Critically Consider the Clinical Applications of Psychoanalysis to the Clinical Structure of Neurosis.

Neurosis was most influentially investigated and treated by the Austrian neurologist turned psychoanalyst Dr. Sigmund Freud in his work as a physician, researcher and writer from the beginning of his medical career in the 1890s right up to the end of his life in 1939. (Freud, 1898, 1923, 1938) Yet Freud predicted that his ideas were unlikely to be evaluated by his contemporaries with tolerance, because of the primacy he gave to the unconscious and defensive psychical mechanisms. His insistence on the importance of infantile sexuality and intra-psychic conflict in psychological development and in the formation of neurotic symptoms, proved to be unacceptable to his scientific contemporaries and became the basis for his parting of ways with the psychology of his day. This situation remains pretty much the same more than a century on.

Freud paints his picture of neurosis in his writings On the Psychical Mechanism of Hysterical Phenomena (1893), Neurosis and Psychosis (1923), Inhibitions, Symptoms and Anxiety (1926) and others. In his short essay Neurosis and Psychosis he wrote, “neurosis is the result of a conflict between the ego and id (i.e. the individual and its instincts).” (Freud, 1923a, p.149, words in brackets my translation into lay terms.) He also described the ‘transference neuroses’ and ‘narcissistic neuroses’, “Transference neuroses correspond to a conflict between the ego and the id; narcissistic neuroses to a conflict between the ego and the superego.” (Freud, 1923b, p.152)

Neurosis, for Freud, originates from a person refusing to accept a powerful sexual or aggressive instinctual impulse, refusing to allow it a motor outlet, or forbidding it the desired object at which it is aiming. The neurotic defends itself against its own instinct by the defence mechanism of repression, but the repressed sexual or aggressive wish struggles against the control of the superego conforming to the laws of civilised society. In an attempt to find instinctual discharge, the psyche creates a ‘substitutive’ compromise formation over which the neurotic has no conscious control. In other words, the instinctual energy forces itself upon the individual as a neurotic symptom.

The ‘psychoneurosis of defence’ – hysteria, obsessional neurosis and phobia – are such compromise substitute formations of an intra-psychic conflict between instinctual wishes and obstacles to their fulfilment. They are examples of the so called ‘return of the repressed’ that produce a disguised satisfaction of instinctual desires. Disturbed by these indirect expressions of their own sexual and aggressive instincts, the neurotic feels its unity threatened by the intruding instinctual energy disguised in distorted form. In such cases, the neurotic has come into conflict.
with its own instincts in the service of society. Psychoanalytically then, the neurotic is under the influence of an unconscious instinctual wish. Unconscious because the surging ‘contrasting representations’ and ‘irreconcilable ideas’ are so difficult to reconcile, that by an effort of ‘counter-will’ the neurotic decides ‘to forget the thing’ i.e. the instinctual conflict. (Freud, 1893, p.149) Recollections of the instinctual wish are absent from the neurotic’s mind, because they occurred in auto-hypnotic semiconscious psychical states such as intense excessive laughing, crying, fright, ecstasy, etc., which were not connected associatively with normal consciousness. The person experiencing the intense instinctual wish is not fully aware of what is going on, because they have been blinded by an excessive amount of instinctual energy. Therefore, according to Freud, it is already impossible to discuss with a neurotic patient what determined their neurotic symptom or behaviour pattern, without considering a hypothesis which characterises their condition.

**Psychic Structure**

Freud’s first two models of the mind – the economic and dynamic – viewed the development of the ego or individual, primarily in terms of the dynamics of their instinctual desires. From 1923 onwards, adhering to his new structural theory, he used concepts like ‘psychic structure’, ‘psychic apparatus’ and the ego, id and superego in his monograph *The Ego and the Id* (1923). In contrast to drive theory, structural theory concentrates on the formation, development and continued integrity of ‘hypothetical’ psychical or clinical structures, instead of focusing on the dynamics of instinctual drives. (Horney, 1937; Tyson, 1988; Weinshel, 1993) Freud’s structural hypothesis implied that a stable sense of the ego is based on an underlying “coherent organization of mental processes” that functions to regulate the instinctual drives and adapt a person to reality. (Freud, 1923a, p.17) This implies that the development of an underlying psychical structure is what insures the coherence and stability of the surface level cognitive-behavioural experiential ego.

