

Quo Vadis Psychoanalysis?

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After practicing psychoanalytic psychology in the USA for a period of fifteen years, including having a personal psychoanalysis with a typical ego psychological/object relations theory IPA analyst for six of those years, I felt myself at a personal and clinical impasse. Five years after I had been pronounced cured by my analyst, my personal symptoms and suffering were even worse than before I started analysis. I became quite interested in Lacan's teaching, reading his texts, co-founding a Lacan study group, attending the various Lacanian conferences in the USA, but found that all this could not take the place of a Lacanian psychoanalysis.

The first thing that struck me about the Lacanian "psychoanalytic experience" was that nothing that I had read had prepared me for the raw intensity of that experience. In addition, I had expected a much more verbal technique, more oriented toward the analyst's verbal interpretation of my unconscious verbal material. In the USA, Lacanians are criticized for concentrating exclusively on language, only interpreting puns, slips, and other verbal manifestations of the unconscious. It is said that affect is neglected in the Lacanian clinic. My actual experience has been far from that stereotype. While it is certainly true that the task of the analysand is to work on finding the precise words to talk about his "symptom," to try and give symbolic form to the Real that determines him, the analyst's technique is frequently non-verbal. It is not that the analyst is mute or even that interpretations are never used; rather, all is oriented toward the intensification of the patient's daily encounter with the Real in the session which is at the heart of the "psychoanalytic experience."

It is in the daily encounter with the Real that anxiety is met, anxiety that signals the approach to unbearable *Jouissance*. In such a daily encounter, a few minutes feels like a lifetime. The short session, which is represented by the IPA as a horrible therapeutic deviation, a deprivation of the patient's inalienable right to a fixed number of minutes session, becomes,

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in reality, a merciful release from an unbearable encounter with one's Real.

The technique of the Lacanian clinician appears deceptively simple. For the most part, the analyst says little. He tries to allow the analysand to go as far as he can without interference. However, every act and word counts. The technique is strategic, without being behavioral. The analyst directs the treatment, but not the patient. He does not attempt to control the patient's words or actions. To give an example, one may contrast other ways the IPA and Lacanian analyst differ in how time is directed. Not only differing from the IPA analyst on the issue of session length, the Lacanian analyst gives an experience of time that is unusually fluid from the moment one enters the waiting room. Since appointment times are only approximate, sometimes one passes time anticipating the session.

The waiting can be quite profitable, giving opportunity to focus one's thoughts on the daily struggle to verbalize the Real. Other times, one arrives and is seen immediately, giving no time for rehearsal--you must find words before you know it. On other occasions, you think you are going to be seen in a certain order, as things appear to be on a first come, first served basis in the waiting room, but then, mysteriously, an other patient, or yourself, are seen first.

All of this has been quite extraordinary for an American such as myself coming from a personal analysis where he spent countless sessions being asked by his analyst why he was a few minutes late. The endless analysis of being late as my "resistance" went on for years with no apparent resolution. In contrast, Lacanian practice does not permit one to waste valuable session time being engaged in an obsessional, ego to ego struggle over who will control time, as did the IPA practice of focusing on the analysis of lateness as resistance. Due to the fact that both appointment times and session lengths are variable, it becomes literally impossible to routinize the experience of analytic time. The obsessional tendency to make things too predictable, to deaden or control the experience of time, is rendered null in the domain of analytic time by this approach. When time becomes fluid or unpredictable, an experience with the Real of the time of the unconscious becomes more

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probable. For Lacan, unlike Freud, the unconscious is not timeless. Lacan's notions about logical time render psychoanalysis a process with a real beginning, middle and end. The Lacanian approach to analytic time is an effort to render possible an encounter with the Real. With what techniques does the Lacanian analyst intensify and keep consistently occurring this daily encounter with the Real?

A major technique appears to be underlining the Real. When the patient gets closer and closer to the Real, the analyst may grunt or sigh in assent, intensifying the grunts or sighs as the Real is more and more clearly articulated. At some critical point in the session that the analyst must judge based on his analytic "savoir-faire," as the Real is approached by the analysand, the session is cut, sometimes followed by a brief and enigmatic "interpretation."

What the analyst says as the patient rises from the couch is purposely in the form of oracular speech; that is, the interpretation is never a direct meaning-fixing type of comment. Rather, by its very ambiguity, oracular speech stimulates the unconscious to continue to produce new signifiers. Sessions are cut short so that the patient does not have the opportunity to either talk back, to fix, or to deintensify the encounter with the Real.

