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Psychoanalytic Clinic in Institution

Preliminary question: which psychoanalytic orientation?

The terms with which a question is formulated already imply by themselves the choice of an orientation in the very field in which the question is posed. To pose, for example, the question of the age at which a child accedes to the Oedipus complex presupposes a conception of the clinic, linked to both a conception of causality in human pathology and of psychoanalytic action, which is entirely different from that presupposed by the question of the place a child might come to occupy, insofar as product of the sexual encounter between two subjects, in the desire of the Other.

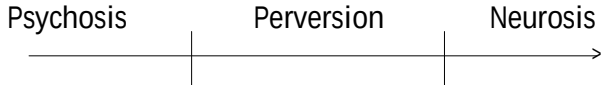
In the same way, the formulation of the question which frames an institutional practice hark backs to presuppositions which converge at a same orientation, at once a conception of the clinic, a conception of the transference and an analytic position. Thus, the question which presides the most often over the exposition of an institutional practice -- «Can one exercise, or how does one exercise psychoanalysis in a hospital, out-patient clinic, mental health center, community?» implies by its very formulation an orientation of this practice whose precedents, unseen, nonetheless command its difference in relation to the orientation supposed by another way to introduce the problem -- «What clinical structures, what subjective positions, which requests does one encounter in a mental health center, a hospital, a community?»

The first formulation puts the accent right away on the «to do» of operators and testifies to an identificatory preoccupation. How and to what point is it possible to apply or adapt a method and a knowledge to another context than the classical context of «private practice»? What can we do for all these people? In other words, are we, in institution, what the

others are, or what we ourselves are, outside the institution? This question on identity proper is at the origin of the «project,» of the need to be useful, the development of a range of techniques distributed according to diplomas and «training» which purely and simply leaves the question of the clinic in the shadows. Moreover, this is confirmed by the simple existence of all the conceptions which define themselves by a term composed with the suffix «therapy» -- family-therapy, behavior-therapy, Gestalt-therapy, etc. These strictly do not include a clinical chapter; which is to say, they don't furnish concepts permitting one to say what is a paranoia, an obsessional neurosis, a melancholia, etc.

Placing the accent on the originality of a method, on the project, on the work of the operators is rooted in a reference to an ideal from which one sees oneself being, which completely blinds one to the primary dimension of the clinic. Everything happens then as if it went without saying that we only encounter a sort of psychiatric subject, average or generalized, neither psychotic, nor neurotic, nor perverse, a sort of invalid *to diverse degrees* -- what good is it to question myself on the clinical structure of a subject if my first concern is the level of my place in the hierarchy of skills -- to which one applies indistinctly a method or the techniques that the institution retains. When the primary preoccupation is «what can I do,» the dimension of structural differences between subjective positions tends to remain implicit, as if its simple evocation, recalling the difficulty or even impossibility that the clinic implies, would already menace the supposed being who supports himself with the «doing» of the operator. Furthermore, one currently notices that where the accent is on the therapeutic potential of a caregiver or a team, the question of the diagnostic is received with distrust or irritation, under cover of therapeutic care («What is important is what we can do for him, and not what he is...») which, in fact, hides the preoccupation for one's own identity as therapist.

In operating thus, as if the same mode of response to the transference where pertinent in every clinical conjuncture -- the difference being reduced eventually to a difference of level in the contents of the interpretations addressed to the subject -- one refers, in fact, to a clinic of the evolutive *continuum*. Behind the apparent indifference to the question of the diagnostic, or behind the distrust of the symptom is a very precise clinic, however implicit, that one supposes: a clinic of regression on an evolutive scale which puts into continuity the different clinical forms as so many manifestations, more or less acute, of a perturbation in a sole «global structure of the personality.» In conceiving clinical types along the lines of their succession, such a perspective ends up homogenizing them and making them degrees of a single pathology:

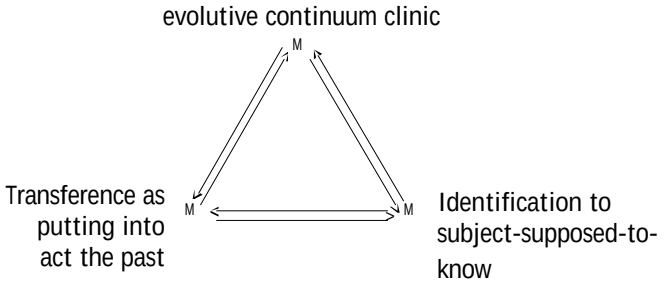


This is why this underlying clinic is not incompatible, and is even entirely identical to a clinic of the coexistence of many, different, diagnostic «nuclei,» even a clinic of the passage from one diagnostic level to another.

