# Politics of Psychoanalysis

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# The demand for symptomatic desegregation

This is the conclusion of a sequence. You have heard my colleagues give a particular account of the results of our practice. It is particular in that it is intentionally oriented to bring out a dimension that we rarely explore in our case studies: the rapid therapeutic effect. As Jacques-Alain Miller remarked during the Conversation of Barcelona, to do so opens up two distinct possibilities: rapid therapeutic effects in long treatments or rapid therapeutic effects in rapid treatments. At the CPCT (Centre Psychanalytique de Consultations et de Traitements), it appears to be rapid therapeutic effects in rapid treatments. That seems evident since we strictly limit the length of treatment. However in many cases, this mode of limited treatment may be misleading. Often, in the cases that come to us, it is a question of subjects who have been suffering for a very long time and who have, in some cases, had various other forms of treatment. We also know that for some of them, the therapeutic effect obtained will only last for a while and that they will have to continue in one form or another. Nonetheless, the experience that they will have had with us is singular, it resembles nothing they have ever known. That is what gives the hallmark and the originality to the CPCT. It is an experiment, it is research. It is not about posing as brilliant therapists who have found a sort of philosopher's stone to treat the untreatable in a flash, it is rather a question about treating what it is possible to treat. To each, we offer something very different from what they have previously encountered.

## *The desegregative operation of the CPCT*

The great demand to which the CPCT is exposed offers food for thought. The free access to the Center places it in the service of a population whose subjective suffering is equaled only by the poverty, indeed the destitution that so often strikes it. The economic argument is a feeble one to account for the significant number of patients who go there. Medico-psychological centers (CMP) also offer free consultations. It seems to me that what we are seeing is rather the emergence of the demand for an alternative to the discourse of standards. In other words we could say that these patients want to escape from the DSM, whether they know it or not. The new clinic stemming from the DSM VI uses the conceptual compass of the observable at a moment "T." The description of the symptom is factual, collected by an objective observer. The diagnosis determines a standardized therapy of the symptom. In short, it is a matter of being expert in the description of the codified surface of human behavior and the strategist of a more and more direct link between diagnosis of this surface and the type of medication. From this clinic have been eliminated all references to meaning, to the subject's proper signifiers, to the unconscious and to enjoyment. This perspective led me to qualify humankind as defined by DSM VI as Man without subjectivity.

The discourse of standards offers the happiness found in categories. Become classifiable, Ladies and Gentlemen, and you will have the right to a protocol. The aim of the modern State, in its economic concern for limiting universal coverage, is well served by groups of sufferers delimited by standardized procedures. In "English Psychiatry and the War," Lacan remarks that psychology basically serves to select, and to this he opposed sectors as an antisegregative machine.

Along the same line, in his seminar on the psychoses, Lacan used the example of elephants. He noticed that when an international meeting is called to elaborate a charter for the rights of elephants it means that they are likely to disappear, that they are going to be extracted from nature. Lacan spoke during the time of the welfare state, of a for-all, a time that held in perspective the inclusion of all citizens of developed countries within universal protection. This guaranteed security for life and protection for all. With the elephant metaphor, Lacan was anticipating the opposite of universal social protection. From the moment the human rights born of the Revolution were converted into rights for protection according to such and such a protocol, changing the perspective of social rights won after the war, they became subject to the contractual world and the object of a generalized negotiation. The legislative measures currently in progress concerning the regulation of psychotherapies demonstrate just this. The authoritarian allocation of treatment according to the rules of the evaluation of good practices anticipates our becoming elephants. We will have our assigned place. It is a matter of handling people as if they were things. And people are beginning to understand what that means. Identifying human beings with elephants has become the key to world management. We have all become elephants, and not just because we do not forget.

What, in a Hegelian way, Lacan perceived about the classification of people under master signifiers has become a minor technique in population management. It is just a matter of classing them under the signifier population-at-risk. What risk signifies is variable, but it is always accountable, allowing for the allocation of tasks and duties. The "risk society" is a society of permanent allocations. For bio-politics, assigning human beings to signifiers means assigning them to classes of symptoms. During his classical period, Lacan subtly deconstructed the inherited traditional clinic for the sake of the particular, even while preserving its main articulations. He will resolutely base his second clinic on the particular of each case and will consider types of symptoms as an epistemological obstacle to be accounted for. Like Foucault, he anticipated the consequences of a bio-politics of identity. The modern-day way of handling populations is no longer by sending them to their death in foreign wars nor is it by ensuring their protection under a welfare state. It is done by creating segments of the population identified ever more precisely and by treating them with differentiated procedures.

