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# Returning to Freud: Clinical Psychoanalysis in the School of Lacan

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# Contents

# 2 Teachings of the Case Presentation

BY JACQUES-ALAIN MILLER

Never—oh, how I wish that this "never" were true and that routine had not numbed me—I never attend Lacan's case presentations at Henri Rousselle Hospital without dreading what will take place there. To put it simply: a man, a patient, an unfortunate soul, will encounter through Lacan the cipher of his destiny and will do so without knowing it. For one or two hours he will be heard, questioned, sounded, maneuvered, and finally sized up; the few words Lacan pronounces will weigh heavily on the scales of his fate, even more so, since Lacan is frequently called upon to interview a difficult case.

Lacan does not teach here. What we learn we grasp in flight, from the patient or the analyst, and we are never sure whether we have been taught something or nothing. There are, however, two or three things that appear to me more certain than the rest, and it is these that I will discuss. These are impressions from which I would begin teaching.

Often Lacan's last question to his patient is the following: how do you see the future? A young paranoiac responded that she was sure now that a page had been turned and that things would get better and better. Lacan approved. She had hardly left the room when he added: "She got off on the wrong foot; she won't get out of it."

Those in attendance were moved by this about-face. During the interview we had not been leaning in this direction, and thus we had been taken in or deceived by the attitude of the questioner no less than by that of the patient.

As a member of the audience, I would say that its function of looking on or overhearing is necessarily dumb. We are there in large numbers as apprentices, and Lacan does nothing to raise us from this abjection. Like a psychiatrist he lets an atmosphere of complicity be created, and this extends to the rèlation between master and students. Lacan works at this and at the same time protects the element of risk in the exercise. There is no physical barrier in the room, and yet

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we could just as well be behind a two-way mirror. One has the impression that Lacan and his patient are enclosed in a transparent capsule; the patient is enveloped by a steady and unvarying attention, by the almost total immobility of the questioner.

Those in attendance are silent, but one guesses that if they spoke they would speak like a Greek chorus. When we are there, we form the *doxa* of public opinion or of modern civilization, and there is, curiously enough, a secret agreement between us and the patient. When the patient evokes "formula ones," we know that he is talking about racing cars, but Lacan does not know, does not understand, and he makes the patient repeat, explain. . . .

The audience awaits a diagnosis that the hospital has not found or on which there is a difference of opinion. The diagnosis will permit the staff to place the problem in a nomenclature and to direct the treatment and the therapeutic strategy. We await a name or label that will fall from the master's lips and will be destiny itself. The audience, waiting for this, is always disappointed; the questioner, the expert, more often than not responds like a Zen master, with a kick in the pants.

It is not that he goes into hiding, that he refuses to pronounce the words "paraphrenia" or "retardation" for fear of labeling, but the labels are pronounced ironically, so that they are annulled. We have learned despite ourselves that the sentence for which there is no remedy is this one: "But he's normal." Thus even when the clinical picture is revealed unambiguously, and even when a diagnosis can be stated in the most classical terms, something of the sense remains suspended. Strangely enough, even when the name or label is spoken, there is deception. The answer we are waiting for is never really given. And nothing shows this better than the fact that for a year some of us have wanted to get together to talk over each of these sessions and to retrace the path of the questions opened by this singular practice. What the patient said was enigmatic, and we were waiting for Lacan to decipher it. And then the deciphering itself was enigmatic and demanded another deciphering. Perhaps there is no better deciphering than by an enigma—especially if it is true that there is no metalanguage.

Is recognizing and classifying mental patients a deciphering? There is a grid that permits us to do it. The grid was developed by psychiatrists in the last century and at the beginning of our own. Doubtless the grid is not absolutely consistent for different psychiatrists—the dividing lines of the one are not those of another, and a symptom described here is neglected there. Some of the clinical forms are marked by the names of their discoverers. But we will not scrutinize this closely; the knowledge of classical psychiatry is designed for manuals and forms a simple,

solid corpus that responds in the large to the demands of everyday practice and, I would add, will not be replaced, if only because chemistry nowadays does not permit the symptom to follow its course as it did in the past.