Yet, if the therapeutic ideal tends to such a clinic as it itself secretes, it is because, on the one hand, it rests on a conception of the transference as the repetition of an infantile past -- more or less «archaic» according to the gravity of the actual deficits -- and that, on the other hand, this same conception of the transference supposes that the interpreter -- the analyst or therapist -- is exterior to the transference. From thence derives a conception of action that is reduced to a response from knowledge (notably as an interpretation of the transference itself), thus excluding the actual relation of the subject's desire to the desire of the Other. This conception reproduces, at the heart of the analytic field, the schema of medical action:

The practice is then essentially conceived of as an application or communication of this knowledge to the patient. And the institutional collective is organized as a set of skills, of knowledge, of techniques coordinated in a global «therapeutic project» which should be prescribed to the patients who present themselves there.

One sees in this way that the devaluation or initial oversight of the clinic in favor of the therapeutic ideal is, in fact, one with an analytic orientation that ties together in reciprocal determination: a very precise theory of causality of clinical phenomena, a conception of the transference and a definition of the act the corresponds:

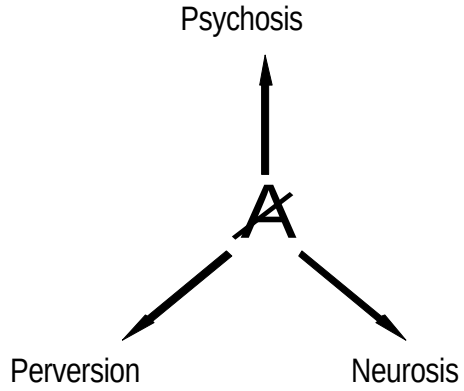


Inversely, the implicit or explicit option for this analytic triangle determines a configuration of institutional practice which puts its

ideal, its potential and its project at the center of gravity to the detriment of a clinic of the subject.

A rotation of 180 degrees is produced in the orientation of a practice when it takes as departure point not the identificatory preoccupation («who are we?») but the clinical preoccupation («who are they?»). Already, the simple fact of describing the diverse clinical forms, modalities of the demand and subjective histories -- often the object of numerous anterior therapeutic actions, moreover -- renders entirely impractical the generic presentation of the method, project and goal of the institution -- conditions to which any subject would have to submit in order to benefit from its effects. So great are the differences between the «projects» of each subject and notably between a subject whose relation to the Other is necessarily persecutive and a subject whose being through or for the Other is, on the contrary, the essential wager of his existence.

Rather than refer to a sole evolutive line, the different clinical types are distinguished from each other along three evolutive lines that diverge from a point that one might call an initial lack of unity: O barred.



When objective difficulty is posed, and opposed to all good will on the part of the Other, we see the dimension of what Freud designated with the term «death drive,» acting sometimes in a ravaging fashion in the existence of the subjects who frequent or stay in the institution. When this difficulty is taken into account first, a discourse on *our* work, *our* method, *our* project becomes less important than the question of what is at stake in the jouissance of the subject, beyond any aim of happiness which magnetizes his relation to the Other-supposed-to-be-able-to-cure.

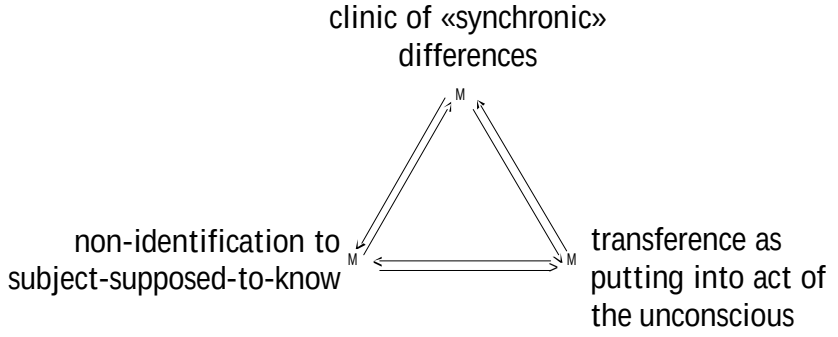
This modification in departure points not only, from then on, renders untenable a discourse on the institutional practice which tends toward generalities and makes abstractions on clinical differences, but, in displacing the accent from the institutional ideal to the real at stake for each subjective position, also modifies, or say rather is accompanied by a modification, at the level of the apprehension of the transference and the corresponding analytic position.

