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PSYCHOTHERAPY, PSYCHOANALYSIS AND HYSTERIA

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It is common knowledge that Freud started as the pupil of his hysterical patients. He wanted to know and that's why he kept on listening to them. During that time, he coined the idea of *psycho*therapy, which was rather new at the end of the nineteenth century. Today, psychotherapy has become a very common practice; it is even so common, that no-one knows any longer what exactly it means. On the other hand, hysteria as such has almost disappeared, so much so that in the latest version of the DSM, the *Diagnostic and Statistical manual,* there is no longer any mention of it.

This means that my paper is on the one hand about something that does not exist any more, and on the other hand about something that exists far too much... So, it will be necessary to define what we, from the psychoanalytic point of view, understand by the word "psychotherapy" and what we consider hysteria to be.

Let us start with a common clinical situation. A client comes to see us because he has a symptom that has become unbearable. Within the context of hysteria, this symptom could be almost anything, starting with classical conversion, phobic complaints, sexual and/or relational problems, and ending with the more vague complaints of depression or discontent. The patient presents his problem to the therapist, and the normal expectation would be that therapeutical efforts will result in the disappearance of the symptoms and in a return to the *status quo ante,* the previous state of health.

This is, of course, a very naive point of view. It is very naive because it does not bring into account a remarkable little fact, namely that in most cases, the symptom is not an acute one, on the contrary, it's rather old, dating from months, even years back. The question to ask at that moment is, of course, why does the patient come now, why didn't he come much earlier? If one looks into the situation, one will always find the same answer: something has changed for the subject and as a consequence the symptom has lost its proper function. However painful or invalidating the symptom may be, it becomes clear that before this change, the symptom ensured a kind of stability for the subject. It is only when this stabilizing function has been impaired, that the subject asks for help. That's why Lacan remarks that the therapist should not try to adapt the patient to his reality. On the contrary, he's all too well adapted, since he assisted in the construction of that very reality.[1]

At this point we meet one of the important freudian discoveries, namely *that every symptom is first of all an attempt at recovery, an attempt to ensure a stabilization of a given psychical structure.* This means that we have to reword the expectation of our client. He does not ask for the disappearance of his symptom, no, he just wants us to repair the original stabilizing function of it, which has been impaired due to a change in

[1] J. Lacan. *Ecrits, a selection.* Trans. A. Sheridan. New York, Norton, 1977, p. 236.

the situation. That's why Freud could coin a very strange idea, strange in the light of the above mentioned naive point of view, namely the idea of "flight into health". You'll find this expression in his case study on the Rat Man. The therapy has just started, there has been a little gain, and the patient decides to stop, he feels much better. The symptom as such has hardly been changed, but apparently that doesn't bother the patient, it only bothers the surprised therapist.

In view of this common experience, it is necessary to redefine the idea of psychotherapy as well as that of the symptom. First of all the idea of psychotherapy, - there are lots of different kinds of therapy, but roughly we can classify them into two opposite groups. On the one hand we have the re-covering ones, on the other hand the dis-covering ones. To *re-cover,* meaning not only to get better, but also to cover something up, to recover, that's almost an automatic reflex of the patient after what we will call a disrupting incident. In most cases, this is also the therapeutical reflex. Patient and therapist form a coalition in order to forget as soon as possible what was psychically disturbing. You find the same process miniaturized in the reaction to a *Fehlleistung,* e.g. a slip of the tongue: "It doesn't mean anything at all, it's because I am tired, etc." One does not want to be confronted with the element of truth that could be distilled out of the symptom, on the contrary, it's precisely what one wants to avoid. It shouldn't surprise us that the use of tranquillizers is very high in this context.

If we apply this kind of psychotherapy to a hysterical patient, we may have a certain success in the short term, but in the long run it will inevitably be a failure. The underlying hysterical question is such that it cannot be covered up. We will see later on that the central hysterical question has everything to do with the basic search for one's identity. While the psychotic question is about one's existence - "To be or not to be, that's the question" -, the neurotic question is "How do I exist, what am I as a man, as a woman, what is my place within the line of generation as a son or father, as a daughter or mother?". Moreover, the hysterical subject will refuse the common cultural answers to those questions, the "received" answers (that's why puberty is a normal hysterical period in which one refuses the general answers to those questions). It's easy to understand now why a supportive "recovering" therapy must fail: those kind of therapies will make use of the common sense answers, that is, the answers that the hysterical subject has precisely refused...

