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Beyond Symptom Accumulation: A Lacanian Clinical Approach to Obsession - A Case Study and Theoretical Exposition

Julie L. Futrell

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BEYOND SYMPTOM ACCUMULATION: A LACANIAN CLINICAL APPROACH
TO OBSESSION
A CASE STUDY AND THEORETICAL EXPOSITION

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Julie L. Futrell, M.A., M.Ed.

August 2014

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Julie L. Futrell

2014

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Julie L. Futrell

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ABSTRACT

BEYOND SYMPTOM ACCUMULATION: A LACANIAN CLINICAL APPROACH TO OBSESSION A CASE STUDY AND THEORETICAL EXPOSITION

By

Julie L. Futrell

August 2014

Dissertation Supervised by Bruce Fink, Ph.D.

Contemporary approaches to psychotherapeutic intervention increasingly utilize a medical-based diagnostic system focused on identifying and eradicating discrete symptoms. Mental “disorders” are determined by identifying “pathological” behaviors and superficial symptoms which are then lumped together arbitrarily and labeled as specific “mental illnesses.” Despite a gross lack of supporting evidence, these “mental illnesses” are then attributed to various brain abnormalities and biological malfunctions, most often with reference to “chemical imbalances” believed to be the origin of mental distress. Evidence for such biological reductionism is presented conclusively, with little regard for the implicit ontological assumptions made by such a positivist perspective. When psychopathology is viewed in this way, the role of human experience is devalued, resulting in an egregious medicalization of human distress that has devastating consequences for those who suffer.

The work of Jacques Lacan offers a radically different approach to diagnostic formulation and treatment that has, until recently, largely been ignored in Western psychology. This dissertation seeks to participate in correcting this imbalance by offering a Lacanian clinical approach to working with obsession. I offer two case studies of former patients—both of whom presented with classic symptoms of the medical syndrome known as obsessive-compulsive disorder—to illustrate Lacan’s structural approach in contradistinction to a descriptive, symptom-based approach. I endeavor to make Lacan’s obsessive structure and his diagnostic schema accessible to mental health professionals interested in employing Lacan’s work. To do so, I utilize a qualitative case study methodology, with particular emphasis on the psychoanalytic interview. I draw specific attention to the difference between obsessive-compulsive disorder and Lacan’s obsessional structure. Finally, I highlight the ethical implications for clinicians of the ideological construction of mental distress as solely biological and suggest that Lacan offers a diametrically opposed discourse that is sorely lacking and needed at this time.

DEDICATION

Dedicated to my patients, all of whom taught me that therapy truly is a labor of love.

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First and foremost, I offer my profound gratitude to my director, Dr. Bruce Fink, without whom I would never have had such extensive exposure to Lacan's work. How fortunate I feel to have been able to call him my director, professor, mentor, clinical supervisor, and now, colleague. His attention to the detail of my work and commitment to helping me develop my own critical thought and clinical expertise have impacted me immeasurably. To be able to actually say (and mean) that I *enjoyed* writing my dissertation bears witness to his unwavering belief in and support of me. Simply put: thank you.

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INTRODUCTION

Locating Lack

Analysis [...] limits itself to a different discourse, one that is inscribed in the very suffering of the being we have before us and is already articulated in something—his symptoms and his structure—that escapes him, in so far as obsessional neurosis, for instance, doesn't simply consist of symptoms but is also a structure.

(Lacan, 1981/1993, p. 134)¹

Introduction to the Problem: The Medicalization of Distress and the Absence of Lacan in American Psychology

Contemporary approaches to psychotherapeutic intervention increasingly utilize a medical-based diagnostic system focused on identifying and eradicating discrete symptoms. Mental disorders are determined by identifying “pathological” behaviors and superficial symptoms which are often lumped together arbitrarily and labeled as specific mental illnesses. Despite a gross lack of supporting evidence, these “mental illnesses” are largely attributed to various brain abnormalities and biological malfunctions, most often with reference to chemical imbalances posited as the origin of mental distress. Evidence for such biological reductionism is presented conclusively, with little regard for the implicit ontological assumptions made by such a natural science perspective.

The primary diagnostic tool for those working in the mental health profession today is *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000)*, published by the American Psychiatric Association (APA). The *DSM-IV-TR* utilizes a descriptive approach to nosology aimed at categorically classifying disorders that are believed to be neatly separated via discrete symptomatology. This type of classification system relies heavily on superficial symptoms that are readily recognizable and attempts

¹ My references to essays contained in *Écrits* will correspond to Fink's pagination (Lacan, 2002, 2006).

to standardize such symptoms across patient populations. Human pathology is consequently viewed in light of similar behaviors and cognitions believed to be abnormal, where the line between “normal” and “abnormal” is defined by an elite group of mental health professionals—primarily psychiatrists—who form the *DSM* task force.

While the *DSM* has been praised for providing a standardized nomenclature for mental disorders that allows mental health professionals to easily converse, it has not been without its critics. Indeed, the history of the *DSM* is rife with conflict. First published in 1952, the first edition detailed 106 diagnoses and was 130 pages in length, while the current version lists over 300 diagnoses and is an incredible 952 pages long (Mayes & Horwitz, 2005). The new edition—the *DSM-V*—is set to be released (amidst tremendous controversy) in May of 2013 and has only further increased the number of psychiatric diagnoses. What has contributed to such a dramatic increase in diagnoses in such a short amount of time? Are people generally more mentally disabled now than in years past or does the dramatic increase in diagnoses instead reflect political, financial, and social motivations operating behind the scenes? Mayes and Horwitz (2005) argue convincingly for the latter—suggesting that changes in the *DSM*, rather than reflecting growing scientific knowledge, instead reflect the

[s]tandardization of psychiatric diagnoses [...] [that are] the product of many factors, including (1) professional politics within the mental health community, (2) increased government involvement in mental health research and policymaking, (3) mounting pressure on psychiatrists from health insurers to demonstrate the effectiveness of their practices, and (4) the necessity of pharmaceutical companies to market their products to treat specific diseases. (p. 249)

Concerns about the reliability and validity of *DSM* diagnostic criteria abound as the *DSM* continues to move toward an almost exclusively biological model, despite its overseers’

claim to its “atheoretical” nature. What appears to be occurring is a medicalization of human distress.²

For example, Mayes and Horwitz, in detailing the history of the *DSM*, point out that the first and second editions of the book, while including biological perspectives on mental disorders, primarily reflected psychodynamic and psychosocial understandings of human distress that focused on broad underlying concepts rather than surface symptoms. Symptoms were not seen as revealing overt disease entities but were instead understood as disguising underlying conflicts. The focus of clinical explanations and treatments was, therefore, on “the total personality and life experiences of the person that provided the context for the interpretation of the symptoms” (p. 250). However, in 1980, the publication of the third edition of the *DSM* saw a shift of emphasis from underlying dynamics to a more medically-based criterion with then-chairman Robert Spitzer—responding in part to pressures from insurance companies for treatment outcome accountability—arguing that mental disorders were simply a subset of medical disorders. This shift to a more biologically-driven understanding of mental disturbance radically changed the landscape of the mental health field, replacing contextual understandings of human experience with diagnostic and quantitative research models imported from medicine. Because insurance carriers would only pay for the treatment of discrete diseases, visible and measurable symptoms became equated with specific “diseases” that could then be treated pharmacologically. Under fire as a “quack” and illegitimate science, psychiatry readily adopted this new paradigm “transforming how society perceive[d], define[d], and treat[ed] mental disorders” (p. 258). Borne from this cataclysmic change

² For a more recent, quite excellent summary of the problems associated with the *DSM*'s categorical approach, see McWilliams (2011, pp. 9-11).

were the era of so-called empirically-validated treatments and a biological vision of mental health that stressed faulty brain chemistry and psychopharmacological medications at the expense of contextual and dynamic psychotherapeutic interventions.

This biological perspective on mental disturbance has only increased with each subsequent edition of the *DSM* and the influence of the pharmaceutical industry on the creation of new “mental illnesses” cannot be overestimated. Recent research into financial ties between *DSM* task force members and pharmaceutical companies that benefit from increased specialization and numbers of diagnoses has been less than flattering for psychiatric task force members claiming impartiality (see Cosgrove, et al., 2006). While it is beyond the scope of this paper to fully articulate such egregious misconduct and conflicts of interest by *DSM* task force members, it is necessary to highlight the biased politics behind the current diagnostic system, particularly because the *DSM-IV-TR* presents itself as holding *the* privileged and correct view of mental disorders. The *DSM-IV-TR* makes implicit assumptions about human nature that it obscures by presenting quantifiable “evidence” to support its claims. Rather than acknowledging that its medical model perspective is but one way of viewing human suffering, it instead presents itself as Truth; the result is that many now believe their mental distress is simply biological in nature. What is missing from such ontological assumptions is any notion of suffering as *meaningful* in a human context. Furthermore, recent investigations into the efficacy of psychopharmacological medications indicates that much of the previous research exalting the effectiveness of psychotherapeutic drugs has likewise been tainted by political and financial motivations (see Harrow & Jobe, 2007; Whitaker, 2004, 2005, 2010).

Concomitant with the proliferation of mental disorders defined by the *DSM-IV-TR* has been an increase in manualized clinical techniques aimed at managing specific “disorders.” In line with natural scientific assumptions and increased pathologizing of human experience has come the demand for “empirically-validated treatments,” also known as “evidence-based practices.” Such a call indicates “the power the positivist research paradigm has gained over the practice of psychotherapy” (Miller, 2011, p. 27). The dominant discourse that proclaims that quantification is legitimation (and discoverable exclusively via the experimental method) still reigns supreme in mainstream psychology, despite the seemingly commonsense notion that humans are complex, malleable beings incapable of being isolated and manipulated as independent and dependent variables. Calls for treatments that can be empirically-validated leave little free reign to the experience and creativity of the therapist and little room for human behaviors and experience that do not fit preformed diagnostic criteria. Manualized treatments require the implementation of predetermined steps aimed at eradicating standardized symptoms. When there is a reduction of symptoms (and there often initially is), we can then say that such-and-such treatment intervention has been “empirically validated.” However, as is increasingly being recognized (see Shedler, 2010), such symptom alleviation is often short-lived, but because long-term follow-up on manualized treatment approaches has yet to be conducted, such information is often obscured. Lost in such manualized treatment approaches are the experience of the therapist and the singularity of the patient. To assume that all human problems fall into easily defined categories that merely need a manual to be overcome is not only astoundingly simplistic, it erases the very qualities that make humans, well, human.

Moreover, the idea that symptoms are all-telling is one that Freud, from his earliest writings, warned against. As Dany Nobus in *Jacques Lacan and the Freudian Practice of Psychoanalysis* (2000), notes,

Freud's first, negative diagnostic rule read that one should not take symptoms at face value. Mental organization had to be dislodged from observable phenomena, and analysts were urged to suspend their judgment and to look for more reliable criteria. (p. 8)

Indeed, Freud often went so far (contrary to those who followed in his footsteps) as to maintain that seemingly neurotic symptoms did not always indicate an underlying neurosis. Symptoms could be profoundly misleading. This, of course, flies in the face of modern psychology and psychiatry where symptoms (such as hallucinations and delusions) are the defining criteria for a diagnosis. Freud believed that symptoms often served as guides for underlying disturbance; however, he did not believe they could be taken on their own merit. Given this, what are we to make of the current emphasis on diagnosis via discrete symptoms and of symptoms taken at face value?

In this dissertation, I will argue that we need an approach to diagnosis and psychotherapeutic intervention that seeks something *beyond the symptom and that recognizes the psychic singularity of the patient*. Rather than argue that there is no value in neurobiological understandings of or cognitive behavioral approaches to mental disturbance, I hope to perhaps poke a small hole in the ideology of biological reductionism that has so thoroughly captured the mental health world by offering an alternative to symptom-based, descriptive clinical approaches. I agree with McWilliams (2011) that “We have become too reductive in neglecting the psychological side of [disorders] simply because we now know more about their biology” (p. 290).

Furthermore, I hope to correct an imbalance that exists in American psychodynamic

theory today by explicating the work of French psychoanalyst, Jacques Lacan, who has largely been excluded from American discourse. As I will show, Lacan's structural approach to treatment and diagnosis recognizes the complexity of human experience and addresses the question—largely left out of contemporary psychology—of human desire.

Whither Lacan?

The work of Jacques Lacan (1901-1981) has, until recently, been principally ignored in the United States. Though prominent in much of Europe and South America, Lacan's clinical writings have gone relatively unnoticed by English-speaking psychologists. The reasons for such exclusion are certainly overdetermined, but Lacan's notoriously difficult and opaque prose is certainly foremost among them. Also prominent is the dominance of ego psychology in America (and, more recently, relational approaches to psychotherapy)—an approach that Lacan critiqued heavily and unabashedly throughout his career. Indeed, Lacan's relentless attack on the strain of psychoanalysis that has historically been mostly associated with America, combined with his obscure style, has done little to ingratiate American audiences to his approach. Despite his lack of popularity in the US, Lacan's immense appeal in other countries should at least prompt us to examine whether his teachings might have something to offer. As Nobus (2000) notes, four years after his death, 19 out of 20 psychoanalytic organizations in France were basing their work on Lacan's teachings.

Recent publications by American psychotherapists devoted to elucidating Lacan's clinical approach (e.g., Swales, 2012; Miller, 2011) suggest there is mounting interest within the therapeutic community in a Lacanian approach radically opposed to the current dominant discourse. While these recent publications indicate positive

movement toward something more than a descriptive approach to diagnosis and intervention, Lacan remains conspicuously absent from therapeutic discourse, as well as Clinical Psychology programs. Where he has been taken up, it has usually been in a highly theoretical manner with little clinical application. For example, many authors apply Lacanian theory to cultural, ideological, and political topics rather than clinical ones (e.g., Copjec, 1994; Stavrakakis, 1999; Žižek, 1991, 1992). While these authors have certainly been important in spreading Lacan's name, they have done little to disseminate his clinical approach (Goldman, 2004). This is particularly curious since Lacan (1973/1981) is known to have said, "The aim of my teaching has been and still is the training of analysts" (p. 230). In spite of this commitment, Lacan himself rarely published his own case studies. To my knowledge, there are only two: A brief mention of Lacan's work with an obsessive patient in "The Direction of the Treatment and the Principles of its Power" (1961/2002), as well as a transcribed interview with a psychotic patient (Schneiderman, 1980). We not only lack case studies by Lacan himself, we also lack texts explicitly applying a Lacanian approach to psychotherapy. As Lacanian psychoanalyst and author Bruce Fink (1997) states, "Few if any books on Lacan available today talk about how one goes about doing Lacanian psychoanalysis, what it really involves, and what thus distinguishes it from other forms of therapy, whether psychoanalytically oriented or not" (p. x). I agree with Goldman (2004) that "There is a need for literature that illustrates the 'how,' that is, the practices involved in 'doing Lacanian psychoanalysis'" (p. 4).

There are, of course, notable authors who have striven to disseminate Lacan's clinical corpus; however, as Miller (2011) notes, many of these often do not escape the

degree of abstraction in their writings for which Lacan himself was notorious. Indeed, it may be the case that these writings only serve to frustrate English-speaking audiences even more by inadequately explaining Lacan's alien terminology and sometimes seeming randomness of procedure (e.g., Dor, 1998; Schneiderman, 1980). Stuart Schneiderman's (1980) edited collection *Returning to Freud: Clinical Psychoanalysis in the School of Lacan* presents both case studies and theoretical expositions by students of Lacan in the areas of neurosis, perversion, and psychosis. Dany Nobus's (2000) *Jacques Lacan and the Freudian Practice of Psychoanalysis* addresses such Lacanian themes as diagnosis via speech and transference, the analyst's desire, and tactics of interpretation. Malone and Friedlander (2000) have also contributed to the clinical literature with *The Subject of Lacan: A Lacanian Reader for Psychologists*, which offers three case examples but remains largely theoretical. Joel Dor's (2001) *Structure and Perversions*, offers two case studies; however, as Goldman (2004) notes, the cases serve more as a complement to the theory than as an exposition of it. Particular concepts and verbatim quotes from his patients are largely missing.

Perhaps most important to my growth as a clinician and a bit more accessible to those unfamiliar with Lacan are the books of Bruce Fink. Fink's (1997) *A Clinical Introduction to Lacanian Psychoanalysis* is a readily accessible introduction to many of Lacan's key analytic concepts such as desire, jouissance, and object *a* and offers several case vignettes. Fink presents two of his own case studies—one illustrating the diagnostic structure of hysteria and the other depicting a case of obsession. Fink's (2007) *Fundamentals of Psychoanalytic Technique* further explicates such Lacanian clinical techniques as scansion (the variable-length session), punctuating and interpreting, and

non-normalizing therapy, to name but a few. Elsewhere, Fink (2003) provides clinicians with a case study of perversion. In these writings, Fink weaves together theory and practice to present an excellent primer for Lacanian-oriented therapy.

While all of these writings have contributed to a greater explication of Lacanian theory and practice to an English-speaking audience, they remain fairly broad in scope. With a couple of notable exceptions, there is a dearth of clinical books exploring a Lacanian approach to specific clinical issues. Swales (2012) recently published a work addressing the issue of perversion from a Lacanian standpoint and offers two of her own case studies to demonstrate Lacan's clinical approach to working with perversion. Miller (2011) has written an excellent primer on Lacan utilizing four of his own case studies to specifically articulate how the therapist "listens to the letter" of the patient's speech. Miller demonstrates Lacan's emphasis on the role of the signifier by attending to his patients' verbatim speech, as well as offering valuable case formulations. Cristina Laurita (2008) addresses the issue of addiction from a Lacanian perspective, and Yael Goldman (2004) offers case formulations of a hysterical and obsessive patient, as well as articulating Lacan's concept of the fundamental fantasy.³

Even shorter in supply are specific Lacanian case studies of obsession. Schneiderman's (1986) *Rat Man*, in which he offers a Lacanian analysis of Freud's infamous case study of obsessional neurosis, is well-known though dated. Serge Leclair's "Jerome, or Death in the Life of the Obsessional" (1956/1980) and "Philo, or the Obsessional and His Desire" (1959/1980) provide excellent case formulations and highlight key components of Lacan's obsessional structure but both require a

³ This is certainly not an all-inclusive list of books written for English-speaking audiences, but instead encompasses work that has attempted to articulate Lacan through case studies.

sophisticated working knowledge of Lacanian theory. In my case presentations, I do not assume a working knowledge of Lacan—I instead attempt to articulate Lacanian theoretical concepts through concrete case examples. Rather than engage in long theoretical discussions of Lacan’s work as has previously been done, I instead direct the reader to specific texts that may aid the reader if s/he desires a more in-depth understanding. My aim is to demonstrate how Lacan’s concepts guided my clinical practice and informed my case conceptualizations. It is thus my hope to contribute to the burgeoning area of clinical literature by utilizing Lacan’s structural diagnostic criteria to elucidate a clinical approach to working with obsessive structure. By emphasizing Lacan’s structural diagnostic criteria, I hope to illuminate why a symptom-based approach to psychotherapeutic intervention and diagnosis is superficial at best and unethical at worst.

I believe the need for such scholarship in this area is twofold: 1) to provide an alternative diagnostic approach to the current dominant discourse as exemplified by the *DSM-IV-TR*; and 2) to articulate how a Lacanian approach to psychotherapy and case formulation can benefit current psychological practices. To achieve these aims, I will first provide a comprehensive account of obsessional neurosis, as well as the various theories and treatment modalities associated with the disorder. I will then explore the history of the case study methodology I will be utilizing and argue for why this method is best suited for illustrating the *how* of psychotherapeutic practice. In Chapter Two, I will offer a brief primer on Lacan’s basic concepts. In Chapters Three and Four, I will present two case studies of patients⁴ I worked with doing long-term, twice weekly therapy. Both

⁴ There are a variety of ways of referring to those who seek psychotherapeutic treatment. Some therapists prefer to use the term “client,” as they believe this suggests a more egalitarian relationship between

patients experienced symptoms of what the *DSM* identifies as obsessive-compulsive disorder (OCD), yet, over time, I came to recognize them as structurally different; consequently, the way I worked with each patient was distinctly different. By highlighting these differences, I hope to not only offer a Lacanian approach to working with obsession—I also hope to show why the medical diagnosis known as OCD is based on superficial symptoms and therefore limited from the start. By doing so, I believe I will have achieved my goal of critiquing the dominant *DSM-IV-TR* biological model of diagnosis while simultaneously contributing to the Lacanian clinical literature. In my final chapter, I will discuss the limitations of my approach and draw attention to the ethical implications my dissertation has highlighted. I will also discuss my methodology and implications for future research, particularly with regard to the impending publication of the *DSM-V*.

Preliminary Observations

There are various obstacles that present themselves at the outset of a dissertation utilizing case studies, particularly Lacanian case studies. Like others, I find Lacan difficult to understand at times. As is the case with any difficult thinker, my understanding has grown as I have read more and as I have become more acclimated to Lacan's prose. Nevertheless, there is still much I do not comprehend and with which I continue to struggle. I wonder (at times) what makes me feel capable of writing a clinical dissertation on Lacan. I am not, after all, a Lacanian analyst. One of the answers that

therapist and client. Increasingly (and unfortunately), mental service providers use the term "consumers" to identify those who "consume" mental health services. Lacan began using the term "analysand" after 1967 because it implies the person being analyzed is the one doing the work (see Fink, 1997). I have chosen to use the term "patient" because I do not believe "client" accurately captures much of the distress and pain my patients experienced, nor do I see the therapist/patient relationship as reciprocal. As I am not, at present, a Lacanian analyst, I do not feel comfortable using the term "analysand," but I do believe the bulk of responsibility for the therapeutic works lies with the patient. I see the term "consumer" as a product of our capitalist society and highly disrespectful to those who seek our help.

returns to me when I pose this question is that I have witnessed the effect that Lacanian praxis had upon my patients when I slowly began to incorporate his methods into my already analytically-leaning practice. I may not be a Lacanian analyst, but I am a Lacanian-oriented psychotherapist (in training). I believe the incorporation of Lacanian techniques into therapeutic practice is possible by anyone who chooses to do so. There is a strange rift in America between “Lacanian” and “everyone else.” I do not believe this need be the case. Lacan has much to offer anyone working in the field of mental health who deals with the tragedies, heartbreak, joy, and beauty entailed in the psychotherapeutic process.

The other answer that returns to me in response to my question is that there are limits to understanding such that I will, of course, never *understand* all of Lacan. I certainly do not believe Lacan wrote his entire oeuvre with the intention that everyone understand his every idea. I believe this is one of Lacan’s most powerful lessons: There is a limit to understanding—a lack. As Lacan (1975/1998) noted, “[R]eading in no way obliges you to understand. You have to read first” (p. 65). To believe I could somehow understand it all and lay it out easily here on paper would be a denial of that lack. My knowledge has limits. My formulations have limits. Despite these limits, I have done my best here to present some of Lacan’s ideas in a way that may be accessible to a greater number of people. Likely, I do him a bit of a disservice by simplifying his ideas so that they are more readily “understandable.”

Then there are my patients. Their confidentiality is of the utmost importance. They each signed a consent form; nevertheless, I have taken every possible measure to ensure their anonymity. All names, places, and identifying information have been

changed. The information I offer is based on their signifiers (i.e., words), desires, fantasies, dreams, and the way their structural economies shifted and moved during the course of therapy. I have had to pay particular attention to my own subjectivity as I have formulated these cases. My formulations changed over the years I spent with these patients as I listened to them speak—as more of the unconscious was revealed. In formulating their cases here, I have reminded myself that I am not an impartial spectator. The way I present the case can never be something completely objective, complete objectivity being a myth of modern science. I have attempted here to stay as close to the letter of the patients' speech as possible, and I have attempted, first and foremost, to respect the difference and singularity of each person.

There are circumstances surrounding my time with these patients that are unique. Firstly, the work took place as part of my psychology doctoral training. Patients were aware of this, and it thus entailed certain conditions that would not normally occur, including patients being aware of certain aspects of my personal life that I would not typically share. They were also aware that I would only be at the clinic for four years. There was a time limit set on therapy from the beginning—something I would not normally advocate. Secondly, the work took place in a university setting which likewise affected therapeutic processes in various ways. Typically, fee is determined between therapist and patient; however, fees were determined by clinic policy and payment was not handled directly between myself and the patient. I also found confidentiality to be an issue at times, as the clinic had an open waiting room where patients often encountered people they knew. A further difference was that breaks in therapy frequently took place when the university closed. This meant patients essentially followed a university schedule

rather than breaks that were set by me as the therapist. Finally, Lacan was not part of my curriculum throughout the time I worked with these patients. The latter were curious when I began punctuating polyvalent phrases and signifiers during sessions. Initially, this obvious change in approach put “me” a little more in the picture than I usually would allow; however, this rather quickly changed as my patients began to question the layers of meaning present in their own words, leading them away from me and on to questions about the unconscious.

CHAPTER ONE

A History of Obsession

I must confess that I have not yet succeeded in completely penetrating the complicated texture of a severe case of obsessional neurosis [...] An obsessional neurosis is in itself not an easy thing to understand.

(Freud, 1909/1955, p. 294)

Literature Review

The seemingly senseless and strange cluster of symptoms that we now identify as OCD has been documented in the literature since at least the early 1600s (Davis, 2008),⁵ although it was not known by that name until recent times. As with many of the psychiatric diagnoses in the *DSM-IV-TR*, the syndrome has acquired a medical nomenclature that attempts to place it in the same register as other biological diseases such as cancer or diabetes; however, the terms “obsessional” and “obsessive” have seen a wide number of different usages over the years. The terms have been used to: 1) denote the clinical syndrome, OCD, 2) as an often derogatory descriptive label for specific behaviors and thoughts (e.g., “Stop obsessing over him!”), and 3) as an indication of a type of character (e.g., “You’re such an obsessive!”). Despite the variety of usages these words have acquired,

The implication of all these definitions is that an *obsession* is an unwanted but repetitive thought which forces itself insistently into consciousness and recurs against the conscious desires of the person concerned. Such thoughts may include intrusive doubts, wishes, fears, impulses, prohibitions, warnings, and commands. Neither reason nor logic can influence these pointless, repugnant, insistent and absurd thoughts, and they persist so tenaciously that they cannot be dispelled by conscious effort. A *compulsion*, in addition to having many qualities in common with obsessions, is generally thought of as expressed in action. (Sandler & Hazari, 1960/1997, p. 163, original italics)

⁵ For a complete history of obsessional neurosis, refer to Davis (2008).

Due, in part, to the coupling of *obsessive* and *compulsive* in the naming of the clinical syndrome, many assume the two phenomena are intrinsically intertwined; however, as McWilliams (2011) notes, this is not necessarily the case and the two are often conceptually and clinically separate. McWilliams further comments that, while analytic explorations of both obsessions and compulsions reveal similar dynamics, the coupling of the two is somewhat artificial with respect to character:

As *symptoms*, obsessions (persistent, unwanted thoughts) and compulsions (persistent, unwanted actions) can occur in anyone, not just in those who are characterologically obsessive and compulsive. And not all obsessive and compulsive individuals suffer recurrent intrusive thoughts or engage in irresistible actions. (p. 290, original italics)

Thus, we see already that common parlance about OCD is not as straightforward as is presented in the *DSM*, nor are superficial symptoms as trustworthy as one might be led to assume. Freud (1907/1959) used the term *obsessional neurosis* to include compulsive acts, articulating his view that compulsions were defensive behavioral reactions to obsessional thoughts and impulses. “People who carry out obsessive actions or ceremonials belong to the same class as those who suffer from obsessive thinking, obsessive ideas, obsessive impulses and the like. Taken together, these form a particular clinical entity, to which the name of ‘obsessional neurosis’ is customarily applied” (p. 117).

Operational definitions aside for the moment, recent epidemiological studies indicate that OCD is on the rise—with some estimates suggesting that between four and seven million Americans suffer from OCD (a fiftyfold increase since 1953, or approximately one in 40 people)—while others suggest rates are even higher (Penzel, 2000). What was once thought to be a rare disorder has been found to be much more

prevalent than previously thought. Reasons for such discrepancies are most certainly overdetermined and include misdiagnosis, overdiagnosis, and patients' failure to report symptoms they view as embarrassing, irrational, and shameful. There is also a crossover between what is termed "classic OCD" and the Cluster C personality disorder known as "obsessive-compulsive personality disorder" (OCPD).⁶

OCD and OCPD are typically distinguished by whether the patient's symptoms are *ego-dystonic* or *ego-syntonic*. As Gabbard (2005) notes, "Obsessions are defined as recurrent ego-dystonic thoughts, whereas compulsions are ritualized actions that *must* be performed to relieve anxiety" (p. 264, original italics).⁷ In OCD, repetitive obsessions and compulsions are intrusive, unwanted, and ego alien to the sufferer. In short, they disturb the person who experiences them (McWilliams, 2011). OCPD, however, is seen as a characterological "pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency" (*DSM-IV-TR*, p. 725). Those suffering from OCPD do not feel disturbed by their symptoms, and more importantly, are *unaware* of their "pathological" nature. Indeed, sufferers may derive great pleasure from the order and rigidity that characterizes their lives.⁸

To complicate matters, the personality characteristics associated with OCPD are often found in those suffering from OCD as well. Despite the *DSM's* attempt to neatly

⁶ The *DSM-IV-TR* (2000) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 684).