**Symptom and Structure**

Freud’s theory that psychic structure is what distinguishes neurosis, psychosis and perversion, is seminal in Lacanian psychoanalytic theory. The crucial difference to be explained is the difference between symptoms and the actual psychical structure of the person. “The most important differentiation is the discrimination between symptom neuroses and character neuroses.” (Reich,
1933) Wilhelm Reich argued that character structures were organizations of resistance, with which individuals avoided facing their neuroses. Later, the Object Relations psychoanalyst Harry Guntrip, wrote that Freud's structural theory in his monograph *The Ego and the Id* (1923), only gained practical importance when Reich's *Character Analysis* (1933) and Anna Freud’s *The Ego and the Mechanisms of Defence* (1936) were published, as these books placed Ego Analysis at the centre of psychoanalytic psychotherapy. (Guntrip, 1961)

According to French psychoanalyst Jacques Lacan, each of us is situated in our inter-subjective world with a specific way of desiring and wanting to be desired. Whereas Freudian psychoanalysis focuses on uncovering the intra-psychic conflicts of unconscious instinctual desire, and Object Relations psychoanalysis focuses on uncovering an individual’s good or bad instincts and their inter-subjective relational psychodynamics. Lacanian psychoanalysis attempts to identify the subject’s psychic structure, precisely by locating where and how the subject’s desire operates both within their psyche and in relations with others. Subjectivity, relationships and psychopathology are tightly interwoven, so that neuroses and other psychopathology present as specific modes of desiring and relating. In the psychoanalytic clinic, character or psychical structure refers to a specific mode of managing instinctual drives, or as Lacanians say, a specific mode of desiring. Although this mode of desiring takes on multiple forms and symptoms, a Lacanian psychoanalyst will not only be able to distinguish a hysterical from an obsessional neurotic, or a pervert from a psychotic, they will be able to distinguish if the desiring phenomena/behaviour/defence is symptomatic or structural.

Freud initially saw development, fixation and regression as tightly interwoven elements in the formation of neuroses. He argued that the desiring function goes through a lengthy developmental process involving two dangers - first inhibition, and secondly, regression. Inhibitions produce obsessive neurotic fixations to earlier developmental stages and the stronger the fixation, the more the desiring function evades conflicts and societal prohibitions by regressing to a fixation. (Freud, 1917)

My argument is this essay is that, it is these vicissitudes i.e. developmental hurdles and obstacles – psychical defences, resistances, denials, avoidances, regressions, repetitions, compulsions, obsessions and fixations – as well as the fact that the subject is crucially only partly conscious of its deepest desires, that make the treatment of neurosis such a complex endeavour. In fact, such developmental hurdles are manifestations of neuroses itself.
Psychoanalytic Treatment

Having reviewed theories of the clinical application of psychoanalysis (Weinshel, 1993; Vaughan & Roose, 1995) to the treatment of neurosis (Stekel, 1907, 1908; Adler, 1921; Horney, 1937; Fenichel, 1945), it is fair to say that the majority of psychoanalysts see psychoanalytic process as a core concept in treating neuroses. Abrams’ (1987) definition, “The psychoanalytic process conceptualizes the route of overcoming neurotic mechanisms.” (p. 442) and that of Dewald (1978), “The psychoanalytic process in adults can be conceptualized as an evolving and progressive interaction between the two participants, each of whom is acutely sensitive to the input and responses of the other” (p.324), apply to processes that can be described as a route to overcoming neurotic mechanisms.

Right at the beginning of psychoanalysis, Breuer and Freud (1893-95) saw catharsis, later termed abreaction, as a necessary condition of recovery from neurotic symptoms. When the method of hypnosis had been given up, the task became discovering from the patient’s ‘free associations’ what he or she could not face or remember. Free association replaced hypnosis in a psychoanalytic treatment that, “consisted in bringing into focus, the moment at which a symptom was formed and in persistently endeavouring to reproduce the mental processes involved in that situation, in order to direct their discharge along the path of conscious activity.” (Freud, 1914, p.147) Remembering and abreacting early life conflicts, reconstructing and modifying difficult early life experiences, is what was aimed at. Abreaction - the discharge of emotion that was attached to a previously repressed experience - was held to be in itself therapeutic, regardless of whether or not the patient fully understood the significance of the repressed experience.