Doubtless at Henri Rousselle this psychiatric corpus is the obligatory reference point; this doxa is the foundation of the place itself. But, to tell the truth, it seems to me to be no less present in the institutions that renounce it, simply because it is the element that determines and justifies any hospitalization. To renounce it, or purely and simply to deny it, is to fall even more under its sway. Breaking away from it requires more of a ruse than that.

Lacan's questions are sustained by this reference, which gives a sense to the "supposed" diagnosis that he will offer. But curiously, at the moment when this sense is going to be solidified or frozen, it is suspended, it becomes a question. Turning on the reference point that was its inspiration, it puts that point into question, suspending its certainty. When I see that, I cannot prevent myself from thinking of what Roland Barthes once wrote about Brecht: that he knew how to affirm and suspend a sense in the same gesture, to offer it and to disappoint the expectation. All of Brecht's plays, Barthes said, finish implicitly with a "Look for the way out!" addressed to the audience.

With Brecht we know immediately that the way out is there; the play is constructed to persuade us that it exists. With the case presentation, however, who would not be persuaded of the truth that Lacan has articulated, namely, that there is no place for hope? "Clinical work," he says, "is the real as impossible to support." Thus the clinical dimension is tragic. It is so for the patient, but also for the therapist. Is it not that which is verified every time—that this real is insupportable for therapists, and more so, the more they devote themselves to it? "Look for the way out." The way out: it is we who name it that; the way out, his way out, the mental patient has already found it—it is his illness. And if we seek the way out for him, in his place, well, that is perhaps our way of being ill.

If this is a truth that we grasp during Lacan's presentations, then clearly it cannot be the object of a dogmatic teaching. We would denature it by making it the only truth when it is only one among others. Nevertheless, this truth is sufficient to temper the spontaneous activism of those who devote themselves to psychotics.

"But," it is said, "can you ignore the fact that these presentations are one of the most traditional exercises in medicine; don't you see what happens when there is a public dissection of the mind where the master demonstrates his know-how for the sole benefit of an audience whose complicity you exemplify, and that in so doing he objectifies his patient? Do you not feel that you are thereby encouraging psychiatric racism and that the influence of psychoanalysis



ought to move in a contrary direction, which is to restore to the madman his status as subject, by listening to him, but not by presenting him?"

I am not defending *the* case presentation; rather, I am talking about Lacan's. I bear witness to what is painful in it. Those who work in the hospital could speak of its beneficial effects on the patient, either because it has given access to speech or because it has led to a more just appreciation of the case. Surely enough, the procedure comes from the university, and this in itself is proof that being silent and listening do not suffice for entering into the discourse of analysis. But how can the interview—whose discipline you would not dream of eliminating and which you would agree is therapeutic in itself—not be profoundly transformed by the truth that Freud prevents us from ignoring—namely, that misunderstanding is the essence of communication? I see well enough that you are persuaded by its contrary and that for you, to speak is to make oneself understood.

We learn a great deal by reading Maud Mannoni here. She says the following about Lacan's presentations:

> Lacan has never felt himself obliged to ask questions about the practice of presenting patients at Sainte Anne Hospital Center, one of the bastions of French psychiatry. In the most classical manner, he has found there examples to justify his interpretation of cases and to show his students a pertinent form of interview. Certainly the student profits, but always within the framework of the dominant psychiatry. Thus Lacan has underwritten, despite himself, a traditional psychiatric practice in which the patient serves as the primary material of discourse and what is asked of the psychiatrist is to come and illustrate a point of theory without serving the patient's interests. A Laing or a Winnicott would never have been able to put himself in this position, which the psychiatric institution reserves for its most eminent physicians. With Laing the effect of his psychotic identification is to open the possibility of identifying with the patient. . . . This form of identification is completely different from that of identifying with an eminent psychiatrist.