The bio-political technique of classing, according to a need to massively standardize, is distinct from the subject's demand. The Cléry-Melin Report aimed at carefully distinguishing the demands addressed to the health care system from the needs to which it has to answer. The demands are put forward by a population, the need is what the State must answer to. It is truly the point of view of the master discourse. With a certain brutality, they have rethought the distinction between demand and need, introduced by Lacan. For Lacan in his rereading of Freud, need is the requirement of the drive, and the demand must pass through language. For them, it is a matter of extracting themselves from language in order to rediscover the purity of need while passing through biological testing or genetic screening. The CPCT is in fact a place where the bio-political identity aimed at by the DSM can be loosened.

### *The psychoanalyst's desire to attain particularity*

As Jacques-Alain Miller pointed out, the only people who go to see an analyst are those who have at least once experienced something enigmatic, a moment of perplexity, some occasion when signifiers escape from their usual signification. Those who live their life as though they were inside a dictionary will not take an interest in psychoanalysis. One must have the idea of a side-step in relation to the world as it seems to obey laws of regularity. Strikingly, we see that proportionally to the world becoming standardized there appears a taste for the esoteric, the sect, and individual beliefs. The "chestnuts" in magazines have an additional item, you know what a chestnut is, it is the kind of article that slips back into magazines every year

with subjects like: what's your salary, buying real-estate, should psychoanalysts be burned alive, love on the beach, etc. Now, there are inquiries into esotericism, satanism, etc. that are making the cover of every French magazine, one after the other. That simply shows that in times of mass standardization, the subject is looking for particular significations. When Freud called neurosis a private religion, he was daringly anticipating what shows itself to be self-evident today.

The patients go to the CPCT because they sense that the symptom, the "thing that's amiss," cannot do without language and that what is needed is an operation of speech that transits through the Other. It can be, above all, a call to the Other's knowledge, one that would deliver the meaning of the enigma and thereby allow liberation from it. Opening a space for the complaint produces a therapeutic effect even if the subject continues to enjoy a symptom that remains subjectively un-assumed. In this respect, we could say that the unfolding of the complaint provides a very rapid boost to life by the very fact that the subject's suffering escapes assignation to a protocol-determined mental pathology, which is itself a radical mortification. During his classical period Lacan would say that the signifier was the murder of the Thing. Nothing better exemplifies this phrase than observing the effects that categorizing the symptom can have on the subject. The CPCT's perspective is totally different. It upholds no ideals about compassion. It is part of the encounter with an analyst who receives the subject's will for desegregation by concentrating on the manifest particularity of the demand.

In Lacan's second clinic, he begins with the singularity of the exception that enjoyment is for everyone in order to question the very notion of clinical categories. The questioning of clinical categories on the basis of the particular becomes insistent from "The Analytical Act" onwards. It is a matter of getting at the particular way "it speaks, it enjoys," which cannot be reduced to a category. In this light, the analyst's desire is to attain the particular of the symptom. In the German edition of the *Écrits,* Lacan indicates that if the symptom is particular in psychoanalysis then "the question begins with this, it is that there are types of symptoms, that there is a clinic. Only here is the thing: it is prior to the analytical discourse, and if the latter sheds a light, it is sure but not certain" (p. 556). The psychoanalytical operation does not offer an *a priori* certitude but hindsight rather. One must go through analysis to know what the symptom is as a particular relation to enjoyment. The whole question is the way the symptom, in its double dimension of belief and knowledge, will be apprehended by the subject during the limited time of the treatment.

Lacan made the symptom a matter of belief, a supposition that the analyst authorizes and that the subject puts to work by engaging in the search for meaning and the deciphering of the symptom. If the neurotic subject addresses himself to the other it is in the name of supposed knowledge that might deliver the symptom's meaning. The delusional subject believes in the personal signification of his symptom and wants to expose the knowledge he has of it. These are very distinctly articulated modes of knotting the relation of the subject to enjoyment, ones the analyst must consider in the handling of transferential effects. To attain the particularity of the symptom, to aim for the singularity of the exception of enjoyment in each case, is to aim for the object *a*. That is, without knowing it, the aim of the technical theory of focalization used in brief therapies. As Lucia D'Angelo reminded us in Barcelona, the focus "is often defined by the motive for the consultation: symptoms, crisis situations, or a decompensation that worries the patient. We always find an exacerbated underlying nuclear conflict intimately linked to this motive; the focus filters into this specific situation". We say that our focalization operates by means of a framing the object *a* or the ordered pair of master signifier, $S_1$, and object *a*. In cases of psychoses, the accent tends to be on $S_1$.

The cases we receive at the CPCT are not typical. Typical neuroses generally go elsewhere, although some, be they "partial or in a network," do come to us. The cases of typical psychoses that come to us want to be considered as atypical, they do not want to be part of a treatment protocol, a permanent allocation impos-

sible for them to imagine as regards their certitude. For those subjects whose ordinary psychosis is more easily medicated with the standards of general medicine, there remains the intolerable reduction of speech to a silence offered by medication. There is also the necessity of finding new fastenings to stabilize meaning and enjoyment.