If you want a typical example of this situation, you just have to read the Dora case study. Through her symptoms and dreams, Dora never stops asking what it means to be a woman and a daughter in relation to the desire of a man. In the second dream we read, *"Sie fragt wohl hundert mal",* she asks quite a hundred times.[2] Instead of paying attention to the question itself, Freud gives her an answer, the normalizing answer: a normal girl longs for a normal boy, and that's it. Being an adolescent hysteric, Dora could only refuse these answers and continue her search.

This means that already at this point, we are confronted with the entanglement of psychotherapy and ethics. There is a beautiful quotation to be found in Lacan's work with respect to this. It runs as follows: *"Je veux le bien des autres",* I - it's the therapist speaking - I want only the best for the others. So far so good, it's the helpful therapist. But Lacan continues: *"Je veux le bien des autres* a *l'image du mien",* - "I want only the best for the others and this according to my image". The next stages bring us a further

[2] S. Freud. *A case of hysteria.* S.E. VII, p. 97.

development in which the ethical dimension becomes clearer and clearer: *"Je veux le bien des autres* a *l'image du mien, pourvu qu'il reste à l'image du mien et pourvu qu'il dépend de mon effort".*[3] "I want only the best for the others and this according to my image, and on condition firstly that it does not divert from my image, secondly that it depends solely on my effort".

So, the great danger of the supportive therapist is that he only supports and promotes his own image in his patients. Inevitably, this results in a master discourse, against which the hysterical discourse is precisely directed, so, the outcome is predictable.

Meanwhile it has become clear that we can't define psychotherapy without defining hysteria. As we have already said, hysteria focusses on the question of identity and the relationships between identities, particularly between the sexes and between the generations. Now it is quite clear that those questions are of a very general nature - everybody has to find an answer to those questions, that's why in lacanian terms hysteria is the definition of normality. If we want to define hysteria as pathology, we have to look for the symptom, and this brings us to a new point.

Strange as it may be, one of the first things an analyst has to do during a first consultation, is to look for a symptom. Why is this so? Clearly the patient presents his symptoms, that's the reason why he comes to see us in the first place. Nevertheless, the analyst has to look for a symptom, more particularly, he has to look for a symptom that can be analyzed. That's why we don't use the idea of "intake" or something like that. The freudian concept in this respect is *Prüfungsanalyse,* a try-out analysis, literally not a test-case but a *taste-case,* one can taste if it is up to one's taste. This has become all the more necessary because of the fact that nowadays, due to the vulgarisation of psychoanalysis, everything seems to be a symptom. The colour of the car you buy is symptomatic, the length of your hair, the clothes you wear or don't wear, etc. This is clearly not useful, and so we have to go back to the original meaning, which is very specific and even operational. You can find it already in Freud's early work, in *Die Traumdeutung, Zur Psychopathologie des Alltagslebens,* and *Der Witz und seine Beziehung zum Unbewussten.* There we find the idea that from the psychoanalytic point of view, a symptom is a production of the Unconscious, in which two different impulses find a compromise so that censorship can be averted. This production is not arbitrary but obeys certain laws, and that's why it can be analyzed. Lacan will elaborate this definition. In his return to Freud, a symptom is of course still a production of the Unconscious, but Lacan specifies that every symptom is structured as a language is, meaning that the central mechanisms are metonymy and metaphor. It is precisely this verbal structure that opens up the possibillty of analysis through free association.

So this is our operational definition of a symptom: we have to find a symptom for analysis if we want to start analyzing. This is what Jacques Alain Miller has called *"la precipitation du symptôme",* the word also exists in English, - a precipitate, - the fact that the symptom has to become visible, tangible, as a deposit of the signifying chain, so that it can be

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[3] J. Lacan. *Le Séminaire, livre VII, L'éthique de la psychanalyse,* Paris, Seuil, p. 220.

analyzed.[4] This means, for example, that merely depressive complaints or marital problems are not a symptom as such. Moreover, it has to be a symptom in distress, because a symptom can be perfectly satisfying. Freud uses in this respect the metaphor of the balance: a symptom, being a compromise, is normally in perfect balance between loss and gain, it gives the patient a kind of psychical stability. It is only when the balance turns to the negative side, that the patient will be prepared to invest in therapy. Inversely, once the balance is restored, it is not that unusual for the patient to take his leave and flee into "health".