⁷ For the full diagnostic criteria for OCD, see (*DSM-IV-TR*, p. 456).

⁸ I would add here that they perhaps derive more conscious pleasure from such character traits. All symptoms provide a certain *jouissance*—a topic I will take up in greater depth later. The "ego-dystonic" symptoms of OCD also provide pleasure; however, patients are usually unaware of how they indirectly enjoy their symptoms.

categorize disorders, there is often no easy delineation between the two. This has prompted many clinicians and researchers to take a *dimensional* approach to obsessive-compulsive disorders, proposing that, rather than being distinct disorders, obsessive-compulsive traits instead lie on a spectrum (Gabbard, 2005; Penzel, 2000; Stein & Hollander, 1993/1997). In this view, disorders that are separated and defined by certain behaviors in the *DSM* including OCD, trichotillomania (compulsive hair-pulling), body dysmorphic disorder (imagined ugliness disorder), anorexia nervosa, Tourette’s syndrome, self-injurious behavior, onychophagia (nail biting), and dermatillomania (compulsive skin picking), are not viewed as different disorders, but rather represent different manifestations of underlying issues. Thus, the “ego-dystonic” obsessions and compulsions associated with OCD—rather than being distinct from the personality organization of OCPD—are instead viewed as one of a difference of degree. As Gabbard (2005) notes,

Symptoms of an obsessive-compulsive nature have also been reported as transitory occurrences during the psychoanalytic treatment of patients with OCPD. However, empirical studies indicate that a wide range of personality disorders may occur in patients with OCD. (p. 572)⁹

What Gabbard is, of course, suggesting (as did McWilliams previously) is that clusters of symptoms occur in a variety of character structures, and as such, cannot be taken at face value as specific “disease entities”—a central point of this dissertation. Under the current diagnostic system, OCD is labeled as an anxiety disorder, Tourette’s syndrome as a tic disorder, anorexia nervosa as an eating disorder, body dysmorphic disorder as a somatoform or delusional disorder, and trichotillomania as an impulse disorder. This focus on overt symptoms and behaviors thus obscures underlying dynamics. The

⁹ For an in-depth analysis of obsessional symptoms and corresponding personality disorders, see Gabbard (2005, p. 572).

important point to be made here is that when a descriptive approach to diagnosis is taken that focuses on symptom patterns, there are innumerable diagnoses that may be concocted.¹⁰ Consequently, there are innumerable therapeutic techniques that may also be concocted to “treat” such disorders. Treatments are, of course, aimed at symptom reduction, and the success of each treatment is measured precisely by this symptom reduction rather than any change in the patient’s psychic economy.

The precursor to the distinction between what are currently termed “Axis I clinical syndromes” and “Axis II personality disorders” lies in the emergence of the ego psychology tradition. Wilhelm Reich (1933) distinguished between what he termed *symptom neuroses* and *character neuroses*, where symptom neuroses were identified as discrete and connected to an identifiable precipitant in a person’s current life that had activated an unconscious conflict (roughly equivalent to contemporary Axis I disorders). A person with a symptom neurosis was believed to have the ability to engage her¹¹ “observing ego” to gain perspective on her symptomatology. By contrast, *character neuroses* were viewed as ego-syntonic (i.e., there was a problem with the development of the observing ego) and indicated a problem at the level of the whole personality. Work with patients with character neuroses was viewed as considerably more difficult than those with symptom neuroses (a belief that is still widely held by many clinicians), with the goal of therapy being the development of the observing ego so that what had formerly been ego-syntonic could be made ego-alien and thus “managed” more effectively (McWilliams, 2011).¹²

¹⁰ To this list, we could also add the newly-formed “hoarding disorder,” seen as a disorder that lies on the same spectrum, but that is, likewise, presented as somewhat different from the others.

¹¹ To be respectful, I utilize both the feminine and masculine pronouns throughout this dissertation.

¹² The notion of an “observing ego” is one that Lacan critiques heavily, as will be outlined in Chapter Two.

On the one hand, the distinction between symptom and character neuroses has been a strength of the psychoanalytic tradition in that it draws attention to the deeper problems adhering to personality structure; however, it also runs the risk of artificially splitting the symptom off from the whole person by emphasizing the development of an observing ego designed to act as master and manager. The point, of course, is that symptoms and structure do not always coincide; however, symptoms are always a response to unconscious conflicts that have not been adequately (if ever) symbolized. Thus, while I agree with McWilliams (2011) that “The practitioner who expects from a patient with an obsessive character the same rate of progress achievable with a person who suddenly develop[s] an intrusive obsession is risking a painful fall” (p. 12), I do not believe this is the case if we remember that underlying the “sudden intrusive obsession” is an enduring character structure that may be just as refractory to change as that of someone who is obsessively structured. In other words, the person who experiences a sudden intrusive obsession may overcome that particular symptom (the obsessive intrusion) more readily, but this does not indicate that treatment will be *easier*—only that a particular symptom may remit more quickly. What is important is that we identify the underlying structural dynamics. Freud, in his early formulations, often fell victim to the conflation of symptoms with structure¹³—at times failing to distinguish between structurally hysterical or obsessive individuals and those who were simply manifesting hysterical or obsessive symptoms; however, by the end of his career, he had clearly begun to discriminate between an “obsessional neurosis in an otherwise nonobsessive

¹³ See Chapter 17 of Freud’s (1917) *Introductory Lectures* where he formulates what he describes as female “obsessives.” In my opinion, the women he presents are clearly hysterically structured with an accompanying obsessional neurosis. Here we see the symptomatology taking precedence over the underlying structure.

person and an obsession that was part of an obsessive-compulsive character”

(McWilliams, 2011, p. 46).

Psychological Formulations of Obsession

Classical Psychoanalysis¹⁴

For these patients whom I analyzed had enjoyed good mental health up to the moment at which an occurrence of incompatibility took place in their ideational life—that is to say, until their ego was faced with an experience, an idea or a feeling which aroused such distressing affect that the subject decided to forget about it because he had no confidence in his power to resolve the contradiction between that incompatible idea and his ego.¹⁵

(Freud, 1894/1962, p. 47)

Freud’s revolutionary accounts of hysteria on the one hand, and of obsessional neurosis on the other, are well-known to comprise the keystones of psychoanalytic theory (Stein, 1997). Indeed, Freud’s (1909/1955) seminal case study, *Notes upon a Case of Obsessional Neurosis*, offers one of the most thorough accounts of the syndrome. The mysterious symptoms that plagued the infamous “Rat Man” offered Freud the chance to work through and explicate his early formulations of the unconscious and the specific meanings that symptoms carried as compromise formations. Freud’s emphasis on the importance of interpreting symptoms is a hallmark of psychoanalysis, and sadly, one that has largely been forgotten in our modern era. Freud insisted throughout his career that symptoms served as disguises for underlying sexual and aggressive tendencies that had

¹⁴ What follows is an abbreviated and simplified version of Freudian theory. My assumption here is that the reader of this dissertation already has at least an elementary understanding of psychoanalytic theory. Consequently, my aim is to highlight the major components of Freud’s theory of obsessional neurosis rather than offer a detailed description. For detailed explanations, the reader is referred to Freud (1894, 1895, 1896, 1907, 1908, 1909, 1913).

¹⁵ It is important to note here that Freud had not yet developed his structural theory of mind. “Ego” or *ich* in German refers to the whole person and is different from “*das ich*,” which Freud later used to refer to the psychic agency commonly referred to as “the ego.” The distinction here is important, as ego psychologists do not make this distinction, resulting in a misunderstanding of Freud’s early use of the term. See Soler (1996, p. 256).

been repressed, and as such, required careful examination and interpretation. Far from being senseless, obsessive actions and compulsive rituals were laden with meaning. “[I]n obsessive actions everything has its meaning and can be interpreted. [...] We express this important fact by saying that the obsessive action serves to express *unconscious* motives and ideas” (Freud, 1907/1959, p. 122, original italics). In Freud’s early work, he explicitly identified obsessions as “surrogate[s] for unbearable sexual ideas” (p. 53) and posited that the obsessive experienced guilt over early sexual pleasure. In fact, Freud initially differentiated hysteria and obsessional neurosis by the response that each had to early sexual experience: Hysterics responded passively and with disgust, while the obsessive’s early sexual experiences were carried out “actively and with pleasure” (Stein, 1997, p. 3).^{16 17}

Hysteria and obsessional neurosis were further differentiated by the way each responded to the incompatible idea striving for consciousness. For the hysteric, “The incompatible idea [was] rendered innocuous by its *sum of excitation* being *transformed into something somatic*” (Freud, 1894/1962, p. 49, original italics); whereas, in obsession,

In order to fend off an incompatible idea, he sets about separating it from its affect, then *that affect is obliged to remain in the psychical sphere*. The idea, now weakened, is still left in consciousness, separated from all association. *But its affect, which has become free, attaches itself to other ideas which are not in themselves incompatible; and, thanks to this “false connection,” those ideas turn into obsessional ideas.* (Freud, 1894/1962, pp. 51-52, original italics)

¹⁶ Freud later questioned his theory of the etiology of hysteria and obsessional neurosis; however, throughout his career, he retained some belief in his original hypothesis. In 1924, he added a footnote to his 1896 paper to this effect.

¹⁷ Freud later suggests that an earlier passive experience lay in the remoter background of obsessional neurosis. See Freud (1896/1962). Soler (1996) suggests that this is what Freud was referring to when he spoke of the “hysterical nucleus of obsession” (p. 252).

Stated otherwise, in hysteria, ideational representatives are repressed and the corresponding affect is converted into a bodily symptom; whereas in obsession, the ideational representative remains conscious but isolated from its accompanying affect. In Freud's early hydraulic terms, each defense—conversion and isolation of affect—served to neutralize overwhelming “sums of excitation.” Once freed from the intolerable ideational representatives, obsessional affects could then, through displacement, become attached to more compatible ideas—resulting in seemingly trivial matters becoming exceedingly important. Here we see one of the classic hallmarks of obsessional neurosis: the import attached to apparently unimportant events (such as the need to walk through a doorway using a certain number of steps or the imperative to turn left when standing if previously one has turned right). It is this false connection between the emotional state and the associated idea that seems so absurd in obsession; however, it is important to note that the affect is not absurd, merely displaced.

In “Further Remarks on the Defense Neuro-Psychoses” (1896/1962), Freud further distinguished between primary and secondary defenses in obsessional neurosis. He hypothesized that obsessional ideas were a first line of defense—preoccupying the person with ruminations to prevent the emergence of unacceptable sexual thoughts; however, if repression was unsuccessful, then the return of the repressed yielded what Freud termed *secondary defenses*, or in common parlance, compulsions and prohibitions. Freud posited that these “protective measures” were “never primary” (p. 172) and could include obsessional brooding, a compulsion to test things, doubting mania, a compulsion to collect and store things (hoarding), burdensome ceremonials and rituals, precautionary measures, superstition, increased conscientiousness, fear of betrayal, and phobias, to

name but a few. As anyone who has ever worked with someone firmly ensnared in an acute obsessional neurosis knows, symptoms readily take over the person's entire life quite quickly. I point out Freud's delineation here between primary and secondary defenses because it anticipates his increasing distinction between an acute obsessional neurosis and an obsessional character structure.

In 1907, Freud began to move away from his hydraulic descriptions of obsessional neurosis to focus more explicitly on character traits. In "Obsessive Actions and Religious Practices," Freud described the sense of guilt so prevalent in obsession and suggested, "Its source [is] in certain mental events, but it is constantly being revived by renewed temptations which arise when there is a contemporary provocation" (p. 123). Furthermore, Freud noted the sense of expectant anxiety and expectation of misfortune, "which is linked, through the idea of punishment, with the internal perception of the temptation." This temptation and the prohibition of it is a never-ending process:

In the course of the repression of this instinct a special *conscientiousness* is created which is directed against the instinct's aims; but this psychological reaction-formation feels insecure and constantly threatened by the instinct which is lurking in the unconscious. The influence of the repressed instinct is felt as a temptation, and during the process of repression, anxiety itself is generated, which gains control over the future. [...] The process of repression which leads to obsessional neurosis must be considered as one which is only partly successful and which increasingly threatens to fail. It may thus be compared to an unending conflict. [...] Thus the ceremonial and obsessive actions arise partly as a defense against the temptation and partly as a protection against the ill which is expected. (p. 124, original italics)

Thus, when protective measures fail (as they inevitably do) prohibitions and compulsions come into play, and the obsessive is caught in an acute neurosis; however, Freud reminds us here that all symptoms serve as compromise formations. "*They thus always reproduce something of the pleasure which they are designed to prevent*" (p. 125, italics added).

In “Character and Anal Eroticism,” Freud (1908/1959) specifically identified the triad of anal character traits he associated with obsessive character structure: orderliness, parsimony, and obstinacy. Drawing upon his work in *Three Essays on the Theory of Sexuality*, Freud (1905/1953) elaborated his notion of the sexual component instincts (better known today as “partial drives”) and suggested that we can “infer that such people [obsessives] are born with a sexual constitution in which the erotogenicity of the anal zone is exceptionally strong,” (p. 170) and that “cleanliness, orderliness and trustworthiness give exactly the impression of a reaction-formation against an interest in what is unclean and disturbing and should not be part of the body” (p. 172). Freud posited that character in its final shape was thus formed out of the constituent sexual instincts. It was not, however, until “The Predisposition to Obsessional Neurosis” that Freud (1913/1958) clearly distinguished between obsessional neurosis proper and the development of obsessional character. Freud postulated that in obsessional neurosis proper, there was a failure of repression and a subsequent return of the repressed; whereas in the formation of obsessive character, repression had been more successful and had thus been replaced with reaction formations and sublimations (Sandler & Hazari, 1960/1997, p. 164). A person could thus have an obsessional character without a corresponding obsessional neurosis, as well as the converse.

Furthermore, in “The Predisposition to Obsessional Neurosis,” Freud first proposed the idea of “pregenital instincts” and of distinct stages in sexual development that were dominated by specific component instincts. Based largely on his work with the Rat Man, Freud identified what he termed the “pregenital, sadistic, anal-erotic sexual organization,” and suggested that a regression from the castration anxiety associated with

the oedipal stage to the relative safety of the anal stage was what characterized the obsessive. Freud noted that many of the issues that are readily identifiable in obsessive personalities such as cleanliness, orderliness, obstinacy, and tendencies toward withholding were prominent issues in toilet training. He reasoned that anal characters felt rage toward parents for imposing social restrictions on their bowel movements prematurely that led to power struggles the child was doomed to lose. Consequently, the experience of feeling controlled and required to perform on schedule resulted in aggressive fantasies and angry feelings the child came to feel as “a bad, sadistic, dirty, shameful part of the self” (McWilliams, 2011, p. 292). Consequently, the need to feel in control, rational, and contained predominated the world of the obsessive. Mastery of objects was likewise of paramount importance.

The role of hate in obsessional neurosis was one Freud highlighted in his analysis of the Rat Man, formulating the doubt and ambivalence characteristic of the obsessive as a product of repressed hatred. Ernest Jones (1913/1997), in his seminal paper “Hate and Anal Eroticism in the Obsessional Neurosis,” likewise held the view that the ambivalence between love and hate was responsible for the alternation between compulsion and doubt in obsessional neurosis. Jones suggested that “The conflict involved in the interference with anal eroticism on the part of the mother [...] must be regarded as one of the most important sources of chronic hatred” (p. 67). Indeed, the Oedipus complex, and the intrusion of another person in the child’s pleasure, provided the necessary conditions for hatred to arise. Citing Ferenczi, Jones correspondingly considered the obsessive’s

omnipotence as a projection of the feeling that one must slavishly obey certain irresistible instincts.¹⁸

Karl Abraham (1924) contributed to Freud's theory of anal eroticism suggesting that the anal stage was divided into two different stages. In the later stage, conserving tendencies of retaining and controlling the object predominated, whereas in the earlier stage, hostility toward the object and tendencies to destroy dominated. Abraham wrote,

If the conserving tendencies, those of retaining and controlling his object, are the more powerful, this conflict around the love object will call forth phenomena of compulsion. But if the opposing sadistic-anal tendencies are victorious—those which aim at destroying and expelling the object—then the patient will fall into a state of melancholic depression. (p. 80)

Abraham further noted that the obsessive was engaged in a world of power struggles and mastery, attempting to force things into a rigid and pedantic system in order to control them. The obsessive desired to rule and possess his object, and this largely resulted from the forcing of a habit on the child prematurely before he was psychically ready. Abraham (1921) suggested that “psychical preparedness” only occurred when the child began to transfer onto objects his own narcissistic feelings, such that the child did not feel dominated but rather *wanted* to perform for the sake of the other person. A transition from the earlier sadistic-anal stage to the later conserving stage thus indicated the individual had begun to spare his object from destruction and was moving toward the genital period, where he would “overcome his ambivalence and his libido [would] attain [...] its full capacity both from a sexual and social point of view” (p. 102). Finally, Abraham identified productivity with the genital stage and pointed out that avoidance of effort was a frequent trait of the obsessional character. Freud (1926/1959) concurred: “It

¹⁸ I would add here, not only must s/he slavishly obey irresistible instincts, s/he must also obey parents and the law.

may be that regression is rendered possible not because the genital organization of the libido is too feeble but because the opposition of the ego begins too early, while the sadistic stage is at its height” (p. 113).

Fenichel (1945), while agreeing with Freud that obsession represented regression to the anal stage due to overwhelming fears of castration and defenses against oedipal longings, later suggested that obsessive doubt reflected the ambivalence between the id and the superego. (Should I be naughty or nice?) He further noted that symptoms expressed distorted commands from the superego and that danger was a threat from within; compulsions were thus felt as positive commands and threats. Consequently, Fenichel noted obsessives were constantly caught up in protecting their loved ones from their own hostile impulses. He identified obstinacy as a way of expressing difficult feelings such as anger and aggression and noted the alternation between deed and punishment. Indeed, Fenichel pointed out that the purpose of many typical compulsive symptoms was to undo perceived aggressive acts and that compulsive rituals generally “represent[ed] a caricature of masturbation” (p. 272). The restricted and rigid world of the obsessive is perhaps best illustrated by Fenichel’s own words:

As long as the timetable functions as the regulator of their activities, they are sure that they are not committing the sins they are unconsciously afraid of; and as long as they know beforehand what they will do afterward, they are able to overcome their fear that their own excitement may induce them to do things they are afraid of. (p. 284)

The tug-of-war that colors the obsessive’s world is thus constant and demanding. In all of his formulations, Freud maintained his emphasis on symptoms as meaningful but also as providing a certain pleasure for the obsessive. The doubt, uncertainty, compulsions, prohibitions, obsessions, and the like—although painful—yield a certain kind of

enjoyment, a sexual satisfaction of sorts. Indeed, he posited that symptoms serve as a substitute for sexual satisfaction. This emphasis on the symptom as a compromise formation, as something valuable in itself, was (and is) revolutionary.

Interpersonal/Relational/Object Relations¹⁹

Contemporary dynamic understandings of the obsessive-compulsive personality²⁰ focus on patients' early relationships with parents rather than emphasizing regression from the oedipal to the anal psychosexual stage characteristic of classical Freudian theory. Intimate relationships, interpersonal elements, self-esteem, management of anger and dependency, and cognitive style are specifically identified and focused upon in treatment (Gabbard, 2005). Clinicians working in this tradition suggest that the obsessive-compulsive person felt inadequately loved and undervalued as a child, resulting in "strong, unfulfilled dependent yearnings and a reservoir of rage directed at the parents for not being emotionally available" (p. 574). Because the early environment was not conducive to the development of normal dependency needs or to the expression of anger specifically and emotional displays generally, the obsessive-compulsive person employs defenses such as reaction formation and isolation of affect to defend against such feelings. In fact, remaining in control of one's affects is of paramount concern to the obsessive, and this may stem from a belief that anger and other forms of emotional display could potentially drive others away. Consequently, intimate relationships pose a problem for the obsessive as "Intimacy raises the possibility of being overwhelmed by powerful wishes to be taken care of, with the concomitant potential for frustration of

¹⁹ I do not mean to suggest that all three of these orientations are exactly the same; however, for brevity's sake, I have put them together because they all emphasize the relationship between therapist and patient as curative.

²⁰ The obsessive-compulsive personality is a term that many psychodynamic therapists use; however, as will be shown shortly, it is different than Lacan's obsessive structure.

those wishes, resulting in feelings of hatred and resentment and a desire for revenge” (p. 574).

A need to control others, as well as one’s affects, is therefore a central component of the obsessive-compulsive personality according to interpersonal theorists.

Unconsciously, the obsessive believes s/he can prevent loss by maintaining supreme control. Unconscious aggressive wishes are also likely to contribute to the fear of losing others. Underlying this need to control is the fundamental belief that nurturance is temporary and can disappear at any given time. The obsessive responds to his or her unconscious rage by becoming overly deferential and pleasing to others. Indeed, obsessives are typically dutiful, rule-oriented, and exceedingly compliant in their attempts to ingratiate themselves to others; however, these behaviors can often be so excessive that they ring false. In this way, the obsessive’s fear of being unloved and underappreciated becomes a self-fulfilling prophecy, as other people distance themselves from such obsequious behaviors. The obsessive is then left with the feeling of being chronically unloved—a feeling with which s/he is all-too-familiar. The repetition here is evident.

Therapists of the interpersonal persuasion also suggest that the quest for perfection which often characterizes the obsessive-compulsive personality is indicative of the belief that if one is “more perfect,” one will finally garner the love and approval missed out on as a child. Those with obsessive-compulsive personalities often had parents who demanded high standards of behavior, expected strict conformity, and were derisive of expressions of feelings. Similarly, object relations theorists emphasize that early objects in the obsessive-compulsive’s life were likely overly authoritarian and

controlling, prohibiting spontaneous behaviors and demanding strict adherence to schedules. As is the case in psychoanalysis, other theorists have found the polar opposite to be the case: Obsessive-compulsive personalities often have a background of underparenting, as in the case of an unavailable mother and an absent or alcoholic father. To make up for the lack of any family standard, the obsessive sets high standards for himself in an effort to push himself to grow. Because there is no clear object on which to model oneself, these standards tend to be overly harsh and unrealistic (McWilliams, 2011). Finally, there is evidence that obsessives often suffered early loss of an object—whether real or imagined—leading to precocious ego development and the belief that the early loss was caused by one’s own death wishes (A. Freud, 1966/1997).

Concomitant with either an overly authoritarian or lax parental presence in early childhood is an overly punitive superego that relentlessly abuses the obsessive—always expecting more and reminding the obsessive that he is never “good enough.” This harsh superego is viewed as an internalization of the parent who could never be satisfied in the former case, and a projection of the obsessive’s unconscious aggressive tendencies onto an invented parental image in the latter (Kohut, 1971). The role of guilt and shame cannot be overemphasized in the obsessive personality. In response to the overly punitive superego, many obsessives are often prodigious workers who achieve great things; however, they are rarely satisfied with such achievements, instead preferring to move on to the next task to be mastered. It is also quite common for obsessive personalities to become so consumed by minutiae that they are unable to make any decisions whatsoever. In an effort to maintain control over all possible choices, obsessives become paralyzed in the decision-making process—leaving them to procrastinate until “fate” ends up making

the decision for them. Obsessives strive for certainty in all matters, and because this is simply an impossibility, end up doubting any decision they could potentially make. They often painstakingly (and to the annoyance of those around them) examine every possible avenue, attempting to come up with the “rational” and “right” decision—one that no person could possibly criticize. Any affective component to decision-making is conspicuously absent.

Obsessional Styles

Shapiro (1965, 1981) suggests that the obsessive-compulsive personality has a certain “neurotic style.” He writes, “By ‘style,’ I mean a form or mode of functioning—the way or manner of a given area of behavior—that is identifiable [...] through a range of his specific acts” (p. 1). Shapiro believes these modes of functioning are characteristic of various neurotic conditions. Specifically, he identifies ways of thinking and perceiving (cognitions), ways of experiencing emotion, modes of subjective experience in general, and modes of activity associated with various pathologies. Interestingly, rather than focusing on the superficial traits of such “neurotic styles,” Shapiro (1965) links them to an underlying psychological structure (what he terms a “matrix”) that “might be of a more general type than the specific traits or mechanisms that could be inferred from them” (p. 2). Furthermore, Shapiro suggests that the disposition to one or another specific form of symptom “may be regarded as essentially a problem of character” (p. 5) and sees style as a product of drives and stimuli plus the “mental organizing capacities” of the individual. In other words, the obsessive-compulsive person behaves in a certain manner not only because of certain modes of response to a stimulus, but also because of the

particular way he experiences or perceives a stimulus. Symptoms are thus viewed as products of a *style of functioning*.

Shapiro sees the characteristic cognitive rigidity of the obsessive as resulting from a distortion in the normal functioning and experience of volitional will. The tense deliberateness and more or less constant pressure the obsessive exerts upon himself represents an early defect in the development of autonomy and self-directed intentionality. Shapiro writes,

In the normal case, intentionality becomes sufficiently well established to function smoothly, without self-consciousness and, for the most part, without any special tension, and the willfulness of childhood seems to develop into an adult's sense of competency and freedom to do with himself what he chooses. In certain cases, however, the development of will and volition is achieved only in a markedly distorted and rigid form. (p. 37)

Stated otherwise, in the normal course of development the child, aided by his environment, learns to trust his impulses and wishes and integrates them in such a way that decision-making derives from his inherent interests; however, in the obsessive character, impulses and desires are rejected as untrustworthy and self-direction thus becomes a function of an always-conscious overseeing will rather than a natural implementation of acknowledged wishes. At heart, the obsessive cannot and does not trust his own impulses. Rather than following an internalized sense of direction, the obsessive obeys the rules and commands of some higher authority he feels obliged to serve. Without these strict imperatives, there is a loss of conviction; thus the very pressure and tension that characterizes the obsessive also keeps him safe: The presence of an external directive under which he can serve is ultimately reassuring. Satisfaction comes not from freely making a decision for oneself, but from the sense of duty of time

served—from a sense of slavishly paying off one’s debt. There is, therefore, confusion between one’s will and one’s genuine wishes—a lack of self-control is assumed when one’s wishes are contrary to the directives of the will.

Shapiro identifies obsessive doubt and dogma then as defenses against a more spontaneous experience of conviction. “If the capacity for volition and the sense of autonomy and will are well established, they can also be relaxed to make room for playfulness, spontaneity [...] A person whose direction of himself is secure can, in other words, afford abandonment of direction of himself in various forms and degrees with neither the expectation nor the fact of disastrous consequences” (p. 37). When this is not present, previously established authoritarian rules and principles make further judgment unnecessary, thus serving a protective function. Consequently, obsessives live in a state of “continuous tension between will and underlying inclination” (1981, p. 86).

Cognitive-Behavioral Approaches

At present, cognitive-behavioral and psychopharmacological approaches are considered by many to be the preferred method of treatment for OCD (obsessional neurosis). This is due principally to the current emphasis on empirically-validated treatments, as well as the dominance of Health Management Organizations (HMOs) that are only willing to pay for such evidence-based treatments (a category psychoanalytic treatment rarely falls into, despite supporting evidence; this issue will be discussed in my Method section below). Cognitive-behavioral formulations of obsessional neurosis do not focus on the historical context of the symptom or the early relationships that may have engendered its development but instead focus on the cognitive distortions or “negative automatic thoughts” of the person suffering from acute OCD. (Note here that we are not

talking about the obsessional character but about the “medical syndrome” as defined by a certain definable set of symptoms set forth by the *DSM*.) CBT models consequently center on helping patients identify maladaptive thinking patterns and management of negative automatic thoughts. Cognitive techniques (e.g., thought-stopping, distraction and dismissal procedures, identification of maladaptive thoughts) are typically combined with classic behavioral techniques (typically, exposure and response prevention, or ERP) in the treatment of OCD. Behavioral techniques such as ERP involve exposing the patient to what s/he obsessively fears in the presence of someone who prevents the patient from engaging in the compulsive activity designed to offset the anxiety caused by the stimulus. The idea is that by “flooding” the patient with anxiety, s/he will learn that s/he can tolerate it with no catastrophic events occurring. Over time, the patient will become “habituated” to his anxiety, thus relieving it. I worked at UCLA for a time in the early 2000s as part of the behavioral unit for OCD. Part of my job was to implement such exposure with patients. One woman I worked with suffered from contamination fears. Part of her “treatment” was to sit on a public toilet seat for a set amount of time without engaging in any undoing rituals. My job was to stand by her until time was up, essentially forcing her to endure terrifying levels of panic and anxiety. Needless to say, I found the treatment to be ethically questionable and, while it may have produced short-term results, in my experience they were not lasting (see above: anxiety displaces onto other things or activities).