Cutting the session is also a way of cutting into the patient's *jouissance*, the satisfaction beyond pleasure that the patient takes in suffering. Since speech itself is filled with *jouissance*, the cut of the session is also a way to cut into the patient's satisfaction in his symptom, the "surplus *jouissance*" that comes from talking about his symptom with his analyst. While talking is necessary on the part of the analysand in any psychoanalysis, from a Lacanian point of view, there is a definite limit to the mutative effects of speech as such. Merely talking about one's problems, "getting one's feelings out," and enjoying being listened to by a sympathetic other, is not what Lacanian analysis is about at all.

In essence, after the session is cut, the patient is dismissed with a sort of unspoken task or work to do for the unconscious. Perhaps, he will dream and, thus, put the unconscious to work in the service of the analysis. Clearly, since

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there is no one final Truth or ultimate symbolization of the Real possible, this technique of the Lacanian analyst can only gradually effect shifts in *jouissance* by underlining those key verbalizations of the patient that open up onto the many partial truths that approach, but

ultimately miss the Real. For Lacan, it is literally impossible to say the whole truth. It is that very impossibility that allows there to be any connection between the Real which is the impossible to say and the Truth which is the impossible to say completely.

How does the Lacanian analyst deal with those times that the patient is in an impasse, when the Real is not able to be approached at all in a session? There are a number of techniques that disrupt *jouissance*, to throw the subject's defenses a bit askew. For example, the analyst may indicate boredom by yawning or by rattling his papers on his desk. He may seem to not hear or even "misunderstand" what the patient is saying. All of this is quite effective in creating a brief anxiety or momentary confusion which cuts into the impasse of *jouissance*. If none of these techniques within the session are sufficiently effective to send the subject's discourse into another "less stuck" direction, cutting the session short is a most powerful method. Upon leaving his session, the patient reflects on why they may have been blocked in their access to the verbalization of their symptom on that day. Anxiety and perplexity may result from the session being cut short, possibly leading to a greater determination on the analysand's part to find a more effective "bien-dire," that is, a more effective way of saying what can't be said of the Real of the symptom. Instead of relying on a concept such as resistance, the Lacanian analyst feels that it is the *jouissance* of the symptom and the too-present object of desire "a" block access to the unconscious. In *Seminar XI*, Lacan described the unconscious as opening and closing. The *object "a"* is described as blocking the opening up of the unconscious, leading the patient to feel that the "truth" to be found in the signifying chain is inaccessible to his associations in the session. The too-present *object "a"* may not only block speech but also lead to an increase in anxiety. Anxiety, for Lacan, is the only emotion that is not deceptive. It signals, the presence of the Truth and the Real but, if excessive, may make it impossible for the analysand to speak.

Current IPA practice is influenced by a mixture of ego psychology and object relations theory as well as so-called interpersonal theory. It is informed by a concept of the ego as masterful and integrative. The analyst seeks to ally with the ego, in essence to convince the ego of the reasonableness of giving up symptoms, to re-educate the ego to better understand and cope with intrapsychic conflict. In essence, the analyst offers himself as a kind of normal ego who will help the patient's weak ego to cope. This is especially the model with severe pathology. Current IPA practice is very much informed by psychoanalytic development psychology which attempts to provide a model of normative child development. Thus, pathology is conceived primarily as a deviation from a statistical norm. Not only is the analyst conceived as a normal ego, but also as a master of truth, the one who knows. Consequently, even if being analytically neutral is taught as the ideal stance, deviation is quite common. Take the example of interpreting resistance. If the patient agrees with the interpretation that they are resisting, the analyst is correct. He knows. If the patient disagrees, the analyst says that they are resisting. The analyst still is the one who knows. In any case, Lacan pointed out that the only real resistance comes from the analyst. This is the only sense in which the concept of "counter-transference" has validity for Lacan, even though he didn't call it that. The analyst's own resistance against the emergence of the Real may block the patient's "psychoanalytic experience" of the Real.

In the Lacanian clinic, the stance of the IPA analyst as the interpreter of sense and meaning is erroneous because he takes himself to be the master of Truth and is personified as the "real" object of the analysand's transference. Instead of realizing that the patient seeks a missing

knowledge and a lost object, the IPA analyst interprets his own counter-transference in order to fill in the patient's missing knowledge, as if he the analyst, by being another subject, like the analysand, could know via "empathy" what the patient doesn't know. The IPA analyst takes himself not to be a "semblant" or stand in for the missing knowledge or missing object; he really believes he could know or be what is lacking in the patient.