With this operational definition, we can start our search for a symptom as a target for our clinical practice. This practice is essentially a deconstruction of the symptom, enabling us to go back to its roots. The most well-known example is probably the analysis of *Signorelli* in Freud's *Psychopathology of Everyday Life,* where one finds a beautiful illustration of the lacanian idea that the unconscious is. structured as a language. Nevertheless, there remains one important point. Every analysis of a symptom, however thorough this may be, ends with a question mark. Even more fundamentally it ends on something that is lacking. When we look at the *Signorelli* analysis, for example, we find at the bottom of Freud's schema, between brackets, the expression: "(Repressed thoughts)", which is just another way of formulating the question mark.[5] Every time a particular analysis is carried through, we will be confronted with something like that. Moreover, if the analyst insists, the reaction of the patient will be one of anxiety, and that's something new, something that does not fit into our idea of what a symptom is.

This implies that we have to differentiate between two different kinds of symptoms. First of all there is the classical list: conversion symptoms, phobia, obsessional phenomena, faulty actions, dreams and so on. The second list, on the contrary, contains only one specimen: anxiety, and more particularly, raw, non-mediated anxiety. Eventually, this one specimen can be extended to what Freud called the somatic anxiety-equivalents, e.g. disturbances of the heart action or of respiration, attacks of sweating, tremor or shivering, and so on.[6]

It is quite clear that those two kinds of symptoms are totally different. The first one is kind of diverse, but can be typified by two characteristics: it always concerns a construction within the signifier, and, secondly, the constructor is the benefitor, - it's the subject who makes *active* use of his symptom. The second one, on the contrary, lies precisely outside the realm of the signifier; moreover, it is not something that is constructed by the subject, the subject is rather at the *passive,* receiving end.

Those radical differences do not imply that there is no relationship between the two. On the contrary, they can be understood in an almost genetical line. We start with the question mark, with what Freud called the "Repressed thoughts". It is at this point that the subject is overcome by anxiety, more particularly by what Freud calls "automatic anxiety" or even "traumatic anxiety":

? -> automatic/traumatic anxiety

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[4] J. A. Miller. *Clinique sous transfert, in Ornicar, nr.* 21, p. 147. This precipitation of the symptom happens within the early development of the transferential situation.

[5] S. Freud. *Psychopathology of everday life,* .S.E. VI, p. 5.

[6] S. Freud. On *the grounds for detaching a particular syndrome from neurasthenia under the description 'anxiety neuroses'*, S.E. III, p. 94-98.

Next, the subject will try to neutralize this raw anxiety by putting a signifier on it, so that this anxiety can be elaborated within the realm of the psyche. It is important to notice that this signifier is a secondary one, taking the place of a first signifier which was never there. Freud calls this a "faulty connection", *"eine falsche Verknüpfung".*[7] This signifier is also the first symptom, the most typical example being of course a phobic signifier. In the meantime, we have defined what Freud called the primary defense process, what he will later call primal repression, in which a border signifier is inserted to serve as defensive lid against a breakthrough of unmitigated anxiety:

? ->automatic anxiety <-> border signifier
first symptom

primal repression

This border signifier, being the first symptom, is only the beginning of an ever increasing series. The elaboration can take any form whatsoever, as long as it stays within the realm of the signifier; what we call symptoms in the proper sense of the word, are only the knots in a larger verbal tissue, while the tissue itself is none other than the signifying chain that constitutes the subject's identity. You know the lacanian definition of the subject: *"Le signifiant c'est ce qui représente le sujet auprès d'un autre signifiant*", "The signifier is what represents the subject for another signifier". Within this signifying chain, the secondary defenses can come into operation, especially repression as such. The motive for this defense is again anxiety, but this anxiety is of a totally different nature. In freudian terms, it's *signal* anxiety, signalling that the signifying chain has come too close to the nucleus, which would result in unmitigated anxiety. This difference is easy to verify in the clinic: patients tell us sometimes that they are afraid of their anxiety, and there you find perfectly the differentiation between those two. So we can enlarge our figure:

? -> automatic anxiety <-> border signifier
first symptom

primal repression

-> further elaboration:
chain of signifiers
signal anxiety
symptoms

repression

In the meantime not only have we differentiated two kinds of symptoms and two kinds of defense, but we have also made a very basic freudian distinction between two kinds of neurosis. On the one hand, we have the **actual neurosis**, on the other hand **the psychoneurosis**.

[7] S. Freud *Studies on Hysteria*, S.E. II, p.67, n.1.

