ERROR IN DIAGNOSIS:
CAUSES AND CONSEQUENCES

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1. A case of Nervous Asthma.

“Dear Doctor; I received on the 4th of February from Mr G. a long recorded letter in which there is no room for doubting the diagnosis of ‘persecutory paranoia’.” So begins the letter addressed by Freud to Weiss on the 12 of February 1924.[1]

Who was Mr G.? We know that he wasn’t unknown in psychoanalytic literature. Two years before, in 1922, Edoardo Weiss — pioneer of Italian psychoanalysis — had published a very interesting case of Bronchial Asthma in the *International Zeitschrift für Psychoanalyse* under the title of Psychoanalysis a case of Bronchial Asthma.[2] Such a psychosomatic phenomenon appeared in the course of the treatment of Mr G. whom Weiss had diagnosed as a case of neurosis. On the other hand, the case was well known to Freud, given that Weiss was in supervision with Freud, as we can tell by their correspondence.

Published cases of bronchial asthma in the psychoanalytical and medical literature at that time were scarce. Apart from three articles published in the *Zentralblatt für Psychoanalyse* and in *Jahrbuch*, between 1911 and 1913, there are no other contributions on this theme till Weiss’s article.[3]

Weiss presents the case as a complete and detailed illustration of the psycho-genesis of asthma as part of the neurosis, and he also presents the case as a therapeutic success. All of this was happening two years before Freud refutes the diagnosis. I would like to comment on this case for you today and to take it as a paradigmatic Freudian theme of our Study-Day.

Let’s start with the cause of the diagnostic error. What does Weiss say about the diagnosis of Mr G.? “A severe neurotic patient reproduced in the course of his psychoanalytical treatment asthma nervosa, symptom that he had started to speak about in his anamnesis; the asthmatic symptom installed itself with unprecedented force and tenacity as never before during the treatment.”

It is clear then that the asthma was triggered under transference. It did not exist before the treatment commenced. This is a very significant fact in itself.

Before going to visit Mr. Weiss, Mr G. had decided to commit suicide. However he also wanted the advice of an old class-mate who was a psychiatrist at the same institute as Weiss. The psychiatrist had advised him to give a psychoanalytic treatment a try.

Freud recommended caution in diagnosis in order to avoid surprises. In *On Beginning the Treatment* (1913), Freud gives the following indications regarding selection of patients for psychoanalytic treatment: “There are also diagnostic reasons for beginning the treatment with a trial period of this sort lasting for one or to weeks. Often enough, when one sees a neurosis with hysterical or obsessional symptoms, which is not excessively marked and has not been in existence for long — just the type of case, that is, that one would regard as suitable for treatment — one has to reckon with the possibility that it may be a preliminary stage of what is known as dementia praecox (‘schizophrenia’ in Bleuler’s terminology; paraphrenia, as I have proposed to call it), and that sooner or later it will show a well-marked picture of that affection.” And further on he adds: “I do not agree that it is always possible to make the distinction so easily. I am aware that there are psychiatrists who hesitate less often in their differential diagnosis, but I have become convinced that just as often they make mistakes. To make a mistake, moreover, is of far greater moment for the psychoanalyst than it is for the clinical psychiatrist, as he is called. For the latter it is not attempting that will be of use, whichever kind of case it may be. He merely runs the risk of making a theoretical mistake, and his diagnosis is of no more than academic interest. Where the psychoanalyst is concerned, however, if the cause is unfavourable, he has committed a practical error; he has been responsible for wasted expenditure and has discredited his method of treatment. (…) In an experimental treatment of a few weeks he will often observe suspicious signs which may determine him not to pursue the attempt any further. Unfortunately, I cannot assert that an attempt of this kind always enables us to arrive at a certain decision; it is only one wise precaution the more.”

