

Normality and Methodology in Psychoanalysis

It is often said that psychoanalysis challenges the commonsense norms that concern health and illness. This is probably one of the reasons why psychoanalysis is sometimes said to have had as much effect on morality as it has had on psychology. However, it is less often said exactly what psychoanalysis has done to achieve this status, and whether this is something to do with psychoanalytic theory or with the clinical practice. I think the platitude is true, but I don't think it is well understood – certainly not by people like me whose interest in psychoanalysis is more theoretical than practical. It is in hope of correcting this deficit that I want to give a satisfactory analysis of the idea that psychoanalysis has a unique relationship with normativity – and in doing so offer the suggestion that this platitude is in fact a lot more interesting than it is usually made out to be.

The concept of normativity is a loaded one that carries many connotations. There are certain of these connotations that I wish to avoid in this paper. For example, I don't mean to engage in the debate about whether psychoanalysis has been a conservative or progressive cultural force. So to avoid these connotations, I just want to make clear now the range of phenomena I want to pick out when I use the words norm, normal, or normative. When people talk about norms they are usually talking about prescriptions of behaviour – rules that tell us how we ought to act or what attitudes we ought to have. To stop the definition here, however, is to unnecessarily limit the scope of the phenomenon. Norms are philosophically interesting because a given norm cannot be reduced to a description of the behaviour that complies with that norm. That is, we could give all the facts about an agent's behaviour without this giving us a description of the norm that this behaviour complies with.

In more detail: If there is such a thing as “normal” behaviour in a given situation (and correspondingly, behaviours that are in some way incorrect or inappropriate), then there is going to have to be a set of facts that describe how we are able to recognise this normal behaviour and distinguish it from deviant behaviour. These facts are also going to be a guide for us in deciding what our own behaviour ought to be. However, any such facts as these are going to be unable to legislate for us in contexts which have not yet been considered. The norm needs to be interpreted as to how it applies to the new context. And yet we manage to follow norms that we recognise, even in new circumstances. So it would seem that any norm is more than just a set of facts about what kind of behaviour that is legislated by that norm. This is the interesting part: the idea that in some sense norms “transcend” the facts.

It is normativity in this broad sense that I want to keep in mind during the paper, and it encompasses the three somewhat varied examples from psychoanalysis that I will be talking about. The first example is Freud's theory of sexuality which finds form in his *Three Essays*. I will want to say two things about this. The first is that what is interesting about the theory is not that it broadens

the types of behaviour that we might group under the normal category but rather that it makes the distinction itself between normal and pathological seem defective. The second thing I want to say is that this interest can only be sustained if Freud's theory turns out to be true. I will then go on to discuss the debate about what the aims of analysis ought to be. The points that I want to raise are best illuminated by the tension between Lacanian and ego-psychological approaches to analysis. I am going to be saying that a distinction between health and truth is what is at issue in this debate, and that to choose the latter over the former is to commit the analyst to an attitude that suspends considerations about the normal in regard to the symptoms of the patient. The last example that will be touched upon is probably the most contentious, and it is a consideration of the kind of methodology that is implied by the aim of truth in regards to psychoanalysis. My argument is that the relation between concept and practice in such a methodology is going to be somewhat distinctive: more specifically, that it will need to be an analogical style of reasoning rather than inductive reasoning that is characteristic of the psychoanalytic consulting room.

Behavioural Norms in the Three Essays

When talking about normality and psychoanalysis one of the obvious points of reference is going to be the first of Freud's three essays on the theory of sexuality. This is the essay in which he discusses what he calls the sexual instinct, and what have been referred to by his contemporaries as perversions of the sexual instinct. Freud begins the essay by outlining the orthodox way of thinking about the sexual instinct. He says:

Popular opinion has quite definite ideas about the nature and characteristics of this sexual instinct. It is generally understood to be absent in childhood, to set in at the time of puberty in connection with the process of coming to maturity and to be revealed in the manifestations of an irresistible attraction exercised by one sex upon the other; while its aim is presumed to be sexual union, or at all events actions leading in that direction.¹

In Freud's view, this traditional picture is subject to two errors. Firstly, it conflates sexual aim and sexual object and assumes a uniformity of these two aspects across cultures and individuals. Secondly, it views sexual instinct as a kind of indivisible unit when it is for Freud a complex phenomenon made up of component drives. The first of these assumptions is undermined by Freud first by making the distinction between aim and object, and then by showing that these two aspects of the libido vary widely. Freud defines sexual aim as the act towards which the instinct is predisposed, and defines the sexual object as that which attracts the instinct. Freud points out a wide variety of

¹ Freud, "Three Essays", p. 135.