Psychoanalysis is an extremely involved process that takes place over the course of a number of years. It is certainly not for everyone and can be harmful if contraindicated. A necessary sufficient amount of ego strength and creative function is required to able to engage in the psychoanalytic process, without the analysand becoming overwhelmed by the emergence of disturbing and upsetting unconscious material released in the process. This is the reason why, before embarking on any analysis, risk assessment and careful consideration is given to the suitability of an analysand, with regard to their psychical structure, their mode of desiring, coping mechanisms and the containing support networks within which they are embedded. A trial period of a few weeks is necessary to assess how the analysand manages to cope with psychoanalytic exploration. If the
analysand can manage the quantities of affect (emotion) released, without it adversely effecting their ordinary everyday life routines, psychoanalyst and analysand agree to continue working together. They develop an intimate relationship which includes transference, a process in which the analysand develops a sort of parent-child relationship with the psychoanalyst and ‘transfers’ early life significant emotions, anxieties and fantasies felt towards their parents, onto the psychoanalyst. This makes for an extremely sensitive and complex relationship in which the psychoanalyst has a huge amount of influence and responsibility, which is necessary, but requires care. If a transference does not develop, a real analysis has not taken place regardless of the general supportive benefit to the analysand. Psychoanalytic process then, is a regressive and progressive interaction between two people, each of whom is acutely sensitive to the responses of the other. It is a complex process characterised by the interpretation of the ‘free associations’ of an analysand (in a hypnoid state of awareness to soften the blow, as every advance of the self is a defeat for the ego), who becomes aware of repressed instinctual wishes and can express differently the unconscious desire behind their anxiety and neurotic symptoms.

**Difficulties in Treating Neuroses**

The major difficulty in treating neuroses is that defence mechanisms make psychoanalysis a highly complex treatment. (Freud, 1917; A.Freud, 1969) Resistance, for example, stands in the way of remembering, abreaction and catharsis. Freud perceived it in his work, through the strenuous efforts he had to make in order to get his patients to remember the causes of their neurotic anxiety. He wrote about the difficulties he encountered in eliciting abreaction and thought that resistances to remembering significant unconscious experiences had to be circumvented by the patient’s being put into a semiconscious hypnoid state of free association and the psychoanalyst’s work of interpretation. (Freud & Breuer, 1895) If we take repression, resistance, reaction formation, repetition compulsion, regression, obsession, fixation and the numerous other defence mechanisms seriously, then we can begin to realise the vicissitudes, i.e. developmental obstacles in the path of treating neuroses. These defence mechanisms are all barriers to the development of a healthy psyche in everyday normative life in general, never mind in the psychoanalytic treatment of neuroses. Further, such defences are operative within the psyche of everyone, including psychoanalysts themselves, so that becoming aware of one’s own complexes, remains the fundamental requirement of psychoanalytic training.
Lacanian Psychoanalysis

In Lacanian analysis, the psyche can be divided into three psychical/clinical structures or categories – neurotic, psychotic or perverse – that manage and control the subject’s instinctual desires. A category, e.g. the category of neuroses, is a master signifier that ‘fixes’ meaning, thereby forming a stable symbolic order in society. Being arbitrary, a master signifier has no signified of its own, it merely stands for the symbolic system itself. For Lacan, people are ‘subjects’ not individuals, because their instinctual desires are subjected to the prohibitions and laws of society and they must find a stable way of managing their sexual and aggressive instincts. Therefore, the three clinical categories or psychical structures have an existential bearing on the condition of being a socialised instinctual animal.

In Freudian terms, determining a person’s psychical structure and psychopathology, is equivalent to discerning the habitual psychodynamics of their instinctual economy. For Lacan, what is decisive is not the psychodynamic conflict between the ego, id and the superego, but how the subject manages being castrated i.e. cut off from its instincts and forced to pursue its desires on “the inverted ladder of the signifier” within the phallic order of society. (Lacan, 1953) The questions to be asked for Lacan are, how fully has the person or analysand acceded to societal castration. How fully has he or she overcome the aggressivity characteristic of the infantile stages of development, and how far has or hasn’t he/she developed, repressed, avoided, expressed or perverted his or her instinctual desires. For Lacan a neurotic is someone who has submitted to instinctual castration, but not without something being left over as neurotic evidence. Language and the symbolic order of social interchange, bound by the rule of law, has functioned to repress what the human animal most deeply desires, but some neurotic symptom or behaviour remains and stands as testimony to a lasting refusal and resentment towards the castrating agency of society.