A differential, structural clinic which doesn't put into chronological continuity the clinical types, but distinguishes them by their synchronic differences -- according to three different modes of relation to the desire of the Other -- implies a theory of the transference that reincludes the actual relation of the desire of the subject to the desire of the Other, and thus an entirely different theory of the transference than that which essentially makes of this relation an affective anachronism -- it is always a figure from the past that one loves behind the figure of the present lover. The consideration of synchronic differences between clinical structures is, on the contrary, correlative to a conception of the transference as the current relation to the Other: whether it be the mother, the doctor, the teacher or the psychologist. The deception of love is not an error in the person, but an error of love in itself, to put it rapidly. It is from this error that the current relationship to the desire of the Other, which is to say, also the transference, tends to be exercised in the direction of the being that the subject believes he will obtain, rather than in the direction of unveiling his lack.

At the same time, what becomes crucial in the response to the transference is no longer the type of knowledge destined to dissipate the error of the subject, but the desire (and the nature of this desire) of the one who responds now. For the status of this desire of the Other is not the same in neurosis as it is in psychosis, as the status of the lost object is not the same. Hence the importance of the clinical moment, insofar as preliminary to the institutional response to the transference, since each of the structures requires a different response, a different position in the transference. One knows only too well the difficulty of differential diagnosis in certain cases, if, to cite Lacan in his seminar on *The Psychoses*, there is nothing that so resembles a neurotic symptomatology than a prepsychotic symptomatology.

One sees the circular relation existing between the choice of an analytic orientation and the departure point of the institutional discourse. If the departure point of the practice is caught in the real of the clinic, it is not due to a vain taste for theory. It is in function of the whole analytic orientation that it is caught up in the real. With the initial choice of the importance of the clinic, it isn't only a question of taste; it concerns the choice of one clinic over another, and with that, a conception of the transference and a definition of the act. In comparison to the orientation expressed in a preoccupation with therapeutic identity, we also represent

the orientation that underlies a displacement of the accent on the therapeutic project of the Other to the clinical structure of the subject, with the same graph as before, but in modifying the terms at each summit:



I would add, without developing it here, that the root of the difference between the two «triangles» resides in the distinction between the desire to be an analyst and what Lacan designated as the «desire of the analyst» insofar as function of the response to the transference.

I will try now to develop some of the consequences of opting for this second orientation. It must have already appeared to you that the first consequence consists of none other than replacing a discourse on the institutional practice «in general» with a differential discourse according to the clinical structures. Unable to speak of everything at the same time, I will speak here of the institutional practice with adult, neurotic subjects.

Neurosis in the psychiatric field

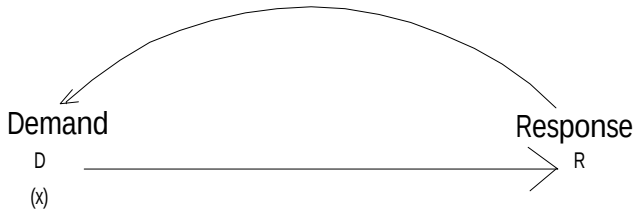
In relation to the psychotherapeutic schema, a radical modification is introduced into the field of the practice when this simple displacement of accent from the therapeutic project of the Other to the «project,» whatever it might be, of the subject is put into act in the functioning of the institution. When the question is no longer what we're doing here, how we work, what is our objective, but what the subject wants to do, plans to do or not do, why he comes here rather than go elsewhere, etc. already the dimension of «to do,» of the project, of the ideal is displaced from the field of the Other to the field of the subject. At the same time, it is now a question that will emerge at the level of method, of objectives, of project, which is to say of demand or request, of this group of people who let the subject speak rather than speaking of what they are going to do for him. The two phenomena are correlative.

If it is up to the subject to say what is his «project» -- to be healed[1] doubtless, but also to speak to someone, to not be alone, to have an occupation, a lodging, to stop drinking, learn to manage his money, etc. -- the institution where he will find all these things -- assistance, occupation, lodgings, communal life, medication, etc. -- finds itself at the same time deported to the side of the instrument, the object with which the subject is going to serve himself, without its having a goal, a project, a request of its own, rather than the side of an Other who uses its instruments to modify the subject. Of course, the institution enunciates some «rules of the game» or some 'no nos' to be respected, but those have nothing to do with the demands that it would formulate for the subject with a view to attaining a modification of the behavior traits of which he complains -- such as the obligation to participate in groups to cure his shyness, for example. The institution simply takes action, adopts the project of the subject. But in the place of what it wants, of its project, of its ideal, nothing is formulated. It remains blank; thus a question place for the subject. At the center of the group of people, activities, responses to the «transitive» requests of the subject; in place of the institutional ideal, there is an *x*.