In the cognitive model, obsessions themselves are not viewed as “negative automatic thoughts,” but are instead seen as stimuli that provoke such automatic thoughts (Salkovskis, 1985/1997). Intrusive thoughts are seen as typical occurrences in everyone;

what makes the obsessive person different is the way s/he *appraises* such intrusive thoughts (i.e., “It is bad that I am thinking this; something is wrong with me”). While most people experience intrusive thoughts as relatively benign, letting them go rather quickly, the obsessive person places catastrophic importance on them. Rachman (1971) suggests that obsessional thoughts are “noxious conditioned stimuli which have failed to habituate” (as cited in Salkovskis, 1985/1997, p. 221). Affective disturbance in OCD stems from these automatic thoughts rather than from the intrusive thought itself. Furthermore, the ideation from which the affective disturbance arises typically relates to responsibility or the possibility of the individual being blamed for some harm done to others as a failure to control the impulse. Correspondingly, compulsive behaviors are viewed as an attempt to “put things right” and avoid being blamed by self or others. The seeking of reassurance from others is likewise seen as an attempt to “spread responsibility” (p. 223). Cognitive distortions in OCD are thus seen to relate to an inflated belief in one’s ability to harm others or the self. Treatment is consequently aimed at making the ego-syntonic negative automatic thoughts more ego-dystonic, such that the patient may more effectively manage symptoms. The ability to identify maladaptive and catastrophic thoughts concerning responsibility for harm to self and others is likewise engendered. Combined with behavioral approaches, the assumption is that, “Cognitive modification of obsessions should concentrate not on modification of intrusions [...] but on the automatic thoughts consequent of the intrusions, and the beliefs which rise from these” (Salkovskis, 1985/1997, p. 235).

There have been numerous studies documenting the efficacy of behavioral therapies (see Rachman, Hodgson, & Marks, 1971/1997); however, not all patients

respond. Interestingly, when patients do not respond well to treatment, it is the patient who is blamed rather than the technique. Jenike (1992/1997) writes, “Outcome studies and anecdotal evidence indicate that *poor compliance* with the behavioral treatment program is the most common reason for treatment failure with behavioral therapy for OCD” (p. 316, italics added). The harsh moralization of such a comment is inescapable and is a primary critique I make of this method: The patient is already struggling with uncontrollable obsessions and compulsions, but it is considered to be the patient’s fault if she cannot make herself sit on a public toilet seat for 10 minutes. The implicit assumption is that we are all *able* to consciously control and manage ourselves. Freud termed this type of therapy a “psychology of consciousness,” meaning that any indication of the unconscious or its motivations is lacking (Freud, 1912/1958, p. 118). Such a therapy lends itself to further fragmentation in the patient by fostering a still deeper split between what is “me” and “not me.” Sadistic, angry, punitive, jealous, sexual, less-than-pleasing thoughts, rather than being accepted as part of one’s being, are instead distanced further and made even more alien.

Given this critique, I would like to momentarily examine the well-known claim in the literature that obsessional neurosis is notoriously refractory to psychoanalytic treatment (Gabbard, 2005; McWilliams, 2011; Penzel, 2000). There are numerous problems with this claim. To list but a few: What type of psychodynamic treatment? (As I hope I have shown, what we mean by this term is radically different depending on which theorist one is reading.) What is the definition of a “successful” treatment of obsessional neurosis? Is obsessional neurosis actually what is being treated? And finally, is the problem with the technique itself (psychoanalysis) or with *what is being treated*

(symptoms)? McWilliams (2011) notes that medications such as the selective serotonin reuptake inhibitors (SSRIs) and CBT are often more effective in those suffering acute OCD than psychoanalytic therapy alone; however, she reports that those approaches are less effective with what she calls the *obsessive-compulsive personality* (which is similar but not quite the same as what Lacan refers to as obsessive structure). Similarly, Gabbard (2005) notes, “[T]he *symptoms* of patients with OCD are notoriously refractory to psychoanalysis and insight-oriented psychotherapy. Obsessive-compulsive personality disorder appears to respond well to these treatments” (pp. 264-265, italics added).²¹ If the definition of successful treatment is a quick remission of a *symptom*, then therapeutic interventions designed specifically for this purpose will most certainly be “more successful.” (Indeed, taking Valium quickly relieves one of the symptom of anxiety.) However, if the definition of successful treatment is a shift in the patient’s psychic economy, treatments aimed exclusively at symptom eradication will likely not be viewed as “successful.” What I am proposing here is that obsessional neurosis has historically been viewed as refractory to a psychoanalytic approach precisely because clinicians have been treating symptoms rather than underlying structural dynamics. Dynamic therapy aims at a restructuring of character formation and the economy of desire; symptom remission occurs as a result of such restructuring but is not a primary aim. As previously noted, acute obsessional neurosis has the peculiar ability to manifest everywhere—as soon as one symptom disappears, strangely enough, it pops up elsewhere; it is *displaced*. It is not surprising that when the goal is efficient symptom management, psychoanalytic treatment is deemed a failure. It aims at far more—lasting and permanent

²¹ See Gabbard (2005, p. 578) for a detailed analysis.

characterological change—and this is not something quickly attained, despite contemporary society’s demand for a quick fix.

Neurobiological Approaches

Biological models of OCD abound today. While it has been established that there is likely a genetic component to the disorder, it is difficult to find two camps who agree on just what role neurobiology plays. From a neurobiological perspective, OCD is taken up as a medical syndrome that must have clearly identifiable neurobiological substrates; however, many of the studies clearly contradict each other, leaving it difficult to identify anything clearly. Two primary hypotheses emerge consistently in the literature: the basal ganglia hypothesis that posits OCD as a dysfunction in the basal ganglia²² region of the brain (Wise & Rapoport, 1989/1997) and the serotonin hypothesis (Zohar & Insel, 1987/1997; Jenike, 1992/1997).

Jeffrey M. Schwartz (1996), a UCLA psychiatrist regarded as an expert in OCD writes in his book *Brain Lock*,

We now know that OCD is related to a biochemical problem in the brain. We call this problem “brain lock” because four key structures of the brain become locked together, and the brain starts sending false messages that the person cannot readily recognize as false. (p. xv)

Using a gearshift of a car as a metaphor for the brain, Schwartz explains that two structures—the caudate nucleus and the putamen—work together like the “automatic transmission” for the prefrontal cortex. The caudate nucleus works with the thinking part of the brain, while the putamen functions as the transmission for the part of the brain that controls body movements. The caudate nucleus, when working correctly, “allows for the extremely efficient coordination of thought and movement during everyday activities.” In

²² For a detailed review of basal ganglia dysfunction and its correlation with OCD, see Wise & Rapoport (1989/1997).

OCD, however, the caudate nucleus gets “stuck in gear” and messages from the prefrontal cortex get stuck there, leaving the person effectively on repeat.

Baxter et al. (1992/1997) suggest that the “gating” function of the basal ganglia is disordered in OCD. Essentially, the gating function “by which certain motor, sensory, and perhaps cognitive impulses are either allowed to proceed through to perception and behavior or are held back (‘filtered’)” malfunctions, leaving the OCD patient overwhelmed with doubt about sensory, motor, and cognitive experiences. Interestingly, Baxter et al. note that the concept of gating is very similar to the concept of repression in analytic thought—whether something is allowed to reach consciousness or whether it is held back.

The role of serotonin in OCD is a controversial one with plenty of studies supporting both sides. The hypothesis rests on evidence that SSRIs effectively treat the symptoms of OCD, while other drugs targeting different neurotransmitters prove ineffective (Baxter et al., 1992/1997). However, as Gabbard (2005) notes, neurotransmitter changes associated with medications may relate either directly or indirectly to the condition—in other words, just because SSRIs improve symptoms does not necessarily mean there is a causal connection. Pharmaceutical response does not provide answers about the etiology of symptoms. For example, the fact that Clonazepam reduces anxiety tells us nothing about underlying reasons for the anxiety. Jenike (1992/1997) notes, moreover, that only 30% to 60% of patients with OCD respond to medication. Penzel (2000) suggests that “A problem in the brain’s use of serotonin is believed to be the main cause of classic OCD” (p. 116), but then continues, “There are a number of studies of serotonin blood levels, but they have not been particularly helpful in

contributing to our knowledge, *since the findings do not seem to agree*” (p. 116, italics added). My point here is that, while there are many studies suggesting a biological component to OCD, they are contradictory and complex and cannot be taken as confirmatory evidence of any specific causal theory. Furthermore, given the polyvalent findings of medication studies, as well as the widely divergent response among patients to psychopharmacological drugs, we would be remiss to firmly assert a biological foundation for OCD.²³

A Brief Interlude

Clearly, the cognitive-behavioral and neurobiological models differ significantly from psychoanalytic theory. It is beyond the scope of this paper to engage in a thorough critique of such models; however, I want to briefly mention that what is left out of these two approaches is any idea of the symptom as meaningful and historical. I find it curious that the *content* of obsessions seems to be of little interest to those ascribing to a cognitive-behavioral or neurobiological theoretical perspective. If we pause for a moment to actually look at the content of obsessions, we notice a curious pattern. Obsessions are often broken down into the following:

1. Morbid obsessions about sex or harm,
2. Contamination obsessions,
3. Religious obsessions,
4. Obsessions of harm, danger, loss, or embarrassment,
5. Magical obsessions,
6. Body-focused obsessions, and
7. Perfectionistic obsessions.

If we take seriously Freud’s contention that symptoms convey a hidden meaning, we notice that the content of obsessions most often revolve around socially unacceptable

²³ Because the focus of this dissertation is not on the neurobiological substrates of OCD, I will direct the reader to Gabbard (2005, pp. 264-266) and Jenike (1992/1997, 2004) for more detailed information.

impulses (e.g., those of an aggressive or sexual nature). What would the biologically-minded make of this? Penzel (2000) seems to recognize the general nature of obsessions, remarking,

Obsessive thoughts and questions can often be about nasty and morbid subjects [...] For reasons we don't yet understand, some people's obsessive thoughts seem to latch onto whatever they may find the most repulsive or disgusting [...] Morbid obsessive thoughts are especially hard to cope with because they are so foreign to the person. They mostly involve sinful, destructive, and/or disgusting acts, wishes, impulses, or mind pictures. (p. 212)

Of course, would Penzel but broaden his perspective, he might take seriously Freud's conjectures in *Notes upon a Case of Obsessional Neurosis* (1909/1955) that the repression of sexual and aggressive impulses results in a morbid preoccupation with them. "According to psychoanalytic theory [...] every fear correspond[s] to a former wish which was now repressed" (p. 39). Thus, if we pay attention to the content of obsessions, we find hostile and aggressive impulses seeking expression. Again, my intent here is not to invalidate the work that has been done in the biological explorations of mental states, nor is it to suggest there is no place for cognitive-behavioral approaches. My intention is instead to draw attention to the human facets of character that are left out of such approaches. It is not a coincidence that *every person* experiencing acute obsessional neurosis struggles with ethical issues surrounding sex, anger, aggression, scrupulosity, and the like. What gene or neurotransmitter is responsible for such a coincidence? I point this out lest we lose sight of the immense complexity, not only of obsessional character and neurosis, but of humanity in general.²⁴

²⁴ For a nice combination of the psychodynamic with the biological, see (Zohar & Insel, 1987/1997).

Cultural Considerations

It is hard to miss the fact that many of the “characterological disturbances” associated with obsessive character are, in fact, traits endemic in contemporary Western society, including excessive work productivity, frugality, perfectionism, and extreme attention to detail. Indeed, the very symptoms of obsessional character that the *DSM* pathologizes are otherwise thought to show “strong moral character” in “normal” people. I would argue that we are living in an obsessive culture today.

If we look at the emphasis placed in schools currently on science over the arts and math over play, we clearly see aim-oriented activities taking precedence over creativity and spontaneity. The very way students today are taught is representative of obsession: Learning is a means to an end—not a process in itself—and the bottom line is measured by scores on standardized tests. What is taught in the majority of schools today is not critical and creative thinking, but conformity to external rules and authority. Indeed, many children are being diagnosed with “disorders” such as Oppositional Defiant Disorder precisely because *they do* challenge rules they view as confusing or illegitimate. Essentially, they are being taught to place their ultimate trust in the authorities around them at the expense of developing their own sense of direction. Furthermore, the emphasis on perfection is one that readily haunts the youth of today. Many students take medication today for test anxiety! The risk of making a mistake is that high. The worry of being seen as lacking is that great.²⁵

²⁵ Lacan (1948/2002) writes, “It is clear that the promotion of the ego in our existence is leading, in conformity with the utilitarian conception of man that reinforces it, to an ever greater realization of man as an individual, in other words, in an *isolation of the soul* that is ever more akin to its original dereliction” (p. 28, italics added).

Furthermore, the emphasis on quantifiable outcome measures and empirically-validated treatments smacks of obsession and is one anticipated by Lacan. Lacan argued that the strict regulation of the time and cost of analysis instituted an obsessional structure “where each analyst had to comply with the demand of the Other for order and regularity” (Samuels, 1993, p. 136). This obsessional drive is clearly evident in modern day psychological practice, where treatments are prescribed by manuals, time limits are strictly reinforced, and success of treatment is judged by mathematical formulas. Complete self-mastery and self-knowledge (and the accompanying presumption that this is possible) are the goals of therapy. Little room is left for notions of the unconscious, and contemporary therapeutic methods often lend themselves to patients’ further objectification of themselves. Therapy is about “managing” oneself, increasing the distance between thought and experience, rather than integration of rejected parts of oneself.

The need for certainty and the drive for mastery are all components Freud associated with the anal stage over 100 years ago. As a society, we value that which is “knowable” over that which retains mystery. We actively denigrate novel and historical ideas that cannot be “proven.” There is no room for what Lacan terms *lack* in our society. As will be shown in Chapter Two—denial of lack is a hallmark of Lacan’s obsessive. The continued emphasis on the “rational” over the “affective” (as if the two constituted a dichotomy) is likewise suggestive of obsession. We embrace those who have “mastered” themselves and are in “control” of their emotions, rather than valuing the beauty of an engaged and emotional life. Pleasure is pursued in thinking and doing rather than in *being*. As McWilliams (2011) points out, “Western civilizations, in conspicuous contrast

to some Asian and Third World societies, esteem scientific rationality and ‘can-do’ pragmatism above most other attributes” (p. 289).

The conditions necessary for the development of obsessive character are eminent in our culture. We glorify it, in many respects (unless you wash your hands too many times, and then you’re just crazy). Productivity and egoistic achievement are hailed as the aim of life in an almost Calvinistic fashion, at the expense of pleasure, the arts, joyful spontaneity, imagination, and play. I draw attention to these cultural concerns here because we are not simply isolated beings completely formed by biology. We are also social beings, and our society influences family patterns and childrearing practices. When the social world emphasizes precision and certainty at the expense of curiosity and wonder, we can most certainly expect to see our cultural obsession manifest itself in the individual.

Method

A larger reason that American analysts and other clinicians have little familiarity with Lacan and little appreciation for his relevance to their work is that the bulk of the writing in English on Lacan is devoted to theory. Clinical case studies in English are in decidedly short supply. Relatively few clinicians present their own and show how the theory applies to phenomena that other clinicians encounter in the framework of their practices.

(Friedlander, 2000, p. 137)

My decision to utilize a qualitative case study methodology reflects, in many ways, the cultural critiques I offer above. I see psychotherapy as an art rather than a quantitative science designed to measurably produce specific outcomes. In fact, our definition of “science” today, with its heavy-handed emphasis on quantifiable verification, often precludes the generation and revelation of certain types of knowledge.

As Fenichel (1945) notes, “To order the unknown according to known categories is the task of science. Compulsive systematizing, performed not for the purpose of mastering reality but rather in order to deny certain aspects of it, falsifying reality, is a caricature of science” (p. 286). Additionally, Lacan (1953/2002) writes, “Psychoanalysis can provide scientific foundations for its theory and technique only by adequately formalizing the essential dimensions of its experience, which—along with the historical theory of the symbol—are intersubjective logic and the temporality of the subject” (p.76). Lacan thus advocates for an unconscious logic that has been ignored by contemporary science. To further articulate my specific methodology, I will first examine the critique of qualitative research generally and case-based research specifically and offer a brief history of Freud’s case studies. Secondly, I will, following Lacan, argue that what has largely been ignored in contemporary research methodologies (including most qualitative approaches) has been any notion of the unconscious. As a corrective, I argue that the psychoanalytic interview is in itself a valid form of qualitative research that takes seriously the notion of the unconscious, thus strengthening traditional forms of qualitative research by providing access to a knowledge that has largely been foreclosed by such traditional methods. Finally, I will offer a brief summary of my own experience with both the case study methodology and obsessional neurosis as a way of highlighting my unique experience in these areas.

To begin, I want to emphasize that my interest is in illuminating the *how* of psychotherapy—what occurs in the session room, what signifiers are produced and how they transform over time, the interpretations I offered and how my patients responded to them, the polyvalence of meaning and language and how this was punctuated—in short, I

want to offer details of the *process* of a Lacanian-oriented psychotherapy. I believe this is necessary as the proliferation of quantitative psychological studies threatens to further deepen the divide already existing between researchers and clinicians. The grounding of theoretical data in concrete clinical examples serves to bring clinical practice into the quotidian realm, rather than leaving it floating in quantitative, empirical research data that often has little to do with the everyday experiences of patients. Indeed, the divide between empirical research and clinical practice is often so great that interventions that look good on paper are either not feasible for clinical application or have little, if any, direct, meaningful impact on patients. Consequently, there is a “widely acknowledged gap between research and clinical practice” and “surveys of practicing therapists find that much of published psychotherapy research is rarely consulted” by them (Walsh, 2004, p. 3).

The dominant discourse in science today holds that there is one objective truth and that it can be discovered via the scientific method. The ontological assumptions of natural science discourse thus assume a static world that can be isolated from human observation and human experience. The contemporary prominence placed on experimental designs (random controlled trials, or RCTs) intended to deduce causal relationships between independent and dependent variables, rather than being viewed as *one* approach to gaining scientific knowledge, have instead come to ideologically dominate the field as the *only* valid research method. Indeed, the very definition of “science” has come to be equated with that which can be “empirically” validated, where “empirical” has been wrested from its original definition of “based on experience” (Edwards, 2007, p. 14) and instead been made to denote that which has been validated

using multivariate statistical methods. However, as Flyvbjerg (2004) notes, the Germanic word “science” (*Wissenschaft*) literally means “to gain knowledge” (p. 424), and thus any attempt to exclusively reduce that which is “scientific” to that which can be *causally* explained is just bad (and incomplete) science. Thus, if RCTs serve as a valuable tool for gaining knowledge, they are nevertheless only one possible tool. The goals of RCTs—pristine objectivity, isolation of variables, and replication of results—pose problems “when we attempt to study psychotherapy, the meeting of two human beings, who engage in a discussion about subjectivity” (Miller, 2011, p. 28). The immense complexity and malleability of human experience is not quite so easy to isolate and replicate.

One of the primary complaints often leveled against qualitative research generally and case-based research specifically is that it is not empirical enough, where, as previously mentioned, “empirical” is inaccurately equated with the employment of “a group comparison method using multivariate statistics” (Edwards, Dattilio, & Bromley, 2004, p. 590). However, if taken in its original meaning of “based on experience,” it is hard to argue that case-based research is actually not *more empirical* than a quantitative multivariate method, where individual experiences are often lumped together and homogenized in the attempt to reduce experience to its lowest common denominators. Indeed, it is more often the case that a case-based method preserves the complexity of real-life situations far better than experimental designs which fictitiously isolate variables from contextual situations. As Yin (2003) suggests, we are always already situated within a horizon of meaning and the case study method “allows investigators to retain the holistic and meaningful characteristics of real-life events” (p. 4). The emphasis on context-dependent experience therefore permits the understanding of complex social

phenomena in a way that cannot be derived from RCTs which have been divorced from context. Furthermore, case studies remain truer to human experience by illuminating the qualitative differences between people rather than seeking to eradicate difference by simply labeling them as “outliers” or “accidents,” as is often the case in RCTs. In case studies, fractures and differences that arise during the research, rather than being discarded (because they throw off the mean), are instead explored and valued for what they can offer. RCTs typically seek a statistical mean across cases and then attempt to apply the mean of the sample to the greater population at large; however, as Edwards, Dattilio, and Bromley (2004) point out, there are certain processes which “cannot be examined by means of cross-sectional group comparison studies” (p. 592) and offer the example of psychotherapy as such a process. Whereas RCTs may be able to quantitatively measure the outcomes of various psychotherapeutic interventions, they cannot tell us anything about the actual individual *processes* that yielded such outcomes.

A second major critique of a case study methodology is that there is a greater proclivity for subjective bias when engaging in qualitative research. Of course, this criticism only makes sense if one is operating from the ontological assumptions underlying the natural scientific method that truth is something to be found “out there” and that what is required to ascertain such truth is the removal of any type of subjectivity. Flyvbjerg (2004) writes, “[B]ias toward verification [is] not simply a phenomenon related to the case study in particular, but [is] a fundamental human characteristic” (p. 428). Thus, the charge that qualitative methods allow more room for the researcher’s subjective and arbitrary judgment tends to ignore the fact that *all* methods are inescapably rooted in the researcher’s preconceived notions and theoretical subjective biases. The type of

research method employed is, therefore, not the problem, but rather how subjective bias is instead addressed by each method. Because qualitative researchers have so consistently been charged with verification bias, they have become sensitized to the issue in ways that more traditional quantitative investigators have not. Consequently, a great deal has been written on the importance of reflexivity in the research process (e.g., Walsh, 2003). It is thus arguable that, due to the very recognition paid to subjective bias within the qualitative field, verification bias actually plays a smaller role there than in a good deal of the quantitative research literature. In this sense, a case study methodology may be viewed as a scientifically rigorous method. In 2005, the APA task force stated that “Evidence-based practice in psychology is the integration of the best available research with clinical expertise *in the context of the patient’s characteristics, culture, and preferences*” (as cited in Goodheart, 2005, p. 2, italics added). A case study methodology takes seriously the patient’s context and culture and attempts to articulate it.

Case studies therefore offer the field of psychology concrete data grounded in the expertise of clinicians. They “comprise the building blocks of analytic theory” and are “a vehicle of instruction and transmission” (Goldman, 2004, p. 17). The case study has a lengthy history and harkens back to Josef Breuer’s and Freud’s (1895/1955) famous study of “Anna O” and continues with Freud’s elaborate case histories of “Frau Emmy von N.,” “Miss Lucy R.,” “Katharina,” and “Elisabeth von R.” in *Studies on Hysteria*. Of course, most famous are Freud’s detailed cases of Dora, the Rat Man, Little Hans, Schreber, and the Wolf Man. Furthermore, the literature is replete with case studies of analysts following Freud who produced a wealth of their own case studies, including Melanie Klein, Donald Winnicott, Karen Horney, Karl Abraham, and Sandor Ferenczi, to

name but a few.²⁶ All of these case studies provide intimate minutiae of the patient's symptoms, historical context, tangled webs of experience and desire, and most importantly, how the patients *spoke their stories*.²⁷ The patient's speech is the most basic tool of analytic therapy and a thorough case study allows us to examine this speech to the letter. It also allows us to see the unfolding of psychotherapy while tying it to a theoretical formulation. By grounding theoretical concepts in tangible clinical examples, the process of psychotherapy is spelled out.

Next, following Kvale (2003) and Swales (2012), I argue that the psychoanalytic interview²⁸ itself is a valid method of inquiry and methodologically rigorous. Swales notes,

The existing body of qualitative research has, both in method and interpretation, largely ignored the unconscious [...] This avoidance is particularly striking within the qualitative research of clinical psychology because most psychologists attribute some importance to the unconscious in human existence. (p. 14)

If we take the existence of the unconscious seriously, we must also acknowledge it as a form of knowledge in itself—one that pays attention to intrapsychic meanings. Most qualitative research methods reflect conscious (ego) knowledge, allowing no room for the unknown; however, the psychoanalytic interview “expose[s] the censored chapter of the unconscious” (Swales, 2012, p. 14). What I am referring to as the “psychoanalytic interview” is the method by which Sigmund Freud, Carl Jung, Melanie Klein, Jacques Lacan, and others have obtained their knowledge on human experience that is presented

²⁶ To read a detailed history of the case study methodology, particularly outlining the above-mentioned theorists' specific cases, see Goldman (2004, pp. 29-55).

²⁷ All of these case studies, with the exception of Schreber, spoke their stories to Freud. Freud's analysis of Schreber was taken from Schreber's autobiography.

²⁸ The initial meetings between therapist and patient are often referred to as “psychoanalytic interviews”; however, I am using the term here not only to refer to such initial intake sessions, but also to the therapeutic sessions that follow. Therapy, in and of itself, consistently produces knowledge that is directly relevant to the case study.

in their classic works. What we are examining when looking at the *how* of psychotherapy is precisely what is happening when two subjects meet. This does not mean that what we are interested in from a Lacanian perspective is the relationship between two subjects, but rather, how interpreting, punctuating, and listening in certain ways affects the patient and stimulates greater exploration of the unconscious. As Kvale (2003) points out, the practice of psychoanalysis itself produces significant knowledge, though it is a form of knowledge production that is rarely given credence. Kvale writes,

After a century of psychoanalytical therapy and knowledge production, the main evidence of the psychoanalytic theory still rests on knowledge accumulated through psychoanalytical interviews, a research method that has hardly been given systematical thought in the social sciences. (p. 88)

Kvale further describes how much of the information presented in current psychology textbooks is based on knowledge originally obtained through psychoanalytic interviews; however, because contemporary scientific discourse refuses to acknowledge the therapeutic interview as a legitimate research method, “Major parts of psychological knowledge are produced by a method that does not exist in a scientific psychology” (p. 92). The solution is to either ban psychoanalytically derived knowledge from textbooks (which would eliminate any notion of neurosis, dreams, the unconscious, defenses, repression, and so on) or to regard the clinical interview as a valid research method and develop its research potentials. In this dissertation, I have obviously opted for the latter, methodically reflecting on my case sessions, process notes, and the patients’ verbatim speech so as to identify repeating signifiers, unconscious manifestations such as slips of the tongue, unprovoked denials, and the like, and places where the conscious narrative stream either faltered or conveyed multiple levels of meaning. This is one of the main benefits of the therapeutic interview: It articulates the gaps and holes—the lack—in the

patient's egoic narrative. Those moments when the patient is at a loss are taken seriously and the clinician/researcher understands that even failures offer invaluable guidance, as I hope to illustrate in my case studies.

The psychoanalytic interview thus utilizes an interpretive method that pays close attention to the patient's speech, seeking to punctuate and interpret polyvalent language and conflicting meanings. Because it invites the patient to associate freely to whatever comes to mind, it does not set limits to the patient's speech in the way a structured qualitative interview might. It instead opens up a space for the unconscious, paying attention to and taking seriously manifestations of the unconscious such as slips of the tongue, bungled actions, affective surprise, unprovoked denials, negation, polyvalent word usage, and unfinished sentences. Ambiguity is not seen as invalidating the data but is instead embraced as reflective of human experience and understood as a type of knowledge in itself. Contrary to the natural science approach, there is no drive to reduce information to a "certainty," but rather an invitation to explore the multiple meanings inherent in discourse. This means that the clinician/researcher does not feel pressured to fit the patient's experiences into predetermined categories but can instead attend to the uniqueness of the patient himself. In itself then, the psychoanalytic interview is an interpretive method that is already a viable research method. When elucidated through the case study, I believe the psychoanalytic interview can deepen and enrich case studies by expanding our idea of what constitutes "knowledge." "If we take "science" in its literal translation to mean "to gain knowledge," the psychoanalytic interview gives us access to a much-needed and neglected form of knowledge—the unconscious.

Given the aforementioned gap between clinical practice and the dominant prevailing research emphasis on RCTs, the psychoanalytic clinical interview operates as a type of therapeutic research that may function to bridge this gap. Rather than, on the one hand, simply offering exciting and entertaining case histories, or, on the other—producing randomly controlled, statistically laden analyses—the therapeutic interviewer instead attempts to methodically reflect on how the evidence for the case study is obtained. Freud himself believed that “one of the distinctions of psychoanalysis [is that] research and treatment proceed hand in hand” (as cited in Kvale, 2003, p. 88). In an attempt to navigate the murky waters between positivist research and clinical practice, Kvale suggests approaching the clinical interview with a focus on the concrete descriptive and interpretative knowledge of human relations produced in a psychoanalytic session.

It is important to note here that I did not conduct my sessions with the patients presented in this dissertation from a researcher’s perspective. I was their therapist, and as trained, I took copious notes both during and after sessions. While I was seeing these patients, I did not think of them as research subjects or participants but as patients under my care. Thus, when it came time for the data collection phase of the dissertation, I sifted through hundreds of pages of process notes, supervision notes, and peer supervision notes. I also had access to my supervisor’s notes, which provided an alternative perspective to my own. The accumulation of process notes over the years allowed me to methodically go through them, seeking out repeating signifiers, patterns in speech and behavior, unavowed desire and jouissance, and larger historical patterns that I was able to situate within the context of each patient’s life. Furthermore, I had the benefit of

discussing my interpretations of the case material with both my clinical supervisor and with peer supervisors. My interpretation and formulation of the case material therefore stemmed from careful examination of my own process notes, experience with the patients themselves, and feedback from at least three other people.