? -> automatic anxiety <-> border signifier first symptom -> further elaboration: chain of signifiers signal anxiety symptoms

primal repression

repression

actual neurosis **psychoneurosis**

This is the first freudian nosology. Freud will never abandon it, he will only refine it, especially with the idea of the narcissistic neurosis. We won't go into that here. The opposition between actual and psychoneurosis will suffice for our purpose. The so-called actual neurosis is not very 'actual' any more, on the contrary, the idea has almost disappeared. The specific aetiology of it, as described by Freud, has become so obsolete that nobody bothers about it any longer. Indeed, who today would dare to say that masturbation causes neurasthenia, or that *coitus interruptus* causes anxiety neurosis? That has a very strong Victorian ring to it, so we better forget all about it. In the meantime, we tend to also forget the basic idea behind those Victorian references to *coitus interruptus* and masturbation, namely that in the freudian theory, the actual neurosis is the affection in which the somatic sexual impulse never succeeds in reaching a psychical elaboration, but finds an outlet in the purely somatic realm, with anxiety as one of the most prominent characteristics, together with the absence of symbolisation. In my opinion, it is still a very useful clinical category, or it could be, for example, concerning the study of the psychosomatic phenomena, which share that same characteristic of absence of symbolisation, and maybe also for the study of addiction. Moreover, the actual neurosis has lately become very "actual" again, or at least one form of it has. Indeed, the latest so called 'new' clinical category, besides the personality disorders, is of course none other than the panic disorders. I will not bore you with the modern details and descriptions. I can only assure you that they bring nothing new in comparison with the freudian publications about anxiety neurosis, dating from the previous century; moreover, they completely miss the point here in attempting to find a mere biochemical basis for the arousal of panic. They miss the point completely, because they fail to understand that there is a causal relationship between the absence of words, of verbalisation, and the rise of a particular form of anxiety. Interesting as this may be, we won't go any further into it. Let us only accentuate one important point: an actual neurosis can't be analyzed in the proper sense of the word. If you look at the schematic representation of it, you'll understand why: there isn't any material to analyze, there is no symptom in the analytical sense of the word. That's probably the reason why Freud didn't pay much attention to it any more after 1900.

This brings us to the proper object of psychoanalysis, the psychoneuroses, with hysteria as the most prominent example. The difference from the actual neurosis is obvious: psychoneurosis is none other than an elaborated defensive chain within the signifier against that primal anxiety-provoking object. Psychoneurosis succeeds, there where the actual neurosis has failed, that's why we can find behind every psychoneurosis the original actual neurosis. Psychoneurosis does not exist in a pure form, it is always mixed with an older actual neurosis, at least, that is what Freud tells us

in his *Studies on hysteria.*[8] It is at this point that we can illustrate almost visually the idea that every symptom is an attempt at *re-covery,* meaning that every symptom is an attempt to signify what was originally not signifiable. In that sense, every symptom and even every signifier is an attempt to master the original anxiety-provoking situation. This chain of signifiers is endless, because there is no one attempt that gives the definite answer. That's why Lacan speaks of *"Ce qui ne cesse pas de ne pas s'écrire",* "That which never stops never being written" - the subject keeps on writing, speaking, but he never succeeds in writing or speaking the definitive signifier. The symptoms, in the analytical sense of the word, are the knots within this ever increasing verbal tissue. This idea has a long history with Freud and found its final elaboration with Lacan. Freud discovered first of all what he called the "compulsion to associate", *"Die Zwang zur Assoziation",* and *'falsche Verknüpfung",* false connections[9], showing that the patient feels the obligation to link signifiers to what he considers as the traumatic nucleus, but this connection is a false one, hence *"falsche Verknüpfung".* By the way, this implies nothing less than the basic principle of behavioral therapy, the whole idea of Stimulus-Response, conditioned-Response and so on, is contained in one footnote in Freud's *Studies on hysteria.* This idea of a compulsion to associate does not receive much attention from the post-freudians. Nevertheless, in our opinion, it keeps turning up at several important points in Freud's theory. For example, further freudian elaboration brings us the idea of *"Ubertragungen",* transferences in the plural, meaning that the signified can be displaced from one signifier to others, even from one person to another. Later on we find the idea of secondary elaboration and the synthetic function of the ego, which is about the same thing, only on a larger scale. And last but not least, of course, we end with the idea of Eros, the life drives, which aim at elaborating ever increasing unities.

