BETWEEN AFFECT AND SIGNIFIER: A COMPARISON OF LACANIAN AND 'MODERN PSYCHOANALYTIC' THEORIES OF PSYCHOSIS

Dany Nobus

In an argument whose insistence should not conceal its undertone of clinical failure, Freud famously asserted that psychotic patients do not qualify for psychoanalytic treatment, owing to their incapacity for mild positive transference (Freud 1905: 264; 1916-17: 447; and 1940: 173). Despite the forcefulness of Freud's claim, psychoanalysts have challenged its accuracy and endeavoured to demonstrate that the remit of psychoanalysis can be extended profitably beyond the realm of neurotic disorders. Through conceptual elaboration and clinical experiment, innovators such as Melanie Klein (1946), Frieda Fromm-Reichmann (1950), Paul Federn (1952), Herbert Rosenfeld (1965), John Rosen (1953; 1962), Gisela Pankow (1969; 1977), Marguerite Sechehaye (1956) and Marion Milner (1969) have tried to prove that psychotic conditions are not just of theoretical interest to the psychoanalyst but offer valuable indications for psychoanalytic intervention.

Theoretically, these authors have criticised Freud's exceedingly narrow conception of transference and have facilitated a deeper understanding of narcissism, aggression and ego-deficiency, as the quintessentially psychotic features. Clinically, they have modified some of the central tenets of classic psychoanalytic technique (free association, evenly suspended attention, interpretation) to accommodate the mental processes of the psychotic patient, and they have transmuted the role of the analyst from a neutral facilitator of psychic productions to a more active, directive guide who oscillates between a supportive mother-figure and a prohibiting paternal agency. In some cases, the therapeutic successes obtained by means of these new psychoanalytic approaches in allegedly severe cases of schizophrenia have been quite spectacular. This observation has led some researchers to question the correctness of the

initial diagnosis and to suggest the possibility of a hysterical structure hiding underneath the overt psychotic picture. For example, in a meticulous historical study of the ostensibly paradoxical label of 'hysterical psychosis' in the psychiatric and psychoanalytic literature, Katrien Libbrecht (1995) has claimed that many of the patients diagnosed as schizophrenic by the new psychoanalysts of psychosis are in fact hysterics manifesting psychotic phenomena. This contentious account has recently been supported by Juliet Mitchell, who has offered the clinical rationale behind Libbrecht's historical research, concluding that 'a number of today's "psychotics" are in fact yesterday's "hysterics" and were correctly designated as such before' (Mitchell 2000: 176).

One of the most far-reaching and influential contributions to a new psychoanalytic treatment model for psychosis is Hyman Spotnitz's clinical paradigm of 'modern psychoanalysis'. Drawing on his yearlong experience with treating psychotic patients and his vast knowledge of the professional literature, Spotnitz argued in his seminal *Modern Psychoanalysis of the Schizophrenic Patient* that Freud had failed to appreciate the specific quality of the psychotic transference, probably as a result of his own countertransference resistance, which may have conditioned his focus on the object-value of the transference and induced the scotomisation of other, narcissistic transference manifestations (Spotnitz 1985: 21-23). Yet apart from re-situating psychosis within an operative framework of narcissistic transference (Spotnitz and Meadow 1995: 55-67), Spotnitz also re-conceptualized psychotic disorders as such. In his view, psychosis constitutes the pathological outcome of a traumatic frustration of the child's maturational needs during the pre-verbal, pre-oedipal stage of psychological development. Rather than attributing this condition to purely environmental factors, and thus eschewing notions such as the schizophrenogenic parent (Jackson, Block and Patterson 1958; Mac Andrew and Geertsma 1961), Spotnitz embraced an interactionist perspective, acknowledging the significance of hereditary, constitutional as well as psychological and social influences (Spotnitz 1987a: 101, Spotnitz and Meadow 1995: 45), without compromising the therapeutic reversibility of the disorder (Spotnitz 1985: 34). Whilst adopting Freud's designation of psychosis as a narcissistic neurosis (Freud 1916-17: 447), Spotnitz also revealed the core emotional disturbances from which the psychotic condition

emanates. In his view, psychosis is therefore not only a pre-oedipal, pre-verbal disorder, but also an emotional illness which manifests itself through a debilitating mixture of narcissism, withdrawal, aggression and destructive impulsivity.