That the passion to understand and to cure the psychotic give birth to the ambition to identify with him—this much makes logical sense. I would say of this ambition that it would be dangerous if it were not so vain, except for the hysteric. Mme Mannoni is wrong to oppose Lacan to Laing and Winnicott; one of the teachings of Lacan's so often decried presentations is precisely that there is a madness in understanding, a madness in communication. The psychotic has his voices to understand him and to communicate with him, and they suffice. As I have said, Lacan understands nothing.

I suppose that Laing hopes that the imaginary identification with the psychotic will become a transference and will lead the patient to enter into a discourse that makes for a social tie. And it seems to me that it is the psychotic absence of social ties that takes the therapist onto a path leading inevitably to social reform. The therapist renounces the project of adapting madness to society only where he can dream of adapting society to madness. From this dream microsocieties have been born, and they are in no way incompatible with modern liberal ideology. Each of them is attached to and organized around a strong personality. When patients' problems are forgotten, those of the members of the staff come to the surface, and the staff comes to share the segregation of those it heals. These new Pinels—do they not serve as underwriters, I ask you? I do not see the master's knees shaking.

There are those who think that anything that shakes the self-confidence of the psychiatrist is excellent. What is more human than for the psychiatrist to identify with his mad patient? Many things would be better, because this aping can only lead the therapist further into an imaginary dialectic where he will finally supplant the patient (who ought to mobilize his interest) by becoming impassioned only for his own condition. I believe these antipsychiatrists to be no less infatuated than their masters. Pretending to call the institution into question, they no longer talk of anything but themselves. And when they speak of rendering society psychotic, who cannot see that they are preparing it for "psychiatrization"?

How can one be a psychiatrist? We leave this tormenting question to those who are. But for those of us who are not, there is the old question: what is a madman? Lacan's presentations lead us back to it and to the response that he sometimes gives: "someone perfectly normal." This response surely discourages you from identifying with the madman. What I want you to see is that when Lacan says this, he is not making a joke.

To do so I pronounce a name that is no longer heard in our colloquia, that of de Clérambault, and I raise his "mental automatism" from the neglect to which the decadence of our clinical work has consigned it. Thus a return to de Clérambault—and why not, if we see that his work motivated Lacan to become a psychoanalyst.

"Clérambault, our only master in psychiatry," wrote Lacan, and I remind you that he added, "His mental automatism . . . appears to us . . . closer to what can be derived from a structural analysis than any other clinical effort in French psychiatry. . . ." Shall we say that this praise, given in 1966, has even more weight because it contradicts Lacan's thesis of 1932?

Mental automatism is de Clérambault's version of Occam's razor; and precisely because it is an instrument, he came to reduce it to the first letter of the word "syndrome."



The introduction of this *S* yields an extraordinary simplification in the clinical approach to psychoses. Attacking the old approach, de Clérambault deconstructed the well-established clinical entities like Magnan's psychosis and wiped the slate clean. French clinical psychiatry had always excelled in the description of the nomenclature of delusional states.

This *S* is not of the same order: de Clérambault proposed it as the initial form of all psychosis (excepting true paranoia and purely interpretative delusions, such as those isolated by Serieu and Capgras, which are most often mixed with mental automatism). As such, *S* is athematic and neuter, which is to say that contents and effective coloration come to it later, according to the "depths"—paranoiac, perverse, mythomaniacal, interpretative—on which it is produced or according to whether or not it is associated with a passion. *S* is autonomous; it does not depend on these passional givens but refracts itself and differentiates itself, thus giving the diverse clinical pictures.

"Delusion is a superstructure," declares de Clérambault, and this "ideation is secondary." The primal *S* of psychosis imposes itself as an irreducible fact of thought, an absolute fact, in relation to which I have no scruples about invoking the Kantian fact of reason, the categorical imperative. Also in question for Kant are the phenomena of enunciation.

