Fifth International Psychoanalytic Congress, appealed to civic society and governments for post-war social renewal on a vast scale. He argued for a direction in psychoanalysis, which was no longer a prerogative of the wealthy and evoked the social responsibility of psychoanalysis. "*where the poor man should have as much right to assistance for his mind……It may be a long time before the State comes to see these duties as urgent*;"[4] The first free psychoanalytic clinic, The Berlin Institute (1918-1933) was established which answered a social necessity of the Real of its time. Freud resisted the medicalisation of psychoanalysis for purposes of adaptation and normalisation. Freud's model contributed to the social legacy of free psychoanalytic clinics today.[5] Can psychoanalysis take up the challenge of re-inserting itself in public mental health services? What are the conditions necessary to maintain a psychoanalytic position, where "*In line with the overall function of the CAMHS, each member of the multi-disciplinary team will be accountable in the delivery of the agreed Individual Care Plan (ICP). Devising an ICP is based on an agreed diagnosis and formulation in collaboration with the child/young person and their parents/carer……. the interventions are evidence-based interventions from multi-disciplinary perspectives".* (Child and Adolescent Mental Health Services Standard Operating Procedure 2015- 2017) [6] (see also Sharing the Vision, A Mental Health Policy for Everyone 2020). ICPs are standardized with a protocolised treatment plan, which is goal directed. This contrasts to psychoanalysis where each subject has an *'inventive opportunity'* to discover their own way of inscribing themselves. It recognises the dimension of choice which is sealed off by management and suggestion.[7] Furthermore effects of interventions can't be defined in advance.

[3] Ibid., p.2
[4] Danto. E., *Freud's Free Clinics, Psychoanalysis and social justice 1918 – 1938*. Columbia University Press. 2005
[6] Sokolowsky. L., *Psychoanalysis Under Nazi Occupation The Origins, Impact and Influence of the Berlin Institute.* Routledge 2021
[6] *Child and Adolescent Mental Health Services Standard Operating Procedure,* 2015-2017 HSE
[7] Miller. J., *The Next Stage of PIPOI*. Psychoanalytical Notebooks, Issue 31, p.13

2. Capitalist Discourse and the Social Order

For Lacan , the unconscious has to do with the social. This is what he will formularize with his theory of the Four Discourses which he elaborated in Seminar XV11.[8] The discourses characterize the relation between the subject and Other and between subject and object, an object which we call *objet a*, a cause of desire.

In 1972,[9] shortly after publication of Seminar XV11, Lacan indicated that Capitalist Discourse, a variation on the Master Discourse where the classic figure of the Other is dependent on the master discourse, had started to fade away. There is no structural limit. The subject has no master signifier and is bound or free to invent it. Hence, there are inconsistencies.

Capitalist Discourse and the discourse of Science copulate with one another and have opened up a different type of social order which has created many possibilities. (e.g. M.A.R, Stem-cell research, technology)

Capitalist Discourse imposes the customs of market oriented thinking on all domains of our lives. Profit-making and the expansion of capital are the motives that drive capitalism on a phantasy that we can be satisfied. In capitalist production surplus value and commodities are fetishized. Lacan gives a non-Marxian account of capitalist culture stressing the logic of consumption rather than mode of production. It takes desire as if it was a frustrated demand that should be gratified. It's as if desire can be satisfied by means of practical solution, that is by means of consumption. It is discontent that is taken seriously. Satisfaction and enjoyment/jouissance are privileged.(Lacan defines Jouissance as a disturbing dimension in the experiences of the body, it is a body event, a speaking body (Seminar X1X). Today, civilization is dominated more by the superego imperative, enjoy, than that of the ideal ego.

The market solutions for distress avoids a confrontation with the fundamental non-rapport of the sexual relation and with basic questions of existence. It affects the way we relate to others, it determines how the subject takes shape, the way the unconscious functions and how health and its treatment are packaged as commodities. Commodification refers to the

[8] Lacan. J., The Other Side of Psychoanalysis. WW Norton & Company, 2007.

[9] Lacan. J., On Psychoanalytic Discourse. *Discourse of Jacques Lacan at the University of Milan on May 12, 1972.*

process by which goods, ideas are branded, they begin to have a commercial value, and will develop a market that will have a range of products and services.[10]

Within this model, branches of medicine has made significant progress in understanding the physiological mechanisms that contribute to patient symptoms and there are an array of medical tests and procedures that can be performed. There is a basis in diagnosis that makes it possible to understand proximal causes, study a disease and evaluate the specificity of particular treatments This works well for medicine, where outcomes for many conditions has improved dramatically, but not so for psychopathology. Outcome studies of treatment and recovery rates are disturbing in both child and adult mental health. [11] (Ref also Sami Timimi who cites outcome studies in USA and UK where the recovery rate is 15-20%)[12].