Since the early 1970s, Spotnitz's ideas have given rise to a new operational theory for the psychoanalytic treatment of psychotic patients, a clinical modus operandi with a solid theoretical basis known as 'modern psychoanalysis' (Meadow 1996b: 137-39). When working with psychotics, the modern analyst generally stimulates the transformation of the patient's narcissistic (pre-oedipal) transference into a more manageable object (oedipal) transference (Spotnitz 1987c: 144), via a continuous reflection upon his or her own narcissistic countertransference resistance (the therapists' unwillingness to ascertain the emotions elicited in themselves by their patients' narcissistic transference) and specific techniques such as maturational interpretation (Spotnitz 1987b: 43-6), ego-dystonic and -syntonic joining, and psychological reflecting and mirroring (Spotnitz 1985: 249-89). As far as treatment goals are concerned, Spotnitz does not consider the patient's return to the pre-morbid, pre-psychotic state of functioning to be sufficiently advanced, for the simple reason that this state is always already pathological (ibid. 34). Instead, he believes that the treatment is only terminated when the patient has re-established a sense of psychic equilibrium and a stable mental foundation for personal growth. As Spotnitz put it at the very end of *Modern Psychoanalysis of the Schizophrenic Patient*: 'The patient who has successfully undergone modern psychoanalysis emerges in a state of emotional maturity. With the full symphony of human emotions at his disposal, and abundantly equipped with psychic energy, he experiences the pleasure of performing at his full potential. When this state has been stabilised, modern psychoanalysis has achieved its ultimate goal' (Spotnitz 1985: 288-9).

In recent years, under the influence of research-active clinicians working at Modern Psychoanalytic Institutes in various parts of North America, yet mainly by virtue of the inspiring and programmatic work of Phyllis W. Meadow, Spotnitz's theoretical vision has been expanded to encompass a broader spectrum of narcissistic neuroses (schizophrenia, manic-depressive psychosis, paranoia), his technical algorithms have been fine tuned to

produce more pervasive and lasting results, and his outlook on psychoanalytic training has been developed institutionally and qualitatively to meet the highest standards of professional practice. The most interesting contemporary developments include extending the application of modern psychoanalytic principles to group analysis (Spotnitz and Meadow 1995: 245-62; Meadow 1996a), fostering the recognition of the so-called 'negative union' (a sensory state of primitive bodily experience occurring during the first months of life) in view of the completion of the treatment (Meadow 1996c), and encouraging a more detailed investigation of the part played by the anaclitic countertransference resistance (the analysts' failure to acknowledge the emotions induced in themselves by the patient's craving for dependency) in the resolution of the patient's maturational needs (Spotnitz 1985: 236; Spotnitz and Meadow 1995: 263).

When studying the modern psychoanalytic theory of psychosis and its clinical implications in light of my own training within the Lacanian tradition, I was first of all struck by some remarkable similarities between the two paradigms, especially pertaining to the techniques used with psychotic patients. In *Modern Psychoanalysis of the Schizophrenic Patient*, Spotnitz stresses on numerous occasions how the psychoanalyst should encourage patients to verbalise their narcissism and aggression, without using these utterances as material for interpretation or fostering understanding. The following passage is particularly revealing in this respect: 'No attempt is made to influence the production of psychotic material. The patient is not discouraged in any way from revealing it but its significance is not called to his attention or explained to him. No effort is made to help him understand it.' (Spotnitz 1985: 166). And even more forcefully: 'The more the patient strives to understand, on the other hand, the more confused and emotionally withdrawn he becomes. Absorption in the quest for understanding creates a barrier to communication, inhibiting progressive verbalisation and facilitating repetition. The striving to understanding thus becomes, in a sense, a form of resistance to verbal communication.' (ibid. 169). When Lacan conducted his seminar of 1955-56 on the issue of psychosis, he devoted the first two lessons to an elaborate critique of Karl Jaspers' notion of the 'relation of understanding' and its impact on contemporary psychiatry (Lacan 1993: 3-28). Taking issue with all clinical attempts at understanding the

psychotic patient, or at encouraging the patient's self-understanding, Lacan argued that if there is an 'understandable kernel' in the psychotic's condition, it will always be 'inaccessible, inert, and stagnant with respect to any dialectic' (ibid. 22). If the patient elaborates on an ostensibly meaningful aspect, it will be 'constantly repeated,' 'without any answer, any attempt to integrate it into a dialogue, ever being made' (ibid. 22).