What is the "echo of thought," which de Clérambault makes the original positive phenomenon of mental automatism, if not a disturbance between statement and enunciation that emancipates a parasitic source? The subject finds himself continually shadowed by a double that emancipates him, accompanies him, or follows him and cannot say anything. Fading, mute, empty, this double still has the power to suspend the subject in the position of receiver. De Clérambault calls this independent enunciation a "purely psychic phenomenon," and he names the play on words (signifiers) that it liberates "verbal phenomena." The terms that I substitute for those of de Clérambault indicate that it is not in some obscure "deviation of influx" that we can found the syndrome of mental automatism but rather in the grasp of intersubjective communication. It follows that the sender of a message becomes its receiver and that the psychotic disturbance consists only in his experiencing himself as such.

The construction is sufficiently Lacanian for us to take the *S* of de Clérambault and make it the first letter of the word "structure." The structure bared—by its celibates—is the subtitle that this dogma of mental automatism deserves. French psychiatry came to repudiate it in the name of sense and personality. Without a doubt de Clérambault thought in terms of mechanism. But this

mechanism is metaphoric (Lacan in 1932 did not see this). De Clérambault did not in any way elaborate on this point, which remains entirely formal, but it was nevertheless no less decisive in instituting a break between psychology and the order of structure.

In a word, de Clérambault made his automatism into something mechanical, but he did this in order to hold on to its autonomy, leaving to Lacan the discovery of the symbolic order. Lacan sought to define the symbolic through a mechanism (certainly not that of de Clérambault, but that of Türing and Wiener), so as to distinguish it from Jung's. Lacan made the symbolic primal and neuter, instituting it thus as signifying and structural. And when he made it athematic, sustaining the point of view that the symbolic is produced first "in the ordinary form of thought, in an undifferentiated form, and not in a definite sensory form," he proposed an idea that is debatable from the point of view of observation but has a logical import that cannot be misconstrued. S means nothing, and this is implied in its name "echo." In question is a purely signifying effect that becomes mad when a delusional deciphering invests it with imaginary meaning.

This construct permits us to distinguish persecution as a delusional interpretation that does not entirely block the efforts of the physician—this because it preserves in the subject the capacities of "confidence, sympathy, tolerance, and expansion"—from true persecution, whose psychogenesis de Clérambault accepts. What is in question in this latter is the structure of knowing; in the former it is the structure of the enunciation. "Interpretative delusions" are another form of "ideogenetic imprint" and would lend themselves equally well to a structural rereading. I will content myself only with evoking this rereading, adding that de Clérambault's deconstruction of Magnan's progressively systematic hallucinatory psychosis seems to me to be epistemologically exemplary.

When the slight separation of the enunciation from itself is amplified until it engenders individualized and thematized voices that appear in the real, when the subject feels himself transpierced by bursts of messages, by a language that speaks of itself, when he feels himself spied on in his inner core and subjected to injunctions or inhibitions whose productions he cannot annex, we then have the great "xenophobia" that Lacan founded in the field of language with his matheme of the Other. Would it be too much to say that the discourse of the Other was already there, in the clinic of psychosis, before Lacan invented it and linked it to the prehistoric Other that Freud found in Fechner? Xenopathic emergences are founded on structure, if structure wants all speech to be formed in the Other. The question is no longer "What is a madman?" but "How can one not be mad?"



Why does the normal subject, who is no less affected by speech, who is no less xenopathic than the psychotic, not become aware of it? The question is more subversive than the identification proposed above. By what inversion do we misconstrue the fact that we are the puppets of a discourse whose syntax preexists all subjective inscription? What is normal is the xenopathia. A subject for whom the Other is no longer veiled is certainly not going to be attained through our imaginary manipulations.

This detour brings us back to the presentation of patients and precisely to the only one Lacan talked about in his seminar last year, the one he labeled a case of pure mental automatism or a "Lacanian psychosis."