Lacan agreed with Freud’s idea that the most deeply desired object is always a lost object, that can only be found through substitute formations. Freud had said that what characterised a neurosis was not the particular drives – life (sexual) or death (aggressive) – at play. Instead of analysing life/good or death/bad drives and their object relations, as the Object Relations psychoanalysts, Lacan argued that the relationship to the ‘loss’ of the primary desired object has to be analysed. His shift from the desired object, to the lack of desired object, created a new dimension for the psychoanalytic treatment of neurosis and redirected attention back to hidden unconscious processes.
Lacan’s views on neurosis are demonstrated in his 1953 seminar *The Neurotic’s Individual Myth*. The seminar serves as especially valuable to an understanding of his view of the status of psychoanalysis as scientific knowledge. As a stylist, he rejected, along with Levi-Strauss and numerous French philosophers, the Cartesian emphasis on analytic and scientific clarity, at the expense of complexity. Lacan argued that Cartesian science dictates its own conclusions which are incompatible with the philosophies of major phenomenologists such as Husserl and Heidegger, but also with the revolutionary doctrines of Freud and the psychoanalytic movement. Lacan sees any demand for scientific clarity – such as the demand for evidence and outcome based cognitive-behavioural treatments prevalent in psychological medicine – as a betrayal of insight and he mocks the scientific demand for falsifiable logic. The only thing that stands and chronically persists, psychoanalytically speaking, is unconscious desire disguised in neurotic forms and behaviours. This is why psychoanalytic treatment is deliberately designed to plunge the analysand into the unconscious psyche, to fight fire with fire.

For Lacan, the key to the treatment of neuroses was not in the content or object of an analysand’s desire, but rather in the ‘position’ of the subject (analysand) in relation to their desires. What matters is a person’s habitual mode of defence against their deepest desires. When Freud discussed obsessional neurosis in detail in the Rat Man case, he wrote that what matters is less the drive, than what he called “*the psychological field*”. (Freud, 1909) When he speaks of the ‘psychological field’ his idea is not simply to find one’s way around, but to find the point from which the perspective is fixed. For example, a neurotic person ‘constructs’ his or her desire by making the other’s (the significant person in their life) object of desire, into the object of their own desire, thus taking the position of the slave and forsaking (repressing) their own instinctual desires and individual identity. They want to be the object of their partner’s desire and will do anything to turn themselves into it, but by always searching for ways to become the object of their partner’s desire, they don’t have to face their own desire. This is a masochistic position because their own desire remains unsatisfied, as a means of persistently searching for new ways of becoming the desirable object for another person. In contrast, the obsessional neurotic is terrified of their partner’s desire and transforms it into a demand i.e. an obsessional compulsive behaviour, which becomes ‘the’ desired object instead of the actual person. Either he or she makes the partner wait for instinctual satisfaction, or turns the demand into an obligation that he/she then fulfils for the other. Either neurotic construction is inscribed around desire and is unconsciously constructed to avoid it. Insofar as desire always refers to a lack-in-being, Lacanian clinical structures cannot be reduced to the positivistic categories of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
Critique of the Contemporary Treatment of Neurosis

Today, in mainstream psychological medicine, the term neuroses covers a highly specific and controversial collection of coded mental disorders, categorised and systematised in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These include Anxiety Disorders (7. 300.02 – 308.3), Somatoform Disorders (8. 300.81 – 300.82), Factitious Disorders (9. 300.19), Dissociative Disorders (10. 300.6–300.15), Sexual Disorders (11. 302.71–302.76, 625.8, 608.89, etc.), Eating Disorders (12. 307.1–307.50), Impulse Control Disorders, Adjustment Disorders, Personality Disorders, Gender Identity Disorders and a whole host of other mental disorders. In fact, the term ‘disorder’ as used in the DSM-IV is a substitute for the term ‘neuroses’. (Mayes & Horwitz, 2005)

In contrast to the scientific trend of multiplying, labelling and categorising every single observable neurotic symptom as a separate psychosomatic, cognitive or behavioural disorder, the Lacanian diagnostic schema simply includes the three classical Freudian categories of neurosis, psychosis and perversion. Yet in psychoanalysis diagnosis remains crucial in situating an analysand as most likely having a neurotic or psychotic psychical structure and determining the psychoanalyst’s position, approach and direction of the treatment, i.e. correctly situating him or herself within the transference and making specific kinds of interventions.