Much more than any other psychoanalytic treatment paradigm for psychotic patients, modern psychoanalysis operates with and on the transference, that is to say it proceeds from the basic principle that psychic conflicts can only be dealt with once they have acquired a transference-value. Modern analysts are therefore particularly attuned to recognising and reflecting the patient's transference-resistance, a procedure which can only be implemented beneficially if they themselves remain in touch with their countertransference. In a similar vein, Lacanian psychoanalysts emphasise the transference both as a *conditio sine qua non* for the start of the psychoanalytic process, an exceedingly important yet potentially explosive factor for its continuation, and a component which needs to be analysed in view of the end of the treatment. Lacan did not accept the possibility — professed by many psychoanalysts in the wake of Freud's intermittent suggestion of a removal, resolution or dissolution of the patient-analyst relationship (Freud 1912a: 105; Freud 1912e: 118; Freud 1916-17: 455) — of the transference being 'liquidated' (Lagache 1952: 112-3), yet he firmly believed in the necessity of a fall (*chute*), or a reduction (*réduction*) of the transference at the end of analysis (Lacan 1967-68: session of 10 January 1968).

Beyond these and other technical similarities, some crucial differences separate the modern psychoanalytic from the Lacanian approach. I shall briefly address what I consider to be the most significant of these discrepancies: 1. The definition of psychosis; 2. The definition of transference; 3. The conceptualisation of psychotic transference; 4. The analyst's position in the treatment; 5. Psychoanalytic treatment goals for psychotic patients. In contrasting the modern psychoanalytic and the Lacanian perspective, I have no intention of demonstrating that Lacanian theory is theoretically and clinically superior to modern psychoanalysis, nor do I wish to make suggestions for an enlightened integration of both frameworks in a new

paradigm of ‘modern Lacanian psychoanalysis’ or ‘post-modern psychoanalysis.’ For the purposes of this paper, it seems more interesting to me to highlight the divergence and to stimulate debate, than to arrive at a new synthesis. Also, as I pointed above, Lacanian and modern psychoanalysts agree on a number of technical points, which indicates that the theoretical differences need to be judged separately from their clinical application, although it would evidently be a worthwhile venture to examine how theoretically different conceptions of mental dysfunctioning and the psychoanalytic strategies for dealing with it can still converge into similar clinical procedures.

In modern psychoanalysis, psychosis is defined as a pre-verbal, emotional illness which is ‘in large measure the product of unfavourable maturational factors connected with preoedipal development’ (Spotnitz 1985: 70). As a result of these maturational difficulties, the psychotic patient is emotionally deprived and retreats into ‘a psychological straightjacket to prevent himself from acting as his aggressive impulses tell him to act’ (Spotnitz and Meadow 1995: 44). In Lacanian psychoanalysis, psychosis, like neurosis and perversion, is by definition an Oedipal problem. It is a mental structure originating in a set of conflictual relationships during which a subject’s access to the symbolic order of language, with all its prohibitions and injunctions, is at stake. Unlike the neurotic, who manages, more or less successfully, to substitute the symbolic law, as represented by what Lacan called the ‘Name-of-the-Father’ (Lacan 1977a: 67), for a continuous exposure to the whimsical demands of the Other, the psychotic, owing to an ‘unsoundable decision of being’ (Lacan 2006[1946]: 145), does not become a symbolically alienated, desiring subject, but remains an object of enjoyment for the desire of the Other. Lacan designated the causal mechanism of psychosis as the foreclosure of the Name-of-the-Father (Lacan 2006[1959]: 465 Aparicio 1984; Grigg 1998; Rabinovitch 1998; Maleval 2000), taking his lead from Freud’s notion of *Verwerfung* as it appeared in his case-study of the Wolf Man (Freud 1918: 79-80), yet extending it to cover the mechanism of projection as explained in the Schreber study (Freud 1911: 66). The psychotic then re-organises the so-called preoedipal relations retroactively through the lens of the Oedipal failure, and via the work of the delusion he or she will try to re-establish a relatively stable level of psychic organisation. When exploring the child’s preoedipal (pre-genital) relations in

his 1956-57 seminar on object-relations, Lacan explicitly rejected preoedipality as a separate stage of psychosexual development, arguing that even the earliest mother-child relationship is always already infected by symbolically induced conflicts of interest (Lacan 1994). The corollary of this outlook is that psychosis is not an emotional disorder but first and foremost a disorder of speech and language (Lacan 2006[1959]: 447-53; 1977a[1964]: 238). Whatever emotions the psychotic patient experiences — anger, anxiety, sadness, etc. — the shape in which they manifest themselves is always conditioned by the symbolic, representational structure in which they are embedded.

