Positive Versus Negative Symptoms

Are there some symptoms that become reinforced, sustained, and even intensified throughout the duration of the symptom episode, while others simply relieve tension? For example, the suffering of psychogenic migraines seems to be sustained, even fortified, throughout the duration of the episode. Such a symptom could be considered a negative one. On the other hand, an average compulsion, or perhaps even a severe one, when acted out, actually relieves tension; that is, the symptom episode (acting out the compulsion) produces a positive result for the person, a relief of tension.

Hence, we may consider that in view of this difference between the experience of sustained or intensified pain with respect to one kind of symptom, and the relief from pain with respect to another, that symptoms generally could be divided into two categories that we may operationally define as positive or negative. This labeling is based entirely on the person’s experience of the symptom as painful or relieving, and not on any objective criteria of good or bad symptoms.

Where in the sequence of events that generated the symptom in the first place can we find what it is that makes for the difference between symptoms that ameliorate tension, versus those that exacerbate it?

The Wish and its Relation to Ameliorating and Exacerbating Symptoms

The answer to the question about what it is that determines whether a symptom is positive or ameliorating, or negative or exacerbating, concerns the person’s original wish that was ultimately thwarted. If this original thwarted wish was a direct one—for a positive outcome of the wished-for scenario—then the ensuing symptom would be positive or ameliorating. The symptom would generate relief of tension. If, on the other hand, the thwarted wish was a negative one—that is, an indirect one, a wish to avoid something—then the ensuing symptom will be negative, or an exacerbating one where tension is increased. In either case, direct
positive wish and relieving symptom, or indirect wish and painful symptom, the subject falls in love with the symptom, because, as discussed previously, the symptom is the wish satisfied, albeit in perverse or neurotic form, regardless of whether the symptom is relieving or painful.

Thus, the symptom is locked in, in perverse or neurotic form, and with respect to cure, it matters not whether the symptom is an ameliorative tension reducer, or a painful and tension exacerbating one. The cohesion of the symptom, its constraint or tight parameter, is impervious to reason of any kind. Rational or cognitive logical appeals or any kind of beseeching of the subject, or any kind of inducements—no matter how attractive—cannot have any curative effect on the symptom. None of these persuasions, seductions, or paradigmatic assumptions of normalcy, will ever have the slightest effect on the symptom. Not the slightest! These are reality oriented appeals and speak an entirely different language from that used by the symptom. The symptom does not respond to usual, manifest logic. The reason for such monumental failure on the part of reality-based appeals, approaches, or even admonitions toward the subject—regarding a relinquishment of the symptom—concerns the very nature of the symptom as an entity in a defined realm of the psyche. The symptom exists in the unconscious. It is condensed, a symbol for a wish; and more so, for a fully gratified wish (that we love), albeit in a translated, transformed, neurotic, or perverse configuration. It is proposed that the symptom can only be communicated with through the code presented here, involving an approach that aims to uncover the original wish by identifying the who toward whom the subject’s repressed anger was originally directed.

Thus, the main theme, and the salient point to the present work, is to indicate that only when the subject becomes conscious of being angry toward this target person, will the symptom begin to dissolve. This is the only language understood by the symptom; that is, by the subject’s unconscious. It is the language of wishes, repression, and the dynamics of the emotional mortar determining immutable laws of the connection between the subject and the who—the object, the other person.

It is in this sense that all of these reality-based genuine appeals, sincere approaches, and even severe admonishments, on the part of others toward the patient to relinquish the symptom, are all doomed to failure. The patient is almost always helpless to do anything voluntarily to assuage the symptom, because by definition, the symptom is beyond the patient’s control. The symptom is a product or a ward of the unconscious, of repression. The symptom only exists because its host, the subject, when reacting with the symptom, is basically in a state of withdrawal.

The Symptom and the State of Withdrawal

In a non-clinical, non-pathological sense, withdrawal is actually, for all people, a natural phenomenon of everyday life, essentially a pause. It is a moment of inner rest. It is a solitary state. It is never authentically interactional, though it may be transferential.