Capitalist Discourse also has subjective implications. The Master discourse traditionally organised by the binary, man-woman, has been transformed. The traditional hierarchies of functions and power identified the name with the paternal function and the social order with the family order. Man and woman were categories that organised civilisation, and gender identification used to be imposed by the family order. The assignment of gender, masculine for the father, feminine for the mother has faded away. The term parent has made it possible to do away with the father and the mother. Fathers and Mothers have become undifferentiated, we are in the era of parenthood, where care takes precedence over authority and name. Function replaces the law of the father or the mother. Function in turn is not transmitted by the name, by the family order. We are now dealing with the one-all-alone, *"speaking subjects who wish to self-identify according to a certainty which they judge to be intimate".*[13] The social order replaces the family order. The centre of gravity of the family has shifted to the child. While this can leave the child lost in front of his/her own jouissance, at the same time it allows for possibilities, possibilities of finding a singular route through the contingencies of that which the child encounters in diverse modes of a shared sense of family.

[10] Vanheule. Stijn., *Capitalist Discourse Subjectivity and Lacanian Psychoanalysis.* 2016. www.frontiersin.org

[11]Although the reliable recovery rates reported are encouraging, (<50%)(on one subscale). it is evident that half of the cohort showed no reliable improvement. There is also the possibility that some may have reliably deteriorated, although rates of deterioration were low (2018: 0.7%; 2019: 5.7%) Gibbons, Harrison and Stallard., *Assessing recovery in treatment as usual provided by community child and adolescent mental health services.* (UK)Cambridge University Press**:** 23 April 2021

[12] Timimi Sami., *Insane Medicine.* 2020

[13] Brousse, M-H., *The Feminine, A Mode of Jouissance.* WAP, Libretto series. 2021 p.18

Families can open up new ways of being a mother and a father without prior standards, which is not without anguish.

3. Disinsertion[14] (Social Discontact)

As we have seen we are in an epoch where the Other no longer guarantees, no longer offers certainty. In Freud's time, social insertion was based on symbolic identification. Today, *objet a,* surplus -jouissance has replaced the Other. *Objet a* is not seen as a support of subjectivity but as a demand that should be satisfied. Insertion is less through identifications than through consumerism and the dream is of satisfaction.[15] The English language dictionary definition of disinsertion highlights the notion of rupture or separation at a point of attachment, which may occur as the result of trauma. This rupture for the children and adolescence we see in the clinic is a disruption of the signifying substance and jouissance. How can the child give his mode of jouissance a social place, insert himself in the social? (for neurosis). The child enters the analytic discourse as a being of knowledge, not only as a being of jouissance. His knowledge is respected as that of a fully-fledged subject, not as a subject to come. *"When the Other asphyxiates the subject, it is a question with regard to the child letting him take a step back, in order to give this child a breathing space".*[16] The work of analysis is to help the child distance himself from the signifier he is assigned by the Other. The jouissance of the Other for some children takes on the quality of the Real. Can we create that breathing space for the child and his knowledge within a public mental health framework?

4. Psychiatric Discourse; Disorder and Diagnostic decision making

"The DSM is the lead instrument for diagnosing psychiatric disorders. It contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders".[17] (APA)

The development of DSM in the 1950's was not motivated by clinical dilemmas but by administrative concerns by Governments, by social scientists, epidemiologists and

[14] Miller. J-A., *Psychoanalysis in Close Touch with the Social.* 2007 p.2 Disinsertion; Social Discontact
[15] ibid. p.2
[16] Miller. J-A., *The Child and his Knowledge*. Orientation for Journée of the Institute of the Child. 2011
[17] American Psychiatric Association

statisticians to quantify mental distress and to clearly delineate disorders. In the 1960's and 70's when psychoanalysis and psychodynamic-based therapies were practised by psychiatry, psychiatry redefined its object by clearly aligning it to medical discourse, to the bio-medical model. There was a shift from a prototype basis to diagnosis to that of a checklist model in the development of DSM 111 in 1980. This checklist of symptoms provides a basis to the classification of disorders in DSM V (2013). It also puts forth that diagnosis should be linked to clinical case formulations, this involves a clinical history and concise summary of the social, psychological and biological factors that have contributed to developing a mental disorder, with the aim of developing a clinical intervention. Despite this nominal inclusion of context, has diagnosis of psychopathology, important in the field of mental health, has psychiatric diagnosis been reduced to a system of categorization, of classification where subjectivity of both the patient and the assessor(s) has been excluded and where the emphasis is on distinguishing between different categories?. *"If diagnosis is to be contextualised, precise ideas between symptom and context must be formalised".*[18] In other words the speaking subjectivity of the child/adolescent, their context, and the function of the symptom has to be explored and not be assigned, consigned by a social Other to a classification.