Whereas modern psychoanalysts essentially distinguish between object-transference and narcissistic transference, each of these versions acquiring positive or negative qualities depending on the nature of the patient-analyst relationship, Lacan initially entertained a distinction between imaginary and symbolic transference (Lacan 1988[1953-54]). Symbolic transference is synonymous with the patient's productive engagement in what Lacan dubbed 'full speech': a type of speech which does not cover up the unconscious and which signals a genuine subjective commitment to the verbalisation of what cannot be talked about. Imaginary transference is exactly the opposite. Here, the patient resists the unconscious, spends her analytic sessions giving the analyst a rundown of what she has done since her last appointment, starts every sentence with 'I think I am...', gossips at length about people she thinks the analyst is also interested in, tries to maintain a certain image of herself to please the analyst, etc. Hence the difference between imaginary and symbolic transference is not that the former is characterised by hatred, aggression and violence, and the latter by love, willingness and cooperation. Loving compliance may as easily be a function of the unproductive imaginary transference as hateful expressiveness may be an ingredient of the productive symbolic transference.

During the 1950s and early 1960s Lacan gradually exchanged his dual conception of transference for a more unitary notion with two distinct aspects. At the end of his *Seminar XI*, for example, he suggested that a given mental structure only shows one kind of transference with two alternating sides, of resistance and desire (Lacan 1977a[1964]: 253-9). More

importantly, however, is Lacan's critique of the Freudian view of transference as an 'emotional tie' (Freud 1916-17: 431-47) and his reformulation of the bond between patient and analyst as an attribution of knowledge. Indeed, from his *Seminar VIII*, *On Transference* (Lacan 2015[1960-61]), Lacan envisaged transference as a function of the 'supposed-subject-of-knowing' (*sujet-supposé-savoir*), thus reducing the dynamic impact of its affective qualities and concentrating on its epistemological value (Miller 1984: 35). This does not imply that Lacan suddenly identified transference as an affectless bond — until the end of his career he also glossed transference as a state of love — but quite simply that he subsumed transferential affect under the more-encompassing category of an (erotic and eroticising) attribution of knowledge.

Compared to Lacan's minimal and tentative assertions in his two main texts on psychosis, the transcript of *Seminar III* (Lacan 1993[1955-56]) and the 1957-58 paper 'On a Question Prior to Any Possible Treatment of Psychosis' (Lacan 2006[1959]), modern psychoanalysis contains a much more advanced and sophisticated theory of psychotic transference. For the modern psychoanalyst, the psychotic patient is confined to a narcissistic, preoedipal and preverbal type of transference, a not necessarily fully-developed, yet regressive emotional bond characterised by bottled up hostility turned inwards (narcissistic defense), a strong denial of feelings and a tight control of destructive impulsivity (Spotnitz and Meadow 1995: 55-67). Yet the psychotic patient is also considered capable of mature object-transference, and precisely herein lies a central strategy of the modern psychoanalytic treatment of psychotics (Spotnitz 1985: 76-7). Helping the patient to develop the narcissistic transference (Meadow 1996d: 194), analysing the narcissistic transference resistance, facilitating the transition to object-transference and analysing its own resistances, whilst all the time staying in tune with their own countertransference, modern analysts do not only diagnose psychosis through transference, but effectuate a cure by virtue of a fundamental transferential transition in the psychotic condition.

Despite being trained as a psychiatrist, registering his first clinical experiences with psychotics, and presenting numerous psychotic patients to a professional audience, Lacan

seemed very reluctant to broach the issue of psychotic transference. Unlike Freud, he was convinced that the psychoanalyst should not back away from psychosis (Lacan 1977b: 12), yet at the same time he was not particularly forthcoming with concrete indications as to how exactly he expected the psychoanalyst to face psychosis. Lacan's reluctance to formulate clinically applicable principles, here, is particularly conspicuous with regard to the existence and precise nature of psychotic transference. In his *Seminar III*, Lacan at one point filed Schreber's relationships with the various masculine figures in his delusional system under the heading of transference, yet immediately qualifying his choice of words with the statement that the concept 'is undoubtedly not to be taken in quite the sense that we usually mean' (Lacan 1993: 31). Shortly afterwards, in his 1957-58 paper, Lacan produced a more inflammatory argument, insisting that much of the literature on psychosis and transference merely fuels many a psychoanalyst's belief that psychosis can be cured in all those instances when a psychosis is not present (Lacan 2006[1959]). Yet instead of entering the debate on psychotic transference himself, and producing a valuable alternative, Lacan postponed discussion of the issue, retreating behind the excuse that his purpose consisted in returning to Freud and not going beyond him. Hence, in Lacanian theory, the question is left open as to whether psychotics manifest transference at all and if so, what type of transference it is. Combining Lacan's reformulation of the transference as a function of the 'supposed-subject-of-knowing' with some of his ideas on the status of psychotic knowledge, it would make sense to argue that psychotic patients, owing to their solidified knowledge and their radical absence of doubt about the truth of their experiences, are unlikely to attribute knowledge to the psychoanalyst, which would exclude them from the possibility of transference. Yet does this absence of the 'supposed-subject-of-knowing' imply that transference is rendered impossible altogether? Don't we run the risk here of falling into the same trap as Freud who, as Spotnitz has perceptively demonstrated (Spotnitz 1985: 21-4), only regarded the mild positive transference as conceptually viable and therapeutically useful, implicitly discarding narcissistic transference as a contradiction in terms?