We can not say that Weiss did not act without caution. Nevertheless neither he nor even Freud could be certain before the appearance of the psychotic symptom that it was a case of psychosis. Why? What were the phenomena that could have made them suspect a psychosis? Making no presumptions, perhaps we could, retroactively, shed light on some of the bizarre elements that belong to a diagnosis of psychosis. It is not a novelty to say that with psychoanalysis a taste was inaugurated for investigating the boundaries of the clinic of psychoneurosis. Where psychotic structure intertwines with perverse practices, psychosomatic disturbances and *als ob* (as if) phenomena are frequent. Today we know that it is not rare when a psychotic patient, who is exhibiting neither hallucinations nor delusions, will, when addressing the analyst, show some of these characteristics. To which Lacan will add a peculiar relation with writing as another trait of non triggered psychoses. The case presented by Weiss shows us how some of the hypochondriacal manifestations are associated with psychotic structure and psychosomatic phenomenon. We'll bring to light in this case what Lacan points out in the Schreber case history in his comments on Macalpine's paper: "What we see from the start are symptoms, initially hypochondriacal, which are psychotic symptoms."[4]

2. A delusion of impoverishment (Kleinheitswahn).

Although Weiss specifies that "Mr G. suffered an acute depression, he did not seem to show any trait of apathy as it happens in the case of schizophrenia". He excludes psychosis on the base of the existence of a 'productive transference' (*Diese Affektion* — the psychosis — *war von allem Anfang an auszuschliessen, da sich bei ihm eine sehr leistungsfaehige Übertragung fur den Arzl herstellte*) and due to the fact that his thought was coherent although inhibited to a certain degree. The assertion that the psychotic was unable to establish a transference was part of a doxa already questioned in the twenties. For instance H. Nunberg had commenced his career with two articles that show indeed a 'clinic under transference' of psychosis.[5]

Weiss also excludes the diagnosis of melancholia, adding that there wasn't "any true melancholic mechanism (…) his conscience did not show any of the pathological characteristics of the above-mentioned affection; no delusion of impoverishment or self-reproach ('*kein Kleinheitswahn, keine Selbstanklagen*'). At this point we should leave Weiss, given that the first description of the patient's state is perfectly compatible with the three types that exist within the delusion of impoverishment. We can see that in relation to possessions (delusion of impoverishment: "he lived with a constant fear of poverty"), and to his capabilities ("Considered himself incapable of doing any work at all and lived off his mother's inheritance") And, as we shall see later it also happens in regard to his moral value. However Weiss maintains that Mr G.'s depressive state must be explained by "the enormous waste of libidinal energy'.

Weiss presents the patient as a 40 year old man, academic, and very intelligent. He lived in a suburban area and a governess looked after the house. The patient was dirty and neglected his dress. He was unable to work and did not manage to stay long in any employment. He lived off the inheritance of his mother who had died two years before the beginning of G.'s treatment. He rejected his mother and hated her because she had treated him cruelly. He refused to go see her when she was dying because he did not want to listen to her final reproach. After her death he did go to visit her grave and then he suddenly felt affection for her.

During those twenty years, before going to see Weiss, Mr G had lost interest in everything although he had a peculiar occupation which was collecting every kind of worthless objects. He lived with a constant fear of poverty; his world's conception was extremely pessimistic. He replied with distrust to anyone that was kind to him.

At the beginning of the treatment he was unable to recall even one event that had aroused a homosexual interest. But from his childhood he had only been homosexually aroused. At the age of 16 he had had his first homosexual experience with a young boy that had been kind to him.

From his 15th to his 20th year he masturbated almost every day. His masturbation was accompanied by homosexual fantasies that burdened him with guilt. To refrain from these impulses he fasted and took long walks. One time he walked 70 Km in a day.

The patient's father had died when he was five years old. At the beginning of his analysis he could only remember his mother's harsh, threatening, and mean behaviour. His mother very often flogged and punished him in other ways without him knowing why she treated him like that. For instance when he came down with meningitis at the age of ten she blamed him saying that it was caused by his filthy behaviour-making reference in this way to his masturbation. She said to him that she could tell

when he masturbated by the colour of his face and that he will be transformed into a pig like his father. Since he was twelve his mother reproached him when his ears were red, when he had acne on his face or difficulty in breathing (*erschwertes Atmen*), these were for her unmistakable signs of either masturbation or sexual fantasies for which she reproached him. When the years passed by, he discovered his mother's hollow and vicious character. He was shouting in the sessions as he expressed his anger and hate that he harboured against his mother, although his hate did not prevent him from being strongly fixated to his mother.

