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## Psychoanalysis and the Academia. At the cross-road between exact and human sciences

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## Psychoanalysis and the Academia

### Abstract

It is proposed that the global mental health crisis in Western society is largely due to the fact that psychology is heavily based upon an exact science model academically and upon a medical model clinically. Indeed, these models largely favor an apperception of mental pathology as essential entities with a biological etiology and this reification of mental pain facilitates a process of non-implication of the sufferer as concerns his condition. The tremendous progresses in brain sciences hold the promise of the acknowledgment of psychology as an autonomous discipline, describing properly mental logics, which are constrained, but not determined, by object characteristics; moreover, these logical operations mandatorily need content from the contingent history of the subject's life to get instantiated. Psychology, then, is on the most acute cross-road between an exact science and a human science epistemology. Consequently, we desperately need psychologists and clinicians, in the field of mental health, who can solidly and confidently apply a particularized approach to mental distress, who can do with the personal feeling of non-mastery, who can base their clinical thinking on the story of the patient and who thereby systematically stay away from any essentializing temptation, while simultaneously being aware that the theoretical framework they operate from is embedded in a continuous scientific dialogue. Psychoanalysis is at that cross-road.

### Keywords

Psychoanalysis ; Academia ; Neuroscience ; Epistemology ; Diagnosis ; Freud

### Global mental health crisis in civilization

The mental health crisis is gigantic, growing, systemic, generalized in the western society and largely spilling over from its proper field to adjacent fields such as work and school. Here we indicate some of the latest 'developments' which further add to the generalized sense of alarm. First, there seems to be a general increase in clinical violence towards mental health patients. In the first place, there is a massive intake of psychotropic medication at an ever-younger age. It was already known for Ritalin, a drug used in case of attention deficit hyperactivity disorder (ADHD), that though the safety of this medication has not been tested on children (for obvious ethical reasons), it could nevertheless be prescribed for children; it is known also that though the youngest prescription age indicated on the notice is 6 years, the American Academy of Pediatrics guidelines having authorized it in 4- and 5-year-olds under some conditions<sup>1</sup>. However, shockingly, in reality at least 10,000 American toddlers as young as 2 or 3 years old are being medicated for ADHD outside established pediatric guidelines<sup>2</sup> and against the strong advice of experts on the matter. Further, though antipsychotic drugs aren't tested for use on children, nor come with usage instructions for such a young population, almost 20,000 prescriptions for antipsychotic medications<sup>3</sup> were written in 2014 in the US for children 2 and younger, a 50 percent jump from one year before. Still in the US, prescriptions for the antidepressant fluoxetine (Prozac) rose 23 percent in one year for that age group, to about 83,000<sup>4</sup>. Trends in Europe are sensibly similar (see Bazan, 2013). In summary, on the topic of psychotropic abuse, it seems legitimate to ask if we have not evolved from a problematic situation to a situation of (criminal) malpractice<sup>5</sup>. Second, as to the use of institutional violence in the mental health domain (ex. psychiatric or specialized institutions or schools), there is an alarming increase in recourse to methods such as deprivation of liberty and of basic rights, such as solitary isolation, including for children under 16, such as fixation and mechanical coercion.

At the other hand, there seems to be a generalized increase in mental disarray in the public at large. Every age and every culture sees a flourishing of "fashionable" psychopathologies, many of which do