Hence, it is easy to deduce that at the term of the treatments proposed at the CPCT it is a matter of obtaining conclusions that may, certainly, be transitory but which are based on the greater or lesser importance of the therapeutic results for a given structure. Determining the structure beyond the symptom is what permits us to more easily plan the outcome. Let us begin by saying that in general, the first therapeutic effect is a boost to life, and sometimes a boost to desire. We also obtain symptomatic resolutions of course, but we keep away from supplementing enjoyment, which always has a more or less malignant effect. The various outcomes of treatment can be briefly outlined as follows. The patient is satisfied with the therapeutic benefit and ends the treatment before or at its anticipated term; the patient decides to continue the treatment elsewhere; the patient is referred for pharmacological treatment while generally continuing to meet with an analyst. And finally, let us add the case of patients whose psychological state is little compatible with an organized operation of speech and for whom a passage to the act is an iterative part of their existence. These patients are referred elsewhere at the time of their first meeting.

As we can see, it is not a matter of linking the demand for desegregation to a new objective: "take care of your problem in four months." That would simply be a new category for a protocol of our own invention. Of course we have one, but we are not entirely caught up in believing in our own rules. To believe as much would be an erroneous objective leading back to fanciful categories that confirm the master discourse on an imaginary level. As analysts we wager on obtaining a formulation that maintains this paradox: receive a subject with a demand that is sufficiently explicit but that does not bar access to a possible equivocation. That is exactly what focusing on the object means. For the neurotic, it means focusing on something that slips between signifiers; for the psychotic, it means focusing on what gives consistency to his certitude. The object need not be read only from the point of view of the master signifier. Putting the accent on the master signifier allows the object *a* to appear clearly. It is not a matter of binding the subject to his master signifiers but rather of clarifying enjoyment in a cycle where it can be treated. I use the term cycle with the acceptation introduced by Jacques-Alain Miller in Barcelona. That is, where a question about enjoyment can find a stopping point, a temporary nomination. Therefore, equivocation between the explicit demand and what is implicitly at stake must, in a limited time, allow the springing forth of the subject as an anticipated certitude.

I will use the example of two cases that taught me about this point. The first is that of a young South American woman who came to the CPCT in a state of profound helpless confusion. Depressed and in a quandary, she did not know what to do with her life. Should she take up residence in France and continue the specialist university courses that disappointed her? How was she to endure the solitude left to her when the lover she had followed to Europe abandoned her? Six months of weekly meetings allowed her to get her bearings. She concluded with the satisfaction of her decision to return to her country where a job and a new love were waiting for her. The CPCT showed itself to be the place for the resolution of a moment of truth. Something of her parents' first meeting in France thirty years before had to be repeated in order for her to meet a new partner. In a strict paternal identification, she had followed her fiancé to be abandoned like her father had been. Like him also – only more quickly, thanks to the treatment's raising of the depressive phenomena – she found a partner-symptom whose nationality and intellectual preoccupations were those of her mother. For this subject, the treatment at the CPCT was the space of an insight into that particular latent truth. This space for insight did not pretend to be a time for understanding. The greatness of the CPCT is in stopping there, even if we know that she will, when the time comes, go to see our colleagues

overseas. This case illustrates that the CPCT is more cosmopolitan that Paris itself and that it makes the language of the other speak. In this sense, it is planetary psychoanalysis. The second case, still in progress, found rapid therapeutic benefits marked by a lightening of important depressive and anxious elements that allowed for a boost to the subject's professional and intellectual activity. I centered precisely on the motive of his consultation. He attributed a particular importance to the feeling that he no longer had a place of his own after having moved house. His demand was to find a place of his own. From there, we went in to unrolling his history, always in connection with that point. It was then possible to get a grip on the coordinates of his present state, linked to the death of one of his parents. Without establishing a cause and effect relationship between the two, this allowed him to unravel the particular ties he was keeping with the defunct. He is in the process of progressively investing a space of his own, to paraphrase the title of Virginia Woolf's story *A Room of One's Own*. It is by focalizing on the signifier apartment, in its position as cause that the subject found a lively relationship with his familial heritage.

In conclusion, the CPCT is the space of a cause that we defend. It is not an ideal cause, it is the cause of a boost of life in a world that attempts to reduce the living to silence. A silence induced by extracting ever more refined protocols and knowledge from the living in order to obtain from it the very key to being that will finally permit its classification. In the face of the desire to massively standardize that has seized contemporary psychiatry we know that there will always be more CPCTs.

*Translated by Julia Richards*