Psychoneurosis is a never-ending chain of signifiers, starting from and directed against an original anxiety-provoking situation. The question right now is of course, what is this kind of situation, and is it really a situation? You'll probably know that Freud thought it was something traumatic, and especially sexually traumatic. In the case of an actual neurosis the sexual somatic impulse can't find an adequate outlet in the psychical realm, so it turns into anxiety or neurasthenia. Psychoneurosis on the other hand is none other than an elaboration of this original anxiety-provoking nucleus.

But what is this nucleus? In the original freudian theory, it is not only a traumatic scene, - it is so traumatic that the patient can't or won't remember anything about it, - the words are lacking. Nevertheless, throughout his Sherlock Holmes-like investigation, Freud will find several characteristics. It is sexual and it has something to do with seduction; the father seems to be the villain, which explains the traumatic character; it questions sexual identity and the sexual relationship, but in a strange manner, because the accent lies on the pregenital; and, last but not least, it's old, very old. There seems to be sexuality before the onset of sexuality, so Freud will speak about a "pre-sexual sexual fright". A little bit later, he will of course recognise infantile sexuality and infantile desire. Besides all those characteristics, there are two others which do not fit into the picture. First of all, Freud is not the only one who wants to know, his patients want it even more badly than himself. Look at Dora: she's continuously looking for knowledge

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[8] S. Freud. *Studies on Hysteria,* S.E. II, p. 259

[9] S. Freud. *Studies on Hysteria,* S.E. II, p. 67-69, n.1.

in the sexual field, she consults madame K, she devours the books of Mantegazza on love, that is, the Masters and Johnson of that time, and she secretly consults medical encyclopedias. Even today, if you want to produce a scientific bestseller, you only have to produce something in that field, and your success is assured. Secondly, every hysterical subject produces fantasies which are a strange combination of their secretly gathered knowledge and the supposedly traumatic scene.

At this point, we must switch to an apparently completely different subject, namely infantile sexuality. The most prominent characteristic of infantile sexuality concerns does not so much concern the infantile-sexual games, rather, the most important thing is their thirst for knowledge. Just like the hysterical patient, the child wants to know, it wants to know the
answer to three related questions. The first problem concerns the difference between boys and girls: what makes boys boys, and what makes girls girls? The second question concerns the origin of babies: where does my little brother or sister come from, where do I come from? The last question is about the father and the mother: what is the relationship between those two, why did they chose each other, and, especially, what do they do together in the bedroom? These are the themes of the sexual researches of childhood, as Freud calls them in his *Three essays on the theory of sexuality.*[10] The child proceeds as a scientist and will forge genuine explanatory theories, that's why Freud calls them "infantile sexual *researches"* and "infantile sexual *theories".* As is always the case, even in adult science, a theory is forged where we don't understand something - if we had understood it, we would not have had any need for a theory in the first place. The point of arrest of the first question concerns the absence of the penis, especially the penis of the mother. The explanatory theory talks about castration. The obstacle in the second question, the one about the origin of babies, concerns the role of the father. The theory talks about seduction. The last stumbling-block concerns the sexual relationship as such, and the theory brings only pregenital answers, usually within a violent context.

We can put this in a little schema:

question of origin	**inf.sex.theory**	**failure**
gender	*castration*	*phallic mother*
subject	*seduction*	*role of the father*
sexual relationship	*primal scene*	*combination*

Each one of these three theories shares the same characteristic: each is unsatisfactory and according to Freud, each ends in a renunciation.[11] This is not exactly true: each may disappear as a theory, but none disappears totally. Rather, they make their reappearance within the so-called primal fantasies about castration and the phallic mother, seduction and the primal father, and of course the primal scene. Freud will recognize in these primal fantasies the base for the later, adult neurotic symptoms.

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[10] S. Freud. *Three essays on the theory of sexuality.* S.E. VII, p. 194-197.
[11] ibid

And that brings us back to our question about the starting point of neurosis. This original scene is not so much a scene, but has everything to do with the question about origins. It is to Lacan's merit that he will rework the freudian clinic into a structural theory, more particularly concerning the relationship between the Real and the Symbolic and the mending role of the Imaginary. There is a structural lack in the Symbolic, which means that certain points of the Real can't be symbolised in a definite manner. Every time that the subject is confronted with a situation concerning those points of the Real, this lacking becomes apparent. The unmitigated Real provokes anxiety, and this in its turn gives rise to never-ending, defensive, imaginary constructs.