Prompted by many a clinician's bemused confrontation with the peculiarities of psychotic patients, the Lacanian community has tried to compensate for Lacan's silence on the matter

of psychotic transference with the organisation of international conferences (Fondation du Champ freudien 1988), the installation of specific work-parties (GRAPP 1988, 1990), and the publication of numerous themed journal issues. Given the volume of existing materials and the often conflicting positions expressed therein, I cannot possibly offer a detailed survey of this body of research within the space of this paper. Therefore I will restrict myself to a presentation of some of the most interesting developments in this area. Addressing the vexed issue as to which position a psychotic patient attributes to the psychoanalyst, Calligaris has distinguished between two conditions, depending on the patient's clinical state. When the patient is not suffering from a psychotic crisis (*psychose hors-crise*), the psychoanalyst is questioned as a knowledge, without a supposed subject; instead of consulting a psychoanalyst, the psychotic in fact consults psychoanalysis as such. When the patient is in crisis, however, the only transference he or she is able to manifest is an unmediated, direct relationship with an imaginary devouring Other, which excludes any possibility for adopting a subjective position (Calligaris 1991). Relying on a minuscule suggestion by Lacan in his 1966 introduction to the French translation of Schreber's memoirs, more orthodox Lacanians have elaborated the psychotic transference as a 'mortifying erotomania' (Lacan 1996: 4). Silvestre, for instance, has argued that whereas the psychotic's initial demand may very well be a demand for signification, the transference will rapidly expose the patient as somebody who proposes his enjoyment to the analyst, as someone who presents himself as an object of enjoyment for the Other. In the best of cases, this position is mediated by the demand for love, yet it may also deteriorate into a position of pure waste. In the latter case, the analyst may feel very tempted to react with a supportive, comforting and nourishing attitude, yet according to Silvestre this reaction needs to be avoided at all costs, since it can easily induce more profound withdrawal, despondency and procrastination, and even suicide (Silvestre 1993: 206-8).

In an extensive monograph devoted entirely to Lacan's theory of psychosis, Maleval has highlighted the notion of 'mortifying erotomania' again, crediting Silvestre for exploring its clinical consequences and adding his own ideas to the deployment of a Lacanian theory of psychotic transference. Maleval's conclusion reads as follows:

> When he addresses himself to an analyst, the psychotic subject first of all demands help with the organisation of his world, and he is quite keen to suppose that the analyst has knowledge on this point, yet he confirms that he himself has knowledge too, which the elementary phenomena [the hallucinations] have transmitted to him. Accepting that the patient testifies to these phenomena without contesting them in frontal fashion is an indispensable condition for the treatment. Being responsive to the demand for supplanting [*suppléer*] the disorder with a necessarily prefabricated knowledge tends to mobilize the mortifying erotomania rather than opposing it. Only in countering the delocalized enjoyment [*jouissance*] can the psychotic transference be relieved.
> Maleval 2000: 373

Apart from making clear, once again, that Lacanians acknowledge the existence of a singular psychotic transference, this passage also shows that they consider the transference to be an essential factor for inducing change and a crucial element for evaluating the effectiveness of the treatment.

The aforementioned developments within contemporary Lacanian theory also demonstrate that it is impossible to dissociate considerations of the psychotic transference from ongoing reflections upon the position of the analyst. Silvestre is adamant that all attempts at feeding the patient's need for gratification are counter-productive and may even elicit the further deterioration of his or her mental condition. This idea chimes with the modern psychoanalytic view, as expressed by Spotnitz and Meadow, that the analyst who tries to soothe the psychotic patient is barking up the wrong tree and may inadvertently invigorate the psychotic mechanism: 'The schizophrenic patient responds to a sympathetic approach by developing a warmly positive attachment, and the more attached he becomes the more schizophrenic he becomes' (Spotnitz and Meadow 1995: 41). Yet, whereas the modern psychoanalyst seems to fluctuate between being responsive and being aggressive, the Lacanian analyst is generally detached to the point of being no more than a secretary for the patient's delusional elaborations (Lacan 1993: 206). Here, the analyst functions as a silent witness, encouraging