Methodologically speaking, I have thus rigorously formulated these cases with careful attention paid to where I could potentially be overgeneralizing or overinterpreting. The benefit of close and multiple supervision is that it places limits on one's subjective bias by incorporating outside voices that serve to inhibit dogmatic interpretations. Consequently, the data produced by the clinical interviews was subjected to careful scrutiny by others than myself. My interpretations are certainly guided by psychoanalytic theory, particularly Lacanian theory; however, because Lacan's emphasis is on the letter of the patient's speech (something directly visible and present) rather than on intuition, affect, or something hidden "deep down," I feel that the formulations are even more concrete and methodologically rigorous.

Given my experience across varying treatment modalities, as well as my more recent attention to Lacanian theory, I believe I am in a position to offer something unique to the field of psychology through my case studies. Firstly, because I do have such varied experience in treatment modalities, my case conceptualizations will necessarily reflect such experience. It is because I have worked with other, more "mainstream" approaches to treatment of "OCD" that I find myself drawn to the structural approach of Lacan. My presentations of my cases will consequently reflect the evolution of my thought and technique, as well as how I believe this evolution affected the development of the cases. I am thus in the unique position of not only being able to contribute Lacanian-informed

case studies to the field (which, as previously mentioned, are already in short-supply), but to also compare and contrast this approach with other symptom-based approaches that I believe, based on my professional experience, fall short.

Secondly, the cases I intend to present were chosen specifically to illustrate the difference between structural and symptom-based approaches. My dissertation therefore focuses on the larger implications of Lacanian theory for diagnosis and treatment rather than articulation of one specific Lacanian technique (e.g., “listening to the letter,” Miller, 2011). While my cases will most certainly illustrate how the therapist should attend to patients of differing structural economies (with a specific focus on work with obsession), this is but one element of the case presentations.

Thirdly, as part of my education at Duquesne University, I designed a qualitative research course on case study methodology. Consequently, I was able to spend a semester investigating not only the history of this methodology but also its contemporary relevance. Since that time, I have continued to follow existing debates and discussions about the validity of the case study method. As such, I believe my specialization in this methodology allows me to provide a deeper and more thorough explication of the case material.

Finally, given my extensive and varied history, both as a student and as a clinician, I believe my case presentations have the potential to speak to multiple audiences. First, my hope is to make Lacanian clinical theory accessible to and applicable for psychodynamically-oriented therapists previously unfamiliar with Lacan. Next, I hope to offer more “mainstream” practitioners persuasive theoretical and clinical arguments for a more structural approach to treatment and diagnosis. Finally, because I have knowledge

of more mainstream treatment modalities, as well as *DSM* criteria, I believe my dissertation will also be of interest to Lacanian psychoanalysts unfamiliar with such information. In addition, because there is a lack of literature in the Lacanian field on specific ways of working with obsession, I believe this, too, will be of interest to those already practicing within a Lacanian orientation. Because I am not a Lacanian psychoanalyst, nor a CBT practitioner, but am familiar with *both* approaches, I believe I have the opportunity to contribute truly unique case material and formulations that speak to multiple audiences.

CHAPTER TWO

Introducing Lacan

I identify myself in language, but only by losing myself in it as an object.
(Lacan, 1953/2002, p. 84)

Whether it wishes to be an agent of healing, training, or sounding the depths, psychoanalysis has but one medium: the patient's speech.
(Lacan, 1953/2002, p. 40)

In what follows, I offer you a simplified description of some of Lacan's basic concepts. As previously noted, my desire is to articulate how these concepts shaped my clinical formulations and practice, and I can best accomplish this through the presentation of my cases. This chapter serves to introduce some of Lacan's theory as I currently understand it and to give a backdrop to the case presentations.

Lacan's Critique of Ego Psychology

Throughout his career, Lacan unabashedly criticized psychoanalysts who, while claiming to follow Freud, radically transformed Freud's teaching by focusing on "ego strength" at the expense of the drives, as well as intuition and affect at the expense of speech and language. Lacan (1953/2002) called for a "return to Freud" in "The Function and Field of Speech and Language in Psychoanalysis," emphasizing that psychoanalysis had moved very far, indeed, away from Freud's revolutionary talking cure. Lacan's stated aim was to bring psychoanalysis back to its rootedness in speech and language:

One can trace over the years a growing aversion regarding the functions of speech and the field of language. It is responsible for the 'changes in aim and technique' that are acknowledged within the psychoanalytic movement, and whose relation to the general decline in therapeutic effectiveness is nevertheless ambiguous. (p. 34)

According to Lacan, ego psychologists such as Ernst Kris, Leo Loewenstein (who had analyzed Lacan), Heinz Hartmann, Michael Balint, and Anna Freud had wrongly interpreted Freud, focusing on the “imaginary” communication between two egos as the therapeutic factor in analysis, rather than on the curative effects of the “symbolic” register of language (constituted by a discourse between the subject and the Other).

Lacan argued that ego psychology (which, as previously mentioned, was primarily dominant in America), rather than exploring the symbolic matrices that structure the unconscious subject, instead served as a behavioral modification tool whose aim was to adapt the individual to contemporary social norms and institutions (Miller, 2011).²⁹ Lacan thus accused the ego psychologists of acculturating psychoanalysis to an American paradigm rather than remaining true to Freud’s original teachings—therapy had become about the patient “modeling” her ego upon that of the therapist, leaving the patient dependent on the therapist and further alienated from her own *desire*. For Lacan, the very becoming of a subject necessarily entails a radical alienation from one’s being due to the instatement of the symbolic order and the operation of the *mirror stage* (to be discussed below); consequently, we are all *alienated* from our being (with the exception of the psychotic and the autistic, who refuse the symbolic order) by the very institution of language. The danger of a therapy that seeks to bring about the identification of the patient’s “weak” ego with the therapist’s “strong” ego is “not of a negative reaction on the subject’s part, but rather of his being captured in an *objectification*—no less imaginary than before—of his stationary state, indeed, of his statue, in a *renewed status*

²⁹ Many of the critical theorists connected with the Frankfurt school in Germany concurred that the function of the American ego psychologists was adaptive rather than critical in nature and had moved too far away from Freud’s fundamental discoveries. See Adorno & Horkheimer (1947/2002).

of his alienation” (Lacan, 1953/2002, p. 44, italics added). Differentiating psychoanalysis proper, Lacan proposes,

The analyst’s art must, on the contrary, involve suspending the subject’s certainties until their final mirages have been consumed. And it is in the subject’s discourse that their dissolution must be punctuated. (p. 44)

Thus, according to Lacan, the ego psychologists had forsaken the unconscious and the function of “full speech [...] to reorder [the] past contingencies” (p. 48) that would allow the subject to assume and subjectivize her history.

The ego psychologists (and I would also add here those of object relations, interpersonal, and more currently, relational persuasions) fundamentally discount the role of speech and language in favor of more “intuitive” approaches that emphasize unmediated contact with the patient and her affect. “[T]he practice of analysis has become focused on an illusory something situated *beyond* speech, which makes itself known in an interpersonal, affective way” (Miller, 2011, p. 4, original italics). This *something beyond speech* is presumably best attended to by focusing on the “therapeutic relationship,” by “following the affect” of the patient, and by attending to one’s countertransference. Relational models focus on the dyad formed by patient and therapist and the way the therapeutic relationship is “co-constructed” (Mitchell & Aron, 1999). Similar to Alexander and French’s (1946) “corrective emotional experience,” the belief is that a strong alliance between patient and therapist is largely what is psychologically curative. Emphasis is placed on “sincerity” (e.g., Malan, 1979, p. 187) and attunement to the patient’s affect and nonverbal gestures—suggesting that the therapist can somehow knowingly interpret such gestures.

Furthermore, some therapists actively argue for engaging and sharing one's own countertransferential feelings at the expense of analytic neutrality to assist in fostering an "authentic relationship" that will thus guide the patient to health (see Mitchell & Aron, 1999; Maroda, 2001). This type of therapy by suggestion is one that Freud (1917/1963), from his earliest days, warned against:

[We] are misinformed if [we] suppose that advice and guidance in the affairs of life play an integral role in analytic influence. On the contrary, so far as possible we avoid the role of mentor such as this, and there is nothing we would rather bring about than that the patient should make his decisions for himself. (p. 433)

Freud insisted on the neutrality of the analyst to give the patient time and space to work through her own resistances so as "to produce the solution of [her] own problems" (Freud, 1917/1963, p. 49) without the accompanying worry of the problems of another person. Lacan (1953/2002) agrees:

[N]othing could be more misleading for the analyst than to seek to guide himself by some supposed "contact" he experiences with the subject's reality. This vacuous buzzword of intuitionist and even phenomenological psychology has become extended in contemporary usage in a way that is thoroughly symptomatic of the ever scarcer effects of speech in the present social context. But its obsessive value becomes flagrant when it is recommended in a relationship which, according to its very rules, excludes all real contact. (p. 39)

Eliciting of the patient's *desire* is of primary import, and it is short-circuited if the therapist becomes a subject for the patient. If, for example, I share my belief in God with a patient, this may prevent her from expressing anger at a mother whom she felt was a religious zealot because she assumes, given my own belief in God, that I would be offended. Here, we are stuck in the imaginary again—an ego-to-ego relationship—when what is needed is work at the level of the symbolic (Fink, 2007). At best, the therapist serves as a "pure function" for the patient, as a placeholder (Fink, 1994, p. 14). This

brings out the transference and allows the patient's desire to come to the fore and become a question.

Speech and Language

[S]ymptoms can be entirely resolved in an analysis of language, because a symptom is itself structured like a language: A symptom is language from which speech must be delivered.

(Lacan, 1953/2002, p. 58)

For Lacan, the belief that one's therapeutic intuition can serve as the basis for a successful analysis betrays the narcissism of the therapist and renders null Freud's fundamental discovery in works such as *The Interpretation of Dreams* (1900/1953), *The Psychopathology of Everyday Life* (1901/1960), and *Jokes and Their Relation to the Unconscious* (1905/1960) of the power of speech and language, as well as of the unconscious. Language structures us from the beginning of our lives, giving existence to thoughts, ideas, emotions, and experiences that could not exist without language because we would have no way of communicating them—of putting words on experience. We are, from the beginning, *subjected* to language, born into a prefabricated web of signifiers that exists before we are even born. These *signifying chains*, which Lacan (1957/2006) describes as a series of signifiers that are linked together and depend upon one another for signification (meaning), structure and define us, often outside of our awareness. Symptoms themselves are a type of language that have yet to be “signifierized” (Fink, 1995, p. 95). Psychoanalysis aims at discursively translating symptoms, moving them along their way to full speech. According to Lacan, the only tool the analyst has to work with is the patient's speech. “This assumption by the subject of his history, insofar as it is

constituted by *speech addressed to another*, is clearly the basis of the new method Freud called psychoanalysis” (Lacan, 1953/2002, pp. 48-49, italics added).

As is oft-quoted, Lacan (1973/1981) tells us that “The unconscious is structured like a language” (p. 149); Lacan maintains that dreams, symptoms, and fantasies also conform to the structure of language. Following Saussure (1972/1986),³⁰ Lacan agrees that language does not operate via a direct and singular relationship between signifier and signified, but is instead “characterized by a complex interrelationship via metaphor and metonymy between one signifier and others” (Miller, 2011, p. 9). Combining his work in structural linguistics with Freud’s work on dreams, Lacan asserts that the processes of condensation (which he equates with metaphor) and displacement (equated with metonymy) are fundamental to language and the two primary mechanisms operative in the unconscious.

It follows that the unconscious (or the symbolic order) consists of letters, phonemes, and relationships between its elements that allow for metaphor and metonymy and thus the production of signification or meaning. Correspondingly, metaphor and metonymy are ways of understanding phenomena that have to do with the symbolic order: symptoms, dreams, parapraxes, subjectivity, desire, and love. (Swales, 2012, p. 21)

In other words, what is important is the *letter* of the patient’s speech—what is actually *spoken*—not what the patient *means*, as meaning is always situated in the imaginary register (to be discussed below) and, as such, socially constructed. The subject is constructed by signifying chains, and indeed, exists and is to be found in language itself. Language speaks through the subject, and “The unconscious is that part of concrete discourse qua transindividual, which is not at the subject’s disposal in reestablishing the

³⁰ Significantly, Lacan parts ways with Saussure and asserts that the signifier dominates the signified, in effect “sliding” over it. Because there is no immediate connection between signifier and signified, language is polyvalent with one signification referring to another signification. “[T]here is no harmonious, totalizing relationship between signifier and signified. [...] The signifier dominates the signified” (Fink, 2002, p. 31).

continuity of his conscious discourse” (Lacan, 1953/2002, p. 50). What are repressed then are signifiers which come to function differently as they “connec[t] to other repressed signifiers in the signifying chain” (Swales, 2012, p. 22). The unconscious may be structured like a language, but it is not the egoic, conscious language of everyday speech; consequently, psychoanalysis seeks to decipher the language of the symptom as metaphor, where metaphor is “but a synonym for the symbolic displacement brought into play in the symptom” (p. 51). In other words, metaphor is the substitution of one signifier for another.

The Mirror Stage and Lacan’s Three Registers

These reflections lead me to recognize in the spatial capture manifested by the mirror stage, the effect in man, even prior to this social dialectic, of an organic inadequacy of his natural reality.

(Lacan, 1949/2002, p. 6)

The function of the mirror stage thus turns out, in my view, to be a particular case of the *function of imagos*, which is to establish a relationship between an organism and its reality—or, as they say, between the *Innenwelt* and the *Umwelt*.³¹

(Lacan, 1949/2002, p. 6, italics added)

Given Lacan’s assertion that symptoms, fantasies, dreams, and speech all conform to the structure of language, we are perhaps now better situated to examine his critique of therapies that seek to “heal” through interpersonal, egoic means. Unlike the ego psychologists whom he claims have misappropriated Freud’s conception of the ego, Lacan (1953/2002) does not see the ego as a psychic agency “whose strength...[is] define[d] by its capacity to bear frustration” but instead views it as “frustration in its very essence” (p. 42). Far from serving as a “reality function,” Lacan sees the ego as the

³¹ Inside and outside—concepts which present their own philosophical controversies; however, such a discussion would lead us too far away from the topic at hand.

symptom par excellence of neurosis—an objectification and *misidentification* of the subject that sets the stage for future symptoms. Ego psychologists such as Anna Freud and Otto Fenichel misunderstood this and identified the subject with the conscious ego that speaks, thus focusing on resistances rather than on the symbolic structuring of the patient (Lacan, 1975/1988).

In “The Mirror Stage as Formative of the *I* Function,” Lacan (1949/2002)—drawing upon the work of ethologists and embryologists—posits that the prematurity of birth specific to the human species results in a fragmented newborn, lacking in coordination and cohesive structure, that leaves it dependent on caretakers. In the mirror stage (approximately six to 18 months), the infant encounters a mirror³² *image* of herself that gives her a sense of being a whole coordinated unity that reaches far beyond her actual developmental achievement. The child identifies with this gestalt—indeed, she invests this image with a certain amount of libido. This identification with the gestalt provides a structuring image that organizes the prior chaos and provides the infant with a sense of coordination and unity that is imaginary—based on an *image*. Lacan writes,

The jubilant assumption [assumption] of his specular image by the kind of being—still trapped in his motor impotence and nursling dependence—the little man is at the *infans* stage thus seems to me to manifest in an exemplary situation the symbolic matrix in which the *I* is precipitated in a primordial form. (p. 4, original italics)

In his 1960 reformulation of the mirror stage, Lacan emphasizes that the presence of a parental Other who recognizes and affirms the child’s image in the mirror (e.g., “Yes! That’s you there! Good baby!”) facilitates—via discourse—the child’s assumption of the specular image. Lacan emphasizes that this approval and recognition by the parent is

³² The mirror could be an actual mirror or caretakers who reflect back to the child unified and coherent figures.

precisely why the mirror image is libidinally invested by the child and serves to later assist in the construction of the ego-ideal—the internalization of the parents’ ideals (Fink, 1997). The approving gestures by the parent(s) establish the child as unique in the parental Other’s world, further strengthening the identification with the image. Lacan (1948/2002) continues,

It is in this erotic relationship, in which the human individual fixates on an image that alienates him from himself, that we find the energy and the form from which the organization of the passions that he will call his ego originates.

Indeed, this form crystallizes in the subject’s inner conflictual tension, which leads to the awakening of his desire for the object of the other’s desire: here the primordial confluence precipitates into aggressive competition, from which develops the triad of other people, ego, and object. (p. 21)

In her capture by the image and desire to please her parents, certain “parts” of the child must necessarily be *negated* and cast out; such is the price the child pays for a unified, stable sense of self and the crucial feeling of being desired by the parents. The mirror image and the resulting ego function as a sort of nucleus upon which further self-images crystallize, offering a promise of unity and self-mastery that are illusory. The ego, therefore, is but a small fraction of the subject—whatever has been reflected back and recognized by the mirrors around her. The subject is therefore alienated from herself, fundamentally mistaking a small piece of herself (the ego) for the whole. Lacan (1948/2002) notes, “The *I* is an other” (p. 24, original italics) shaped by the discourse of others (e.g., people like the subject) and the Other—where the “Other” with a capital “O” refers to Lacan’s symbolic order, which includes the register of speech, language (and, therefore, the unconscious), law, culture, and persons perceived as radically different from the self.

The alienating function of the mirror stage thus results in a splitting off of the ego from the subject and aids in the creation of the split or divided subject—a subject with an unconscious—as those unacceptable parts of the child undergo repression. Importantly, (and necessarily), Lacan therefore distinguishes between the *ego* and the *subject*. Many therapists today conflate the conscious ego with the agentic subject who is masterful and in control. Not so, says Lacan. The subject is the subject of speech—not the subject who is the agent of speech—but the subject who is *determined and conditioned by speech* (Soler, 1996). Lacan maintains that the subject is the effect of speech and, as such, not identifiable with the ego.³³ A brief exploration of Lacan’s three registers will offer further clarity.

Before the mirror stage, the infant exists in the “real”—one of Lacan’s three orders of experience (or registers). The real is the register of fullness and presence. It lacks differentiation; indeed, it lacks *lack*. “[T]he real is without fissure” (Lacan, 1975/1988, p. 97). Soler (1996) refers to the being that exists in the real as the “living being” (p. 261)—a body that has yet to be overwritten by the symbolic order—a libidinal body unmediated by the signifier. It is radically non-discursive and stands outside the symbolic order. The real before the letter, or R_1 , (i.e., before the child’s coming into being in language) is the magical place of (illusory) unity where there is no distinction between infant and mother, mother and breast, inside and outside. *Jouissance*, Lacan’s term for a type of satisfaction that is both painful and pleasurable, is intimately tied to the register of the real as “something actual in the body”—a sexual excitation that is materially present and experienced in the body (Soler, 1996, p. 251).

³³ Readers interested in Lacan’s exposition of speech are directed to Lacan’s (1955/2006) “Variations on the Standard Treatment or “The Function and Field of Speech and Language in Psychoanalysis (1953/2002), to name but two.

Much of the real before the letter is overwritten by the institution of the symbolic order, being drawn into signifiers and restructured; however, there is always a residue of the real left over—a real after the letter, R_2 . This second real contains everything that is excluded from the signifying chain and may be thought of as the site of trauma—as that which has never been symbolized, leaving the subject stuck or blocked in some way. Fink (1997) notes accordingly,

The real [...] is what has not yet been put into words or formulated. It can be thought of, in a certain sense, as the connection or link between two thoughts that has succumbed to repression and must be restored. (p. 49)

The second real is thus associated with fixation and repetition in the subject: It is the thing the subject repeatedly comes back to and stumbles over, circling around it while not quite being able to formulate it in words. It is perhaps an event in the life of the patient that was so psychically overwhelming, it was unable to be incorporated into the subject's chain of discourse. The therapist listens for evidence of this second real in the gaps and holes in the subject's discourse—in that which has been excluded—for by its very exclusion, it takes on a materiality that structures the signifying chain. According to Lacan, the real must be symbolized through analysis; interpretation therefore aims at the real, seeking to restore missing links in the signifying chain of the subject. Interpretation is said to have “hit the real” or “hit the cause” when it creates truth for the subject, freeing up her desire and shifting her customary ways of achieving *jouissance* (Fink, 1997).³⁴

The mirror stage and the construction of the ego as a symptom act to firmly instate the infant in the *imaginary* register, which refers to the images we have of

³⁴ The real is never completely symbolized. There is always something that falls away and resists symbolization. See Fink (1995, pp. 24-31).

ourselves, others, and the world around us. As we have seen, in the mirror stage, the imaginary order is based on identifications with and imitation of others and is characterized by ego-to-ego relations. It is thus a dyadic order whose differentiation reaches only so far as what is “me” and “not-me,” where what is “not-me” is viewed as narcissistically threatening to the ego. As we have discovered, the ego is formed by negating intrapsychic parts of the subject that do not correspond to the unified mirror image by which the subject has been captured; however it is also the structure of the self-preservative ego to negate *all* that is “not-me.” Miller (2011) states,

Not only must the ego say “anything other than the two-dimensional unity I see in this mirror is not me” to keep itself intact. It must also negate *any Otherness of the mirror or mirror image itself*. The mirror must have no existence for itself. Rather it is there to reflect the ego; for all practical purposes it *is* the ego. [T]o be a mirror, the mirror has to be nothing else, just as to be an ego the subject must be largely negated. (p. 84, original italics)

The imaginary order is, therefore, structurally characterized by rivalry (and its complement, identification) and aggression (Fink, 1997). It is not surprising then that in “Aggressiveness in Psychoanalysis,” Lacan (1948/2002) identifies the “paranoiac structure of the ego [...] that is the very delusion of the misanthropic beautiful soul, casting out onto the world the disorder that constitutes [its] being” (p. 21). Faced with the task of defending against all that falls outside the imaginary gestalt (both intra- and extrapsychically), the ego is a sentinel that must always remain on guard.

Therapies then that seek to “strengthen the ego” function to further alienate patients by reinforcing the narcissistic mirage that lies at the heart of their neurosis—they only deepen the (mis)identification with the ego and do not inspire the patient to ask what s/he as a subject desires. Psychotherapeutic approaches that focus on the relationship

between therapist and patient remain trapped at the level of the imaginary order, focusing on dyadic relations rather than on speech, language, and the unconscious—in other words, on the symbolic order and the way the patient positions herself with regard to the Other. Such “two-bod[y] psycholog[ies]” focus on affect, countertransference,³⁵ and intuition; they function to make the patient an object for herself, thus replicating the narcissistic wound that already lies at the core of her being (Lacan, 1975/1988, p. 11). What is at stake for Lacan is “the realization of the truth of the subject” (p. 21). Thus,

If, as we must, we take speech as the central feature of our perspective, then it is within a three- rather than two-term relation that we have to formulate the analytic experience in its totality. (p. 11)

In other words, the issue Lacan takes with ego-oriented therapies is their lack of recognition of the symbolic. For Lacan, the imaginary register is “[r]estructured, rewritten, or ‘overwritten’ by the symbolic, by the words and phrases the parents use to express their view of the child” (Fink, 1997, p. 88). The linguistic order supersedes the imaginary, replacing the rivalry and aggression characteristic of it with symbolic concerns regarding achievement, guilt, the law, and authority, to name but a few. This overwriting is closely tied to Freud’s Oedipus complex whereby the child gives up the mother as the source of jouissance to become a socialized being—in a word moving from a dyadic relationship to triadic ones. Verhaege (1999) writes, “[T]he Oedipus complex is the process through which everyone has to go in order to move from two to three elements, that is, to break away from a mirror relationship with another person who is the same, and take the steps towards a third person, another other” (pp. 33-34). Further

³⁵ Lacan (1975/1988) writes, “No one has ever said that the analyst should not have feelings toward his patient. But he must know not only not to give in to them, to keep them in their place, but how to make adequate use of them in his technique” (p. 32).

explorations of Lacan's view of the development of the subject will help articulate these processes.³⁶

On Becoming a Subject: Alienation, Separation, and the Paternal Metaphor

What is at issue is the subjectivity of the subject, in his desire, in his relation to his environment, to others, to life itself.

(Lacan, 1975/1988, p. 1)

According to Lacan, the advent of the subject occurs via two logical movements and is closely tied to what Lacan terms the paternal metaphor or the paternal function. The paternal function is responsible for the birth of the subject into the symbolic order and serves as the “button tie” that anchors the entire symbolic realm (Fink, 1997, p. 93). An in-depth discussion of the paternal function and its accompanying movements of alienation and separation are not necessary for our purposes, so I will direct the reader to Fink (1995, pp. 49-79) for a more theoretically sophisticated account and give a general overview here.

The paternal function is the process by which an authority figure or someone/thing representing the law (typically the father in traditional nuclear families) comes between the mother and child, effecting at least a partial separation between the two—resulting in the instatement of what Lacan terms the Name-of-the-Father. Despite its name, it is important to note that the paternal function is a *symbolic function*—it is a metaphor for the institution of a third between mother and child. Consequently, the successful instatement of the paternal function does not require the actual presence of a father or a male figure: It requires the presence of someone—a third—representing the *law* (the symbolic order) that stands outside of the mother/child dyad. Thus, the authority

³⁶ It is important to note that the real, imaginary, and symbolic are not successive “stages” through which a person moves. Rather, they overlap and are intricately “knotted” together.

that comes between the mother and the child can be of any gender and may, indeed, be the mother herself.³⁷ This intervening figure may be thought of as the “second Other,” where the primary caretaker is the “first Other” (Verhaege, 2009, p. 79). What is important is that a separation is effected that provides the child the symbolic space necessary in which to come into being as a desiring subject.³⁸ This occurs through the movements of alienation and separation.

Alienation

The first movement of this function is called *alienation* and corresponds to what Freud termed “primal repression.” The living being in the real (not yet a subject in Lacan’s terms) is confronted with the radical Other of language and is forced to make a choice—submit to the Other of language and become a socialized, speaking being or reject the symbolic order altogether. The odds are obviously stacked against the child, so in a sense, the “choice” of the child is forced; however, it is possible for the child to reject the incorporation of the symbolic order, thus resulting in psychosis. In submitting to the Other as language, the child essentially allows the signifier to stand in for her. This can be represented as follows:

Other
child

I say the child must submit to language because in so doing, she is irrevocably separated from the real—from her living being. Language pre-exists her, and as such, acts as a sort of straightjacket, allowing her to operate only within the parameters of that pre-existing

³⁷ For a detailed description of the Name-of-the-Father, see Fink (1997, pp. 80-81) and Swales (2012, pp. 30-33).

³⁸ Lacan reformulates Freud’s Oedipus complex here. Samuels (1993) writes, “The Oedipus Complex structures the relation between the Real subject of sexuality, the narcissistic relation with the image of the mother, and the Symbolic intervention of the father” (p. 75).

symbolic system. In a sense, this first step toward subjectivity requires the child to give up her real being in exchange for a place within language and the symbolic order. The certainty and wholeness of the real are given up for the *possibility* of being, thus creating lack and doubt about one's existential place. "Alienation engenders [...] a place in which it is clear that there is, as of yet, no subject: a place where something is conspicuously lacking. *The subject's first guise is this very lack*" (Fink, 1995, p. 52, original italics). In other words, the child is alienated within language. There is a gap or a lack engendered by the incorporation of language that is structurally necessary and unavoidable (if one is to become a subject).

This incorporation of language consists of a further knotting that must occur between language and meaning—signifier and signified. According to Lacan, this occurs via the father's (or second Other's) prohibition of the *jouissance* the child enjoys with the mother (as first Other). *Jouissance* is a term that is not easily translated into English, nor is it one that remains static in Lacan's work, but roughly speaking it entails a type of pleasure in pain or a "getting off" of sorts. Before the intrusion of the second Other, the mother serves as the sole source of the child's *jouissance*—lovingly holding her, gazing into her eyes, breastfeeding her, and so on. The two are a unity, and the child has exclusive access to the mother. In a typical Western family, it is usually the father who intervenes in this relationship, perhaps admonishing the child for being a "baby" or a "Momma's boy." In so doing, he pushes the child to separate from the mother, thereby prohibiting the *jouissance* the child derives from her. Metaphorically, the father's "No!" cancels out the mother as the source of *jouissance*:

Father's No!
Mother as Source of *Jouissance*

The child is forced to *give up* a certain jouissance—a certain satisfaction he derives from her. In Freudian terms, the child undergoes a certain castration, a loss of the primary love object.

As I have indicated, jouissance implies a satisfaction that entails both pain *and* pleasure. Certainly, the child enjoys its special relationship with the mother, enjoying her touch and gaze, and perhaps (likely) hates the second Other for imposing restrictions on this jouissance; however, the immediacy of the relationship with the mother also produces anxiety for the child. Indeed, the mOther's³⁹ closeness is often perceived as dangerous to the child who perhaps fears being devoured, smothered, or engulfed by her. The lack of a gap, or to use Lacan's terms, the *lack of a lack* is precisely what produces this anxiety. This could reflect the child's wish to be the unique desire of the mother, or it could also be a genuine reaction on the child's part to a mother who is seeking gratification of her desires via the child (Fink, 1997). In either case, the important point is the anxiety produced in the child as a result of the overproximity of the mother is eased by the interruption of the second Other's prohibition. Fink writes,

The father protects the child from the mother (as desiring or as desired), setting himself up as the one who prohibits, forbids, thwarts, and protects—in a word, as the one who lays down the law at home, telling both mother and child what is allowed and what is not. (p. 80)

“Successful” alienation thus entails the child's incorporation of language and sacrificing of her living being, as well as a sacrificing of satisfaction obtained with the mother. The Name-of-the-Father or the second Other's “No!” serves as a powerful signifier that indicates something to the child about her relationship with mother: “Daddy doesn't like it when Mommy holds me/I am not supposed to like touching Mommy, etc.” In other

³⁹ I spell mOther here with a capital “O,” as I am referring to her as a desiring being, as radically Other.

words, the prohibitive signifier creates a *meaning* for the child. Consequently, word is tied to meaning, signifier to signified, in a bond that cannot be broken once instituted. This is what Lacan (1960/2002) refers to as the “button tie” that securely situates the subject in the linguistic order (p. 291).