The freudian infantile sexual theories will find their counterpart in Lacan's well known formulations: *"La Femme n'existe pas"* - The Woman does not exist; *"L'Autre de l'Autre n'existe pas"* - The Other of the Other does not exist; *"Il n'y a pas de rapport sexuel"* - "There is no sexual relationship". The neurotic subject will produce his answers to this unbearable lightness of not-being: castration, the primal father and the primal scene. Those answers will be elaborated and refined within the personal fantasies of the subject. This means that we can specify the further elaboration of the signifying chain in our first scheme: this further elaboration is nothing less than the basic fantasies, from which the eventual neurotic symptoms will arise, with in the background the ever-lurking anxiety. This anxiety can always be traced back to the original situation that triggered the defensive elaborations in the imaginary. For example, Elisabeth von R, one of the patients in the *Studies on Hysteria,* becomes ill at the thought of the sheer possibility of having an affair with the husband of her deceased sister.[12] In the Dora case study, [13]Freud will note that a hysterical subject is not able to bear a normally exciting sexual situation; Lacan will generalize this idea when he states that every meeting with sexuality is always a failed one, *"une rencontre toujours manquée,* too late, too early, at the wrong place etc.[14]

Now, let us recapitulate for a moment. What are we talking about? We are talking about a very general process, what Freud calls at a given moment the *Menschwerdung,* the becoming of a human being. The human being is a subject, that is a "speaking creature", a *"parlêtre",* and this means that he has left nature for culture, that he has left the Real for the Symbolic. All human productions, that is, all the productions of the subject, can be understood in the light of that structural failure of the Symbolic in relationship to the Real. Society itself, culture, religion, science, are originally nothing but an elaboration of those questions about origins, that is they are attempts at an answer. That's what Lacan tells us in his famous article *La science et la vérité.*[15] Indeed, all those cultural productions produce essentially the how's and why's of the relationship between man and woman, between parent and child, between subject and group, and they will lay down the rules that govern at a given time and a given place not only the answers to those questions, but even the right way, the discourse, to find an answer. The difference between the answers will determine the particularity of different cultures. What we find on this macro-social scale is reflected on micro-scale within the

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[12] S. Freud. *Studies on Hysteria,* S.E. II, p. 155-157.

[13] S. Freud. *Fragment of an analysis of a case of hysteria*, S.E. VII, p. 28.

[14] J. Lacan, *Le séminaire, livre XI, Les quatre concepts fondamentaux de la psychanalyse,* Paris, Seuil, p. 53-55 and 66-67.

[15] J. Lacan. *Ecrits*. Paris, Seuil, 1966, p.855-877.

development of the individual members of a society. When a subject is constructing his own particular answers, when he is elaborating his own chain of signifiers, of course he will draw material from the big chain of signifiers, that is, from the Big Other. As a member of his culture, he will share more or less the answers of his culture. It is at this point that we meet hysteria again at last, together with what we have called the re-covering or supportive psychotherapy. However different these supportive therapies may be, they will always fall back on a shared answer to those questions. The only difference lies in the size of the group who share the answer: if the answer is a "classical" one - e.g. Freud with Dora - it is the answer of the greatest common denominator of that culture; if the answer is an "alternative" one, then it falls back on the shared opinion of a smaller alternative sub-culture. Besides that, there is no essential difference.

The hysterical position is essentially a refusal of the shared answer **and** the impossibility of making a personal one. In *Totem und Tabu,* Freud remarks that the neurotic subject takes flight from the unsatisfying reality, that they avoid the real world, "which is under the sway of human society and of the institutions collectively created by it".[16] They avoid this collective creation, because the hysterical subject sees through the fallacy of the guarantee of that shared answer, she detects what Lacan calls *"le monde du semblant",* the world of make-believe. She does not want an answer, she wants The Answer, she wants the Real Thing, and, moreover, it has to be produced by the big Other without any lack whatsoever. To be more specific: the only thing that would satisfy her is the dreamt-of primal father that would guarantee the existence of The Woman, which would create the possibility of The Sexual Relationship.

This last proposition enables us to predict where the hysterical symptoms will be produced, namely exactly at those three points where the big Other fails. That's why these symptoms always become apparent within a transferential situation, and this in clinical practice as well as in everyday life. In his early publications, Freud discovered and described the mechanisms of symptom formation, especially the mechanism of condensation, but he noticed soon enough that this was not the whole story. On the contrary, the most important point was that every hysterical symptom was constructed for or against somebody, and that was to become the determining factor in psychotherapy. The lacanian theory on discourse is of course the further elaboration of this original freudian discovery.