With regard to decision-making in diagnosis of mental health disorders, I'd like to briefly address three elements.

a) The symptom

Psychiatric diagnosis of disorders do not explain symptoms. Take ADHD, it's a description of a cluster of symptoms for example, inattentiveness, distractibility, impulsivity or take depression… 'is the presence of low mood and negative thinking'…. it cannot explain itself. A description does not explain itself. Symptoms are messages in code, they are personal constructs related to the subjective experience of the patient, but these are not explored. The question of how the symptom functions in the context of the child/adolescents life is omitted.('*young boy who suffered from hyperactivity*,….. he '*couldn't stay in one place'…*)[19] The DSM decontextualises mental suffering because it disconnects the symptom from the

[18] Vanheule. S,. *Psychiatric Diagnosis Revisited. From DSM to Clinical Case Formulation*. Palgrave Macmillan 2017; p.83

[19] Freda. Francisco Hugo., *The Way of the World,* Psychoanalytical Notebooks. Issue 31 p.26

personal construction process in which mental suffering is embedded.[20] And while it may offer a reification, diagnosis covers the Real of suffering

b) Reliability of diagnosis

"DSM has been the cornerstone of substantial progress in reliability".[21] Reliability is one of the key concepts used to evaluate the quality of research. Reliability is about the consistency of a measure across time, across items and researches. Claims of substantial progress in reliability across all domains is exaggerated if we look at the coefficients of inter-rater reliability.

How do we account for the variations*? "Daily practice, says Vanheule, including research is marked by subjective idiosyncrasies as well as "sloppy" thinking, reflective of conceptual bias in both of logical lines of reasoning and it's debate"*.[22]

c) Validity

Validity relates to the correctness of measurement. A measuring instrument is valid if it assesses what one wishes to know. Psychiatric diagnosis is often presented as an objective statement of fact but is in essence a clinical judgement based on observation and interpretation of behaviour.

A clinical example; Jamie was a 6 year old boy who presented with symptoms pertaining to difficulties in reciprocal social interactions (with parents and others), difficulties with regulating behaviours and emotions, he didn't seek comfort from his parents. Changes in daily routines provoked outbursts. In his dialogue there were lapses/stilling in his narrative. The psycho-social factors included, early out of home placement, maternal trauma and parental separation. There was some minimal elaboration on the function of the symptom in the first instance. The DSM diagnosis was one of Reactive Attachment Disorder. However on review in the clinic by a different group of clinicians, the diagnosis was changed to that of Autistic Spectrum Disorder. While both disorders have common characteristics, the treatment pathways are different. What determines the differential diagnosis when the child's

[20] Op cit, p.94
[21] *DSM V; 2013.* P.5
[22] Vanheule. S,. *Psychiatric Diagnosis Revisited. From DSM to Clinical Case Formulation*. Palgrave Macmillan 2017; p.83

presentation remains the same? Is it just linked to interpretation of thresholds or what of it is related to the subjective bias of the clinician? One of the main weaknesses of the DSM is its lack of validity.

5. Considerations for Re-insertion of Psychoanalysis

Can psychoanalytic discourse have clinical effects in public mental health services, effects that are based on the particularity of each child and adolescent?

A function-oriented approach to a symptom rather than a disorder-oriented approach considers the interplay of psychological, social and biological factors in a different way than the DSM proposes. Freud was one of the first initiators of this function-oriented model. We see it in his case analysis of Dora and his insistence that the meaning of the symptom is case specific*….."In every instance the meaning can be a different one according to the nature of the suppressed thoughts which are struggling for expression*".[23] There is in other words, a subjective logic in someone's functioning.

In conclusion, I would like to suggest 3 points for consideration;

1. As a pragmatic step to reinserting psychoanalysis in Child and Adolescent Public Mental Health, I take from Vanheule his proposition of Case Construction as a response to the classificatory system of the DSM[24].

   Characteristics of the Case Construction include;

   - Case formulations focus on the nature and the underlying structure of someone's experience.
   - They are not longitudinal observations that reflect the path of the symptom, the information gathered expresses logical relations between specific aspects of someone's functioning.
   - Function orientated diagnosis is a narrative formulation that highlights the specificities of someone's problems and strengths.
   - It articulates a plausible construction of the function of the symptom but it is never complete

[23] Freud. S., *Fragments of an Analysis of a Case of Hysteria*. SE Vol 7 p.40

[24] Vanheule. S,. *Psychiatric Diagnosis Revisited. From DSM to Clinical Case Formulation.* Palgrave Macmillan 2017; p.167-200

- It allows for the aggregation of information across an MDT about symptoms for a bottom up mapping.

2. In Miller's paper of 2007, '*Psychoanalysis in Close Touch with the Social',* he proposes that through the matheme, through "*mathematical armature"* we may be able advance and formalise both a psychoanalytic base to the symptom and the quantification of symptoms. *"The constitution of a psychoanalytic base to the symptom capable of being quantified would have the most favourable effects on the quality of our clinical transmission, including its most subtle aspects".*[25] What qualitative research and clinical case formulations have in common is a focus on language and an explicit emphasis on constructing well-reasoned assumptions about someone's functioning. This indeed may be an interesting idea.

3. And it may be that the development and work of CPCT's in France and other countries can lend itself to the expansion of free psychoanalytic clinics and research outcomes of psychoanalysis.

In conclusion, Vanheule's proposal of case construction, adjoined with Freud's desire that psychoanalysis has a social responsibility in the public domain, provides an axis to Miller's invitation to consider a psychoanalytic base to the symptom which is both capable of being quantified and of having effect on that quality of that which we transmit.

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[25] Miller. J-A., *Psychoanalysis in Close Touch with the Social.* 2007 Psychoanalytical Notebooks. Issue 31. p.33