cases in which both aim and object deviate significantly from the presumed norm. What makes this presentation of deviant cases all the more powerful is that many things are included that we do not consider pathological at all. For example, of kissing, Freud says:

the kiss, one particular contact of this kind, between the mucous membrane of the lips of the two people concerned, is held in high sexual esteem among many nations (including the most highly civilized ones), in spite of the fact that the parts of the body involved do not form part of the sexual apparatus but constitute the entrance to the digestive tract.²

Although this presentation of perverse cases might have the effect of making us feel as though the traditional picture of sexuality is somewhat naive, Freud's goal is not to construct some kind of sexual taxonomy. Instead, the idea is that what has been called the sexual instinct is a complex phenomenon made up of component drives, and that these perverse cases give us an insight into what these components might be. On one interpretation of Freud, each of these drives correspond to a different phase of development in the child. This is the well-known theory of "psychosexual development." This polymorphous proto-sexuality of the child is narrowed along acceptable channels by the contingencies of development, and the affects of shame and disgust that are symptomatic of this repression function to ensure that only certain expressions of the drives become manifest in the adult's behaviour. Freud talks about the role that disgust and shame have in relation to the narrowing of the sexual instinct by drawing an analogy with the kind of irrationality that is involved in the reticence of a man to use his girlfriend's toothbrush. Although he has no such qualms about kissing his partner, he will be avoid sharing a toothbrush – even though he has no grounds to suppose that his mouth is any cleaner than hers.

What the commonsensical theory of sexuality sees as sexual normality – i.e. "sexual union" – is thus theorised by Freud to be composed of elements that are themselves pathological according to that same theory. This is the first way that we might understand the way that psychoanalysis (in this case, psychoanalytic theory) implies the breakdown of the concept of normality. The assimilation to the normal case to that of the pathological means that there are no longer any normal cases – all cases are understood using the categories of psychopathology, which means that all cases are to some extent pathological. As it stands, however, this is only interesting if the theory upon which it rests turns out to be true. If we learned that Freud's theories about sexuality turned out to be in large part false and that there was indeed a norm against which sexual behaviour could be measured, then we would no longer be able to say that Freud's challenge to the concept of normality had any relevance to us. The platitude that I mentioned at the beginning of the paper would no longer be interesting in any kind of

² Freud, "Three Essays", p. 150.

substantive way. However, there are other ways to understand the breakdown of normality in psychoanalysis.

Normality in the Aim of Psychoanalytic Treatment

We might, for example, consider the role that normality plays when the aims of analytic treatment are discussed. When thinking about the word “treatment”, I cannot help but think that it is unfortunate that psychoanalysis continues to use terms that come from medicine, as I think that the connotations of these terms obscure what it is that actually goes on during the session. Freud himself warned the analyst against the desire to cure, and certainly in the Lacanian tradition the emphasis placed upon the value of psychoanalysis as a kind of therapeutic process is downplayed tremendously. So this brings up the question for us: what exactly is the aim of analysis? Or maybe better (considering the dissensus on this topic): what *ought* to be the aims of analysis?

The goals of clinical psychoanalysis within the Lacanian tradition are best brought into view by contrasting them with those of the ego psychologists of the same era. Ego psychology was the brand of psychoanalysis initiated in the U.S. by Heinz Hartmann and his collaborators, and those who practice it today consider it to be the most orthodox of the contemporary psychoanalytic schools. The primary idea that serves as the basis for much of the theory of this group is that dysfunctional behaviour is a product of the ego’s defense against the drives, the super-ego, and social reality. From this basis two inferences are drawn. The first is that we should not only be looking at the effects that this inner conflict has on the character of the patient, but must also consider the effects that what Hartmann calls the “autonomous ego functions” have upon the way that these conflicts play out. These autonomous ego functions include things that are usually considered to be the domain of experimental psychology – perception and motor coordination are two examples. One can see in this the basis for an expansion of clinical psychoanalysis into a truly general psychology, and it is probably for this reason that the idea of autonomous ego functions had so much appeal at the time. The second inference that can be drawn from the ego-psychological picture of internal conflict is that dysfunctional behaviour can be corrected by a strengthening of the ego in regards to internal and external conflicts. A stronger ego is one that will be better aligned with reality, as well as better able to cope with the incessant demands of the id and superego. Thus, one of the primary tasks of analysis is to ensure that the ego is adequately adapted to reality, and this is done by strengthening the ego by an identification of it with the healthy, “adapted” ego of the analyst. Despite Hartmann’s protestation that there can be no universal scale against which the well-adaptedness of an individual can be measured, there are explicit values against which he actually does measure such a concept.³ The most striking example is “social compliance.”