The central innovating idea of Freud in this respect is that every symptom contains an element of choice, the *Neurosenwahl,* the choice of neurosis. If we look into it, it is not so much a choice but more a *refusal* to chose. Every time a hysterical subject is placed before a choice concerning one of those three central themes, it tries to avoid it and wants to keep both alternatives, that's why the central mechanism in hysterical symptom formation is precisely condensation, to condense both alternatives. In his article on the relationship between symptoms and hysterical fantasies, Freud remarks that behind every symptom, there is not one, but two fantasies, a masculine one and a feminine one. The net result of this not-choosing is, of course, most of the time ending up with nothing at all. You can't have your cake *and* eat it. Freud gives a very plastic illustration, when he describes a certain hysterical attack, in which the patient plays both parts in the underlying sexual fantasy: on the one hand the patient pressed her dress up

[16] S. Freud. *Totem and Taboo*, S.E. XIII, p.74.

against her body with one hand, as the woman, while she tried to tear it off with the other as the man...[17] A less obvious, but not less frequent example concerns the woman who wants to be actively emancipated and identifies with the man, but whose sexual life is crammed with masochistic fantasies, with the net result of frigidity.

It is this refusal to choose that makes the difference between the hysteria of every *parlêtre,* every speaking creature on the one hand, and pathological hysteria on the other. Every subject has to make certain choices in his or her life. He can take the easy way out with the ready made answers of his society, or he can make more personal choices, depending on his or her degree of maturity. The hysterical subject refuses the ready made answers but is not prepared to make a personal commitment, the answer has to be procured by the Master, who will never be master enough.

This brings us to our last point, the aim of the psychoanalytic cure. Earlier, when we distinguished between the *re*-covering and the *dis*covering forms of psychotherapy, it was quite clear that psychoanalysis belonged to the discovering ones. What do we mean by that, what is the common denominator of this statement?

Well, what is the basic instrument in psychoanalytic practice? It is, of course, interpretation, the interpretation of the so-called associations produced by the patient. This is very well known, the popularisation of the *Interpretation of Dreams* made everyone familiar with the idea of the manifest dream content and the latent dream thoughts, the therapeutical translation work etc. It works far too well even, because if one isn't careful, one ends up with Georg Groddeck and the "wild analysts", that is, the machinegun style of interpretation. At that stage, the difficulty is not so much in making the interpretation, but in making the patient accept it. The so-called therapeutical alliance between therapist and patient very quickly becomes a therapeutical battle about who is right. Historically speaking, it is the failure of this over-enthusiastic interpretation process that gave birth to the silent analyst. You can even follow this evolution in Freud himself, particularly on the point of dream~interpretating. His first idea was that an analysis could be carried out solely by means of dream-interpretation, that's why the title of his first great case study was originally meant to be "Dream and hysteria". But Freud changed it into something completely different, *"Bruchstück einer Hysterie-Analyse",* just a *fragment* of an analysis. And in 1911 he will warn his pupils not to give too much attention to dream analysis, because this can become an obstacle to the analytic process.[18]

Nowadays it is not that unusual to find the same evolution on a smaller scale during the process of supervision. The young analyst is enthusiastically engaged in the interpretation of dreams or symptoms, even so enthusiastically that he loses sight of the analytic process itself. And when the supervisor asks him or her what his final goal is, he or she finds it very difficult to answer. Something about making the unconscious conscious, or symbolic castration... but the answer remains rather vague.

If we want to define the goal of psychoanalysis, we have to look back at our schematic representation of what psychoneurosis is. If you look at it, you'll see that neurosis as such is nothing but one endless signifying system, that is, *the basic neurotic activity is interpretation as such, starting at those points where the Symbolic failed and ending with the phantasies as idiosyncratic interpretation of reality.* So, in this respect it

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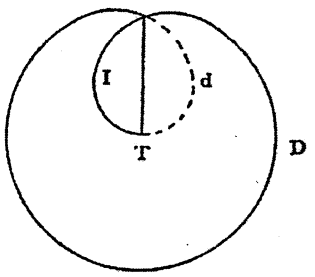
[17] S. Freud. *Hysterical phantasies and their relation to bisexuality,* S.E. IX, p. 166.
[18] S. Freud. *The handling of dream-interpretation in psychoanalysis,* S.E. XII, p. 91 ff.