The subject had in fact read the *Ecrits*, but this took nothing away from the authenticity of his experience: he was subjected to what he called "imposed speech," which intruded into the sphere of his private cogitation. He could not recognize himself as its speaker, even though the speech most often assigned him the place of grammatical subject of the statements. Each phrase he heard demanded that he complement it with a phrase of another kind, "reflexive," which he knew himself to be emitting. In contrast to the "imposed" statements, he did not figure as the subject of the "reflexive" statement. He witnessed in this way the emergence of the discourse of the Other, but directly, without this soothing misapprehension of the reversal that makes us believe that we speak, when in fact we are spoken. From there we move to the transformation that poses the question of madness. "How do we not sense," Lacan asked, "that the words we depend upon are imposed on us, that speech is an overlay, a parasite, the form of cancer with which human beings are afflicted?" If we identify ourselves with the psychotic, it is insofar as he is, like ourselves, prey to language, or better, that this is what he teaches us.

The teaching by the patient at Lacan's presentations—that is how it should be described—goes farther than a ratiocination on the idea that the norm is social, that one man's madman is not the other's, that normality is mad, and that madness is logical. There is no good usage of the word "normal" that is not antonymical, and Lacan uses it as a synonym of its contrary. Present him with someone slightly retarded, with a cultureless soul who was in the Italian campaign, or someone perhaps hit by a car on the Place d'Italie, someone asocial, a mythomaniacal nobody, even a bum, lazy, unconvincing in his xenopathia, and doubtless a little hysterical—there is a good chance that Lacan will label him normal. A strong personality will lead us closer to paranoia: paranoiac psychosis has no relation to personality; as Lacan corrected himself, it *is* personality.

The patients presented are not in fully delusional states: Lacan is not confronted with senile dementia; the chronic psychosis is rare. What do we see?

Some people representing elementary phenomena, about which the essential question is to give a prognosis of the evolution of the illness, and then others who in Lacan's sense are normal but are troublemakers whom the police or the courts have sent to the asylum and who may well spend a lot of their time coming and going because they have not been correctly grasped by the symbolic. They retain a defect, an inconsistency, and for that reason there is most often no way to hope to see a readaptation.

I recall a person presented last year whom Lacan counted as "one of these normal psychotics who make up our environment." "They want to give me validity," she said at the beginning, and she was right, because the large audience gave her a public. "I always have problems with my employers, I do not accept being given orders when there is a job to do, nor having a schedule imposed on me; I am neither a true or a false patient, I have identified myself with several people who do not resemble me, I would like to live like an article of clothing. . . ." Doubtless we note some beginnings of the creation of language; she had the fleeting idea that she was being hypnotized and that someone wanted to pull the strings, but there was nothing that took on any consistency. She was perpetually floating. As she said, in a remarkable formula, "I am my own part-time employee." A mother, she wanted to "resemble a mother," and when Lacan evoked her child, from whom she is separated, by showing a photograph, she did not respond.

From my notes I reconstruct when Lacan said: "It is difficult to think of the limits of mental illness. This person hasn't the least idea of the body that she is putting into this dress. There is no one to inhabit her clothing. She illustrates what I call 'seeming' [*le semblant*]. No one has been able to crystallize her. It is not one of the more marked forms of mental illness. What she says is without weight or articulation; to oversee her readaptation seems to me to be utopian and futile." Then, referring to Kraeplin, "We can call it a paraphrenia, and why not qualify it as of the imagination?" He continued, "It is an exemplary mental illness, the excellence of mental illness itself."

Doubtless this is teaching by enigma, but it makes us aware of what it is to suffer in having a "mentality." Every speaking being, gnawed by language, has a "mentality." Is hypnosis anything other than the effect of suggestion inherent in speech? Is the effect of mythomania not inherent in the subjective splitting induced by the signifier? What makes this patient excellent, demonstrative, is the fact that her being is pure seeming: her identifications, so to speak, have not formed the precipitate "me"; there is no crystallizer, no person, no one. She is retarded, if retardation consists in not being inscribed in a discourse. She was hypomaniacal, troubled, an imaginary without ego, a mirror attached



everywhere but captivated by nothing, pure "mentality" out of control. No master-signifier, and at the same time nothing that gives her substance, no object *a* to fill her parentheses and give her validity. (The object *a* is a singular Lacanian substance, made of a lack, but a lack that is constant gives to a subject an illusion of synthesis.)