The psychotherapeutic schema inverses this initial configuration. On the one hand we have the subject who comes with his problems, who poses his question to the Other and makes the Other work; he doesn't understand, he can't, and it's up to the Other to say what he knows and what it can do for him. On the other hand, we have the institutional ensemble with a project of work, a set of techniques and a knowledge waiting to be applied to his case. The *x* is on the side of the subject; the *ideal* -- objective, end, reason for being -- is on the side of the institution. The subject will frequent the center or stay in the institution with a view to being enrolled in the program of activities and practices that are destined to ameliorate his state, at the limit, to cure him. A contract is established which reconciles the subject's request with the Other's request. He requests healing? The condition for staying or frequenting the center is that he accept to let himself be healed, that he follow the program that the institution had set up to realize its reason for being. At the heart of all this apparatus will be the counter-request of the Other.

The frequentation or stay thus find themselves justified by a goal, a reason, an objective which are none other than those of the institution, as becomes apparent when the subject who doesn't put enough conviction into it and who is only there, in sum, for the «advantages» is told in a menacing tone, «This isn't a hotel. It's not a club, here.» This lets it be understood that the operator is not there to play guardian, or cruise director, but «therapy»...

Yet, what the psychotherapeutic schema covers up is the fact that this inertia on the part of the subject is precisely the consequence of the schema itself. The subject comes with his question, his problems, his difficulties and the Other responds in proposing itself as holding the method, the program and the knowledge that are supposed to resolve them. For this reason, nothing changes in the position which had always been that of the subject in his relation to the Other: that of an identification to a lack -- what is lacking in knowledge, what is lacking in satisfaction -- which is a defense against a desire raised so high that no satisfaction, no knowledge can ever hope to surmount it; whatever is offered, it is never the right thing. This position permits the subject to obtain in return a gain in being, precisely that gained by the subject by the very fact of his making his negativity the cause of the inconsistence in the Other, the cause of his burden as well as his worry, the cause, in sum, of his desire. All the while in participating in the planned program, all the while in conforming to the project of the team, the subject camps out always in the position of he who poses the question to the Other, provoking its effort, its work, its solicitude («But what should be said to him? How should I take him? What program should we propose?»). He remains the *x* which sets the Other to the challenge of deciphering. At the heart of his demand is the object of the desire of the Other.



The *x* remains on the side of the subject's demand; the ideal, the knowledge on the side of the Other's response.

The addition of a practice of speech, whether or not with a psychoanalyst,[2] changes nothing in the circuit demand-response (speech-listening) if it leaves unchanged the schema bearing the maintenance of the «project,» of the «to do,» of the ideal on the side of the response. As long as the Other is there to elaborate the method, the technique, the knowledge which is supposed to make the subject come back from his false ideas about others, about women, about men, about authority, work, pleasure, etc. and orient him toward the natural objects of his desire, nothing will change in the structure of the address which might leave the subject in place of the question of what he is for the Other, and the Other in place of

the knowledge he believes able to propose disguised as a response. The more the Other mobilizes and goes to the trouble to elaborate this response, the more its transferential idealization is secretly sustained by the jouissance of the enigma that the subject makes of his being for his knowledge. Being-question is a position determined by closure; the subject finds in it a way to make himself the cause of the Other's desire, the counterpart of a being more precious than any satisfaction that might be attained if he went to work, even when this being is also at the root of that about which he ceaselessly complains.