The patient was fifteen years old when he got to know from the dictionary that children were born from women, and it was only when he was eighteen that the sexual act became clear to him.

3. Attacks of asthma.

The first attack of asthma during the treatment occurred after his governess had pulled out from the garden his favourite plant. He became agitated by the feeling that she did not love him.

After a year of analysis a shift in the treatment was produced on making conscious infantile sexual impulses towards his mother. Mr G. remembered that when he was a boy (slightly older), his mother told him that during breast-feeding, he had bitten her nipple. This disgusted him. Later on he evoked an older memory in which once when lying in bed with his mother, he placed one of his legs over her abdomen and his mother complained that he was hurting her. Surprised, he pulled his leg away. He later on remembered having experienced a very strong sexual curiosity towards and having spied on her, when she went to the toilet, in order to see her penis, that he imagined to be huge. Then later in the course of the treatment he had a wet dream one night. He dreamt that he was in bed, that his mother walked in and kissed and hugged him. He woke up with a spontaneous ejaculation.

From then on the patient began to feel sexual emotions with women. "In my experience", Weiss writes, "this was the first time that it was possible to free strong heterosexual desires through the analysis in a homosexual man of that age (. . .) the patient had to pay a high price for his freedom because becoming conscious of erotic feelings for his mother were accompanied by intense attacks of bronchial asthma." As long as these feelings were 'repressed', the patient was free of asthma. When he feared seeing himself rejected or abandoned by a woman, firstly he would be on the verge of tears, then, the effort to hold them back provoked an asthma attack. Weiss interpreted this respiratory retention in anal terms and as a form of protest. Each time attacks appeared in the treatment, he associated and remembered all the situations in which he had been treated with hollowness by his mother, that is, each time he felt left in the lurch by the maternal Other. Psychosomatic *jouissance* erupted in his body in the form of asthma as the non-symbolised return of the mother's desire.

During this phase of the analysis, Weiss continues, he had an intense asthmatic attack at home. No sooner did his mother's woman friend enter the room than the attack disappeared.

As his hostile tendencies towards the mother became more conscious, his depression mitigated in an appreciable manner. He became active and began to take an interest in scientific work and problems. Mr G. wanted to translate into Italian some of Freud's writings. After two and a half years of analysis Weiss writes: "He became heterosexual."

After these therapeutic results, he published the case whilst the patient was still in treatment.

4. *The meeting with Freud.*

Towards the end of 1922, Mr G. falls in love with a woman of his own age whom he marries after a brief engagement. During their honeymoon in Vienna the patient desires to relate his history to Freud. The latter invites him to come to a session of the Vienna Psychoanalytical Association which impressed him a lot. Unfortunately, we don't known anything about this visit, except Freud advised him to interrupt his treatment momentarily and that on leaving his consulting room the patient had a serious asthmatic attack which stopped when he met up with his wife. Freud informed Weiss about these events, pointing out that the patient cannot expect any further improvement from the treatment. Undoubtedly, it's after having personally met the patient that Freud intervened in this decisive way.

We hardly know anything more about this meeting, but everything seems to indicate that it has to be considered as the eruption of A-father with no reason, that is to say, the triggering conjuncture of the

psychosis. In effect, what appears to trigger the psychosis is the figure of knowledge incarnated by Freud, linked to his marriage and honeymoon where the call to the Name-of-the-Father is put into play.

We also know that the patient had further serious attacks of asthma when his wife became pregnant. Weiss doesn't understand the relation, explaining it in Oedipal terms: "The birth of a child can provoke an asthmatic attack, the new born can frustrate you of maternal love."