Lacan notes that prohibition creates desire: It is when I no longer have something that I realize I *want* it, that I am *lacking* it. Due to the prohibition enunciated by the second Other, the child is no longer supposed to crave the mother’s warm touch, her soft embrace (the law says it’s not okay); consequently, the child must repress her desire for the *jouissance* she experienced with her. While the child’s incorporation of language and separation from the mother provide the initial symbolic space necessary for the subject to come into being, they also produce a residue—a *remainder*—of that which has been sacrificed. Lacan calls this remainder *object a* and identifies it as a result of primary repression. The notion of object *a* undergoes significant transformations and revisions in Lacan’s oeuvre.⁴⁰ (Indeed, one could dedicate an entire dissertation to the topic.) For our purposes, I will highlight Lacan’s formulation of object *a* as the residue of the real that is left over and continues to exist after the institution of the symbolic order. Object *a* is, on the one hand, the ineffable *agalma* (see Lacan, 2001) that interrupts the automatic unfolding of the signifying chain precisely because it resists symbolization. It is the thing that cannot be accounted for, therefore, disrupting the symbolic order. Object *a* can, on the other hand, be understood as the *rem(a)inder* produced by the limitations placed on the child’s *jouissance* with the mother: It is a last reminder of the supposed mother-child unity that the child clings to in an effort to ignore her division and sustain the illusion of wholeness. Object *a* is thus a symbol that indicates the lack in the child’s being (what has

⁴⁰ For a detailed account of the evolution of object *a*, see Fink (1995, pp. 83-97).

been lost), as well as the lost object the child clings to in her attempt to avoid acknowledging that lack. Lacan later identifies object *a* as the *cause of desire*—the ever elusive object that, if it could just be found, would offer the hope of a return to a fullness of being and to the *jouissance* one experienced before the letter.⁴¹ As such, object *a* structures the drives and desires of the subject and represents the presence of an unsymbolized real element in the symbolic order (Samuels, 1993). It is worth noting that these formulations of object *a* are not mutually exclusive; indeed, they both point to that ineffable rem(a)inder that escapes symbolization and is thus recaptured in fantasy. (As we will see, the subject's fantasy involving object *a* tells us something about the way the subject positions herself with respect to the Other's desire.)

Lacan tells us that, in undergoing alienation, the child is “eclipsed” by language—“that the subject here slips under or behind the signifier” (Fink, 1995, p. 52); however, as of yet, s/he is only a placeholder in the symbolic order. The signifier takes the place of the child's living being. For the complete advent of the subject, however, the second movement of the paternal function must occur.

Separation

This second movement in the paternal metaphor is what Lacan terms separation. Whereas alienation involves the child's encounter with the Other as language, separation involves the child's encounter with the Other as *desire*. By way of alienation, there has been a separation between mother and child and a repression of the child's longing to return to the *jouissance*-filled harmony s/he imagines existed before alienation. As a separate being, the child is left to wonder what purpose s/he serves. S/he may ask, “Why

⁴¹ We might refer to the *jouissance* of the real (before the letter, before the institution of the symbolic order) as J_1 and the *jouissance* after the institution of the symbolic as J_2 . See Fink (1995, pp. 60-61).

did my parents have me?” “Who am I to my parents?” “What do they want from me?” “Who am I?” Now separate, the subject is unknown to herself and seeks the answer to her existential questions via the recognition and approval of her parents. In short, s/he wants to know that s/he is desired. This leads the child to an encounter with the mOther’s desire and the question of what *she* wants. The child asks of the mother, “Chè Vuoi?” What do you want (Lacan, 1960/2002, p. 300)? This question is fueled by both anxiety and curiosity. On the one hand, the child wants nothing more than to be the mother’s ultimate desire—this would ensure her uniqueness and answer her existential questions. Furthermore, this would provide the child with a sense of the fullness s/he believes s/he experienced pre-alienation and further aid her in ignoring her own division. On the other hand, this longing to be the object of the mother’s desire is fraught with anxiety, predominantly because, post-alienation, the Other is initially taken up as the Other of *demand*. Thus, despite her longing for love and recognition, the child’s anxiety regarding the mother’s demand is still present, though to a lesser degree. If the child perceives that the mother is seeking to gratify herself via the child, anxiety will be provoked. The child will perceive herself as being the object that would fill the demanding Other’s lack, thus leaving her no symbolic space of her own. Essentially, s/he will see herself as nothing more than an extension of the mother and fear that s/he will be swallowed up by mOther’s lack.

For the child to further separate from the mother, demand must be superseded by desire. This occurs through the articulation of the mOther’s lack/desire.⁴² Oftentimes, this occurs by the mother expressing her desire for her partner, or she may express a desire for a certain dress or piece of artwork. The point is, the child recognizes that s/he is not

⁴² Lack and desire are coextensive. If one desires something, it is because one does not have it.

the be-all and end-all for her mother—that mOther desires something outside of her. The symbolization of the mOther’s desire thus opens up a space for the child to come into being in her own subjective position with her own desires, rather than remaining trapped in the anxiety-filled role as the mother’s object of *jouissance*.⁴³ The child’s anxiety is, therefore, allayed by the *naming* of the mOther’s desire. Lacan tells us that the word is the death of the thing—that by putting words on that which has not yet been named, some of the affective force of the real is “drained away.” When the mOther’s desire has not been named, the child is left with her demand alone and the accompanying belief that s/he will be swallowed up by that demand.

Furthermore, the general structure of desire enables the child to further separate from the mother. Whereas *jouissance* can be satisfied with a specific object (the child fears s/he is that object), desire desires more desire. It does not seek an object—it seeks its own continuation (Lacan, 1957/2006). Due to the fundamental lack in language, desire is something that can never be fully satisfied; it is structurally impossible. Because language is imperfect, we can never quite ask for what we want. Desire is that unnamable thing that cannot be articulated and that supersedes demand, going beyond what the subject asks for. Consequently, the child can never satisfy the mOther’s desire, as the satisfaction of desire is structurally impossible (except, perhaps, in dreams and fantasies); however, the nature of the mOther’s desire is enigmatic to the child—s/he wonders what her mOther desires. Fink (1997) writes,

Once that which the mOther is missing is named, the *object* the child was for his mOther can no longer exist. For once desire is articulated in words, it does not sit still, but displaces, drifting metonymically from one thing to the next. Desire is a product of language and cannot be satisfied with an

⁴³ This is precisely the definition of the Lacanian pervert. The pervert undergoes alienation, but does not undergo separation, remaining instead as the object of the mOther’s *jouissance*.

object. The naming of the mOther's desire forces the child out of his position as object, and propels him into the quest for the elusive key to her desire. What does she want? Something ineffable that seems to characterize the endless series of things her desire alights upon—what in Western society is known as the phallus. (p. 178)

Lacan's conceptions of the phallus are numerous, but for our purposes we can conceptualize the phallus as the signifier of lack or the signifier of the Other's desire. It is what the Other *wants*. The child attempts to ascertain what it is and to model her desires on those of the parental Other. Not only does s/he want to be desired by the Other, s/he wants to desire like the Other, having no being of her own. Thus, Lacan's well-known dictum, "Man's desire is the Other's desire." What is important here is that the encounter with the Other's desire stimulates the child's—it serves as the motor force of her developing desire. S/he wants to understand others' desires, and this necessarily leads to the engagement with desire itself. Thus, "The Other's desire causes ours" (Fink, 1997, p. 55).

In summary, the first movement of the paternal metaphor is the encounter with language and the prohibition of the child's *jouissance* with the mother as the first Other. The child sacrifices both her living being and *jouissance* before the letter in exchange for a place within the symbolic order. As a result of these sacrifices, object *a* falls away and is left as a rem(a)inder and reminder of the real, forever constituted as the "lost object" that will structure the subject's desires.⁴⁴ The second moment of the paternal metaphor

⁴⁴ Gallop (1985) writes, "What if the object of desire [object *a*] were not yet an 'object' but an indefinable something, radically indefinable, the result of primary repression? The primary repression was never present to consciousness, nor to any 'je' [ego], but is primordially and structurally excluded. There is no past state that was once present to which one could return, even in fantasy. The return cannot be imagined because one does not know the 'object.' What Lacan calls desire is precisely the result of this primary repression and yields up nostalgia beyond *nostos*, beyond the drive to return, a desire constitutively unsatisfied and unsatisfiable because its 'object' simply cannot ever be defined" (p. 151, original italics).

involves the child's encounter with the mOther's lack and the symbolization of her desire. The two moments can thus be represented as follows:

| Alienation | Separation |
|---|--|
| <u>Father's No!</u> Mother as jouissance | <u>Father's Name</u> Mother as desire |

Alienation thus entails a coming-into-existence of the divided being who is alienated in language; whereas, separation leads to the advent of a desiring subject.

A Structural Approach: Diagnostic Considerations

Medical diagnostics begins with the particular (the symptom) and moves toward the general (the syndrome), based on a semiotic system that is entirely focused on the individual's complaints. Clinical psychodiagnostics begins from the general (the incipient complaint) and proceeds toward the particular (where $N = 1$), based on a system of signifiers that is part of a wider relationship between the subject and the Other.

(Verhaege, 2004, p. 6)

Given our understanding of the two movements of the paternal function, we are now in a position to examine Lacan's diagnostic schema. Contrary to a symptom-based approach to diagnosis, Lacan's structural approach seeks to situate the symptom within the context of the subject's psychic structure and the symbolic matrix in which each and every person is born. Lacan's diagnostic criteria are ontological—they posit that people take up certain *subjective positions* in the face of suffering, specifically in the way they respond to separation. To address the distinction between a descriptive approach to diagnosis and a structural one, I would first like to address the concept of structure.

For Lacan, we are not simply bundles of neural networks and neurotransmitters, but rather, desiring beings moving about in the languaged world of the Other. The symbolic matrix is thus the context in which we are embedded—the network of preexisting signifiers, cultural rules, relationships, and history that “determine what is

allowed to be said, done, or even experienced” (Goldman, 2004, p. 110; see also Fink, 1995, p. 18 and p. 179). While some of the “context” in which we are embedded is certainly social and interpersonal in nature, what Lacan refers to as “structural” is essentially the symbolic dimension as Other that inhabits the subject and operates outside her awareness. Fink (1995) writes,

The unconscious is not something one knows, but rather something that is known. What is unconscious is known *unbeknownst* to the “person” in question: it is not something one “actively” consciously grasps, but rather something which is “passively” registered, inscribed, or counted. And this unknown knowledge is locked into the connection between signifiers; it consists in this very connection. *This kind of knowledge has no subject, nor does it need one.* (p. 23, original italics)

This is a concept that is often difficult to grasp because of the all-too-frequent conflation of “knowledge” with “consciousness;” however, what Fink is articulating is that a symbolic system develops in the subject that remembers *without conscious thinking* and that acts in accordance with certain internally established rules. For example, as a child develops, her unconscious inscribes certain signifiers and experiences of which the child has no conscious knowledge. As the child traverses the movements of alienation and separation, signifiers are repressed, connecting with other elements in the signifying chain, developing complex connections with them. Thus, in the very process of being repressed, these words or parts of them take on new roles. The unconscious is thus an assemblage of signifiers, phonemes, and letters that cannot be forgotten precisely because the “past is recorded in the [signifying] chain itself, determining what is yet to come” (p. 19). Thus, the symbolic matrix is governed by a syntax—a set of rules or laws that prohibits certain combinations, resulting in impossibilities in the signifying chain. The way the symbolic matrix is constructed ciphers new experiences and events according to

its syntax. Consciousness is not necessary for memory—the unconscious counts, inscribes, remembers: “The unconscious is nothing but a “chain” of signifying elements, such as words, phonemes, and letters, which “unfolds” in accordance with very precise rules over which the ego or self has no control whatsoever” (p. 9). Stated otherwise, the subject contains and acts on knowledge without having any idea s/he is doing so.

Utilizing set theory, Lacan suggests that unconscious processes have little to do with conscious thinking or meaning, and concludes that analysis entails a deciphering process that does not so much aim at revealing meaning as at “reducing signifiers to their nonmeaning (lack of meaning) so as to find the determinants of the whole subject’s behavior” (as cited in Fink, 1995, p. 21). In his analysis of the Rat Man, Freud (1909/1955) draws attention to the fact that ideas can become grafted onto words to which they bear no obvious relation by what he terms “verbal bridges” (p. 213). These verbal bridges have nothing to do with conscious meaning and instead refer to the literal relations among words as they are constituted in the unconscious. Lacan’s point here is that the subject is subjugated by the signifier and is structurally defined by these unconscious determinants.

When I speak of a structural approach to diagnosis and treatment, it is this symbolic system and all of its manifestations to which I refer. Via repression, which signifies a breaking of a link for Lacan rather than a “pushing down,” signifiers become displaced; thus what counts in a structural approach is the wording, the signifiers that are specifically chosen, and how they are linked to other signifiers. It is the letter that manifests the unconscious. Lacan thus suggests the therapist “become practiced in the art of finding these displaced signifiers [...] in the letter of the speech we actually hear,” as

“The goal of finding the letter is to free it to become once again a part of the patient’s discourse” (Miller, 2011, pp. 42-43). Part of the work of therapy is, therefore, to make the implicit rules of the symbolic matrix more explicit to patients themselves so that they may come to “subjectify” their desires (Fink, 1997, p. 56). What is required is an articulation of the unconscious logic operating within the patient so that missing links may be restored in the patient’s thoughts and feelings.

I am emphasizing here what can seem like abstract theorizing on Lacan’s part not only to address the difference between a descriptive nosology and a structural approach, but also to highlight the difference between Lacan and insight-oriented therapies that emphasize the “personality organization” of the patient (e.g., Gabbard, 2005; McWilliams, 2011). While the latter certainly contextualize symptoms and view the patient in terms of underlying dynamics, their approach differs in that it does not identify deeper structural components that defy signification; therefore, the focus remains on helping the patient develop “insight.” In *Seminar I*, Lacan (1975/1988) writes, “One shouldn’t make a character trait into a constant of the personality, still less a characteristic of the subject” (p. 27). Diagnostic schemas that focus on personality organization differ from Lacan in that they tend to be defined by a mixture of personality traits, customary defenses of that particular personality, and underlying causal dynamics. What are left out of such diagnostics are the deeper symbolic constellations that structure the subject’s relationship to the Other’s desire. For Lacan, desire organizes human experience, and this emphasis on desire and its manifestations via the signifier are what differentiate a Lacanian approach.

Neurotic Questioning

Lacan (1957/2006) tells us in “The Instance of the Letter or Reason since Freud” that neurosis is a question being poses for the subject. Diagnosis indicates a structural position that a subject takes with regard to the symbolic Other, as well as to the object. A Lacanian approach to therapy does not set as its goal symptom remission but instead aims at a shift in the patient’s psychic economy, transformations in desire, and subjectification of one’s jouissance. Structural positions are instated via an individual’s response to the processes of alienation and separation as described above; consequently, each structural position is essentially a way of solving the problems of alienation, separation, and castration. For Lacan, there are three primary diagnostic structures: neurosis, perversion, and psychosis and each is constituted by a defining form of negation.

In this dissertation, I am interested in the structure of neurosis, which is further broken down by Lacan into hysteria, obsession, and phobia.⁴⁵ Repression is the form of negation operative in neurosis, though what is repressed is different in each structural category (Fink, 1997). (For example, hysterics tend to repress ideas, whereas obsessives separate ideas from affect, as outlined in Chapter One.) Structural differences between hysteria and obsession concern the way the subject relates to the Other’s desire, as well as the parsing of the existential question of being that is of most concern to the patient. Lacan (1981/1993) tells us that obsessives are concerned with the question of existence, “Am I dead or alive?” or “To be or not to be?” (p. 168, 180). The hysteric, however, is concerned with her sexual being, “What is it to be a woman?” or “Am I a man or a woman?” (p. 171). These questions are often posed via symptoms, relationships, patterns,

⁴⁵ In this dissertation, I focus specifically on obsession, but will also take up hysteria as a means of showing how superficial symptom recognition always falls short.

and unconscious manifestations; the therapist must thus decipher the symptom in relation to the psychic structure of the individual.

Soler (1996) reminds us of Freud's discovery of infantile sexuality and emphasizes the loss of sexual satisfaction (owing to the prohibition of *jouissance*) as constitutive of neurosis. It is the frustration of the infantile desire to remain at one with the mother that poses a problem for the neurotic. Freud posited that the sexual excitation (or *jouissance*) the child encountered was experienced as something heterogeneous, and thus something to be defended against. Thus, the first sexual experiences of the child are traumatic, and the child assumes a *position* with regard to this experience. The defense is her answer to the problem posed by sexuality as real—as *jouissance* that is something actual, something material, in the body. The sacrifice of *jouissance* that is required in the process of socialization is therefore one the neurotic struggles with, feeling as if s/he got a raw deal in this process (Lacan, 1973/1981). Perhaps the satisfaction s/he gave up was better than what s/he was promised? To put it differently, in castration, the child relinquishes some *jouissance* in exchange for the promise of symbolic achievements. Via the Oedipal complex, the child gives up bodily attachment to the parental Other for the ego-ideal—striving to please her parents by getting good grades, being a star soccer player, winning awards, and so on. The problem for the neurotic, however, is that s/he feels that the praise s/he receives for doing so is not all it was made out to be. S/he experiences guilt, anxiety, fear, and so on as s/he struggles to ascertain her place in the world. S/he wonders, “Who am I to others?” “Am I desired?” The neurotic subject seeks to answer these questions of separation via the Other's desire (Soler, 1996). S/he models her desire on the Other's desire, desiring the objects the Other seems to want, liking the

music the Other likes, etc. Perhaps s/he attempts to ascertain the Other's desire so that s/he can become the object that would fulfill the Other (object *a*).⁴⁶ Essentially, s/he incorporates aspects of the Other's desire as her own and attempts to embody those qualities that would make her desired by the Other. These strategies represent attempts to overcome separation by denying one's division in the hope of regaining the *jouissance* and wholeness that was sacrificed. (The image of the child trying to crawl back into the mother's womb is one that would be illustrative here.) In short: the neurotic subject has not completed the process of separation—s/he has not accepted her castration, to use Freud's terms. As such s/he takes up a position—a stance—with regard to the Other (the Other as desire, the law, language, cultural norms, etc.). It is this position that often gets in the way of what the neurotic says s/he wants. Indeed, most neurotic subjects complain of wanting something but getting in their own way. They are inhibited by factors they do not comprehend. These factors are situated in the deeper *structure* of the subject, and symptoms are “sites of localized *jouissance*” (Soler, 1996, p. 255). In other words, there has been a failure of defense that has resulted in a return of the repressed as a symptom. If what the subject was defending against was a certain type or amount of *jouissance*, it makes sense that the symptom itself would contain a certain amount of “kick” for the neurotic subject.

How does this formulation fit with the questions of this dissertation? What are called “classic OCD” symptoms do not necessarily indicate an obsessive structure, but are rather ways of speaking that have yet to be symbolized. From a Lacanian standpoint, to merely “attack” such symptoms would produce no transformative effect on structure, nor would it allow us to “interrogate the unconscious” (Lacan, 1961/2002, p. 283). To

⁴⁶ As will be seen in hysterical structure.

take such symptoms at face value and to apply a medical diagnosis to them is to miss what they are speaking to and for. Lacan (1953/2002) tells us that the subject is a question (p. 84). What question is the subject attempting to answer? How are symptoms a movement toward speech? How can we help the patient *speak this question in words rather than through symptoms*? Freud's great achievement was his recognition of the power of words—the ability of the symbolic to transform the real, in Lacanian terms. Psychoanalysis allows for the working through of symptoms by allowing “strangled affect to find a way out through speech” (Breuer & Freud, 1895/1955, p. 68). Indeed, Lacan (1953/2002) tells us that “Psychoanalysis has but one medium: the patient's speech” (p. 40).

Given that in differing structures the relationship to the symbolic Other and to the Other's desire is organized in different ways, the importance of early diagnosis in a Lacanian-oriented therapy cannot be overstated. This is not to suggest that the therapist's provisional diagnosis never changes as therapy progresses, but that the Lacanian-oriented clinician attempts to structurally diagnose the patient as early as possible as differing structures require differing stances on the therapist's part. This was a position that Freud (1895/1955) advocated as well: “A decision on the diagnosis and the form of therapy to be adopted has to be made before any thorough knowledge of the case has been arrived at” (p. 256). In a Lacanian-oriented therapy, the diagnosis orients the treatment. There is no manualized treatment, and while there are certain therapeutic guidelines that are adhered to (punctuating signifiers, interpreting in an evocative manner, etc.), symptoms are examined for their uniqueness and the therapist's stance is determined by the patient's structural economy. For example, because the hysteric is constantly attempting to

ascertain the Other's desire to cover over lack, I would be more prone as a clinician to situate the hysteric on the therapeutic couch so that she would be unable to read my facial expressions. Likewise, because the obsessive is most comfortable pretending the Other is dead, I would perhaps make my presence more known to him in an attempt to "hystericize" him, or open him to the Other. When, as clinicians, we begin to see the patient as more than a mass of symptoms and instead delve into underlying structural components, we open up a space so that desires trapped in a circuit of suffering may be loosened and transformed—egoic identifications dissolved—in hopes that the person may come to enjoy more freely.

A Note on Gender

In psychoanalytic literature, hysterics are typically identified as female, while obsessives are usually male. There has been much criticism of psychoanalysis from feminists who are less than enthused by Freud's positioning of women as "passive" and men as "active"—to name but one critique. I want to draw attention here to the fact that historically, the majority of hysterics have been female and obsessives male; however, this has nothing to do with biology nor does it indicate anything about how proactive a woman is. Rather, structure reflects culture in many ways: childrearing practices, patriarchal configurations, family systems, educational practices, and religious and spiritual beliefs, to name but a few. In his *Clinical Introduction to Lacanian Psychoanalysis*, Fink (1997) offers a social-psychological explanation for the correspondence between hysteria in females and obsession in males. Fink suggests that in Western culture, there is a tendency for mothers to nurture their male children more generously than their female children. This suggests to male children that they are lacking

in something—something that mother can provide. Later, boys attempt to overcome separation by completing themselves with an object (object *a*) related to the mother. They thus seek in fantasy an object that will complete them.

Daughters, on the other hand, tend to be breastfed for shorter amounts of time and are given the impression that it is the mother who is lacking something. Consequently, as a strategy for overcoming separation, daughters attempt to become the object that can fulfill the mOther. It is, therefore, the mOther who is lacking and the daughter positions herself as object *a*—the object that fills the mOther’s lack. Fink notes that if oedipalization occurs, she then attempts to complete the male Other instead of the mOther. Fink further suggests that the role of the father influences the adoption of structure because fathers tend to compete with their sons more readily than daughters and vice versa. Thus, fathers are more vigorous about separating their sons from mOther, while remaining content to allow the daughter to occupy mOther’s time.

It is important to note here that what Fink is suggesting arises, in many ways, from the learned sex roles prevalent in society today. Lacan does not believe that anatomy is destiny; in fact, his masculine and feminine structures refer instead to the way a subject desires and obtains jouissance.⁴⁷ The idea that men are supposed to be “stronger” and “less emotional,” while women are supposed to be “softer” and “more emotional” plays a significant role in the development of structure. Historically, women have been assigned the role of caretaker—anticipating others’ needs and fulfilling them—hallmarks of hysteria. The modern day caricature of men as objectifying rascals who love their beer and pornography illustrates, in many ways, the filling up of one’s lack with *objects*. While these characterizations are certainly not true of all families, they

⁴⁷ See Fink (1997, p. 134)

are, as Fink writes “statistical generalities in contemporary Western societies” (p. 258). In other words, there are specific types of ideals and traits at work in obsession and hysteria that are inculcated within a family context. Structures then are not universal but instead reflect the typical organization of society and culture.

Lacan has been critiqued heavily by feminists for his concept of the “phallus” (e.g., Irigaray, 1985); however, I think it is important to note that Lacan is being *descriptive* here rather than *prescriptive*.⁴⁸ He is not suggesting that the current state of affairs is the way things *should be*, but rather describing the *way things are*. The phallus, as the signifier of desire, does not mean in antiquated Freudian terms that all women would like to have a penis; instead, it points to the very real fact that historically (and I would certainly argue contemporarily) having a penis has been associated with power and privilege. The phallus, therefore, does not refer to the penis as an anatomical organ—the penis as real—but rather to the symbolic phallus—as the signifier of desire, which in Western culture is typically associated with power, prestige, and money: things only available to men historically. In my view, what Lacan is drawing attention to (and Freud before him with his notion of hysteria) was precisely the fact that women have not had access to the phallus (as Lacan tells us, there is no signifier for Woman).⁴⁹ For example, Freud’s hysterics manifested “glove anesthesia” as a protest against their proscribed and limited roles as caretakers of the family. While I am not suggesting that Freud’s descriptions of women were always complimentary, I do believe that psychoanalysis has attempted to highlight the social discrepancies between men and women. I, therefore, disagree with many of the feminist critiques lodged against Lacan as “phallogocentric,”

⁴⁸ He has also been praised for highlighting the role of cultural factors above biology (as I seek to do here) by some feminist writers. See Ragland-Sullivan (2000).

⁴⁹ See Soler (1996, pp. 56-57, 59).

specifically because I believe they derive primarily from misunderstandings of his notion of the phallus. That being said, Fink writes, “All efforts to change women’s and men’s roles notwithstanding, as long as the phallus remains the signifier of desire, these different structures seem unlikely to disappear” (p. 162).⁵⁰

The second case I present is somewhat unique in that it is a case of male hysteria. Female obsessives certainly also exist—in fact, some would argue that we are seeing an increase in women who are obsessively structured (see D. Miller, 2005). (Given the drive toward an increasingly obsessive culture as explained above, this is not surprising.) Fink (1997) suggests that oftentimes patients who do not conform to traditional clinical categories pose diagnostic problems for clinicians who often end up lumping them together into the category of “borderline.”⁵¹ This crossing over of categories presents significant challenges, particularly if one is only working at the level of the symptom rather than situating the symptom within the context of the subject’s psychic structure. My case presentations will highlight these difficulties further.

⁵⁰ For an in-depth look at Lacan’s notion of masculine and feminine structure, see Lacan (1975/1998).

⁵¹ Lacan does not recognize “borderline” as a structural category. See Fink (1997, p. 77).

CHAPTER THREE

Dead Man Walking (Into a Dead End): A Case Study of Obsession

I have always been alone. I assume it's because something is wrong with me. So I watch what others do and try to imitate that. But the more I do that, the further I feel from myself.

Keenan, March 2010

The question of death is another mode of the neurotic creation of the question—the obsessional mode.

(Lacan, 1981/1993, p. 180)

Introduction

In this chapter, I explicate Lacan's formulation of obsessive structure via a case study of a former patient of mine. My aims are to illustrate how Lacan's formulations guide my clinical work and to likewise articulate how my own understanding of Lacanian theory has been furthered by my work with this patient (and others, as well). My hope is that by presenting such concepts in a clinical context, they may be more concretely understood and useful to clinicians. Readers interested in more in-depth discussion of theoretical concepts are directed to listed sources. My primary goal is to illustrate how I utilized Lacan in my clinical approach.

In my presentation of "Keenan" (an alias, of course), I discuss Keenan's issues with time, death, deferral, and desire, and I draw attention to how his symptoms are tied to his history and parental discourse. I also situate Keenan's symptoms within the context of the obsessive's psychic structure. I end by discussing the particular therapeutic techniques I utilized with Keenan.

On Being “Nothing” Presenting Problem and Initial Interviews

Keenan began therapy with me in his early twenties. For 30 months, he attended therapy twice weekly, rarely missing sessions. Prior to our work together, Keenan had been in therapy for approximately two years with another therapist at the clinic where I trained. Our work together ended when I completed my graduate training. Keenan made the decision at that time to not continue with a new therapist, despite my expressed desire for him to do so,⁵² stating he was “frustrated by the idea of opening to another person,” and that he “avoid[ed] it at all costs.” As will be seen, this desire to avoid opening to another person “at all costs” is a key component of obsessive structure; indeed, the obsessive is characterized by what Lacan refers to as his “nullification” of the Other. Obsessives would prefer, for the most part, for the Other to just not exist, for the existence of the Other seems to wreak havoc on their ability to desire. As will be shown, a “hysterization” of sorts had to occur before Keenan fully engaged in therapy.