The problem the DSM authors had with using the term neuroses, is that it draws attention to hidden unconscious psychosomatic mechanisms and does not merely refer to conscious cognitive-behavioural phenomena. (Horwitz & Wakefield, 2007) The psychoanalytic treatment of neurosis is a bottom up approach, attempting to tackle the fundamental underlying causes of neuroses, not only surface neurotic thoughts and behaviours. Arguably, hidden psychical mechanisms can only be known of and worked with by trained psychoanalysts, but analysts themselves have an unconscious that operates in the psychoanalytic treatment process, as it does in everyday life in general like everyone else. Yet Cognitive-Behavioural Therapy (CBT) has become the standard psychotherapy treatment for neuroses. It works top down, on the conscious ego surface level of the mind, by changing the neurotic’s thinking and behaviour patterns that maintains their anxiety. In terms of aetiology, CBT does not reach very far back to the structural underlying causes of neuroses.

In spite of the importance that psychoanalysts continue to place on the fundamental aetiology of infantile sexuality, unconscious intra-psychic conflicts, repressed emotions and the neurotic
anxieties, thoughts, behaviours and symptoms that these create, the role of instinct and desire in organising and defining psychical structure and psychopathology is still understated in mainstream psychological medicine, that merely manages observable surface neurotic phenomena. The clinical method of abreaction has been disregarded in favour of more observational cognitive-behavioural methods and techniques, so that the close relationship between body and mind, feeling and thinking, analysand and psychoanalyst, is increasingly polarised with intellectual insight replacing emotional insight. By conceptualizing clinical categories primarily in terms of psychopathology and certain modes of thinking and behaving, mainstream psychotherapy and psychiatry neglect the aetiology of unconscious motivations and casts structural psychoanalysis as outmoded. Yet there need not be this schism or polarity between consciousness and the unconscious, thinking and feeling, behaviour and desire, as instincts, thoughts and behavioural interactions and relations with other people, affects psychic structure and personality development and vice versa.

Another interesting critique of the psychoanalytic treatment of neuroses, from a Lacanian perspective, is the operation of the desire of the analysand and the psychoanalyst. The state of or lack of functioning of the analysand’s desire might be assumed to be dysfunctional, in that the person may be presenting with relationship difficulties. While it is commonly assumed that the psychoanalyst is a completely sane and fully functioning healthy person. Much more interesting, is the interaction of the primary ideal desirable objects of analysand and psychoanalyst. The Lacanian question here is, where is desire i.e. the life force, in psychoanalytic treatment? If it is not there, what exactly blocks it. The usual scenario is that the analysand places the psychoanalyst in an ideal position of authority as the subject supposed to know, then this position gradually breaks down as the analysand comes to see their problems and analyst more realistically. While the analysand that is able to think, fantasize about and act on their desire, can be said to have reached a normative position with regard to the functioning of their will to live.

Regardless of the difficulties of assessing how a ‘normative’ psychoanalytic treatment works, or assessing its effectiveness or how a treatment can be said to have successfully effected a cure, there are cases in which the psychoanalyst must admit that the solution of a conflict by a neurosis is one of the most tolerable socially sanctioned ways of coping with intra-psychic conflicts. The neurotic that needs psychoanalytic treatment simply has too debilitating symptoms or behaviours patterns that prevent their enjoyment of life. Treatment of their neurosis by psychoanalytic psychotherapy can pave the way for resumption of normal development, lead to profound changes and lay the
foundation for a fulfilling life. Freedom from anxiety, inhibition, obsession and fixation can enable a former neurotic to meet the obstacles and challenges of life and pursue their deepest desires.

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