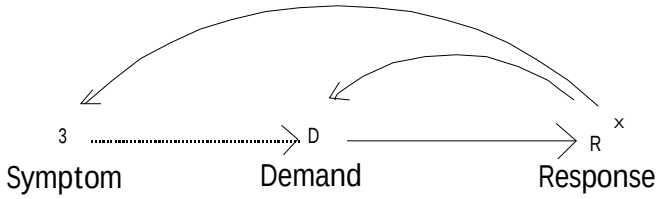
On the contrary, what happens if the group receiving the demand -- which is always, at bottom, as Lacan has shown, a demand for love (a demand to be heard beyond all that one demands) -- what happens if this institutional group responds in such a way that the subject doesn't know what their project is, the goal and end which motivates this reception? What might happen if, in the field of the response to his demand, the subject encounters not a total void -- for he will encounter a lot of people and things there -- but a central void in place of the project and ideal coming from the Other to justify its presence in this field? Well, what happens, quite simply, is that it falls to the subject now to ask himself why he made the request, why does he want to frequent the center rather than something else? Why does he want to live, join in the crafts, sports, artistic expression, computers and other marvelous activities there, rather than outside? In short, it is up to the subject to elaborate, on this side of what he came looking for (which the ambient discourse whispers to him already: to be surrounded with a framework, helped, healed...) something of the why this procedure -- why in the sense of «because of what.»

It mustn't be forgotten that the frequentation of a center, the participation in so-called therapeutic activities and living in a community unlike the others are firstly the consequence of a difficulty. They are not the same as this difficulty, for it is manifest that these activities and this life first constitute something that comes *in place of* activities and a life which are difficult, problematic, unbearable to do or live «outside.» They are thus firstly the consequence of difficulties engendered by the symptom before being the pretended remedy. Moreover, it's difficult to imagine how the fact of experiencing anxiety in social bonds, for example, can be «healed» by the experience of artificial social bonds, imprinted with goodwill, openness or any other therapeutic quality, anymore than anorexia could be absorbed by the action of a qualitatively different modality of feeding. The «amelioration» obtained within the institutional perimeter melt like snow in the sun once the subject leaves, when a modification of his subjective position in relation to the Other of knowledge has not taken place. This why outfitting the stay or frequentation of a psychiatric institution with a therapeutic end precisely hinders the subject from questioning himself on the symptomatic nature of this very stay or this very frequentation. This

makes for an impasse in the possible deployment of this question which would go so far as to question what in his life repeats, jams up, remains opaque to him and brings him, among other things, to the institution. Before being those of which he complains in the institution, his symptoms are firstly those which, in life outside the institution, place him in the necessity to stay in institution and postpone, eventually, the moment to leave. Condition of the possibility to «go to work,» not of the team, but of the subject himself, this interrogation on his destiny, including his being in psychiatry, is already a modification of the initial subjective position of patient or victim. The elimination of this moment only gives rise to the obscenity of professional rituals which only ratify the assimilation of an momentary institutional condition due to the symptom with a social definition; «getting help» becomes an alternative to the ordinary, social condition -- a sort of trade or civil status. Outfitting these moments with a therapeutic goal hinders the recognition of the substitutive, palliative nature, and thus of their «symptomatic» nature. On the contrary, when they are not justified by a therapeutic goal, they can manifest themselves to the subject in the prolongation of what motivated his presence in institution and, from then on, be connected to what hinders or burdens him in his life outside the institution.

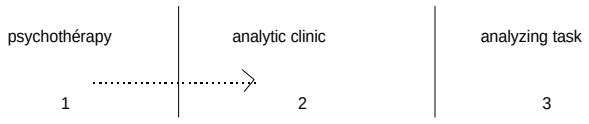
But, then, what is the goal of the institution? What good are all these activities and all this personnel? What does the team expect of the subject? It is precisely setting out from these questions, which take the place of the awaited request of the Other lack, that the subject is brought to ask himself what pushed him or obligated him to stay. And, occasionally, it is this that brings him to finally recognize it as an intimate contradiction. For example, when he complains of the derisory or useless character of the activities, or refuses to continue to live with these people «who have problems» at the same time that he doesn't even envisage or do anything to leave, it is in this sort of moment that the clinical reason for his stay will be displaced toward an elaboration of his difficulties, malaises, fears, lack of interest which hold him up in face of the perspective of leaving, rather than leading him to yet another remedy, yet another therapy, yet another institution. The void he encounters in place of the institutional ideal comes back as a question. From then on, the reasons for his presence in institution take the form of signs of internal division, an opposition of self to self, a foreign body proper to himself. Denuded in its clinical dimension, his presence in institution sends him back to a preliminary question and constitutes a modification, albeit minimal, of his position. The stay is transformed into a clinical stay in the sense of an interrogation on the cause of the very stay.