not stand the test of time (see also Hacking, 1985). Our age, with “modern aches” such as depression, borderline, ADHD (e.g. Moncrieff & Timimi, 2010), burn-out etc.<sup>8</sup>, then, is no exception to this rule, but some particularities are noticeable. The mental health sector has mediated prevention campaigns as well as proactive screening procedures as never before. There is reason to believe that those are effectively contributing to the spreading of the epidemics<sup>9</sup>, by increasing the general awareness and preoccupation in a keenly informed way, and even by directly increasing suspicion of pathology or deficiencies in our assessing of ourselves and others (see also Kutchins & Kirk 1997). This, however, is deplorable, since the availability of a (catchy) label with a list of attached symptoms speeds up the “reification” of the mental pain in those who are in (real) mental discomfort, facilitating a process of non-implication of the sufferer as concerns his condition (see also, Hyman, 2010). Indeed, why should one question oneself on its proper implication in his suffering when its illness is described in terms testifying of its generalizability, thereby suggesting that if it has fallen upon him, he was simply struck by bad luck? But, alas, there is no treatment for bad luck. Another particularity of our age is the tendency to confound discomforts, difficulties and particularities with pathology, as a result of which, logically, anybody is a potential patient. For example, in 1988 the term of “autism spectrum” was launched<sup>10</sup> describing a range of conditions not restricted to the former diagnosis of “autism”, characterized by severe social and communication impairments. In 2013, this new diagnostic label was included in the new DSM-5 collapsing social and communication deficits into one domain and loosening the restriction of onset age from 3 years to an “early developmental period”. Needless to say this widely broadens the number of potential patients, who, since they may suffer from “communication difficulties”, characteristic of the human condition, are encouraged to consider themselves as mentally ill by receiving a label which suggests a proximity on a continuum with a severe mental condition. Other examples from the DSM-5 are the “Caffeine Withdrawal Disorder”, with symptoms including fatigue, headache and difficulty focusing and the “Minor Neurocognitive Disorder”, including also the memory problems which sometimes characterize older age; grief is more readily diagnosed as a “Major Depressive Disorder”, and children with temper tantrums three times a week or more are diagnosed with “Disruptive Mood Dysregulation Disorder”. Again, note that the invitation to relabel life’s difficulties or oddities into classified and characterized pathology comes from the mental health domain itself. Third, there is a parallel tendency to relabel social difficulties or problems of living together as psychopathology. Besides pathologizing the intimate realm, we thereby also pathologize the social realm. For example, problems of bullying on school yards are relabeled in terms of “bullying personality disorders” in children, work (motivation)-related difficulties are relabeled in terms of “burn out”, difficulties of going along with colleagues are termed as “harassment”, and, through this labeling move, claimed by clinical psychologists as pertaining to their expertise. This, again, is deplorable because this kind of reification concentrates the spotlights upon the individuals, encouraging a thinking away from the social and institutional context as potentially contributing factors: for example, for bullying problems, the bullier is under suspicion of psychopathic tendencies, for burn-out problems, the employee is under suspicion of perfectionism etc. Finally, it may be noticed that the invention of new labels is increasingly defensively – and even aggressively – directed towards the others: we already had the “Oppositional Defiant Disorder” in the DSM IV, but more recently the newest fashion in terms of psychopathology are all the various narcissistic and psychopathic diagnoses, especially treasured when it comes to appraise partners, colleagues and bosses. In conclusion, these last decennia we, academic psychologists, have largely favored an apperception of mental pathology as essential entities, the catch of which is seemingly as contingent as the catch of a coincidental virus, as it may be due to essentializing determinations which we have not chosen for and which we can’t desist from.

## Failure of the anatomo-clinical model for mental health

Taking all this together, we can not say that, in the domain of mental health, we were able to hang on to Hippocrates warning: *Primum non nocere*, “First do no harm”: ironically, and in some way of a caricature, we are confronted with an increase in mental distress for those who are not (yet) being taken charge of, together with an increase of violence against those who are being taken charge of. Despite the invaluable progresses of psychology in these exciting times of brain progresses, we must admit that mental health care in the Western world is something of a failure. Paradoxically, the proximity and overabundance of good external explanations for the rise of mental misery has efficiently prevented the field from any serious self questioning (a well-known principle of resistance): indeed, we, academics and clinicians, are most obliged to neoliberal capitalism which easily qualifies as the sufficient cause for loneliness, consumerism, egocentrism, meritocracy, the loosening of social bonds, etc. and thereby the (Western) world’s global distress (see e.g. Verhaeghe, 2014). However, I propose that, independently of the fact that there may be truth in the influence of difficult social conditions, the amazing rapidity and extent of the global mental health crisis is first and foremost due to our active – even if not necessarily malignant nor even fully conscious – contribution to this breakdown.

What, then, is going wrong? I propose that the all too exclusive recourse to an exact science model for teaching psychology in the academia at the one hand, and to a medical model for thinking clinical psychology, at the other, are far more decisive and far more proximal causes to this crisis than the prevailing socio-economic model. With the advances in neuro-imagery and with the amazing uncovering of the brain mysteries, a wind of scientific enthusiasm has blown through the field of psychology. The old dreams, by which our discipline has seen the light of day, the “resolutive recompositive model<sup>11</sup>” of XVIth century anatomy first (Mengal, 2000), and thanatomo-clinical model of Bayle<sup>12</sup> in the XIXth century thereafter, has grown vivid and intense again: again we vow that, soon, we will be able, for all mental pathologies, to lay bare the linear cause-and-effect chain which from specific biological (anatomical, genetic, neurochemical, neurological) defects will logically result into specific psychopathologies, much like in medicine logical chains have been described which go from the virus, from the genetic defect or from the physiological disturbance to the somatic pathology. However, our times might also be the first to be confronted with the patent failure of this model for the field of mental health. For example, when the first planning conference for the DSM-5 was held in 1999, « participants had high hopes for undergirding many diagnoses with specific biological indicators such as brain scans or genetic tests. In the end, the revision process, led by psychiatrists David Kupfer of the University of Pittsburgh in Pennsylvania and the APA’s Darrel Regier, found no such markers that could serve as reliable diagnostic guides. » (Miller & Holden, 2010, p. 770). In another example, Gonon et al. (2011a) show that the most robust effects on a possible association between ADHD and the DRD4 gene<sup>13</sup> are reported only in initial studies, while ulterior publications, which partially or completely rebut the initial findings, are not mediatized.