After the birth of his son Mr G. takes up his treatment again, but this time he brings little material and the analysis does not progress. The patient begins to experience hostile feelings towards Weiss, Freud and psychoanalysis, accusing the treatment of being the cause of his terrible situation. Weiss writes: "If the analysis had not freed him of his fixation to his mother, his depressive state would certainly have persisted, but he would not have suffered from asthma." What happened was undoubtedly the fall of identification — such as it was — by which the subject assumed the mother's desire.

Freud writes to Weiss on this point: "One can ask oneself whether the patient's position is not provisional and therefore only a certain way of detaching oneself from the doctor, in which case the whole matter would not mean very much. There has been more than one patient who recovered his health on insulting his doctor. Or, indeed, you have had the bad luck to stumble on a latent paranoiac, and by curing his neurosis opened up a path to a more serious disorder. That happens to each one of us sometimes against which there is no remedy."[6]

What is in question here is a phenomenology different to that of neurosis. The dimension of insult and injury is present in the encounter with the Other, and they seem to emerge as a way of mobilising meanings at the very limit of meaning.

5. *Mr G.'s mother*

The case of Mr. G shows us an array of symptoms which, to be truthful, for having slipped out of the hands of Weiss, cannot be elucidated analytically and can only be reconstructed at certain points. What happened? Simply that whilst reconstructing the case, Weiss was able to discover except for a few details the whole reach of meaning and mechanisms whose play we appreciate in neurosis. There we have the sense of Federn's assertion that Lacan will use in 1955: "There is nothing that more closely resembles a neurotic symptomatology than a prepsychotic symptomatology."[7] In this matter, Federn advised not to remove the reticence of the psychotic, for the rapid and sudden disappearance of a serious neurotic symptom constitutes a sign of 'latent' psychosis.

How to isolate from amongst the clinical phenomena the effects of foreclosure before this reveals itself through the eruption of a delusion? How could we diagnose Mr G.'s psychosis without waiting to be surprised by its onset? Beyond the descriptive clinic there exists in the case two elements which lead to the diagnosis. They are the following:

1. the way Mr. G recollects and, articulated to this
2. the way the patient describes his mother.

To begin with one encounters above all in this case scenes of *jouissance* similar to the primitive scenes of the neurotic. There the first problem occurs: how to establish the difference when we come across phenomena resembling scenes of *jouissance* in neurosis? The first criterion is to discover the differences based on the phenomenology of repression.

Freud's assertion was that in psychosis the unconscious is on the surface, that is, visible. Freud divided transference neuroses from psychoses, indicating that in the former the repressed is veiled, that is, displaced, whilst in psychosis the repressed is on the table, or what amounts to the same thing scenes of *jouissance* have a fixed, undisplaced character. In the same perspective Lacan remarks in *Seminar III*: "In the case of the neuroses the repressed reappears in loco where it was repressed (…) The repressed reappears in loco beneath a mask. The repressed in psychosis, if we know how to read Freud, reappears in another place, *in altero*, in the imaginary, without a mask."[8]

If we begin with Lacan's definition of the unconscious structured like a language, we have to refute this criterion. We cannot be satisfied with the expression that in psychosis the unconscious is 'on the table', because for Lacan the unconscious is on the surface of discourse. For that reason the psychotic is no more on the surface than the unconscious of the neurotic. Where to find it? In the real, that is, by its presence in hallucinatory perception.

Weiss describes in the case of Mr G. that he was surprised by a series of memories from early infancy of a very particular impression: "When he was in bed beside her — in his second or third year —

he was in the habit of putting his leg over his mother's body which caused him to work out that his mother had a huge penis." This memory is in addition particularly strange in the way it was evoked as a sudden capacity for remembering.

Nunberg referred to this way of recollecting in psychosis: "From my experience in not very advanced cases (this would perhaps be true in all cases in the initial state of psychosis) an extremely acute self-observation is established combined with a capacity for recollecting."[9]

If the unconscious is defined rather as a way of forgetting of memory, as a way of losing the memory of the first trace of *jouissance*, how can one not remark that it is not about something of this kind here? It concerns memories which trigger the emergence of a *jouissance* right at the point at which the subject appears like a complement of the Other of *jouissance*, like the uncommon appearance of a wet dream about the mother.