Keenan arrived early for his first appointment—a behavior he would continue throughout our work together. Time was important to Keenan: He did not want to “keep [me] waiting.” Initially, he would keep rigid watch over the clock in the session room, often telling me when it was time to end the session. When I noted his strict adherence to the clock, he said he was “measuring time” so that he knew “when it [was] time to end.” Keenan rarely requested to extend a session a couple of extra minutes to finish a story (something that differentiates the obsessive from the hysteric), and his ability to do so—to articulate a demand—only came toward the end of our work together; Keenan was

⁵² I clearly indicated to Keenan my desire for him to continue his work in therapy. Lacan says the motor force of therapy is the “analyst’s desire,” and certain Lacanians advocate for calling patients when they miss sessions, expressing the desire for them to continue therapy, etc. This is different from many therapies that take a more “hands off” approach. See Lacan (1960/2002, p. 309) and Fink (1997, pp. 4-21).

strictly regulated by the Other's time—another characteristic of obsessive structure. In *Seminar VIII*, Lacan (2001) describes how the obsessive believes he is doing “everything for the Other” (Ch. 14),⁵³ including living according to their time schedule. To shake up Keenan's rigid compliance with (and reliance on) the Other's time, I eventually turned the clock so that he could not see it and began *scansion* sessions. Scansion, leading to what is known as the variable-length session, is a technique whereby the therapist ends the session on a particularly noteworthy or striking point, so as to *punctuate* the patient's speech (Fink, 2007). This punctuation may serve to highlight polyvalent meanings in something the patient said or draw attention to a manifestation of the patient's jouissance or desire of which he is unaware. Scansion has not been particularly popular in American psychology, where time and money are equated (“But I paid for a 45 minute session!”); however, I have found it to be especially useful in getting the patient's unconscious moving because it serves as a type of castration and intervenes at the level of the real—instituting a “cut” that disrupts the subject's fixation. With Keenan, “cutting” sessions short or allowing them to go over when needed interrupted his ability to “measure time” according to the Other.⁵⁴

Keenan's presenting complaint was that he felt socially isolated because of the abject anxiety he felt around other people. He wanted to find a way to socialize “without having to adapt [his] individual self to other people.” He emphasized this last point, stating he was willing to forego social and dating relationships if it meant he had to “change [him]self.” Keenan said,

⁵³ The version of *Seminar VIII* I am drawing from is the forthcoming translation from Bruce Fink. As such, I do not yet have accurate page numbers.

⁵⁴ For more on the process of scansion, see Fink (2007, pp. 47-73).

I have reached a plateau in the events of my life, living routinely *without any desires* being satisfied. I'd like to discuss thoughts on that but have no one in my personal life to talk to. I will never set aside or cover up my individuality, no matter the benefits it may allow, such as having a more active social life due to being less selective of the company I keep or assimilating others' interests or perspectives. I have no goals.⁵⁵

At the time, Keenan only had one friend whom he rarely saw or spoke with and had never been in a dating relationship or had sex. His social interactions were limited to his daily encounters with his bosses at the local store where he worked for minimum wage as a sales clerk. He described feeling “uncertain” and “nervous” when “thinking” of approaching people. Keenan said he was also hoping therapy would give him some “increased intellectual stimulation” as he felt his life was “repetitive.” He worried that life would “always be the same” and that “nothing would ever change.” He hoped engaging in intellectual *thinking* would alleviate some of the monotony he felt. Finally, Keenan reported feeling “depressed” because of his social isolation, a feeling he said began around the age of 11 when his family moved from Michigan to a small town in West Virginia without telling him of their intention to do so.⁵⁶

In spite of his stated desire for increased social contact and change in his life, Keenan rarely altered anything about his daily routine—often working long hours without adequate compensation—something he complained about vigorously but did little to change. When I inquired why he did not ask his bosses for a raise, his standard reply was, “I don't know.” In fact, despite his obviously high intelligence, there was a lot Keenan seemed to “not know.” For example, he longed to find a new job where he would

⁵⁵ All direct quotes derive from my own note taking. At times, I took notes during sessions, while at others, I took them immediately following. Throughout my training, I experimented with differing techniques; however, writing down patients' speech verbatim was something I found valuable throughout.

⁵⁶ Keenan's parents told him they were going on vacation. It was only upon arrival in West Virginia that Keenan was told the family would not be returning to Michigan.

be “respected” but told me he “d[idn’t] know how a person finds a job.” Similarly, he shared that he wanted to learn how to drive and obtain a driver’s license, but again, claimed ignorance as to how one would go about such a process. Initially, I responded by inquiring as to whether he had checked the local paper for job notifications or searched the internet for driving schools.⁵⁷ My questions were typically met with a blank look, a shrug of the shoulders or a shifting downward of gaze with no verbal answer. It became increasingly obvious that, despite his professed desire for a more stimulating life, Keenan was profoundly invested in his own inaction and in his own failure. He seemed to want me to outline a plan—a set of rules—that he could follow, so that he could then not follow them. He would frequently begin sessions by saying, “I don’t know what to say...” or “I don’t really have anything to talk about...” followed by a blank stare that would last for several minutes, as if he was waiting for me to speak first. At other times, he would come with a readymade list of conversation topics and would seem irritated if I interrupted him, often telling me he needed to get through everything before “time was up.”

Keenan said he felt “stuck” and as if he “should be further along in life.” He felt he was not really living the life he was “supposed” to be living, which was that of an artist. Keenan had attended a local art school for approximately three years before “dropping out” a few semesters shy of graduation. “Dropping out” would perhaps make the decision seem a bit more decisive than it actually was: In reality, Keenan felt unable to meet the “deadlines” required by the school and told me he could not finish many of

⁵⁷ This is not a tactic I would take now, as it amounts to therapy by suggestion, something both Freud and Lacan warn against. At the time I began seeing Keenan, I was not yet engaged in Lacanian praxis. Indeed, much of my shift toward Lacan occurred because of the change I saw in patients such as Keenan when I began utilizing Lacan in therapeutic practice.

his class projects because he did not “have enough experience yet” to complete them. When I asked if that wasn’t precisely why he was attending school—to gain experience—he merely shrugged his shoulders. This feeling of always being behind and trying to catch-up was characteristic of Keenan—he never felt ready or prepared—preferring instead to defer acting until he was “completely” ready. Keenan did not want to be *lacking* in anything. This constant deferral led to a state of complete inaction for Keenan wherein he felt incapable of making any decisions for himself. Indeed, Keenan often told me he felt he was just “waiting for something to happen.” With regard to his “dropping out” of school, this “waiting for something to happen” eventually resulted in the school dropping Keenan, effectively removing the responsibility of making a decision from Keenan and allowing him to instead volley any number of complaints against the school. While Keenan seemed to not know how to pursue social relationships, a driver’s license, or a new job, he was quite adept at identifying what was wrong with society and eloquent in articulating his critiques of the “conformist sheep” around him. He indicated that part of the reason he had “dropped out” of school was because “they” were not interested in “true art,” but instead were only interested in producing “capitalist” propaganda for advertising agencies. He felt disillusioned and wanted “nothing” to do with it. This is what led to Keenan’s low paying job and dissatisfaction with his life. In many ways, Keenan’s attention to social issues was admirable. He felt strongly about political issues and attempted to act ethically in his life. This was certainly the case he presented when describing the reason he “dropped out” of school. He cared deeply about the state of society; however, there were also ways where such “caring” served as a defense for him, as will be shown.

I noticed in our initial interviews that Keenan barely mentioned his family. He told me he had two older brothers with whom he barely spoke, that his father worked with computers, and that his mother was a housewife who “used every possible mechanism to escape, including pills, food, and religion.” Interestingly, he also referred disgustedly to his mother as a “conformist sheep,” suggesting she had “found religion” to be like “everyone else.” Beyond that, Keenan had little to say and when I pushed for more information, he responded by telling me he was not “interested in talking about [his] past because it [was] unimportant.” Furthermore, he said he had moved away from West Virginia to “get away from [his] family.” All of this was said with little affect, another predominant characteristic of Keenan. He spoke in an almost regimented style, with little inflection in his voice. He rarely made any slips of the tongue and seemed to think about every word before actually speaking it—again exhibiting a deferral of action (speech in this case) in favor of thought. He sat as far as possible from me in the session room and most often stared down at his lap during session. During the initial interviews, I mostly just listened, but if I did happen to make a comment or an interpretation, he would become quite upset if I did not use his exact wording—glaring at me and stating, “That’s not what I said.” Keenan could not tolerate me as an Other, intruding upon or interrupting him in anyway. He made this quite evident in a variety of ways which I will address throughout the case.

Many of the structural features of obsession are identifiable in Keenan’s initial interviews, both in his speech and action (or rather, inaction): his need to annul me as an Other (as evidenced by his irritation when I spoke and his frequent refusal to speak, among other things), the repetition he felt “stuck” in and his inability to move forward

(despite his professed desire to do so), his constant deferral of action when he felt he was not “completely ready” (i.e., when he felt lacking), his feelings of superiority to the “conformist sheep” of society (yet his expressed desire to connect with them), his feelings of guilt and shame, his emphasis on thinking at the expense of affect, his withholding tendencies, and his concern with “measuring time,” which, as we shall see, is a metaphor for death in the obsessive. As should already be evident, the structurally obsessive person is a massive mixture of paradox and contradiction—stuck between one pole and another—leaving him unable to move. In his case study of the Rat Man, Freud (1909/1955) noted the ambivalence between love and hate in the obsessive. While Lacan reformulates this somewhat, this ambivalence, and the inaction that results from it, are structural features of the obsessive.⁵⁸ Did Keenan really want social relationships or did he want to maintain his isolated position of superiority? If he longed for life to be more stimulating, why did he constantly retreat to his thoughts?

The obsessive is caught in a trap and this is manifested via his symptoms. In a way, we can view his symptoms as both questions themselves and as answers to the questions he poses (Lacan, 1981/1993). What is important here is that the symptoms tell us something about the way the obsessive takes up the Other—the way he relates to the Other’s desire and to jouissance. My role as a therapist is to listen at the level of the symbolic, so that I may embody the Other for the patient and assist him as he explores the unconscious coordinates that have unknowingly governed him up to this point. As

⁵⁸ Lacan (1953/2002) writes, “[T]he obsessive manifests one of the attitudes that Hegel did not develop in his master/slave dialectic. The slave [the obsessive] slips away when faced with the risk of death, when the opportunity to acquire mastery is offered to him in a struggle for pure prestige. But since he knows he is mortal, he also knows that the master can die. Hence he can accept to work for the master and give up jouissance in the meantime; and, unsure as to when the master will die, he waits. This is the intersubjective reason for both the doubt and the procrastination that are obsessive character traits” (p. 97).

previously indicated, Lacan tells us that neurosis is a question being poses for the subject. Let's begin by exploring Keenan's question.

Keenan's Question and the Obsessive's Desire

According to Lacan, the obsessive's question concerns his very *existence*—"Am I alive or dead?" or "To be or not to be?" His question derives directly from his stance with regard to the Other—particularly the Other's desire. The obsessive's response to the processes of alienation and separation is to deny his own being as a divided subject by clinging to the lost object; however, he refuses to admit any relationship between the object and the Other. In a word, the obsessive refuses to acknowledge lack, which, as we have seen, is coextensive with desire. Fink (1997) cites an example that may help us concretize this somewhat abstract formulation. The child's first source of satisfaction is the mother's breast: We can say it is his primary source of *jouissance*. Via the weaning process, a sort of separation from the mother occurs whereby the child's *jouissance* is prohibited and the breast is constituted as object *a* (the lost object)—the cause of his desire. This loss of something so pleasurable is traumatic for the child, and the obsessive attempts to overcome this enforced separation by fantasizing that he retains the object, thus remaining a unified whole. However, he refuses to acknowledge that the breast (the object) was part of the mOther, instead fantasizing that he is complete so long as he has any number of available fungible objects at his disposal (pp. 118-119). What the obsessive cannot abide is lack/desire—his or the Other's—because it points to his very castration;⁵⁹ therefore, to defend against the loss of his *jouissance* and the separation from

⁵⁹ Fink (1997) writes, "What the neurotic wishes not to recognize is that desire is not so much something you have as something you do not have. It springs from lack, and no one can say what he or she really wants, desire having no unique object. A demand is a specific want, not a vaguer, more diffuse *wanting*. It is something you seem to 'have,' like a need, a biological need to eat. It is the Other's wanting—or as

the mOther, he nullifies or neutralizes the Other. The obsessive finds it far easier to tolerate the pain of separation by pretending he did not need anyone in the first place; however, to desire—to feel alive—one must be able to experience lack. If desire is sustained by the Other and the obsessive is perpetually nullifying the Other, we can see why his very existence would be a question.⁶⁰

In “The Subversion of the Subject and the Dialectic of Desire,” Lacan (1960/2006) tells us that the obsessive subject refuses his own fading (aphanisis) when faced with the object; he fears his own annihilation in the face of the Other’s desire (and, therefore, his own). In a sense, it is an either/or situation: either you exist or I do. Consequently, he plays dead and prefers if the Other does too. In so doing, he hopes to relieve himself of any encounter with desire: He hopes to *master* his desire by petrifying himself (Soler, 1996). We can therefore say that the obsessive subject’s strategy for dealing with separation falls on the side of the subject.⁶¹ He seeks to prevent his own vanishing by annulling the Other. However, in destroying the Other’s desire, he destroys his own as well. With this background, we can now begin to situate many of Keenan’s presenting problems and symptoms within the context of obsessive structure.

Initial Therapeutic Aims

Given the tendency to nullify the Other, how is therapy possible with an obsessive subject—particularly a psychoanalytic therapy that emphasizes the unconscious, which is perhaps the example of the Other par excellence? Lacan tells us that a “hysterization” of

Lacan says, ‘the lack in the Other,’ the incompleteness of the Other—that the neurotic cannot abide” (p. 64, original italics).

⁶⁰ Leclaire (1959/1980) writes, “The other is necessary to sustain desire. [...] There is no desire that can sustain itself in the isolation of a solitary daydream” (p. 127).

⁶¹ In distinction to the hysteric, whose strategy falls on the side of the object, as will be shown in the next case study.

the obsessive is needed—an opening and attentiveness to the Other that indicates a change of position in relation to desire. As obsessives tend to strive to be fiercely independent of the Other, this is not an easy task to accomplish, nor is it an easy state to maintain. In a Lacanian-oriented therapy, the therapist must initially seek to be situated as the “subject-supposed-to-know,” meaning the patient places the therapist in the position of the Other and assumes the therapist possesses a certain knowledge about him of which he is not yet aware. Given that the obsessive barely acknowledges the Other, much less attributes any type of knowledge to him or her, this is one of the more difficult feats to achieve.

My first sessions with Keenan vacillated between his idealization of me and his complete nullification of me. (Really, the two are the same, as idealization is based on a fantasy rather than on any actual person in the room.) Initially, Keenan told me he had never met anyone who “understood [him]” the way I did, and he attempted to do everything he assumed I wanted to the letter. This is a seemingly peculiar characteristic of the obsessive: Despite their proclaimed fierce independence from the Other, they prefer to know the rules and procedures upfront and tend to rigidly follow them. They are essentially trapped by the Other or “suspended in the time of the Other” (Lacan, 1957/1977, p. 12). This makes sense, however, if we understand that such rigid conformity to the rules prohibits any spontaneous movement or desire on the part of the obsessive. It also serves to cut the Other’s desire off at the pass: If Keenan could do everything he thought I wanted, perhaps I would be lacking in nothing, thus permitting him to escape any encounter with my desire (he having plugged it up, so to speak). Samuels (1993) writes,

[T]he obsessional subject attempts to hide its symptoms by complying with the demand of the Other insofar as the Other's desire does not put its narcissism and feeling of self-security at risk. [...] For what the obsessional seeks is an unconditional form of love where it receives everything that it is lacking from the Other. [T]he subject's constant compliance with the demand of the Other [...] serves to hide the inner feelings of hostility towards both the Other and himself. (p. 89-90)

Keenan's idealization of me was short-lived and was quickly replaced by his complete annulment of me. He would come to session (always on time), sit as far from me as possible, tell me he had "nothing to say" and then sit and wait, staring down at his pants. As previously mentioned, when he would speak, he would engage in long social critiques or complaints about his job. Any interpretations I made were either met with a shrug of his shoulders or no answer at all. When we would have a session where I felt as though some progress had been made, he would come to the next session with no memory of the previous one. If I asked him a question, he would often ignore me, choosing instead to keep his head lowered. At times, he would begin to speak, saying, "Oh, I wanted to tell you something..." and then he would go quiet. When I prompted him, he would say, "I forgot." This "forgetting" happened during every session for a few months. I was at a loss; certainly, spontaneous forgetting can be indicative of repression; however, this "brick wall" (as it came to be known) that kept "coming down" seemed a little too well-timed.

In "The Function and Field of Speech and Language in Psychoanalysis," Lacan (1953/2002) writes, "For the function of language in speech is not to inform but to evoke. What I seek in speech is a response from the other" (p. 84). And, in *Seminar I*, Lacan (1975/1988) writes, "An essential element of the coming into being of the other is the capacity of speech to unite us to him" (p. 48). For Lacan, symbolic exchange is what

links human beings to each other. Keenan did not want a response from me, much less a connection to the Other. His refusal to speak can thus be seen not only as a negating of the Other, but also as a *refusal* of the Other. The one thing Keenan knew I wanted from him was his speech—his free associations, fantasies, dreams, and so on. Yet, his “brick wall” would conveniently “come down” when his response was called for, thus preventing any symbolic exchange between us. In this sense, he was refusing to give me what I wanted: He was refusing to *be the cause of my jouissance*. This stance regarding the Other’s jouissance is characteristic of neurosis in general; however, with the obsessive it is closely tied to the anal stage and to *withholding*—a symptom of Keenan’s that became more predominant as therapy progressed.

Samuels (1993) writes, “In the anal stage, the subject’s refusal of the demand of the other results in a generation of pleasure and the feeling of self-control” (p. 48). This need for self-control is closely linked with the desire for mastery—both imply a contained, unified subject. In *Seminar VIII*, Lacan (2001) formulates the demand in the anal stage as “[t]he demand to retain excrement, insofar as it no doubt finds something which is a desire to excrete” (Ch. 14). He continues, “[E]xcretion is also *mandated* at a certain time by the educating parent. The latter demands that the subject *give something* which satisfies the maternal educator’s expectation” (Ch. 14, italics added). This “excremental gift” is thus demanded by the Other on the Other’s time table—in other words, when mommy or daddy says so. Thus, in the anal stage, the child is almost completely dominated by the Other. This formulation plays a significant role in many of Keenan’s symptoms, as I will continue to illustrate; however, for our purposes now, what is important is to recognize that Keenan’s “inability” to speak—his withholding—served

the purpose most certainly of nullifying me as an Other, but also served as a source of jouissance for him—a way of “getting off” by not producing for me. It was, therefore, both an act of aggression, as well as a source of satisfaction for him.⁶² Because I was not initially listening at the level of the symbolic, I missed this; instead, I focused on things such as his lack of affect or his relationship with me. I’ll turn next to what changed this element in my therapeutic stance.

On Listening Differently

What it means for the analyst to occupy the place of the Other is to attempt to hear the double entendres and homophones in the analysand’s speech, to hear how they resonate with his or her history and the oppositions and categories most prominent in her culture, religion, education, and general background.

(Fink, 2012, personal communication)

One thing Keenan was never at a loss of speech for were descriptors of himself. Lacan speaks of *master signifiers* and how they form the fabric of the symbolic matrix that contributes to the constitution of the subject’s unconscious. These master signifiers are evident in the patient’s discourse if the therapist is listening for them and often connect back to the discourse of the parents, providing clues to the wording of symptoms. Furthermore, master signifiers often serve the purpose of freezing the subject in time, disallowing any type of movement. One of the aims of therapy is the “dialectization” of these master signifiers, resulting in a shaking up of the subject’s discourse so that movement (via metaphorization)⁶³ can occur (Fink, 1995, p. 79). Swales (2012) notes,

⁶² I am not suggesting these were conscious manipulations on Keenan’s part—quite the contrary. He was unaware of where he was obtaining jouissance. Part of the therapy involved highlighting or punctuating unrecognized desires and sources of jouissance.

⁶³ Fink (1995) writes, “Metaphor [...] brings about a new configuration of thoughts, establishing a new combination or permutation, a new *order* in the signifying chain, a shakedown of the old order. Connections between signifiers are definitively changed” (p. 71, original italics).

Master signifiers, in their locus in the unconscious, do not become meaningful until they are dialectized through interpretation—until they rise above the bar, making connections with signifiers in the conscious signifying chain. When interpretation reveals a master signifier, the revelation is experienced by the subject as a jubilant one [...] because she feels as though she has mastered a previously insistent, inexplicable determinant of her behavior by gaining some knowledge about it. (p. 40)

According to Lacan, the unconscious content that drives the symptom is typically hidden in plain sight—in the discourse of the patient—and not in the “depths” of the psyche as many depth psychologies suggest (Miller, 2011).⁶⁴ Consequently, master signifiers may be readily available in a patient’s speech; however, the historical constitution of the signifier and its consequent role in the formation of symptoms has been repressed. The revelation of master signifiers in the subject’s discourse is therefore a primary aim of analysis. Thus, in analyzing the specific signifiers Keenan used to describe himself, we can begin to relate these to the constellation of signifiers that constitute his history (Schneiderman, 1980).

Keenan described himself as an “outsider” who felt both “conspicuous and invisible at the same time.” He said he was “boring, repetitive, nonexistent, excluded, empty,” and “just taking up space.” Furthermore, he told me he “[didn’t] know [his] feelings,” and he didn’t feel much “other than shame.” Indeed, when I would ask Keenan how he *felt* about something, his reply was always, “I don’t know.” He could not identify sadness or happiness in other people; in fact, he claimed ignorance of all feelings whatsoever. This was interesting given his statement, “Feelings threaten to overwhelm me, *swallow me*. It’s like the stuffing of a teddy bear—if you pull it out, I worry you won’t be able to get it back in.” Above all, Keenan’s favorite way of describing himself was as “nothing.”

⁶⁴ See Lacan’s “Seminar on the ‘Purloined Letter’” (1966/2006, pp. 6-30).

Keenan seemed content to spend sessions talking about how worthless he was, how little others thought of him, how people were always trying to take advantage of him, and how boring and repetitive life was. He would become irritated if I attempted to point out any type of manifestation of the unconscious saying, “You know, I do actually *think* about this stuff,” as if the unconscious was simply something available to rational inspection. When not passively ignoring me, he would become irritated with me for “blaming” him for not living his life the way he “should.” Any attempts I made to bring such statements into question were met with silence. Keenan was fine with speaking so long as I did not actually enter the picture. Boring and repetitive was precisely how I was beginning to feel about our sessions, and it was this realization, combined with two particular sessions with Keenan, that helped me understand Lacan’s distinction between listening at the level of the imaginary and the symbolic. These sessions also marked a turning point in Keenan’s situating of me as the subject-supposed-to-know.

About eight months into therapy, Keenan was quite excited because he had begun dating a woman for the first time. Abby had approached him on the bus, and he had been moved by her smile and free-spiritedness. Despite the fact (or likely because of the fact) that she told him initially that she was not interested in a relationship with a man right then, they began dating and moved in together fairly quickly. New to all things sexual, Keenan was nervous about his “lack” of experience. During one of their first “make out” sessions, Keenan described feeling as though he didn’t have the right to touch Abby, in spite of the fact that she was “thrusting” into him. I replied, “Is it difficult to feel worthy?” What followed stunned me: He began crying and shouting, “It wasn’t like that—you’re making a big deal out of a moment. Can’t you see I don’t feel that way

about myself anymore? I want to leave the bad stuff in the past, and you're *fixing me in that spot*. You're not letting me be different!" I attempted to clarify my meaning, engaging with him as another person in the room; however, things only got worse and the session ended with him telling me he "[couldn't] have a good weekend now" because of me.

The second session occurred about two weeks later. Keenan was still complaining about his lackluster job and occasionally looking at job postings online (a suggestion I had made when he told me he did not know how a person goes about finding a job). He came to session excited about this "amazing job" he had found, but then told me he did not want to apply for it because if "they" told him his art portfolio (something he had yet to put together) was no good, he would know for certain that he could not do what he wanted to do. Our conversation was as follows:

Keenan: "If they don't like my work, it would mean I am no good."
Me: "You would feel rejected?"
Keenan: "Yes, so I need to get a lot better before I apply."
Me: "Do you think it's possible that you could be rejected even if you were really good, almost perfect?"
Keenan: "Yes, but it's less likely."
Me: "Perhaps you would like to control the rejection?"
Keenan: "You know, it's really insulting when you do that. Tell me what I'm thinking. You completely disregard what I'm saying."

I tried, at this point, to explain that I was not disregarding what he was saying but was simply attempting to share what I thought. It did not matter: No matter what I said, Keenan did not comprehend. He began crying and became hyperfocused on my words, yelling at me, "That's not what I said!" when I so much as inserted an extra "the" into a sentence. The session ended with Keenan telling me, "It just reminds me of the way everyone has always spoken to me. Teachers, parents [...] then when I try to tell them

they're wrong, they don't listen. I don't know how to communicate. I don't want to talk to you anymore because I don't know how to speak.”

There are several points to be made about these sessions. The first is that Keenan had begun to allow himself to be affected by me. Despite his best efforts, I was becoming a person who could upset him as evidenced by his tears in both sessions (which were two of the three total sessions in which he cried during the three years we worked together). Many therapists would say this was progress as the *transference* was beginning to develop, even if negative; however true this may be, the mistake I made was engaging this transference at the level of the imaginary rather than the symbolic. As a reminder, the imaginary is characterized by ego-to-ego relationships that are fundamentally aggressive and centered on rivalry. The imaginary is thus the register of the ego and of narcissism, where narcissism indicates a fixated belief in one's unity and wholeness (as constituted in the mirror stage). The ego, as the neurotic symptom par excellence, is the site of fixation, repetition, negation, and death; it seeks its own continuance at the expense of desire and movement. Thus, it seeks, above all else, its own self-preservation. The imaginary is dominated by the ego, and therefore, “The narcissist can only define itself by the response or feedback that is received from the Other. Without the response of the Other, the subject feels like *nothing*, as if it had no definition or form” (Samuels, 1993, p. 73, italics added).

In the first session, Keenan (who had spent months telling me he was “nothing”) was upset because I interpreted his sexual discomfort as his feeling “unworthy” and because I was “fixing” him in that place. We can clearly see here the manifestation of the imaginary: What I say Keenan is, *he becomes*. My reflection of him is what he must be,

and furthermore, I am “fixing” him there—he has no choice. “The level on which the other is experienced locates exactly the level on which, quite literally, the ego exists for the subject” (Lacan, 1975/1988, p. 50). Keenan’s experience of me was as an other (with a small o), a rival—someone just like him, what Lacan refers to as a “semblable” (Fink, 2004, p. 169). This is precisely the place the therapist does not want to occupy because it traps the therapy in the register of the imaginary rather than bringing to the fore the patient’s relationship to the symbolic Other. By responding to Keenan’s outcries by attempting to explain myself or help him understand my interpretation, I simply engaged him at the level of the ego. What other response could he have other than to tell me I had ruined his weekend? For him, in that moment, I was just another person telling him who he was, and I was not telling him what he wanted to hear. As has been noted extensively in the psychoanalytic literature, part of the issue in obsession is precocious ego development that outstrips libidinal development (or an overly rigid ego that excludes desire, to use Lacan’s terms). The last thing Keenan needed at that moment was further engagement of his already rigid ego.

The second of the two sessions introduced two issues: the fundamental lack in language and the symptom of deferral so present in the obsessive. I will take the former up first and discuss the latter further on. Keenan’s accusation was fundamentally that I was misunderstanding him—telling him what he thought instead of listening to what he was saying. When I attempted to explain that I was listening to him but merely offering a *different* insight (my own), he grew hyperfocused on the way I was wording what he had said. He needed me to repeat his sentences exactly as he had spoken them. This need for certainty and exactness reflects Keenan’s inability to tolerate the basic limitations of

language, as well as his irritation at my offering a different viewpoint. Again, we can clearly see the manifestation of the imaginary here: There is no room for difference, for Otherness. What Keenan was coming up against was the fact that language, by its very nature, is fundamentally *misrecognition*. No amount of strict adherence to wording can cover over the lack intrinsic in language—the gap between signifier and signified. The certainty the obsessive searches for represents his attempt to deny lack and division—even that which structurally exists in language itself. Freud (1909/1955) noted the Rat Man had an “obsession for understanding” whereby he needed to understand the precise meaning of every syllable spoken to him. What else is this if not the denial of lack and an attempt at refusing one’s very alienation within language? Language points to the irretrievable real left behind with its attendant promise of wholeness and unity. We can thus view Keenan’s anxiety in light of this encounter with the Other of language. Indeed, his final words of the session, “I don’t know how to communicate. I don’t want to talk to you anymore because I don’t know how to speak,” are suggestive of his struggle with the limitations of speech and language.