the patient to construct the delusion as a relatively stable solution to the traumatic intrusion of hallucinatory voices and petrifying bodily experiences (Soler 1987). Additionally, however, Lacanian analysts try to tackle the psychotic's submersion in the chaotic maelstrom of uncontrollable enjoyment, fostering the creation of a liveable mental space and an acceptable level of social competence (Broca 1985, 1988). To realise this, a set of symbolic rules is imposed which blocks the destructive channels of the psychotic's enjoyment, such as self-mutilation, suicidal attempts and interpersonal violence, and enforces alternative outlets such as writing, painting or making music (Soler 1987: 31).

This brings me to the last aspect of my brief comparative study of modern and Lacanian psychoanalysis: the treatment goals for psychotic patients. Here, it strikes me that modern psychoanalysts are much more optimistic than their Lacanian counterparts. Whereas modern psychoanalysts believe in the reversibility of the psychotic condition, and advocate a view which stresses the replacement of the preoedipal, narcissistic transference with oedipal, object-transference, Lacanian psychoanalysts generally restrict themselves to the installation of a less debilitating, more manageable structure, which does not mean that the question of a normalisation of the psychotic structure has not been raised (Lazarus-Matet 1988). Lacanians consider neurosis, psychosis and perversion — the three constitutive structures of mental functioning in Lacanian theory — to be mutually exclusive and do not believe in the possibility of transforming the psychic determinants of one structure into those of another structure. At best, a semblance of neurotic functioning can be achieved through the installation of a so-called 'suppletion' (*suppléance*). This term, which Lacan advanced in his seminar on Joyce (Lacan 2016[1975-76]) covers a welter of psychic realisations, ranging from imaginary identifications to symbolic creative productions and real somatic phenomena, which may prevent the outbreak of a flourishing psychotic picture (when the patient is pre- or post-psychotic), or stabilise the psychotic condition when the patient is effectively in crisis. Instead of a full recovery and the installation of a neurotic structure, Lacanians have often promoted the installation of a suppletion as one of the most advanced goals of the psychoanalytic treatment of psychotics (Brousse 1988; Liart 1988; Stevens 1988).

As I pointed out earlier, it has not been my intention in this paper to champion Lacanian psychoanalysis as a more conceptually sophisticated, theoretically correct and clinically valuable approach to psychosis than modern psychoanalysis, even less to stimulate the integration of both frameworks into a new paradigm. Modern psychoanalysts have definitely done more work over the past forty years to rescue the psychotic transference from the archives of oblivion than Lacanians, and also seem to have a more substantial notion of how the psychoanalyst can use the psychotic transference to the benefit of the patient.

Whereas modern psychoanalysts emphasise the preoedipal affective determinants of the psychotic disorder, Lacanians focus more exclusively on the Oedipal impact of the symbolic order and the psychic functioning of speech and language. For André Green, Lacan's emphasis on the material cause of the signifier (Lacan 2006[1965]: 743) was sufficient to argue that Lacan had failed to acknowledge the significance of the affect in psychoanalysis (Green 2001), to which Lacan replied by saying that 'a body . . . is . . . affected only by the structure' (Lacan 1987: 22). Similarly, a Lacanian analyst could easily criticise modern psychoanalysis for failing to incorporate a (post-)structuralist theory of language, a neglect made worse by the strong emphasis on verbalisation in modern psychoanalytic practice, to which the modern analyst would presumably reply with the statement that a word only matters in terms of its affective value. The challenge is not to evaluate one paradigm in terms of the other, to criticise modern psychoanalysis for not being sufficiently Lacanian or to take issue with Lacanian psychoanalysis for not being sufficiently 'modern', but to investigate how each approach can benefit from the confrontation, not with a prospect of obtaining intellectual superiority but for the sole purpose of offering a better form of treatment to our psychotic patients.

References

Aparicio, S. (1984). La forclusion, préhistoire d'un concept. *Ornicar?* 28: 83-106.

Broca, R. (1985). La psychanalyse, un nouveau mode de lien social? *Quarto* 20/21: 5-9.

Broca, R. (1988). Le psychanalyste face à la psychose sous transfert *Les psychiatres et la psychanalyse aujourd'hui* 179-83 (ed.) GRAPP. Paris: Navarin.

Brousse, M.-H. (1988). Question de suppléance. *Ornicar?* 47: 65-73.