## Advances in physiology and neurosciences push to consider the autonomy of psychology

There is an unsuspected real big advantage to the progresses in neuroscience, namely, their probable failure to resolve the mysteries of the soul and of its wanderings is, paradoxically, full of promise. I have defended previously that psychology, as a discipline separate from philosophy first, and as a scientific discipline of its own thereafter, has, paradoxically, each time been promoted in this gain of autonomy by the virtue of the progresses in biology (Bazan, 2011b). In the XVIth century it were the spectacular progresses in anatomy (e.g. the “muscle men” drawings of Vesalius), which, undermining Aristoteles’ doctrine, lead to the foundation of a new discipline, called anthropologia and divided

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into anatomia at the one hand, and, for the first time, psychologia (Bazan, 2011a, 2015). Indeed, by the progresses in anatomy, it then became crystal clear that it was the body, through the innervated muscles, which enabled men to move and that it was the body, through the blood circulation, which heated men's blood. In Aristoteles' view these were two key faculties of the anima, the soul. In response to the threatening "emptying" of the soul of its defining functions, it was then firmly reaffirmed by the Reformists Melanchton, Snellius and others, by a signifier of its own, as the domain of will, discourse and imagination (Mengal, 2000). However in the XIXth century a new assault on the prerogatives of the soul was made, when through the progresses in neurophysiology, brain areas specific for, among others, language functions (such as the Broca and Wernicke areas) were described. This led to the first attempts to define psychology not by the exclusiveness of some of its functions, but by the specificity of its organizing principles (e.g. Wundt, 1867; Mill, 1882; Helmholtz, 1896), and thereby, paradoxically, to the settling of psychology as a scientific discipline separate from physiology. Following the same logical dynamic, I expect that in this era of gigantic progresses in neurosciences, it will be again from neuroscience that will come the decisive impetus for the recognition of the mental realm as an autonomous organization level (Bazan, 2011a, 2015). It will come from neuroscientists because by taking measure of what neurosciences can do, they are at the same time first in line to thereby understand what neurosciences can't do. For example, on a seminar on February 2nd, 2016, the world famous neuroscientist Etienne Koechlin spoke about "the mechanisms and computational processes which govern the mental representations independently of their material substrate and its content".

What we are moving towards, in my opinion, thanks to the progresses in neuroscience, is the acknowledging of a field describing the way "mental representations are governed", independently of their material substrate, i.e. we are moving toward acknowledging an autonomous field of psychology, the mechanisms and processes of which aren't in any linear fashion deducible from their physiological substrate. Up until now we have been able to keep our materialistic dream safe by claiming that we haven't reached technological precision yet, that there remains neurons we haven't explored yet, that we are progressing towards probabilistic algorithms which might translate brain into meaning, but now that we are slowly but surely getting through it, we are taking the measure of the fact that the soul is not in the brain. This is, we are taking the measure of the fact – and starting to mourn it – that the materials of the brain will not be able to help in the struggle with meaning, proper to the human condition.

### A human science clinical model is interpretative both for the patient's distress and for the complexity of the brain

This, then, might be a decisive turning point, a point at which an exact science model might seize the operational stake of an epistemology of another kind, namely the human science model, for its contribution in understanding and "treating" the human condition. It is striking to see how Freud himself already struggled with the reconciliation between the two epistemologies: as a very enthusiastic lover of science, he is true to a scientific rigor in the whole of his productions, but he is also not too anxious to indicate, at the same time, that his case studies resemble more the writing of novels than the writing of scientific papers (Breuer & Freud, 1893-1895, p. 160).

