PSYCHOANALITIC THEORY AND MEDICOLEGAL ASSESSMENTS

Are all psychiatric disorders just biochemical?

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August 2008

One is often surprised at the variability of intensity, duration and eventual outcome of patients/clients to whom one gives a diagnosis of Posttraumatic Stress Disorder or Adjustment Disorder. Indeed in many cases of Adjustment Disorder, one wonders why it is that this particular person has decompensated into an illness that has lasted even long enough for them to arrive for an Independent Medical Examination (IME). One often thinks that quite a significant percentage of people in the community would go through similar traumatic circumstances without decompensating beyond the day or a few days at most. However, one sees an occasional person who goes on for a very long period of time without a significant recovery.

Similarly, one sees people with Posttraumatic Stress Disorder (PTSD) who have a life-threatening event and decompensate psychologically. Some people stay decompensated indefinitely, into an illness of considerable severity. One also sees, for instance, members of the Police Force who manage to get through many years of seeing a great many traumas only to suddenly find one that they are unable to deal with and how this one triggers a decompensation that becomes widespread and leads to their discharge on medical grounds from the police force.

Having an extensive background in psychoanalytical theory and practice led me to wonder about the reasons for the differing outcomes that one sees in otherwise apparently normally functioning people. DSM[1] itself has no interest in aetiological factors and avoids psychoanalytical concepts. Psychoanalysis is anathema to many of the proponents of an organic model of psychiatry as well as this recent group who rely on a descriptive checklist in order to come to a diagnosis. From this diagnosis it is a short trip then to a checklist of treatment options not infrequently including medication. All this is may be of great value in treatment of the patient but does not help us in trying to understand the variations we see placed before us by out client/patient of the variations on the initiation of and decompensation into the illness, its course and final outcome. I would like to submit my views from my psychoanalytical perspective in this presentation.

In my recent psychoanalytical studies I have come to an understanding of personality disorders that is coherent and remains stable over time. In my experience, and I am sure that of most practitioners, many diagnosable personality disorders change their particular diagnostic label at least once over the course of the years. The checklist provided by DSM is useful at a cross section in time but in personality disorders rarely do we see a consistency like we may see with, for instance, Major Depressive Episodes or Schizophrenia. My understanding is that this has always been the case in psychiatry.

In my studies there are three structural diagnoses to make on a patient, namely neurotic, psychotic and perverse. Psychotic has a particular meaning in this theoretical structure because it speaks of an unstable personality structure that is present in all those people who will later end up with a psychotic illness as well as those who have what can be called an untriggered psychosis. It is mostly this group of people with an unstable personality structures in the community who present us with the characterological disorders currently called personal disorders and who present with AD or PTSD.

In an IME we do not have much time to take a long detailed history of childhood events that may lead to a careful estimate of the structure of the personality. However, I have noted in these clients at IMEs that they had a childhood devoid of physical holding often described as “there was nothing touchy or feely in our family” or there may be violence or both parents may be working. At more brief history taking one will often hear such things as “I had a perfectly normal childhood” and only if one has time can one find out that there was in fact a void in the childhood. In addition, one may ascertain that the client/patient when a child felt completely at the mercy of a controlling parent although often they will add “but I loved him or her very much”. Most people say that they had a normal childhood when they present to an IME and I suspect most patients say that to their GP or

[1] Diagnostic and Statistical Manual of Mental Disorders – A system developed by the American Psychiatric Association, now in its fourth edition.

to their psychiatrist. It is only in the details that one finds the absence of the physical manifestations of love, of love of the child who later grows up to be our client or patient.

This absence will frequently lead to an unstable personality structure. Characteristics of this structure that one sees in those moderately affected are a certainty about, for example, right and wrong; a degree of obsessionality way out of the normal range which may include a diagnosis of obsessional personality disorder; and particularly of a fear of being controlled by others in the environment which may be a supervisor or somebody similar.

It is my theoretical conception that those more severely affected by this unstable structure (of their personality) are the ones who do least well after exposure to events in their work environment. I see some rough correlation between the degree of childhood isolation and deprivation and the prognosis for the client/patient.

We often see clients/patients with a pain disorder associated with psychological factors where there is no anatomical lesion to explain the perception of pain and I wonder if it is not a small step to label this as psychotic, that the experience is a delusion. If so I think it possible that the administration of an antipsychotic drug, with appropriate careful monitoring might be valuable, at least in some cases; and I would add, particularly the severe cases.