In the transference-countertransference interpretation

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paradigm, the IPA analyst interprets the transference resistance when the patient does not show appropriate affects and "normal" love fantasies about him. The analysand must sexually and affectively desire the person of the analyst in order to have the "corrective emotional experience," to have normal object relations afterwards. For the Lacanian analyst, what is loved in the analyst is that the analysand supposes that the analyst is a subject who has the knowledge that is missing to the subject as to how to make sense of the lack of a sexual relation between the sexes. When Lacan said, "There is no sexual relation," of course, he did not mean that men and women don't have sex. What he did mean is that it is traumatic for the human being that men and women's desires are not reciprocal, that each of the sexes relates to a different object of desire, that men and women are not "made for each other" in any biological or psychologically pre-determined way.

For an IPA object-relations oriented analyst such as Winnicott, or others of the British school, the patient has suffered from traumatically unempathic parents, and now, the analyst shows that he will be the "good-enough mother" who can make it all better by his empathic listening, if only the patient would stop resisting and trust him. Thus, a basic confusion exists in the IPA clinic between the external interpersonal relation (even when called internalized object relation) and the *object "a"* as "extimate" object, that is, the object that is, at once, most intimate, and yet, exterior to the subject, as well.

Lacking any concept of the object as radically and permanently lost (as was the case in Freud's theory) and, thus, having no place in their theory for notions such as desire and *jouissance*, the four fundamental concepts of psychoanalysis, what Lacan identified as the unconscious, the drive, the object, and repetition, have been rendered as either innocuous or are ignored. Psychoanalysis in the IPA, as practiced today, is scarcely more than a theory of normative ego and object relational functioning. Object Relations Theory, in particular, is a pseudo-scientific theory that places heavy emphasis on conformism and Puritanism, pretending that the absence of "politically-correct" moral virtues indicates a weak ego and poor interpersonal relations. The healthy "genital" character

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is allowed precious little individuality and his sexuality must be monogamous, if he is not to be judged "promiscuous," and thus, undifferentiated and primitive in his object relations. In such a theory, there is so much unacknowledged moralism, that there is little room for a true ethics of psychoanalysis. Speaking the truth and not giving way on one's desire, as expounded by Lacan in *his Seminar VII*, are not signs of a healthy, well adapted ego, nor are good object relations. Undoubtedly, one would see ethical heroines such as Antigone as being poorly adapted to her

society and, thus, as someone with ego deficits, including poor reality testing and poor object relations.

Is it no wonder with such a theory, that IPA psychoanalysis is conducted strictly on an imaginary level? After a session where I had discussed the effects of a particularly traumatic set of events with my father. I wondered how it was possible that I had not discussed this in my first analysis, given its extreme importance.

I can only imagine that being stuck at a certain level of imaginary discourse in my previous analysis had as a result that I never arrived at this traumatic Real. It was as though my whole treatment had been a kind of huge detour in the Imaginary circumventing any direct approach to the Real.

How can all of this be made clear to American clinicians, in particular, who are sure that, as they live in the greatest country in the world, that, of course, they must be practicing the best of all psychoanalyses. Lacan is truly an affront to their narcissism as they can not integrate him into their melting pot of theories. It is simply not democratic that he may be correct and they not. At the very least, Lacanian theory should be able to be integrated into the "melting pot" of American eclecticism. The fact that Lacanian theory can not be integrated and that Lacanian practice is a radical rebuke to that of the IPA account for the generally hostile attitude toward Lacan. As one venerable IPA analyst put it to me: "Lacan, what does he know?" Indeed, Lacan is hated, and thus, de-supposed of knowledge a priori. Many IPA clinicians, for the most part, not only do not know Lacan's work--they do not want to know it.

Yet, why should this come as a great surprise? Many IPA clinicians proudly believe that their theory is a real

advance over Freud's, let alone Lacan's theories. It is difficult to imagine Lacan's teaching ever having any real impact in the world of the IPA without, first, the validity of his return to Freud and his critique of post-Freudianism being acknowledged. For this to happen, there must, first, be a dissatisfaction with the results of the psychoanalytic clinic as practiced in the IPA. Perhaps, the increasing growth and popularity of numerous non-psychoanalytic psychotherapies in the world are signs of such a growing dissatisfaction. So far, IPA analysts take these signs of discontent to be merely evidence of a resistance against the Truths that they bear. Undoubtedly, this "resistance" is to be understood with the help of their own counter-transferences.