Freud's metapsychology being firmly grounded in neurology, he opens the way for an exact science-understanding of this conceptual apparatus. His early works "On aphasia" and "Project for a scientific psychology", far from being deluded youth mistakes, form the firm bedrock of his metapsychology, as first off, in the rest of his oeuvre, he remains true to the terminology introduced in these so-called "pre-analytic works" and second, he simply copies and pastes a number of paragraphs (on word and thing representation) from "On aphasia" into "The unconscious". The importance of this grounding

can not be overestimated. It suffices to list the different visionary insights of Freud predicted in The Project to remain dazed by his genius. Indeed, in chronological order, in 1895 he predicts (1) Sherrington's synaptic transmission, which will be scientifically established two years later (Foster & Sherrington, 1897); (2) Hebb's law of memory, stated in 1949; (3) the mirror neuron mechanism (e.g. Decety & Grezes, 1999), proposed in very similar wordings as those of Freud in 1895, and finally (4) the mental importance of the Helmholtzian efference copy system, which has been gradually discovered the last twenty years (see Bazan, 2007a) 18. Beyond being dumbfounded by these insights, one should be asking this question: how comes Freud is able, with only the "rudimentary" neurological knowledge of the turn of the century, as compared to what we now know, to make such accurate predictions? There's only one way to explain his unreal advantage: he is informed by the intimacy of his patients' stories on what result the brain mechanisms must lead to. He has the building blocks, and he has the end result and so, he logically puzzles from the one to the other – and the predictions listed above are necessary waypoints, which he must suppose.

If he simultaneously turns to a more novelistic style for the narration of his case studies, it is thus not in repudiation of the exact science model, but it is out of sheer clinical necessity. Why is this? Simply stated, one could say that psychopathology, or mental discomfort more generally, results from accumulating mental tension, which does not find a way of getting "adequately" discharged, i.e. discharged such as not to create more novel tension. (E.g. would we simply act or speak out what has been suppressed or repressed, we would create more tension than the tension resulting from the defensive move.) The essence of clinical work then is the continuous, inventive search for ways to discharge quantities of excess tension, essentially through the (motor) act of speaking. The "healing" part of clinical work is, mythically, the finding of ways to discharge excess tension tied to a more original, maybe even inaugural, event, incriminated for the symptom. Indeed, a core Freudian idea, is that unbearable events, especially early in life, come under repression (e.g. Freud, 1894/19), whereby the scenic or narrative trace of the event is disconnected from its emotional memory, which then essentially is a potentiality of stirring up the (inner) body, i.e. of creating body tension, primarily anxiety. Even if the representational part of the trace can be effectively shielded from discharge (i.e. from expression), the emotional part cannot and will search to "falsely" connect (Freud, 1894, p. 52) with other representations in the actual life of the subject, which bear enough similarities with the original event as to represent it. Thus, the (first) essence of clinical work is, on the basis of the actual symptoms presented by the subject in their diversity and on the basis of his or her life story, to formulate hypotheses on what must be logically supposed about the anterior life of a subject, so as to lead to the current symptoms. Indeed, on the basis of these hypotheses, which are or aren't communicated to the subject (and when they are, this is called "interpretation"), the clinician will be more apt and engaged in finding discharge avenues for his patient, while all the same respecting his or her rhythm and readiness.

**The universalizable elements of mental life are logics, i.e. formal operations**  
Well now, clinicians are not essentially helped by the neuronal mechanisms of e.g. memory or empathy in formulating hypotheses on what must be supposed about the anterior life of a subject, when hearing the details of the actual suffering: what they are essentially helped with, is by the narrative of the patient's life stories, as well as by universal mental logics connecting events to symptoms. The latter – e.g. the primary caregivers play essential roles; e.g. even if we don't remember early events representationally, we commemorate them through repetition in acts etc. – through their universalizing dimension, may be called the science of psychology (or, tentatively, of psychoanalysis). Why are these mental organisatory logics not the logics of the brain, not the neuronal logics, why is the discipline of psychology not an outgrowth of neuroscience? The crucial reason is that never the knowledge of the neurophysiology in and by itself is able to yield these