³ The most striking example is “social compliance”. *Ego Psychology and the Problem of Adaptation*, p. 31.

This way of thinking about the aims of analysis makes a great deal of sense if one has the same notion of the ego as Hartmann does. For someone like Lacan, though, this idea is anathema. The Lacanian conception of analysis is one that begins in ignorance and ends in knowledge. The object of this knowledge is described by Lacan as the truth of one's desire – and the aim of analysis is to have the analysand discover, recognise, and take responsibility for this truth. I might iterate at this point the difference between demand and desire that is so central to Lacanian analysis. A demand is an expressed desire for an object. For example, the statement 'I want to live in a mansion' is a demand. To satisfy this demand will not however eliminate desire from the life of the individual – desire will simply be displaced onto new objects, new demands. The analysand begins with a series of questions or problems about the meaning of events in his life or patterns of behaviour that he repeats, and through the process of analysis he comes to recognise his desire as being both separate from his demands and as being particular to him – the analysand. Hence the Freudian adage: "Where it was, there I shall be." This is the idea that dysfunctional behaviour seen as somehow alien to the patient comes to be seen by the ends of analysis to be integral to the patient's character. The goals of Hartmannite ego-psychology run counter to this picture in a couple of ways. The most important difference lies in the type of thing which is to be discovered. That is, if the clinic is required to serve as a place in which evidence is generated for psychoanalytic theory, then emphasis will be placed upon general principles in contrast to the particularity of the individual's desire. This would seem to run counter to the goal of Lacanian analysis as the realisation and identification with the truth of one's (unconscious) desire.

The other in which it differs is that it seems unlikely that the best way for one to get at the truth is to model the patient's ego upon the ego of the analyst. For Lacan the ego is a deceptive organ, something whose function is not to aid in the adaptation to internal and external reality but rather something that dissembles and leads astray – something, when brought into the analysis, represents '...the sum total of the analyst's prejudices.'⁴ The basis for this attitude can be found at least partly in a differing conception of how and when the ego develops in the child. In Hartmann's view, the ego is present from the very beginning⁵ – it plays an important role in that it mediates between internal and external reality. On Lacan's view, the ego is only formed through a process of identification with external images that begins after birth. This is the well-known "mirror stage". The paradigm for this process is the child who perceives their reflection in the mirror as a unity over which they have ownership and control, but to limit imaginary identification to this heuristic example would be an error. The point of the story about the mirror stage is to illustrate the way that the ego can only take on

⁴ Lacan, J, *The Seminar of Jacques Lacan, Book I, Freud's Papers on Technique 1953 – 1954*, trans. J Forrester, Cambridge University Press, Cambridge, 1988, p. 23.

⁵ Hartmann, H, Kris, E, and R Löwenstein, 'Comments on the Formation of Psychic Structure', *Psychoanalytic Study of the Child*, Vol. 2, 1946, p. 19.

unity from what it finds outside itself, and to show that this unity is unsubstantial – it is based upon a misrecognition. This is why the level of the ego is the level of both erotic love and of aggressive rivalry: an attack on an imago with which the ego is identified will surely be interpreted as an attack on the unity of the ego itself. With this in mind, any attempt to model the analysand's "weak" ego upon the "strong" ego of the analyst is one that is surely predicated upon an error – that is, upon the belief that the ego can form a sufficiently concrete foundation for "healthy" functioning, and that this kind of situation is something that is desirable.

So how does this tie into what I have been saying about normality? Firstly, we can see that the attempt by Hartmann to build the foundations of a psychoanalysis that could unite with general psychology necessitates the idea that the clinical setting is a kind of laboratory in which general facts about human beings can be discovered. Facts that are particular to the individual in treatment become irrelevant and perhaps even inhibit the pursuit of this aim. What we end up with instead is the adaptation of the individual to reality by the modelling of the patient's ego upon the analyst's. In ego-psychological analysis, then, the point of the whole endeavour is twofold. First, to discover general principles that can be form the basis for a "psychoanalytic science"; second, to adapt the patient's ego to reality. Insofar as the latter task is performed by changing the patient's notions of what and what is not real or important in his life, the analyst avoids the more important mission of leading the patient to understand the meaning of what *already is* real or important for him – this meaning being the goal that has precipitated the analysis in the first place.