In both sessions, I responded to Keenan at the level of the imaginary, arguing with him, attempting to get my point across. A particularly illuminating supervision session, the introduction of Lacan to my theoretical curriculum, and almost a year with Keenan changed my approach. I realized that giving him suggestions or specific tasks was essentially telling him what he needed to do in order to be lovable in my eyes. Such an approach could only further alienate Keenan in the mirror image of the Other in which he had been captured from the beginning. It also “spared him the more anxiety-provoking question: What does [s]he want of me?” (Fink, 1995, p. 145). Stated otherwise, Keenan

needed a symbolic space in which to encounter his terror of desire, so that he could ascertain what *he wanted* rather than what everyone else wanted him to be. To allow for such a process, his identification with and misrecognition of his ego as an *I* needed to be revealed. In “Aggressiveness in Psychoanalysis,” Lacan (1948/2002) writes, “Again, let me repeat, this imago reveals itself only to the extent that our attitude offers the subject the pure mirror of a smooth surface” (p. 17). By not engaging as a semblable and instead listening and interpreting at the level of the symbolic, I could more readily bring Keenan’s stance in relation to the Other to the forefront, allowing him to confront the stagnancy and misrepresentations of his ego. By giving him *my* lack—my pure desirousness—I could offer him the place to come into being. For Lacan, this is what constitutes love: giving what one does not have.⁶⁵

Before delving into Keenan’s childhood—a step he gradually grew ready to take—I would like to return to the issues of deferral, inaction, and death in the obsessive. Keenan was very good at doing nothing while always being busy. A year and a half into therapy, he was still working at the same low paying job he had sought to escape since our first session. He had made some progress: He told his bosses he would no longer do any free labor, but he had yet to ask them for a much-deserved raise. This was significant for Keenan, as his ability to ask for anything—to make a demand—was almost completely non-existent. To ask for something would be to engage himself in some way—to put himself into the picture—and, in his mind, to ingratiate himself to the Other. The second session noted above is indicative of what kept Keenan from moving forward:

⁶⁵ Lacan (1961/2002) writes, “But the child does not always fall asleep in this way in the bosom of being, especially if the Other, which has its own ideas about his needs, interferes and, instead of what it *does not have*, stuffs him with the smothering baby food it does have, that is, *confuses the care it provides with the gift of its love*” (p. 252, italics added). To give one’s lack is to allow the subject the symbolic space necessary to come into being on his own terms rather than on the therapist’s. This is the gift of love.

his sense that he was never quite prepared *enough*. Keenan was always catching up or preparing but never acting. He was always “measuring time,” waiting for others to tell him what to do, waiting for something to happen. Lacan (1959/1977) notes that the obsessive is awaiting “the death of the Master.” In *Seminar I*, Lacan (1975/1988) writes,

What is the obsessional waiting for? The death of the master. What use does this waiting have for him? It is interposed between him and death. When the master is dead, everything will begin. (p. 286)

Lacan is referring to Hegel’s master/slave dialectic here. Keenan played the role of the slave—accepting that he must sacrifice himself to others at the expense of his own satisfaction—until the Master died. Thus he waited, sitting in his martyrdom. He played dead because to do otherwise would have meant to engage desire, to enjoy, and to risk the encounter with the Other. If death was coming anyway, at least Keenan would be prepared. The obsessive does not feel free; he feels the demands made upon him by the (m)Other in the anal stage were too much and that he is still enslaved. Consequently, he “commit[s] suicide so the Other can wring nothing out of [him]” (Fink, 2012, personal communication). He thus dutifully works, shows up on time, but remains fixated and stuck, unwilling to give up anything to the Other. This was Keenan’s constant concern—that “nothing would ever move.” The anal metaphor is apparent. Yet, Keenan put more effort into keeping things the same than he did anything else. Perhaps his constant deferral was a way of putting off death: a way of remaining frozen. His statement that he was “measuring time” so he would know when it was “time to end” was suggestive of such a notion. A look at Keenan’s early years may cast greater light on many of his symptoms.

Family Context and Personal History

As our work continued, Keenan began to speak more freely about his past. He stopped withholding his speech from me as much, indicating a change in the way he obtained jouissance. He slowly began to open to me as an Other—allowing me to make interpretations without needing to counter my every word and becoming more accepting of manifestations of the unconscious. His need to oppose me lessened, and I attribute this, in large part, to my situating myself at the level of the symbolic rather than the imaginary. Without an opposing ego to engage in battle, he was left to truly confront the question of his subjectivity. With my removal of myself as a parental other came some relief on Keenan's part that I believe allowed him to become genuinely curious about the symbolic matrix that structured him (though I did not use those words with him). He was no longer fighting me the way he unconsciously was still fighting his parents (and the Other—the “they”). Finally, though I do not believe the therapeutic relationship is the curative factor in therapy, I do believe that my toleration of his frustration and anger allowed him to begin to vent directly much of the hostility he had so far only passively expressed (e.g., remaining silent in therapy). Keenan shared that, “Frustration was punished when [he] was a kid. All showing of emotion was punished.” Aggression and hostility remained difficult for him to express, as well as any type of demand or request; however, Keenan did begin to situate me as the subject-supposed-to-know and this provided fertile ground for us to begin to explore his childhood and his dreams. As a therapeutic note: When I feel as though the patient has situated me as object *a*—as the cause of his desire—I will typically invite him to begin lying on the couch as a way of further removing myself as an other in the room. With Keenan, I decided to keep our sessions face-to-face because of

his desire, more often than not, for me to simply disappear. Had I asked him to lie on the couch, it would have been far too easy for him to escape the confrontation with the Other's desire. By keeping him upright, he was forced to interact with me as an Other; consequently, the question of what I wanted from him—of my desire—was one he could not evade.⁶⁶

MOTHER...and Everyone Else: The Early Years

I feel stuck in a rut. I find it hard when I can't make something better for others, like I can't move on. It reminds me of Mom—not being able to fix Mom...

Keenan, January 2012

Keenan was the youngest of three boys—the middle brother was two years older and the eldest, four. He described his family as “distant and isolated” from one another and his childhood as a lonely place where he was largely left to fend for himself. Keenan reported that he did not talk much with his parents growing up and was not particularly close to either of his brothers who typically “retreated” to their bedrooms to play videogames. Before the family's move to West Virginia at age 11, Keenan said his father was “barely around”—leaving for work before Keenan awoke and typically arriving home after he had gone to bed. After the family's move, Keenan's father worked from home; however, Keenan said they “barely interacted” as his father did not like to be “interrupted.” Keenan described his father and brothers with little affect, merely reporting factual information; however, when he began to describe his mother, there was visible disgust on his face and agitation in his voice.

⁶⁶ Lacan says that the subject's speech to the Other comes back to him in an inverted form. By asking “What does she want from me,” Keenan was also asking, “What do *I* want?”

Keenan described his mother as “always depressed and sick” and as continuously “popping pills.” She was a housewife who had never worked and spent most of her days sleeping and eating large amounts of food. When he was a young boy, Keenan said he would often arrive home from school and his mom would be “passed out on pills” or else would be “inattentive” to him, leaving him to take care of himself until bedtime. Keenan said, “She wouldn’t acknowledge me when I got home [from school]. There was no communication. I thought I wasn’t doing enough to get attention or earn affection.” Keenan can rarely recall his mother making him dinner and said when she did that “her food made [him] nauseous.” Keenan further described his mother as a “morbidly obese” diabetic who would spend her nights consuming large amounts of candy. She would frequently request that he “stop” her when she headed to the kitchen to get bags of candy; however, when Keenan attempted to do so, she would yell at him that she was a grown woman and could do what she wanted. (It is worth noting here that Keenan is an extremely thin man who told me he “never developed an appetite.”) When recounting this story to me, Keenan disgustedly said, “She knows she’s diabetic. She’s killing herself.” The manifestation of disgust in a patient’s discourse is often indicative of jouissance—of a secret enjoyment he cannot admit and of which he is likely unaware. It is quite conceivable that Keenan secretly enjoyed that his mother was “killing herself”—something that Keenan’s childhood dreams and compulsions also pointed to. Furthermore, as will be shown, Keenan’s general disgust with his mother indicated an eroticization of sorts that will be articulated in Lacan’s formulation of the child’s position in relation to the mOther’s desire in obsession.

Keenan's earliest memories (going back to around the age of three) are suggestive of a time when the family experienced more cohesiveness and happiness. Keenan recalled his parents spending time together and family vacations to a nearby waterfall where he fell into the water and soaked his clothing three years in a row, which always resulted in Keenan getting to wear one of his dad's dry shirts. When I asked how it was possible that he fell into the water every time the family visited the waterfall, Keenan shrugged his shoulders and laughed. Likely, Keenan enjoyed wearing his father's clothing—perhaps fantasizing about being his father or taking his father's place. Other memories from early childhood support this formulation. With the exception of the family vacation memory, Keenan's early memories consisted almost exclusively of time spent alone with his mother. His brothers had left for school and his father was working long hours, leaving Keenan alone with his mother. He recalled the two of them going places and enjoying their time together, telling me that she mostly *lived for him because he needed her*. However, he had a particularly vivid memory of being in the park with his mother at the age of four in which he noticed "she had changed." He was running around and playing and noticed his mother was not engaging with him as she typically did. "She looked very sad. I just remember worrying that she was so sad." Shortly thereafter, Keenan went to West Virginia to visit his grandparents and said, "When I returned, I didn't recognize my mother. She *looked* different. I pulled away from her and began crying." According to Keenan, his mother had gained a significant amount of weight while he had been away. The details of how long he was away were not available to memory, but what is important is that Keenan perceived a change in his mother—both physically and in her emotional availability. "She was just different."

In an effort to make his mother feel better, Keenan—the already burgeoning artist—drew a picture for her of Garfield the cat standing on a scale. When he presented it to her, she burst into tears and slapped him, accusing Keenan of insinuating she was “fat.” In recounting this story to me, Keenan claimed he had no idea what she was upset by—he had just tried to draw a picture for her to cheer her up, unaware of the link his mother would make between the fat cat standing on a scale and her recent weight gain.⁶⁷ Keenan was “confused” and “upset” by the fact that he had hurt his mother’s feelings.

Shortly after this incident, it was time for Keenan—almost six years old—to begin kindergarten. He described his mother as “sad” when he began school and himself as “feeling anxious” about leaving her. Keenan would often pretend to be sick at school so that he could be sent home to “check” on his mother. One memory of Keenan’s captures this early dynamic with his mother well: It was raining quite hard, and Keenan got out of the car and began to cross the huge parking lot to the school. He looked back and realized that the road atlas had fallen out of the car. Concerned that his mother might need it, he ran back—soaking himself in the process—to put the map back in the car. He told me, “I had to look out for things to make sure she didn’t get any more sad. I was willing to get more soaked.”

Around this same time, Keenan noted that his father, who was already largely absent, began spending even more time away from home. Keenan’s mother began spending more time in bed, leaving Keenan almost exclusively to himself. Regarding his parents’ relationship, Keenan shared, “I just remember feeling sad for my mom. I don’t remember seeing them happy.” I responded, “Shouldn’t it have been dad’s job to make

⁶⁷ It is quite possible that Keenan was not yet mature enough to understand this “change” in his mother and was trying to work it out for himself by visually articulating it. This does not mean that he was trying to insult his mother, which was her assumption.

mom happy?” Keenan’s response was to tell me that his dad was “working all the time” and that “he just wasn’t there.” He ended the session by stating, “I remember my mom making me feel safe until I went away to school.”

How can we make sense of Keenan’s early childhood, particularly with regard to the development of his obsessive structure? Boothby (1991) writes, “For Lacan [...] the key issue in the Oedipus complex is not the availability of the mother to the desire of the child but the position of the child in relation to the desire of the mother” (p. 148). In many ways, we can see that early on Keenan functioned as the privileged object of his mother’s desire: They were always together with little intervention from a third party, and Keenan probably felt like her special, favored child. It has been noted in the psychoanalytic literature that the obsessive feels he was loved too much by his mother and typically held a privileged place with her (Dor, 1991; Leclaire, 1959/1980). Indeed, Keenan’s mother seemed to be gratifying her needs with Keenan rather than with her absent husband. Furthermore, we can see from Keenan’s belief that “[he] had to look out for things to make sure she didn’t get any more sad,” as well as from the emphasis he placed on the absence of his father, that Keenan likely situated himself as the object with whom his mother could find the satisfaction she was not able to get from his father. In other words, he identified himself as the phallic object for his mother. Lacan (1961/2002) asks, “To be the phallus, isn’t that the final identification with the signifier of desire” (p. 251)? If we stopped here, we would perhaps be describing the pervert; however,

What is at issue is not, strictly speaking, a standing-in for the object of the mother’s desire. [...] The question here is rather one of supplementing what is missing in the satisfaction of the mother’s desire, which presupposes that this satisfaction was clearly represented to the child as lacking. [...] On the one hand, the child is well aware that the mother is dependent on the father when it comes to her desire; but, on the other

hand, she does not seem to be getting from the father everything she presumably expects from him. When the child perceives this gap in maternal satisfaction, he sees the way clear to providing a supplement. (Dor, 1999, p. 111)

Keenan clearly encountered his mOther's desire for something outside of him—this was likely “the difference” in her he could not quite put words to. Several incidences noted above suggest a shift that removed Keenan from the position of his mother's privileged object; indeed, we can see Keenan's separation anxiety when entering school as representative of his desire to recapture that privileged position. It is also quite possible that Keenan felt the need to put on a show for his mother in order to make her feel better.

In spite of this encounter with his mOther's desire, Keenan's recognition of his mother's dissatisfaction and their special dyadic relationship early on constituted a source of jouissance for him. Freud posited that obsession was a response to infantile sexual activity that was experienced as overwhelmingly pleasurable. In Lacanian terms, we can say that “The subject is captivated by jouissance” (Soler, 1996, p. 252). In response to his assumption that his mother was dissatisfied, Keenan became the passive object of her jouissance which was a source of pleasure for him, as well as a source of anxiety. On the one hand, Keenan was his mother's special object; however, on the other, he likely experienced this as overwhelming—as if he was going to be engulfed by his mOther's desire. The captivation by the mother's dissatisfaction, even while acknowledging the law of the Father, is characteristic of obsessive structure and leads to a short-circuiting in the obsessive's own circuit of desire. Keenan felt *necessary* to his mother: As he said, “She *needed* me.” This need on the part of the mother makes it difficult for the child's own demands and desire to manifest. In “The Subversion of the Subject and the Dialectic of Desire,” Lacan (1960/2006) states,

Desire begins to take shape in the margin in which demand rips away from need, this margin being the one that demand—whose appeal can be unconditional only with respect to the Other—opens up in the guise of the possible gap need may give rise to here, because it has no universal satisfaction. (p. 689)

Consequently, the future obsessive's needs are satisfied as soon as the beginnings of a demand are articulated—as the unfulfilled mother takes charge, seeing the child as a possible source of compensation. The obsessive is satisfied at the first sign of desire. Leclaire (1959/1980) notes, “The mother answers her son's hope with a manifestation of her own desire. The burgeoning desire of the child, just barely emerging from the exactions of need or the awaiting of demands, finds itself all at once disengaged, confirmed, and better yet, satisfied” (p. 124). Desire cannot manifest without lack and space must be given for demands to be articulated. Both are short-circuited in obsession; consequently, desire and demand collapse. Lacan (1961/2002) writes,

Those passions for being are, moreover, evoked by any demand beyond the need articulated in that demand, and the more the need articulated in that demand is satisfied, the more the subject remains deprived of those passions. (p. 252)

The obsessive thus remains trapped in his mother's orbit and his *jouissance* remains tied to her—this is where anxiety prevails—structuring the obsessive's desire as *impossible* because the closer the obsessive gets to realizing his desire, the more he (as subject) feels eclipsed by the object (his mOther's overwhelming desire). He adopts a position with respect to this desire—the Other's desire: neutralizing it by playing dead. He thus either “tucks his own desire away” or longs for things he can never have. Both strategies are ways of maintaining his desire when faced with the object. It is perhaps clearer now why it is an either/or for the obsessive: It is either you or me, not both/and—either you can desire or I can.

Closely connected to his strategy for maintaining desire is the obsessive's refusal of castration which is "first and foremost a refusal of the Other's castration (of the mOther's first of all)" (Lacan, 1961/2001, p. 256). Not only does the obsessive deny his lack, he refuses to accept that his mOther is castrated—that she does not have the phallus and is thus lacking in something. Fink (2004) notes,

The obsessive refuses to accept this [his mOther's castration] because he feels that it means something about him: It means that she wants something unthinkable from him, his very being perhaps. Better to deny the existence of her lack ("the lack in the Other") than face the horrible anxiety her desire ("the Other's desire") elicits in him. Nevertheless, his jouissance remains tied to her, and it is only by veiling the connection between her and the contraband that excites him that he can find any satisfaction. (p. 36)

It is, therefore, far easier to plug up one's own lack with exchangeable objects (and compulsive symptoms) than to face the Other's desire. Objects thus serve an imaginary function for the obsessive—allowing him to evade the desire of the (m)Other.

Let's return to Keenan to illustrate these theoretical concepts concretely. With the retreat of Keenan's mother to her bed came the retreat of any type of activity or desire on Keenan's part. The reaction of his mother to his drawing of Garfield—consciously designed to cheer her up—served, alongside other factors, as a type of condemnation of Keenan that resulted in feelings of guilt, shame, and a covering over of his desire. How could he have hurt mother so much? We can see from Keenan's early interactions with his mother that his guilt and feelings of responsibility were already firmly instated and were thus a significant component of his symbolic matrix. Lacan (1953/2002), discussing Freud's analysis of the Rat Man, speaks of the "symbolic debt" of the obsessive—"the fateful constellation that presided over the subject's birth, the unfillable gap constituted

by the symbolic debt against which his neurosis is a protest” (p. 87).⁶⁸ What was the symbolic debt that led to Keenan having such feelings of guilt? Keenan’s comment to me (with regard to his Garfield drawing) that he “was being nice but hurt someone,” suggests a deeply ingrained fear of his own impulses. Soler (1996) notes,

The obsessive generally feels guilty [...] This is why Freud, in deciphering the symptoms, finds shame regarding the first sexual experience in the obsessive [...] [T]he fact that the obsessive takes the sexual blame or fault (in French the word “*faute*” has two meanings: a sin and lack, fault and deficiency) upon himself, feeling guilty and shameful, is linked to the fact that he is greatly attracted to the sexual experience. (p. 255, original italics)

The obsessive defends against overwhelming jouissance⁶⁹—he likes it too much. Excessive enjoyment is thus something to be feared and distrusted. We can recall Keenan’s falling into the water three years in a row during the family’s vacation and his laughter when telling the story: The result of his falling into the water was that *he got to wear Dad’s clothing*. The oedipal implications are patent: He was three to five years of age when he fell in the water and fantasized about being his father, longing for his mother’s exclusive attention. Once rejected by his mother,⁷⁰ his desire to enjoy her was repressed, leading to feelings of guilt and debt that could not be linked to any conscious idea. We can hypothesize that Keenan’s constant sacrificing of himself when confronted

⁶⁸ In his analysis of Freud’s treatment of the Rat Man, Lacan (1953/2002) writes, “[I]t is by recognizing the forced subjectivization of the obsessive debt—in the scenario of futile attempts at restitution, a scenario that too perfectly expresses its imaginary terms for the subject to even try to enact it, the pressure to repay the debt being exploited by the subject to the point of delusion—that Freud achieves his goal. This is the goal of bringing the subject to rediscover—in the story of his father’s lack of delicacy, his marriage to the subject’s mother, the ‘pretty but penniless girl,’ his wounded love-life, and his ungrateful forgetting of his beneficent friend—to rediscover in this story, along with the fateful constellation that presided over the subject’s very birth, the unfillable gap constituted by the symbolic debt against which his neurosis is a protest” (p. 87). See also Freud (1909/1955).

⁶⁹ The hysteric likewise defends against jouissance but, as we will see in the next chapter, for different reasons.

⁷⁰ Note here that, in this instance, the mother instituted the law—she enacted the Name-of-the-Father and her consequent separation from her son. As Keenan noted, his father was “barely around,” unlike his mother who was very much “around.” We can see that in Keenan’s case, his mother enacted the Name-of-the-Father.

with the Other was a way of assuaging this ever-present guilt, as well as a way of avoiding his desire. While this may sound like an antiquated theoretical construction, I believe much of what followed supports such a formulation.

I'll Never Be Fat: Keenan's Middle Years

At the age of six, Keenan recalled running across the schoolyard and “feeling [his] cheeks bouncing.” He associated this with his mother’s weight gain and decided to stop eating. As mentioned earlier, Keenan told me he “never developed an appetite.” We can see this as a metaphor for desire: Food as that which nourishes and gives life was rejected by Keenan with the loss of his mother. It also symbolized a refusal of his mother and a move to almost complete isolation. Although Keenan indicated he would occasionally play with the neighborhood kids, he said they “didn’t really like [him]” and “were just letting [him] hang around.” Keenan made few attempts to befriend other children, instead passively sitting by and watching. This passivity may be linked to his position as his mother’s early privileged object (Dor, 1999) and, as we have seen, continued to play a prominent role in Keenan’s adult life.

From age seven to 11, Keenan’s mother underwent a series of back surgeries that left her almost completely confined to her bed (a place she was already largely occupying). During this time, Keenan recalled his mother “making fun” of him for having no friends, telling him he was no good at math, and punishing him for comments she deemed “sexual.” At age seven, he found these random punishments confusing, as he did not yet understand sexual innuendo. For example, Keenan was attempting to screw a garden hose into a spigot one day and he said, “*I can’t get it on.*” This was met by a slap across the face from his mother that did not make sense to Keenan until he was much

older. Around this same time, his mother also “found religion,” something that had never been present in the household before. When speaking one day, Keenan exclaimed, “Oh my god!” and this, too, was punished with a slap across the face. During this same time, Keenan’s eldest brother frequently “beat [him] up and choked [him].” Dad was nowhere in the picture, and though he was unable to voice it then, Keenan eventually shared in therapy that he was “angry” with his father for not “stopping mom.”

All of this culminated in what Keenan declared were “a rejection of [his] parents’ values system” at the age of seven and a further drawing inward. Concomitant with this withdrawal were the development of feelings of panic, being trapped, and a slew of compulsive symptoms. Before delving into these symptoms, how can we situate their origin in terms of desire? Fink (2004) writes, “If I condemn someone’s desire, I signify to him that his desire does not correspond to any lack in me. If I stop him from seeing any sort of lack in me, his desire vanishes and his being evaporates” (p. 33). Faced with constant ridicule and derision, Keenan’s choice was to conceal his desire and to “make [him]self as small as possible.” There was no room in the household for anyone but mother, and it is perhaps in this context that we can understand Keenan’s presenting complaints that he was just “taking up space” and that he was “nonexistent.” Indeed, these are signifiers of Keenan’s “lack of appetite” and the wording of many of his symptoms. Perhaps he hoped he could make himself small enough to disappear? Keenan’s compulsive symptoms, as well as his childhood dreams, communicated what Keenan was not yet able to speak.

Shortly after the rejection of his family’s value system (his denial/refusal of the Other), Keenan began *needing* to do things a certain number of times or else “someone

would die.” This included turning the locks on the doors six times to “check” they were locked, saying “excuse me” multiple times after he sneezed or belched when his mother was nearby, and having to walk to the *kitchen* in a certain number of steps or else “lightning would strike [him].” During this time, he also began having nightmares of someone “grabbing [him] from behind and kidnapping [him].” He was terrified of the dark, particularly of the cracks in the basement, where he thought someone could possibly “crawl in and take [him].” Keenan also became concerned with symmetry. As an example: If he stood up and turned to the right, he had to sit back down so that he could stand back up and turn to the left. Finally, Keenan took the common kid’s game “step on a crack, break your mother’s back” seriously—worrying about stepping on cracks and holes in the concrete. Notably, this last symptom developed around the age of 12—shortly after the last of his mother’s back surgeries.

Keenan clearly struggled as a child with the ambivalence he felt toward his mother—he loved her, yet she had betrayed him. Consequently, the hostility he felt manifested itself in symptoms and dreams. As we discussed each of these symptoms in their particularity, I punctuated certain signifiers and polyvalent phrases, allowing Keenan to make connections. For example, I punctuated *mother’s back* as he repeated the child’s rhyme to me, which prompted him to talk about his anger toward his mother for her invalidity. When he talked about needing to walk a certain number of steps to the *kitchen* or else lightning would strike him, I gently said, “or your mother?” He snapped his head up in surprise—the surprise that crosses the face of a patient when the unconscious has broken through and a link has been reestablished. The punctuation of *kitchen* led to a discussion of Keenan’s disgust for his mother’s overeating and her *lack*

of self-care. Perhaps he hoped his mother would be struck by lightning on her way to the kitchen—punished for her excessive jouissance? Such an interpretation on my part also aimed at revealing Keenan’s own discomfort with the excess of jouissance so clearly present in his mother’s relationship with food. Moreover, his “disgust” with his mother pointed toward something beyond simple disgust, as will be demonstrated shortly.

A particularly interesting session involved Keenan’s sneezing and belching compulsion. If Keenan did either in the presence of other people, he felt the need to say “excuse me” twice, then four times, then eight times, and so on, which others found quite irritating. Keenan said he felt he needed to be certain that he had “corrected [his] rudeness” because it felt as though he had “upset some balance.” He recalled that his mother very much despised when anyone in the household would belch. I repeated (i.e., punctuated) *despised*, and he said, “Yes, it really irritated her.” Keenan continued, “In fact, now that I think about it, I would continue saying excuse me until she turned around and yelled, ‘WE HEARD YOU!’” In session, Keenan was able to identify in his symptom a desire to irritate his mother—to express hostility rather than to “correct some rudeness”; however, we can also see how his mother’s response that she had “heard him” reinforced his symptom: It made him feel he existed.

Keenan’s dreams of being kidnapped and his compulsion to “check” the locks by locking and unlocking them six times were closely connected. When I asked him to associate to the word “check,” he responded, “coming home to check on my mom when I was in first grade.” This led to a discussion of his feelings about having responsibility for his mother at such a young age and his sense that she had not reciprocally provided that kind of care for him. He seemed to be circling around something—just on the edge—so I

asked, “If your concern was that someone might come in to kidnap you, why would you turn the lock to the unlock position? Couldn’t they enter in the split moment when the door was unlocked?”⁷¹ It was then that Keenan was able to connect the fear of being kidnapped with the wish to perhaps vanish and his “checking” of the door locks with his desire to be rid of the mother whom he had always had to “check” on. In *Seminar I*, Lacan (1975/1988) writes,

The fact that the subject relives, comes to remember, in the intuitive sense of the word, the formative events of his existence, is not in itself so very important. What matters is what he reconstructs of it. (p. 13)

A bit further, he continues, “It is less a matter of remembering than of rewriting history” (p. 14). What occurred in those sessions with Keenan was his assumption of his role in the formation of his symptoms—the assumption of his place in his history. Such a rewriting entails an integration of those parts of the subject that have been rejected, as well as recognition of the position the subject has taken with regard to the Other: In Keenan’s case, his hatred for his mother and father and his wish to be rid of them.

Keenan’s need for symmetry, what he called his need to “cancel out” things, was not a symptom he was able to integrate fully into his history by the time of our termination. He said, “When things are even, I can calm down.” At the end of our work, Keenan was no longer turning right to cancel out the left, but he did still appreciate symmetry. J.-A. Miller (2003) describes the compulsion as a way to “suture the subject together, even illogically” (n.p.). In other words, it serves to conceal lack. When things are even, there is nothing left out—there is no remainder. When Keenan canceled out left by turning right, he created a perfect sphere—the symbol of an uncastrated and unified

⁷¹ It is interesting to note that Keenan needed to turn the lock *six times*. If we surmise that the first turn was to the “locked” position, that would leave the sixth turn at the “unlocked” position. It is also interesting to note that it was at the age of *six* that Keenan first separated from his mother when going to school.

whole. In *Seminar VIII*, Lacan (2001) speaks of the sphere as representative of a rejection of castration. While Keenan was not yet able to articulate such thoughts, his ability to tolerate the holes in the whole had certainly grown by the end of our work together.

Castrating Mothers and Dead Ends: Keenan's High School Years and Beyond

Keenan's high school years were characterized by what he termed his mother's "humiliation" of him and his own inaction. Keenan's mother continued to dominate the household as an absolute authority—often suddenly developing headaches on special occasions, including Keenan's birthday, so that family outings were regularly canceled due to her "illness." This happened more often than not, resulting in little interaction within the family. Particularly notable during this time were the confusing sexual messages Keenan's mother conveyed. When the family would venture out for dinner, Keenan's mother was fond of yelling, "PENIS!" as loudly as possible—often when Keenan's schoolmates were dining at the same restaurant. Keenan's father would idly sit by as this happened, making no attempt to restrain his wife to save his sons' embarrassment. At other times, she would yell upstairs, "Your father and I are going to have sex on the couch now! Don't come down!" On the few occasions when she would cook for her sons, she was fond of "stabbing sausages" viciously and laughing as Keenan stood by watching. Keenan, now old enough to understand sexual innuendo, felt humiliated by his mother's castrating—even mutilating—tendencies. This type of behavior culminated in a routine visit to the doctor's office where Keenan's mother "grabbed [his] ass" when faced with the doctor and laughed, telling the doctor, "Don't worry. We're just friends."