The perception of scenes of *jouissance* that Mr G. narrates brings out the status of recollecting when the function of memory fails him. It is the case for Mr. G whose entire thinking or libidinal energy are captive of that scene in which he is functioning as the complement of the *jouissance* of the maternal Other. There are neither displacements nor lacunae, and if there is a sign of memory in neurosis, it's amnesia.

Freud indicates as much when he tries to deduce desire from a 'first experience of satisfaction' which is in essence impossible to refind or in other words mythical. This first experience of satisfaction is invented by the neurotic because his memory in some way 'throws *jouissance* off course'. The semantic flow of signifiers which is a vehicle for *jouissance* in neurosis masks, disguises *jouissance*. Freud describes it to Karl Abraham in trying to explain the difference between neurosis (hysteria) and psychosis (dementia praecox): "The hysteric distances herself considerably from infantile auto-erotism and exaggerates object-investment (…). In consequence, in childhood, it relates to the need of the object by way of fantasy and covers over infantile auto-erotism with fantasies of love and seduction. A little like lovers who can no longer conceive of a time in which they did not know each other and construct on the basis of not very solid points of reference meetings and previous relations, that is to say, a part of the sexual traumas which the patients narrate, are or can be fanatsies".[10] Whilst in psychosis, "I have noted that the patients as they progress towards finishing in dementia, lose any analogy with hysteria and express without resistance their fantasies (infantile sexual) as if the latter had now lost their value".[11]

A fundamental element for the diagnosis is the mother's description in this case. The latter has two characteristics that are really surprising. On the one hand, it is about a mother whose body is described as non-emptied of *jouissance* (the spying patient hallucinated a huge penis after the scene in which he placed his leg on her belly), it's a mother full of *jouissance*.

But, on the other hand, she is also a mother full of knowledge. The memories that Mr G. has of her are those about her severe and threatening behaviour: "She often beat him or punished him in other ways (…), she used to say to him that she could tell when he masturbated on his colour". The patient described her as an object that would permit the premonition of lack on the horizon. The memories evoked by Mr. G also do not reply to a field of reality where anything allows one to see that the drive had become demand. The scenes are quite distant from those which a neurotic can describe in so far as *jouissance* appears here with no disguise.

Finally, we see one more time in the case of Mr G. that the diagnostic error is not a simple error in the order of technique, but one must take it as an example that there is no clinic without an ethics. This case surely taught a lot to Weiss who in 1936 at the Congress of Marienbad, where Lacan presented the mirror stage, returned to this theme of structural diagnosis in a work called *The Early Diagnosis of Psychosis in the Analysand.*

Translated by Gabriela Van den Hoven

1. S. Freud/E. Weiss, *Lettres sur la pratique psychoanalytique*, Editions Privat, Collection Rhadamanthe, Paris, 1975, p.69.
2. E. Weiss, *Psychoanalyse eines Falles von nervösen Asthma* in I.J.P. VIII Jarhgang, 1922, pp. 440-445.
3. *Ibid.*, pp. 454-55.
4. J. Lacan, *Seminar III, The Psychoses*, transl. R. Grigg, Routledge, 1993, p.313.

5. R. Wälder, *Über Mechanismen und Beeingflussungsmöglishkeiten der Psychosen* in I.J.P. X, 1924; K. Landauer, *Die Passive Technique* in I.J.P. X, 1924; H. Nunberg, *Über den katatonischen Anfall* in I.J.P. VI Jahrgang, 1920, and *Der Verlauf des Libidokonfliktes in einem Fall von Schizophrenie* in I.J.P. VII Jahrgang, 1921.
6. S. Freud/E. Weiss, *op. cit.*
7. J. Lacan, *Seminar III, The Psychoses*, p. 191.
8. *Ibid.*, p. 105.
9. H. Nunberg, *Über den katatonischen Anfall*, *op. cit.*
10. S. Freud/K. Abraham, *Correspondence*, Gallimard, Paris, 1969, p.10.
11. *Ibid.*, p.13.

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