is obvious that the analyst should not help extending this interpretation system, on the contrary, his goal is to deconstruct this system. That's why Lacan can define the ultimate goal of interpretation as reduction of meaning. You probably know the paragraph in the *Four fundamental concepts* where he says that interpretation in the sense of providing us with significations is no more than a prelude. "Interpretation is directed not so much at the meaning as towards reducing the non-meaning of the signifiers(...)" and:
"(...)the effect of interpretation is to isolate in the subject a kernel, a *kern,* to use Freud's own term, of *non-sense,(...)".* [19]The analytic process brings the subject back to the original point from which he has fled, which Lacan later called the lack of the big Other. That's why psychoanalysis is truly a *dis*-covering process, it discovers layer upon layer till it ends up at the
original starting point, where the Imaginary started. This also explains why moments of anxiety during the analytic process are not that unusual, because the closer one gets to that starting point, the closer one comes to the basic point of anxiety. The *re*-covering therapies on the other hand work in the opposite direction, they try to install the common-sense answers of adaptation. The most successful variant of the *re*-covering therapy is of course a concretely realised master discourse with an incarnation of the master in flesh and blood, that is, of the primal father guaranteeing the existence of The Woman and The sexual Relationship. The last example of this style was Bagwan.

So the ultimate goal of the analytic interpretation is that kernel. Before reaching that ultimate point, we have to start at the beginning, of course, and in that beginning we find a fairly typical situation. The patient places the analyst in the position of the Subject that is Supposed to Know, *"le sujet suppose de savoir".* The analyst is supposed to know, and that's why the patient produces his free association. During this free association, the patient constructs his own identity in relation to the identity that he ascribes to the analyst. If the analyst should confirm this position, the one that the patient gives him, if he confirms it, the analytic process stops, and the analysis will be a failure. Why ? This can easily be shown with a well known lacanian figure, namely the interior eight.[20]



D: line of demand.

I: line of 'identification' intersection.

T: point of the transference.

d: desire.

If you look at the interior eight, you see that the analytic process, represented by a continuous closed line, can be interrupted by a shortcut. The moment the analyst

[19] J. Lacan. *The four fundamental concepts of psychoanalysis,* Penguin, 1977, p. 212 and p. 250.
[20] J. Lacan. *The four fundamental concepts of psycho-analysis.* Trans. A. Sheridan. Pinguin, 1991, p. 271.

confirms the transferential position, the outcome of the process will be an identification with the analyst in that position, and that is the shortcut. The patient will stop deconstructing the surplus of meaning, on the contrary, he will even add one to the chain. So we are back to the re-covering therapies. A lacanian interpretation aims at the refusal of this position, so that the process can go on and on and on... The effect of this ever increasing free association was beautifully described by Lacan in his *Function and field of speech and language.* It runs as follows:
"Does the subject not become engaged in an. ever-growing dispossession of that being of his, concerning which (...) he ends up by recognizing that his being has never been anything more than his construct in the imaginary and that this construct disappoints all his certainties? For in this labour which he undertakes to reconstruct *for another,* he rediscovers the fundamental alienation that made him construct it *like another,* and which has always destined it to be taken from him *by another".*[21]

The effect of the construction of one's identity is ultimately the deconstruction of it, together with the deconstruction of the Imaginary big Other, who reveals himself as just another homemade product. We can make the comparison with Don Quixote by Cervantes, Don Quixote in analysis for that matter. In analysis he could have discovered that the evil giant was only a windmill and that Dulcinea was just a woman, not a dream princess, and last of all, that he was not an errant knight, except for the errant of course.

That's why the analytic work has so much in common with the so-called *Trauerarbeit,* the work of mourning. One has to mourn over one's own identity as well as over the identity of the big Other, and the mourning process itself is nothing but the deconstruction of the signifying chain. The goal is then, of course, exactly the opposite of the jubilant identification with the analyst in the position of the big Other, which would only be a repetition of the first alienation or identification, the one of the mirror stage. The process of interpretation and deconstruction implies what Lacan called *"la traversée du fantasme",* the journey through the fantasies, the basic fantasies with which one had constructed one's own reality. This or these basic fantasies cannot be interpretated as such. On the contrary they constitute the interpretation of the symptoms. Through this journey, they are revealed, which results in a very particular effect: the subject drops out of it, that's the *"destitution subjective",* the destitution of the subject (if that is a correct translation), and the analyst drops out of it, that is *"le désêtre de l'analyste".* From that point on, the patient should be able to make his own choices, in full conscience of the fact that every choice is indeed a choice, without any guarantee outside the subject. That is the point of symbolic castration, where the analysis necessarily ends. Beyond that, it's up to the subject himself.

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[21] J. Lacan. Ecrits, *a selection*, Norton, New York, 1977, p. 42.