Calligaris, C. (1991). *Pour une clinique différentielle des psychoses*. Paris: Point Hors Ligne.

Federn, P. (1952). *Ego Psychology and the Psychoses*. New York: Basic Books.

Fondation du Champ freudien (Eds.) (1988). *Clinique différentielle des psychoses.* Paris: Navarin.

Freud, S. (1905). On Psychotherapy *The Standard Edition of the Complete Psychological Works of Sigmund Freud* Vol VII: 257-268 (ed.) J. Strachey. London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1911). Psycho-Analytic Notes Upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides) *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* Vol XII: 3-82 (ed.) J. Strachey. London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1912a). The Dynamics of Transference *The Standard Edition of the Complete Psychological Works of Sigmund Freud* Vol XII: 97-108 (ed.) J. Strachey London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1912e). Recommendations to Physicians Practising Psycho-Analysis *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol XII: 109-120 (ed.) J. Strachey London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1916-17). Introductory Lectures on Psycho-Analysis *The Standard Edition of the Complete Psychological Works of Sigmund Freud* Vol. XVI-XVII. (ed.) J. Strachey London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1918). From the History of An Infantile Neurosis (The 'Wolf Man') *The Standard Edition of the Complete Psychological Works of Sigmund Freud* Vol. XVII: 7-122 (ed.) J. Strachey London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1940). An Outline of Psycho-Analysis *The Standard Edition of the Complete Psychological Works of Sigmund Freud* Vol. XXIII: 144-207 (ed.) J. Strachey London: The Hogarth Press and the Institute of Psycho-Analysis.

Fromm-Reichmann, F. (1950). *The Principles of Intensive Psychotherapy*. Chicago/London: The University of Chicago Press.

GRAPP (Ed.) (1988). *Les psychiatres et la psychanalyse aujourd'hui*. Paris: Navarin.

GRAPP (Ed.) (1990). *Sublimation et suppléances*. Paris: Navarin.

Green, A. (2001). *The Fabric of Affect in the Psychoanalytic Discourse* (trans.) A. Sheridan. London/New York: Routledge.

Grigg, R. (1998). From the Mechanism of Psychosis to the Universal Condition of the Symptom: On Foreclosure *Key Concepts of Lacanian Psychoanalysis* 48-74 (ed.) D. Nobus. London/New York: Karnac Books.

Jackson, D., Block, J. and Patterson, V. (1958). Psychiatrists' Conceptions of the Schizophrenogenic Parent *American Medical Association Archives of Neurology and Psychiatry* 79: 448-59.

Klein, M. (1946). Notes on some Schizoid Mechanisms *The International Journal of Psycho-Analysis* 27: 99-110.

Lacan, J. (1967-68). *Le Séminaire XV, L'acte psychanalytique*. Unpublished transcript.

Lacan, J. (1977a[1964]). *The Four Fundamental Concepts of Psychoanalysis* (ed.) J.-A. Miller, (trans.) A. Sheridan. London: The Hogarth Press and the Institute of Psycho-Analysis.

Lacan, J. (1977b). Ouverture de la section clinique *Ornicar?* 9: 7-11.

Lacan, J. (1987). Television *Television/A Challenge to the Psychoanalytic Establishment* (ed.) J. Copjec. (trans.) D. Hollier, R. Krauss and A. Michelson. New York: W.W. Norton and Company.

Lacan, J. (1988[1953-54]). *The Seminar, Book I, Freud's Papers on Technique* (ed.) J.-A. Miller, (trans. with notes) J. Forrester. Cambridge: Cambridge University Press.

Lacan, J. (1993[1955-56]). *The Seminar, Book III, The Psychoses* (ed.) J.-A. Miller, (trans. with notes) R. Grigg. New York/London: W.W. Norton and Company.

Lacan, J. (1994). *Le Séminaire, Livre IV, La relation d'objet*. Texte établi par J.-A. Miller. Paris: du Seuil.

Lacan, J. (1996). Presentation of the Memoirs of President Schreber in French Translation (trans.) A. J. Lewis, a*nalysis* 7: 1-4.

Lacan, J. (2006[1946]). Presentation on Psychical Causality *Ecrits* 123-58. (trans.) B. Fink. New York: W.W. Norton and Company.

Lacan, J. (2006[1959]). On a Question Prior to Any Possible Treatment of Psychosis *Ecrits* 445-88 (trans.) B. Fink. New York: W.W. Norton and Company.