One might represent the logic of this moment in the follow fashion:



The *x* designates, in place of the response (constituted by all that the institution is supposed to contain in relation to the demand addressed to it), the point of lack in place of the demand of the Other, of its project, of its ideal. In this *x* originates another retroactive vector no longer concerning, for the subject, the question he poses to the Other, but the question that is posed to him about what causes his address, about what doesn't work in his life.[3]

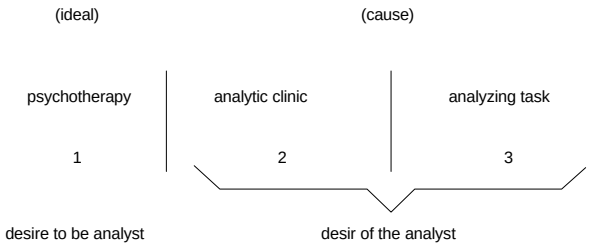
To motivate enrollment in the psychiatric field through a *goal* is not at all the same as to do it through a *cause*. In the first case, the clinical moment is short-circuited in favor of the ends of the institution. When the response to the enunciation of a suffering, a difficulty, an incapacity is a therapeutic program, the form of the symptom hardly differs from a medical symptom, a sort of foreign body, and the care of explaining and treating it is left to the knowledge of the Other -- when it isn't already formulated as such by the subject himself («I was advised to come to the center because I'm in a depression»). On the contrary, when the institutional response includes, in place of its ideal, a void (which is not a pure void because it is full of the same activities and personnel as one encounters in institutions oriented otherwise)[4] this central silence becomes the resource of a mutation in the very structure of the relation to the Other, and with it, in the status of the symptom. It is no longer question of verifying if the motivation of the subject corresponds well with the *project* of the institution, but leaves to the subject the elaboration of the *cause* of his coming. This difference in the reception of the demand, which doesn't seem like much, however marks an essential threshold: nothing less than the passage from the relational structure proper to the psychotherapeutic field to the relational structure proper to the field of the psychoanalytic clinic.



The passage between the two fields, between one and two, is correlative to a mutation in the subjective position of the demander. It already includes a displacement, be it infinitesimal, along the vector going from the pure demand for love -- which is the native position, if you will, of the neurotic subject -- to the desire to know. With the passage of *x* -- which is to say, what makes speak, what makes work -- from the side of the subject to the side of the Other, the subject cedes a bit on his closed position and can engage in the elaboration of a knowledge that would respond to his demand.

Giving up on a therapeutic ideal, abandoning our powers of explanation, counseling, directing, above all if one knows through experience that they have no other results than to provoke the repetitive denial of what is «beyond the pleasure principle,» is well worth the subjective mutation which is at stake here. Six months, one year of «symptomatic» stay is worth lots of years of therapeutic amelioration which modify nothing in the position of the subject, neither regarding his jouissance, nor even regarding his circuit of social security benefits. And after all, don't we know that these requests for analysis can take six months, a year, if not longer before attaining the threshold of a decision?

We consider, at the Foyer, that the application of the analyst's discourse does not correspond to the injection of psychoanalysis in the psychotherapeutic field, but to the substitution of a clinical field permitting the subjectivation of the symptom for the psychotherapeutic field.[5]



Naturally, this mutation of the subjective position is not automatic, as is the application of the therapeutic project. It remains possible for the subject to not cede on the jouissance of his question and his ineffable truth. At least we don't add the alibi of a therapeutic program to his refusal to set to work, which is, after all, his right. And it isn't by our wanting for him in his place that anything will be modified in his subjective position.

[1] Note already that if there were only the objective of being healed, it is difficult to see how this suffices as justification for the presence of the institution. Thus, before even coming to the clinic to be healed, the subject comes *because* of the fact that he cannot be healed «outside.» The axis of the ideal: *to* be healed (from whence proceeds the identification of those responsible as «healers») passes in silence under the axis of the cause: *because* he refuses or cannot be healed outside.

[2] Alfredo Zenoni. «Objet du transfert et reponse de l'analyste.» *Quarto* #44/45: Oct., 1991; pp. 59 - 64.

[3] Designated by the letter ***epsilon?*** as initial of the symptom.

[4] This is not the case when the activity is referred to a specialist from whence it exits transformed into a therapeutic activity: horseback riding becomes hyppotherapy, crafts become ergotherapy, the interview becomes psychotherapy, etc.

[5] The choice which must guide a practice of analytic orientation in institution is not that of making an exception to the ensemble of the institutional field, but of modifying the field. In other words, it isn't about adding an analyst to an institution with «a therapeutic project» as the element that is not submitted to the demand of the institution, but, to put it briefly, that he take part in the transformation of this very institution, even in the creation of another institution.