Perhaps belaboring Lacan's fleeting indications, I will say that our clinical work makes us distinguish between the illnesses of mentality and those of the Other. The former derive from the emancipation of the imaginary relationship, the reversibility of ego and object, troubled in no longer being submitted to symbolic scanning. These are illnesses of being that approach pure seeming. To illustrate the latter, I evoke another case, that of a delinquent (twenty years in prison) who for three years has been hearing himself think and who has the impression that the world hears him and hears obscenities.

What we sense most clearly is that he can speak perfectly correctly: "from my early childhood," he says of himself, with emotion. He is fifty-two and bears the name of a father he never knew. Of himself he says: "I am a dirty bastard." That is his conviction; he does not float, he is not confused, he knows what he is, and he is worth nothing: he is manure. He has attempted suicide. Could we without this simple letter O (for Other) make a series of the people in his history, from the highly placed person who pardoned him to the eminent psychiatrist who examined him, to his wife, so perfect that he has no reproaches to make against her. He says starkly that his wife replaces his mother.

Throughout his life he has been faced with a perfect Other who has left no place for him, and this is why the Other does not err: he himself has been identified with waste, he *is* manure, and he takes his subjective consistency from this incontrovertible certainty. This is how we understand what Lacan says at the end. "He is unsubmersible." And he adds: "He believes in his wife, his belief is unshakable."

He believes in his wife as he would believe in an apparition from the beyond. He believes in a complete Other who lacks nothing; there is nothing he can give her. And from this he knows his own truth. His certainty of being "shit" and his belief in his wife are the same thing and are the same as the intrusion of the vulgar voice of the Other, which hurts him.

Finally a physician asks Lacan a question that law and humanity dictate: "Is he dangerous for his wife? I fear he is, I believe. . . ." "No," answers Lacan, assured of the structure, "he is for himself. I am afraid he will try again to commit suicide."

If there is a teaching in the presentation of patients, it is this: "Look for the certainty." One imagines that Lacan has gone to look for knowledge and cer-

tainty in Descartes and Hegel—which is also true—but what he says derives directly from concrete experience. If there is a clinical practice to be founded, it is in using these terms.

Knowledge, that is all the paranoiac knows. His relation to knowledge establishes his symptom. What persecutes him, if not a knowledge that ambles around the world, a knowledge that becomes a world. The subject, most often, is certain of the moment when he passes to the other side, of the moment of the onset of psychosis that Marcel Czermak described this morning. [See chapter 12 of this book.]

And where is this function of certainty more in evidence than in erotomania? This is what makes all psychotherapy so vain: it knocks its head against an unattainable certainty that engenders its own proofs. De Clérambault has made this into an entity whose validity is not questioned here. Instead of "certainty" he used the word "postulate," whose logical accent is perfectly appropriate to this function.

Because the erotomaniac believes in the Other's love, he believes nothing and no one, not even the Other who wants to tell him the truth. "He speaks to me in contraries," says the erotomaniac of his Other, "he was speaking to me in inverted parables."

The female erotomaniac elects an Object, in de Clérambault's sense, a canonical figure of the Other, who has no place for her. She is constituted in her delusions as its lack, passionately sought after. She is thus what is lacking in the Other who lacks nothing, this Other who is benefactor, omniscient and, if possible, asexual: the priest, the professor, the physician.

Mental illness is serious when the subject has a certainty: it is the illness of the unbarred Other. How is one to "therapy" this with speech, when speech can become idle talk? The illness of mentality, if it is not serious, does not take speech seriously, since the dimension of the Other is deficient. Who will explain the psychotic's transference?

# PART TWO. NEUROSIS