Lacan, J. (2006[1965]). Science and Truth *Ecrits* 726-45. (trans.) B. Fink. New York: W.W. Norton and Company.

Lacan, J. (2015[1960-61]). *The Seminar, Book VIII, Transference* (ed.) J.-A. Miller, (trans. with notes) B. Fink. Cambridge/Malden MA: Polity.

Lacan, J. (2016[1975-76]). *The Seminar, Book XXIII, The Sinthome* (ed.) J.-A. Miller, (trans. with notes) A. R. Price. Cambridge/Malden MA: Polity.

Lagache, D. (1952). Le problème du transfert *Revue française de psychanalyse* 16 (1/2): 5-115.

Lazarus-Matet, C. (1988). Une 'normalization' psychotique ou une paranoïa 'bénigne'? *Actes de l'Ecole de la Cause freudienne* 13: 91-4.

Liart, M. (1988). La suppléance comme tentative de guérison *Actes de l'Ecole de la Cause freudienne* 15: 17-20.

Libbrecht, K. (1995). *Hysterical Psychosis: A Historical Survey*. New Brunswick/London: Transaction Publishers.

Mac Andrew, C. and Geertsma, R.H. (1961). A Reanalysis of Psychiatrists' Conceptions of the Schizophrenogenic Parent *Journal of Clinical Psychology* 17: 82-87.

Maleval, J.-Cl. (2000). *La forclusion du Nom-du-père. Le concept et sa clinique*. Paris: du Seuil.

Meadow, P.W. (1996a). Breaking Taboos in Group Therapy *Modern Psychoanalysis* 21 (2): 267-92.

Meadow, P.W. (1996b). How We Aim to Be With Patients *Modern Psychoanalysis* 21 (2): 137-54.

Meadow, P.W. (1996c). Negative Union *Modern Psychoanalysis* 21 (2): 293-303.

Meadow, P.W. (1996d). The Preoedipal Transference *Modern Psychoanalysis* 21 (2): 191-200.

Miller, J.-A. (1984). Transfert et interprétation *Actes de l'Ecole de la Cause freudienne* 6: 33-7.

Milner, M. (1969). *The Hands of the Living God: An Account of a Psycho-Analytic Treatment*. London: The Hogarth Press and the Institute of Psycho-Analysis.

Mitchell, J. (2000). *Mad Men and Medusas: Reclaiming Hysteria and the Effects of Sibling Relations on the Human Condition*. London: Allen Lane/The Penguin Press.

Pankow, G. (1969). *L'homme et sa psychose*. Paris: Aubier-Montaigne.

Pankow, G. (1977). *Structure familiale et psychose*. Paris: Aubier-Montaigne.

Rabinovitch, S. (1998). *La forclusion. Enfermés dehors*. Ramonville Saint-Agne: Erès.

Ragland, E. (1995). *Essays on the Pleasures of Death: From Freud to Lacan*, New

York/London: Routledge.

Rosen, J.N. (1953). *Direct Analysis: Selected Papers*. New York: Grune and Stratton.

Rosen, J.N. (1962). *Direct Psychoanalytic Psychiatry*. New York: Grune and Stratton.

Rosenfeld, H. A. (1965). *Psychotic States: A Psychoanalytical Approach*. New York: International Universities Press.

Sechehaye, M. (1956). *A New Psychotherapy in Schizophrenia*. New York: Grune and Stratton.

Silvestre, M. (1993). Transfert et interprétation dans les psychoses *Demain la psychanalyse* 201-11. Paris: du Seuil.

Soler, C. (1987). Quelle place pour l'analyste? *Actes de l'Ecole de la Cause freudienne* 13: 29-31.

Spotnitz, H. (1985). *Modern Psychoanalysis of the Schizophrenic Patient: Theory of the Technique*. 2nd Edition. New York: Human Sciences Press, Inc.

Spotnitz, H. (1987a). The Narcissistic Defense *Psychotherapy of Preoedipal Conditions* 101-16. Northvale/London: Jason Aronson, Inc.

Spotnitz, H. (1987b). The Maturational Interpretation *Psychotherapy of Preoedipal Conditions* 43-6. Northvale/London: Jason Aronson, Inc.

Spotnitz, H. (1987c). Techniques for Resolving the Narcissistic Defense *Psychotherapy of Preoedipal Conditions* 137-51. Northvale/London: Jason Aronson, Inc.

Spotnitz, H. and Meadow, P. W. (1995). *Treatment of the Narcissistic Neuroses*. Northvale/London: Jason Aronson Inc.

Stevens, A. (1988). Aux limites de la psychose *Ornicar?* 47: 74-9.