Another way to get at this is to draw a distinction between the pursuit of truth and the pursuit of health. In the beginning, the psychoanalytic method was devised as a way to treat hysterical symptoms – that is, it was an instrument to achieve health. However, Freud found that the efficacy of this method was dependent upon the truth of the material that came to light during the analysis. Therefore, therapeutic intentions within the analytic session might be a disruption to the work of analysis rather than a help, insofar as they would prevent the analyst from getting the patient to see what they are actively trying not to see. And indeed, it is possible that therapeutic consequences of the analysis might never come about despite the discovery of truths about the self. When we look at Lacan's criticisms of ego-psychology, for instance, we can see that truth and health in analysis are not necessarily always compatible. I want to say that the difference between those who think that adaptation should be the aim and those who think that self-knowledge should be the aim corresponds to this distinction between the pursuit of health and the pursuit of truth. Thus, for Lacan, analysis is not a therapeutic procedure. The aim of analysis is not to restore the patient to some kind of normal functioning, but rather to understand the nature of his own idiosyncratic pathologies.

Conceptual Norms and Psychoanalytic Method

I take it that much of what I have said so far is relatively uncontroversial within the Lacanian school. However, I would like to say that there is one more way that we can understand the way that normality is undermined in psychoanalysis. This is the aversion towards general categories that can be seen in psychoanalytic technique – in the way that this technique is read directly off the aims of analysis. It might come as a surprise to some to hear about this aversion, since one complaint that is usually levelled at psychoanalysis by its critics is that its practitioners rigidly cling to its theoretical concepts despite any contradictory evidence. But this complaint could not be further from the mark. If we take the debate between Lacan and ego psychology seriously, one thing that we learn is that one important principle of psychoanalysis is that the analyst should not be legislating for the patient. That is, the role of the analyst is not to demonstrate to the patient that his behaviour can be meaningfully explained through the use of psychoanalytic categories (which is to effectively “normalise” this behaviour by making it comprehensible) but rather to allow the patient to come to a realisation about the patterns that govern his behaviour and interactions with other people. The best way to do this is certainly not to shoehorn his associations into the preset configurations afforded by psychoanalytic theory, whatever this might be for the analyst. One might have thought that the evolution and elimination of various psychoanalytic concepts in response to the changing problems in the clinic has given us a clue here.

But what is the alternative? Surely general categories cannot be avoided during analysis, at the risk of there being no solid guide for choosing one type of interpretation over another. One solution to this problem is to have the analysand himself do most of the interpreting. Fink, in his recent *Fundamentals of Psychoanalytic Technique*, suggests this when he says:

...in the interest of putting the analysand to work, interpretations should generally be polyvalent – that is, susceptible of at least two meanings, the analysand being given the task of exploring all of them.

The idea here is that the analyst extracts expressions and patterns of speech from the patient’s own idiom for use in interpretations – expressions that may have a idiosyncratic meaning for the patient. For the analyst to assume that he understands this meaning is to project his own particular prejudices onto the patient. If the meaning of his interpretations is ambivalent, on the other hand, the particularity of the patient’s way of understanding others is preserved and can be explored. It is possible to see now why the inductive method would be inappropriate to the task that is attempted in psychoanalysis. The theory that comes out of the experience of the clinic needs to be used in the very same place in a way that is conducive to this pursuit of self-knowledge. If analysts were to do nothing but abstract general facts about from their patients that were meant to be applicable in every possible case, then a mere application of these facts would achieve nothing but a categorisation of the

circumstances particular to each patient under these general facts. In this situation, the patient would not achieve nothing but a mere redescription of his problems in the vocabulary of psychoanalysis.

In light of these considerations, I suspect that instead of theory being applied to the patient in a categorical fashion, the theoretical concepts are used in the clinical setting in a way that could be described as analogical. That is, they are used in reasoning about a particular case in a way that draws upon a knowledge of past cases, rather than an explicit definition of the concept. The interesting thing about this analogical kind of reasoning is that it allows the particular case at hand to constrain the meaning of the general categories that are used. This is because there are three points of reference from which the analyst can decide whether the application of a particular concept is justified. The first is the class of cases in which the concept in question was obviously inapplicable but which bears a threshold similarity to the case at hand. The second is the class of cases in which the concept has been applied in the past. The third point of reference is the case at hand itself. This way, the case at hand plays an active role as it constrains the past cases which could be considered relevant in deciding which concepts are applicable. In fact, there is nothing more that can determine this conceptual content apart from particular cases of its application – thus, new cases continue to limit as well as expand the scope of cases which determine its meaning (i.e. the kinds of cases in which it can be justifiably applied). This approach to the relationship between theory and practice is another aspect of psychoanalysis that undercuts the notion of normality. In this case, however, the kind of thing undercut is the idea that there are transcendent norms which govern the correct application of theoretical concepts within the clinic. By leaving a space open for the meaning of their theoretical concepts to be partially determined by the particularity of the case they are faced with, practicing psychoanalysts, in a way that is quite paradoxical, put the patient's particular circumstances at the centre of their theoretical edifice.