mental logics, while the other way around does work: indeed, when, informed by (the intimacy of) the clinical encounter one is equipped with these mental logics, it becomes heuristically very productive to interpret the brain physiology, such as was illustrated with Freud's predictions of The Project<sup>20</sup>. So, of course mind and brain are related, but the heuristically productive interpretative move is from the mind to the brain, and not from the brain to the mind. However, the very fact that the mind can inform about the brain, testifies how its functioning is constrained by the conditions settled by the brain. (Indeed, the mind – such as anything else – is constrained by the conditions for its existence (Van de Vijver & Demarest, 2013), which here are precisely the bodily physiology, or the biological realm at the one hand, as well as the other, or the social realm, at the other). However, as explained, this constraining is not a determination, as the mental logics are not spelled out by the biology of the brain. But, what becomes clear is that the universalizable part of mental care is given by logics, i.e. by formal operations, which are distinct from determinations by the very fact that they can only be applied in hindsight from the actual symptom to the mythical past, which needs to be supposed. Moreover, as these are formal operations, they mandatorily need content from the contingent history of the subject's life to get instantiated, to become concrete. This is the essential reason why psychology is on the most acute cross-road between an exact science and a human science epistemology: what is needed for the operation of making sense, is, at the one hand, universalizable logics, constrained by object characteristics and at the other, the subjective, contingent history of the particular patient.

### Psychoanalysis at the crossroad of exact and human sciences

This then, indicates the irreplaceable importance of teaching psychoanalysis in academia today: indeed, psychoanalysis is one of the very rare approaches in psychology, which respects both epistemologies at the same time in their radical implications. Of course, there are many approaches in academic psychology which (eagerly) lean upon the advances of neurosciences, and even if the main aspiration often is one of understanding the mind thanks to insights in the brain mechanisms – which, by the way, is also the main thread for this novel domain of “neuropsychanalysis” (Solms & Turnbull, 2002) – the fact remains that this dynamic also settles psychology, and psychoanalysis, in the larger concert of sciences. Psychoanalysis, even if for some it should be considered out of this concert of sciences, is nevertheless firmly embedded in it by way of some of its founding figures, such as Freud and Lacan. As already discussed, Freud's very impetus comes from an enthusiasm for biology, Darwinian biology (Sulloway, 1979), as well as more specifically, physiology. He was an eager disciple of the physicalist physiology school, represented by Ernst Brücke with whom he did research in Vienna, as well as by Wundt, von Helmholtz, Du Bois-Reymond at the Physical Society of Berlin (Physikalische Gesellschaft zu Berlin; Bernfeld, 1951). But Jacques Lacan, who operated a return to Freud in the midst of last century, was also an eager scholar of a variety of adjacent scientific disciplines, such as ethology, anthropology, optics, mathematics and biology (for an overview, see Bazan, 2009). What is much more exceptional, however, is that psychoanalysis is one of the very rare approaches with such an exact sciences embedding, while simultaneously holding on to a strict human science epistemology for the clinical work. Indeed, it is Freud himself who steps down from the “master-model” he had seen with Charcot, and who relinquishes to the patient the seat of the knowledge on his proper distress. It is Freud himself who, in line with acknowledging the importance of the narrated life stories for his clinical work, gives the floor to the patients in the clinical encounter. The difference between the medical (or exact science) and the psychoanalytic (or human science) approach is in some ways keenly revealed by the difference between Charcot and Freud. Charcot was a physician, who never abandoned the anatomo-clinical model of Bayle and who, desperate of not finding in his deceased hysterics the brain lesion or alteration which could explain her pathology, bequeathed to Freud the task of characterizing this “functional lesion”; at the same

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time, in his clinical work, he was the master possessing the knowledge about his patients, who merely acted as figurants for his clinical “show”. Freud, being a great admirer of Charcot, had the same impulses to start with, but then let himself being taught by his patients and by their stories, giving them the floor and holding onto their words, even if this meant for him to be shoved from the comfort of an exact science or medical position.

That particular stance is what we now desperately need in the field of mental health: clinicians who are solid in their endeavor to include in their clinical thinking the particular story of the patient as an essential part of their work – not as a kind of bonus or an act of good will or of humanity, but as a constitutive aspect of the clinical epistemology, failing which, no real clinical work is possible – while simultaneously being aware that the theoretical framework they operate from (the one which informs about the mental logics) is embedded in a continuous dialogue with adjacent scientific disciplines. In this perspective, it is not that psychoanalysis should be tolerated in academia out of respect for its history, out of respect for its contribution to a whole range of human science branches (such as literature, history of arts, political science etc.), out of respect for the growing amount of scientifically established prove of its effectiveness, out of tolerance for its difference, out of awareness of it being still used a lot on the clinical terrain, but rather, out of sheer need on the clinical terrain. We desperately, and very urgently need (a new generation of) academic psychologists who can solidly and confidently apply a particularized approach to mental distress, who can do with the personal feeling of non-mastery, who can base their clinical thinking on the story of the patient, who thereby systematically stay away from any essentializing temptation<sup>22</sup> – and who by doing all this, far from abandoning the larger scientific concert, to the contrary are acknowledged an essential and unique role in informing this scientific dialogue.

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