When discussing his mother's behavior in session, Keenan said, "She really gave mixed messages." The conscious meaning of Keenan's statement was that he felt his mother both condemned sex (the water hose incident), yet also took every opportunity to sexualize anything she could. However, I was listening for what was *not being said*—for what was being excluded from his conscious narrative. Another way of hearing Keenan's statement that his mother was sending "mixed messages" was that he was confused about his position with regard to his mOther—was he her privileged object or outcasted son? Keenan's discourse suggested a certain nostalgic evoking of his phallic identification. He said,

My mom would often mumble under her breath such that I couldn't hear her. When I would ask her what she said, she would say, "*Nothing.*" I felt like Mom knew things but was keeping them from me—sexual things. I think she enjoyed being the only one who knew something. It frustrated me. I felt *excluded*.

Keenan's oedipal frustration was clear here: He had been "excluded"—he could no longer be the phallic object for his mother. Notably, the signifiers "excluded" and "nothing" were words Keenan used in his initial interviews to describe himself—they were aspects of his parental discourse that unconsciously formed the fabric of his symbolic matrix, carrying him along and determining his relation to his desire, as well as his symptoms.

We can see further evidence of Keenan's continued erotic attachment to his mother in the signifier "disgusting." Keenan would frequently refer to his mother as "disgusting" or would say he felt "disgusted" by her. During the session when he described his mother "grabbing [his] ass," he immediately began talking about how "disgusting" and unworthy *he felt* in his everyday life. These kinds of seemingly

unassociated leaps from one topic to the next are usually indicative of a repressed link or connection that, when listened for, can provide fruitful associations. As previously mentioned, disgust typically points to a certain jouissance the subject has but of which he is unaware. We can hypothesize that Keenan's "disgust" for himself indicated an unconscious desire to be his mother's phallic object and served as a source of overwhelming jouissance that further contributed to a veiling of his desire.

Keenan spent the rest of high school underperforming academically and essentially being a bystander. He described how his parents would often forget to pick him up at school and never expressed interest in his grades or school activities. When his family began having financial issues, Keenan "stopped asking for anything" and began eating even less. In his words, "There was never enough for the five of us," so he "wanted to cause the least interference." Keenan's sacrifice of himself, while appearing to be an act of giving on his part, also allowed him to escape responsibility to the Other. It functioned to keep his desire tucked away neatly and afforded him the opportunity to blame others for his lack of engagement.⁷² Keenan's tendency to situate himself as a spectator is structurally characteristic of the obsessive. Fink (2004) describes how the obsessive identifies with the Other:

The Other here is placed on the sidelines, in the position of a spectator in his box, a spectator who is bored precisely because he does not participate in the games but who remains intact thanks to his isolation. [...] The subject's unconscious desire is removed from the game and retracted into the position of the spectator. (p. 27)

Lacan suggests that the role of spectator functions as a way of sheltering the obsessive from death. For Keenan, it also served to shelter him from further ridicule by his mother.

⁷² This was, of course, not consciously Keenan's reason for his sacrifice, and I very much believe he was attempting to help his family; however, the underlying hostility was what needed to be brought to light.

Keenan said the way he survived high school was by focusing on the rational. He stated,

People who dominate have a place. I've never understood why people do certain things or why certain people feel bad to me. I came to realize that power comes from understanding the reasons people do what they do. It helps in not being hurt by others and in not getting lost. I never knew what was going on as a child. I felt *overwhelmed*. I just stayed as small as possible. I withdrew. I figured I'd get so small, I would eventually disappear. So I started studying people in high school. Being cognitive has really helped me.

When he shared this, I was reminded of his statement early in our work together that, "Feelings threaten to overwhelm me, *swallow me*." When talking with Keenan, one would never guess he felt as if his feelings were going to engulf him—he was as steady and pedantic in his speech as almost every other obsessive with whom I've spoken. Indeed, the isolation of thought and affect that is typical of the obsessive was one of Keenan's most distinguishing characteristics. Soler (1996) notes,

In obsession, the link with the Other's desire is not absent but dissimulated, covered over. The repressed term comes back in the mind. [...] The return of the repressed in the signifying chain dissimulates the gap [...] that is, it sutures it. (p. 263)

We can comprehend Keenan's emphasis on understanding and rationality as a denial of lack; however, we can also locate his symptoms in his words—in the signifiers he chooses: "Feelings threaten to overwhelm me, *swallow me*." Swallow is a word that readily connects to Keenan's mother and her overwhelming appetite—her excessive *jouissance*—and Keenan's failure as a young child to prevent her from eating her bags of candy each night. Stemming from such failure was Keenan's ever-present guilt and his unconscious hatred that manifested itself in compulsive symptoms (e.g., the *step on a crack...game*). To *swallow* was thus indicative of having an appetite—of metaphorically

engaging desire. Thus, to feel would be to be engulfed by mOther—to be *swallowed up* by her. We can thus tie a constellation of symptoms to this one master signifier: *swallow*. Keenan’s symptoms were certainly overdetermined, but by attending to his speech, we can see how his symptoms manifested in his discourse and repeated his parents’ discourse from so long ago. Keenan’s symptoms were structured like a language—they were carried along by the words of his past and constituted by conditions that pre-existed him.

The Dream of Dead Grandma

I will end my presentation of Keenan’s childhood with a dream that plagued him throughout his youth and that, at times, still recurred during his adult years. The dream was so important to him that he drew a full-sized illustration of it to show me. I think the dream illustrates well many of the issues that define the obsessive. Keenan shared that he often had dreams where he was inside a school, a building, or a house of some sort that had endless hallways or staircases that went nowhere or came to a “dead end.” In the dreams, he would wander from hallway to hallway, turning around when he reached a “dead end,” but never really going anywhere because it was *impossible*—the hallways led nowhere or the stairwells just kept going down, “leading you someplace where you don’t know what’s going on.” Keenan said, “There was always one more path, another hallway.”⁷³

In one particular rendition of this dream, Keenan was in a house that reminded him of his great grandmother’s. Keenan had no memory of his great grandmother, as she had died when he was fairly young; however, the house had remained in the family. As a child, he visited the house once and remembered it being like a “tomb” he didn’t want to

⁷³ There were thus always infinite decisions to be made.

disturb. He recalled that the basement was “claustrophobic” and contained “old pickled foods that looked like body parts.” He thought it was “creepy” and described “feeling trapped.” Here is the dream and his associations to it:

I’m in a house that looks like my great grandmother’s. There are infinite staircases going up. I keep climbing, up and up. I don’t have to make a decision. I never have to make a decision. I don’t have to struggle with decisions. I never stop and say I should do something else. I just keep going deeper. The goal is of reaching the top. It takes a really long time to get there. It’s an attic door, and I go up the final staircase. I finally arrive and *it’s my dead end*. My great grandmother is sitting there in a rocking chair. She’s silhouetted from behind, rocking, looking at me. The room is dusty. I wasn’t supposed to find her. She’s hidden away to wait for other people. *She died waiting...*

In many ways, the dream captured Keenan’s struggles well: his desire to evade responsibility by “just waiting” for something to happen, his constant deferral of action, the repetition in his life, and his repressed hostility (perhaps dead great grandma represented his mother?). But, above all, what the dream represented were Keenan’s questions: Am I dead or alive? Am I going to die waiting, hidden away from others? Am I going to die alone, waiting for others that never arrive? This was a dream that we repeatedly returned to over the thirty months we worked together. Keenan’s associations to it changed as he grew and changed. I will leave his final associations for the end of the case presentation. I now turn to Keenan’s life once he departed from his parents’ home.

Fantasy, Sex, and Impossible Desire

Keenan had a problem with dead ends, deadlines, and playing dead. When he described what happened before “dropping out” of school, he said, “I felt trapped. I just let anxiety overwhelm me until something happened.”⁷⁴ He talked about how he couldn’t (wouldn’t) meet the school’s (Other’s) deadlines and how he didn’t like “finished

⁷⁴ Schneiderman (1986) writes, “If the obsessional boxes himself into a dead end situation, it is because he has a problem with the question of his desire” (p. 90).

projects.” He preferred things to be left undone so that there was always something that could be added or bettered. He complained the school did not give him the tools he needed to do well and his teachers did not provide adequate instruction. Furthermore, he said he did not feel he could “compete” with other people. Keenan constantly worried he was going to be “stuck” in a “dead end” job. Keenan had a view of himself that he was trying to protect, and if he didn’t try at anything or really engage then he did not have to call that view of himself into question: His ideal ego could remain intact. Much of Keenan’s inaction was in the service of maintaining this ideal ego. It was easier to give in or not try than to compete. At least then he could continue to imagine himself as great. Keenan made it impossible for himself to advance in life by constant inaction. He enjoyed desiring things he could not have. Consequently, nothing ever moved in Keenan’s life: Life was on repeat. Desire was stuck. It was high school all over again.

Keenan did not fantasize or daydream much. He had difficulties masturbating because he worried the people he fantasized about would “find [him] disgusting” and be “offended” if they knew he was thinking of them. When he was able to masturbate “successfully” (to use Keenan’s word), he “couldn’t feel good” about himself the following day. Keenan’s definition of successful masturbation was to be able to ejaculate—something that rarely occurred for him. Even in masturbation, Keenan’s tendency to withhold was evident. Keenan had begun masturbating at the age of nine and described it as “new and exciting.” His mother told him at the age of 10 that masturbation was sinful and wrong, but Keenan said he “felt no guilt” and “found it pleasurable,” despite (or because of) his mother’s disapproval. His problems with masturbation now, he claimed, owed simply to his inability to fantasize. He saw no connection between his

mother's early remonstrations and his current difficulties. Indeed, it was impossible for Keenan to even put "sex" and his mother in the same sentence. Despite the many statements he made that were obviously oedipal in nature, it was an idea Keenan could not bear. I simply let him talk about his inability to "compete," punctuating words that pointed toward where he was unknowingly obtaining jouissance. For example, when he told me of his mother's early disapproval of his masturbation, he clearly looked pleased. I said, "Perhaps you enjoyed pissing your mom off?" Keenan looked surprised—he had been unaware of just how much he enjoyed his passive retaliation toward his mother.

A clear example of the jouissance Keenan obtained from the "disgust" he assumed people would have for him if they knew of his fantasies was evinced by the "shame" and "disgust" he expressed at himself when he began sexually fantasizing about me. Keenan spent several sessions discussing how worried he was that I would never "want to see" him again if I knew what he was thinking. He felt incapable of verbalizing his fantasies, yet he brought them up during every session. It was as if he wanted me to drag them out of him—a game of withholding something from me that he knew I wanted (his fantasies)—or perhaps wanted me to want. It was a repeat of the game of speech, "I won't speak first." I was unwilling to be complicit in the game, which forced Keenan to take initiative if he wanted me to know his sexual fantasies. More importantly, it served as a realization for him that he actually did want me to know his sexual thoughts about me. This was the jouissance—the "disgust" he was worried others would feel if they knew he was fantasizing about them: A desire to be recognized and a "getting off" on making others into sexual objects. A comment Keenan made highlighted his growing awareness of his positioning of others as objects rather than as people:

I find it troublesome, worrisome. I can go long stretches of time alone. I don't even think of people until I get lonely, and then I think of them only for my needs. It doesn't even matter who it is.

I responded, "It sounds as though you feel you use people?"

Yeah. I don't even think of them. I mean, as long as they serve my needs, it could be anybody. I end up being separate because of it.

Keenan's tendency to erase the person with whom he was involved, and yet still retain her to reap the benefits of what she had to offer—in other words, his nullification of the Other—was beginning to come into view for him (Miller, 2011). Furthermore, his constant erasure of the Other left him "separate"—something that was increasingly dissatisfying to Keenan and that indicated a slight shift in his relation to desire.

Keenan's sexual relationship with Abbay (the girlfriend he had moved in with almost immediately after meeting) echoed several themes that arose when we discussed masturbation. Initially, he didn't feel as though he "[had] the right to touch her." He worried he was somehow being aggressive toward her—that she wouldn't want him to touch her. This was in the context of Abbay actually being the more aggressive one in their sexual play. We can read in such comments Keenan's early guilt about his overwhelming attraction to *jouissance* and his fear of his own impulses. Because it was not okay to experience such satisfaction (with mother), he positioned himself as "aggressive" and worried about harming her. (Such a fear also suggested that Keenan entertained sadistic sexual fantasies that did not conform to his ego identifications.) The purpose this stance served for Keenan was as a defense against his own *jouissance*, as well as a refusal of Abbay's. Perhaps he did not want to give her any satisfaction either? Keenan's desire to have Abbay watch him masturbate supports such a formulation. He spoke at length about receiving his first "blow job" from Abbay and about feeling

“carefree” and “wanted,” but he never mentioned giving Abbay oral sex or pleasuring her in any way. In fact, when he did talk about Abbay, he told me he thought she was “faking” her orgasms and complained about how loudly she “moaned.” It was as if Abbay’s very presence bothered him, or as if her “moaning” represented a jouissance she had that he experienced as overwhelming. Keenan would fantasize about other women during sex (he seemed to have no problem fantasizing at these moments) and shared that he “still look[ed] at other girls” because he “wanted to keep [his] options open.” We can see here how Keenan constantly maintained his desire as impossible. While having sex with Abbay, he was dreaming of all the women he was missing out on by being with Abbay. Yet, he stayed with her, signing new apartment leases and continuing their daily lives, despite his comment that he “[didn’t] think [he’d] ever be able to be with Abbay and be satisfied.”

Keenan’s inability to orgasm during sex provided “fertile” material for therapy, allowing him to connect elements of his past with his present—something that only became possible when Keenan began to take seriously the existence of the Other. When describing his relationship with Abbay, Keenan’s speech was peppered with spatial and temporal metaphors. Abbay gave him “no space.” He had “no space” of his own. Abbay “bulldozed” over him, allowing him “no space or time,” and so on. Keenan seemed unable to ask Abbay for what he needed—to articulate a demand to her. This brought up the question of his needs. He stated, “I can’t express anything with her. I have no time alone.” I asked, “You’re not allowed to have needs and ask for them to be met?” He responded, “My needs aren’t needs at all. My needs are food, water, and sleep.” He continued, “It seems strange to me. At age 14, I didn’t ask for anything. No clothes. I ate

twice a day. I got good at just getting by, not asking for anything. I do the same with Abbey. I just push my needs aside, and it's wearing me down." I responded, "So an orgasm isn't a need, so therefore, not okay?" I scanded the session there, hoping to set Keenan's unconscious moving. The session, indeed, marked a change for Keenan: He was beginning to call into question his own sacrifice of himself and his desire. Furthermore, he was beginning to identify the difference between needs and desire. Increasingly, Keenan was becoming a question for himself, again indicating a dialectization of his desire. Movement was occurring.

We spent several more sessions discussing Keenan's inability to ask for the space he needed. He "didn't want to hurt Abbey's feelings," to which I responded, "How did that work out with your mother?" Keenan was ready by this point to begin examining the connections between his past and present—it did not need to be so covered over anymore for him to feel safe. This was evidenced by Keenan's next session. He arrived jubilant:

I sat Abbey down and I explained to her my need for solitude. I told her I felt like I only had THIS much space and that I needed more. I feel like she actually listened and heard me. I feel as though I've created a better place for myself. *There's a distinction between me and her now. She keeps trying to make us one.*

Exactly two weeks later, Keenan experienced his first orgasm with Abbey—that is, with another person. We can perhaps better understand this by examining Keenan's last two sentences: "*There's a distinction between me and her now. She keeps trying to make us one.*" There was little separation between Keenan and his mother. She dominated him in the present as she had in the past. He had never left her orbit and thus was *swallowed up* by her lack. Without a clear distinction between the two of them, there was *no space* for

Keenan to desire or to come into being as a separate subject. He had to keep his desire tucked away; when he felt he had no space, he played dead.

We can situate some of Keenan's discourse around sexuality in this context. For example, we can now see Keenan's inability to fantasize while masturbating as an inability to distinguish between his mother and other women. His own disgust suggested there was an unconscious connection between his mother and the women and men who played a prominent role in his fantasy life, as well as the *jouissance* he derived from such fantasy. Keenan's comment that he "couldn't feel good about [him]self" the day after masturbating was suggestive of an incredible moral censor that served to punish him for such fantasies.⁷⁵ It also was suggestive of a need to punish himself for enjoying—to distance him again from too much pleasure. Likewise, Keenan's comment that he felt he did not have the "right" to touch Abby indicated a strong and continued attachment to his mother. What is important to note here is that in creating *space* between Keenan and Abby, a further separation from his mother was also enacted that allowed him to stop identifying everyone with her. Keenan identified this connection himself when he remarked, "Abby wants to fill the role of my mother. She (s)mOthers me. She needs constant reassurance of my love." He then associated Abby's "mothering" with "death." I scanded the session there.

I did not articulate this formulation for Keenan so that he could have "insight" into what had transpired: I did not need to. What was important was that a shift had occurred, and it did not come about because Keenan somehow consciously "understood" it. Therapy aims at change, not understanding (Fink, 2010). Missing connections, dissimulated links had found their place in Keenan's signifying chain—in his symbolic

⁷⁵ There is, of course, *jouissance* in such punishment for the obsessive.

matrix and history—allowing for greater movement on his part. Keenan continued to work through much of his early childhood in his relationship with Abbay, increasingly voicing what he needed. In one of our later sessions, he said, “My relationship with Abbay is just like my parents. My dad let my mom run everything, just like I do.”

The anal metaphors in his speech pointed to the demand he still felt in the face of the Other. Referring to emotions, he said, “I always hold it in...” and was able to identify how such withholding constituted a way of blaming the Other rather than taking action. Keenan was also able to identify how sacrificing himself for the sake of the Other allowed him to actually escape truly being responsive and engaged. I asked him one day if there was a way that choosing to stay with Abbay kept him from having to truly open up. He responded, “Yeah, I guess if I’m so busy with her steamrolling over me, I don’t really have to think about what I want or feel.”

Keenan went back to school and began to take more initiative. When he felt confused, he asked for the teacher’s assistance rather than just “waiting for something to happen.” His need to erase the Other slowly lessened as he began to explore what he wanted and what he enjoyed—as he became more of a subject. In Lacanian terms, we can say he felt less eclipsed as a subject when faced with the object. The problem of “deadlines” that had resulted in his initial failure in school seemed to hold him up less the second time around. He said, “Before, I would put it off and put it off and put it off rather than face the deadline. It feels less anxiety-provoking now—like more of a challenge.” In the same session, he said he felt more capable of competing now:

I feel invigorated, creative. I’ve never had a long-term project or something to plan for. I’ve always just had short-term projects. [...] I’m not familiar with wanting anything. I stopped wanting things a long time ago. I always thought wanting something would hurt someone else. In

high school, joining clubs would financially hurt my parents, etc. So I just stopped wanting. It's a very different approach, allowing yourself to want things. I used to just follow others' plans. There was nothing specific about what I wanted. Now, there's increasing specificity.

Keenan had now found enjoyment in working toward something—in giving of himself rather than withholding. He earned straight As that semester and joined an art competition with a group of other students.

In one of our final sessions, I asked Keenan when he felt most alive. He said, “When I complete a piece of artwork. I see myself coming into existence.” We can contrast such a statement with Keenan's statement two years earlier that he “didn't like finished products.” In the former, there's a satisfaction obtained in his creativity. In the latter, there is only a desire to keep desiring. We ended the session by discussing his childhood dreams of endless hallways and staircases that went nowhere, always ending in a “dead end.” I asked him how the dream would be different now, to which he responded, “I would go out the door. I would decide to create something. Pick something up and create. Enjoy creating something.” Where before there were only dead ends, there was now a door—a choice—that led to something life-sustaining and satisfying.

Final Dreams

Keenan made tremendous strides during our work together; however, his decision not to continue therapy with another therapist after my departure from the clinic because of his fear of “opening [him]self up” to another person certainly points to the work that remained for him. At the time of termination, he still had trouble asserting himself, continued to struggle with self-defeating behaviors (though they were shorter in duration), and remained in a relationship in which he felt dissatisfied. I believe two

dreams he brought toward the end of our time together signify, in many ways, both the work Keenan accomplished and what was left unfinished. Here is the first dream:

In my dream, there's a disembodied penis. There's a person in the other room, and what I do to the penis impacts the other person. I'm doing sexual things to it. I'm giving it fellatio. I'm stroking it. Masturbating. Enjoying it. What bothers me is that it's disembodied...

Here is the second dream:

My friend is having problems with a picture frame. I tell her, "I know something about framing." It wasn't working because she was trying to fit a frame into a frame. I realize it's like old patterns repeating.

Rather than provide a lengthy analysis, I will simply point out two things about the first dream: On the one hand, it is a disembodied penis—it is an *object* with which he is satisfying himself. The onanism is apparent. On the other hand, there is a person in the other room, and he is aware that his actions *impact this other person*. In the second dream, Keenan makes a change—he stops trying to fit a new frame into an old one. He realizes he has to make a change and stop simply repeating old patterns. The dreams offer a nice picture of where I left off with Keenan—situated somewhere between his endless hallways that always led to dead ends and his desire to create a new frame for himself, one enlivened by vitality and creativity.⁷⁶

The Language of Symptoms: Therapeutic Aims and Conclusions

In order to free the subject's speech, we introduce him to the language of his desire, that is, to the primary language in which—beyond what he tells us of himself—he is already speaking to us unbeknown to himself, first and foremost, in the symbols of his symptom.

(Lacan, 1953/2002, p. 80)

⁷⁶ For IRB purposes, I saw Keenan once more following termination. Again, his speech was a nice example of how far he had come and the work that remained. He said, "I'm definitely changing, taking more initiative. I wonder now why I do so much for people. School is different. Now, when I don't like something, I ask what I can do to change it. I feel a bit of spark. [...] Our last session was rough. It took me 10 minutes after I had left to realize I wasn't going to have my person to talk to anymore. It might be better that I don't have you to talk to. It makes me speak to others."

My work with Keenan aimed at encouraging him to become a question for himself—to explore and question what he thought he knew. A sampling of questions that arose for Keenan along the way included what it would mean to really *want* something, what it would mean to compete and succeed, and how feelings could be sources of vigor and vitality rather than of terror and dread. We were able to explore these questions by examining the deeper components of Keenan’s psychic structure and by giving a historical context to Keenan’s symptoms. By paying attention to the singularity of his symptoms, we were able to situate them within the symbolic matrix that was unconsciously formative of Keenan. We looked at his symptoms in light of the context of his family history, his parents’ discourse, and Keenan’s psychic structure. We identified how Keenan’s symptoms were tied to master signifiers that needed to be brought to light in order to be put in their place in his signifying chain (as S2s instead of S1s).

Through this exploration, we came to understand the function that Keenan’s symptoms served with regard to the Other’s desire (which, of course, was also his own), as well as his stance with regard to *jouissance*. Keenan’s case illustrates how compulsive symptoms serve as a type of suture that allow one to cover over one’s own lack by offering satisfaction that “plugs up” one’s division (Soler, 1996). Helping Keenan face this lack so that he could relinquish some of his symptoms entailed enabling him to *speak* that which he had never felt able to speak before. Language helps master early trauma; it puts words on that which fixates, thus impacting the real—draining it of its affective power. Keenan needed to find words so that he could move beyond the repetition that is engendered by things that have yet to be symbolized. The automatism of repetition was identifiable in Keenan’s speech—in his pedantic language that rarely changed. I knew

things were beginning to shift for Keenan when he began making use of more metaphorical language in session, and when his signifiers began to expand and change.

Keenan did not recognize that his rationality and thinking were two of the symptoms he used to ensure his own existence (if he was thinking, he could be sure he was alive). Consequently, his thoughts and the thought process were eroticized—they were a form of substitute satisfaction and carried a jouissance of their own. Soler (1996) writes,

In the strictest sense, the obsessive symptom itself is what Freud called *Zwang*, a compulsive thought of jouissance. Thoughts of jouissance are not thoughts about jouissance; they are thoughts that serve as a *vehicle for jouissance*. The result is that, in the obsessive's thoughts or signifying chain, we have, side by side, thought as a defense and thought as a vehicle of jouissance. The result is the sense of absurdity felt by the obsessive, when, for example, he cannot help thinking about insults, or when he is full of doubt and inhibition that make it impossible for him to arrive at a conclusion due to contradictory terms in his thoughts. (p. 274, original italics)

Thus, we can understand Keenan's "rational thinking" as an indication of his own lack of awareness of what he was "getting off" on—of where he was unknowingly obtaining jouissance. As Keenan began working through his own "dead ends," his source of jouissance began to shift: He found satisfaction in creativity and working toward long-term goals.

We can similarly comprehend many of Keenan's symptoms in light of his need to tuck his desire away or to maintain it as impossible. In *Seminar VIII*, Lacan (2001) writes, "In action, desire ordinarily achieves its demise rather than its fulfillment" (p. 5). Keenan's symptoms were certainly overdetermined; however, his symptoms served the purpose of allowing him to continue desiring. By not acting, Keenan could continue to want. He could also maintain his ideal ego. By maintaining his superiority over the

“conformist sheep” of society, he protected himself from having to actually engage and take the risk associated with any action. He also avoided any real responsibility to others. If Keenan was to actually *desire* something publicly and then not get it, it would be the ultimate castration. To state his desire was to expose himself to vulnerability and loss. All choice entails loss. So instead, Keenan veiled his desire and never made any choices, instead sitting back and “just waiting” for things to happen.

Keenan’s constant deferral because he “didn’t know enough yet” was also a way of maintaining his desire; however, it also pointed to the problem of mastery that is structurally characteristic of the obsessive. The obsessive longs to master everything, so there can be nothing left out—no lack is allowed. By focusing on concrete knowledge and understanding, Keenan hoped to be able to comprehend people and “why some people felt bad.” It was easier for him to search for answers by being a spectator of others than to acknowledge that there are just some things that cannot be known or comprehended. It was also easier to maintain this position than to *feel* the pain of a mother who shut him out so early in life and a father who never was really there to begin with. Above all, Keenan’s deferral and wish for mastery reflected his desire to master his own desire. By playing dead, Keenan could perhaps achieve such a state. Lacan (1975/1988) writes, “Death is experienced as a problem of mastery” (p. 48). Keenan’s childhood dream of climbing up and up and up with the goal of reaching the top, only to be met by “[his] own dead end”—his dead great grandmother who died “waiting”—reflected his question, the obsessive’s question: Am I dead or alive? Until Keenan began to ask this question and address it via his words, he was doomed to repeat the same patterns over and over—which was one of his primary complaints about his life. He was

stuck in the imaginary, with all of its attendant doubt, sameness, and illusory promises of unity.

My role

Throughout our work together, I encouraged Keenan to put words to what had never been spoken before. I invited him to speak what had thus far remained unspeakable. This meant facilitating his openness to the Other—particularly the unconscious as Other. To do so, I invited him to speak whatever was on his mind and to associate to dreams, fantasies, and parapraxes (e.g., slips of the tongue and bungled actions). I asked him to complete sentences that he began and did not finish. Oftentimes, when a patient begins a thought and then drifts off, this is indicative of a competing, unconscious thought seeking to break through. By asking Keenan to finish his sentences, I was emphasizing the manifestations of his unconscious. As has been noted, Keenan did not take kindly to notions of the unconscious initially. Despite this, I continued to punctuate the few slips of the tongue he did make, to punctuate polyvalent phrases, and to draw connections between past and present. I highlighted unprovoked denials and suggested that perhaps they were hiding a truth he did not want to face. He gradually grew more curious about this “Other” language that was speaking through him. When Keenan grew less afraid of the Other and began to become intrigued by the unconscious, he remarked, “This stuff is crazy! I can’t believe all of this is connected!” This is the beauty and power of the unconscious—it always surprises the patient, shaking him from his center where he is convinced he has it “all figured out.” This was particularly important with Keenan, as his desire was almost completely veiled due to his denial of the very lack the unconscious so beautifully illustrates.

In order to offer Keenan the *space* he needed to come into being, I simply gave him my lack—my desire that he become a question for himself. As we have seen, space—or rather the lack of space—was a major component in Keenan’s symptomatology. By giving him my lack—my desire—I forced Keenan to confront the Other’s desire, and I allowed him to do so without imposing my beliefs or values upon him. Aside from the first few months when I mistakenly offered suggestions to Keenan, I kept myself as a subject out of the room. I did not share any personal information with Keenan, nor did I talk about my countertransference with him. It is worth noting that Keenan’s poor response to those first few months of therapy was what led me to Lacan and to the realization that there is a sort of violence that occurs when therapists tell their patients what to do. Firstly, it entails a certain arrogance—a belief that somehow the therapist “knows” best, and therefore, the patient should model himself on the therapist. Secondly, it serves to alienate the patient from his desires even further by repeating what occurred in the mirror stage—a construction of an ego based on the Other.

There may be times when patients need more guidance and direction, and I do not take an absolutist approach here. But, generally speaking, by my taking a more “blank screen” approach, Keenan was compelled to face the anxiety necessary to shift his subjective position in relation to the Other, as well as his stance with regard to *jouissance*. If I had been a flesh and blood “person” in the room, Keenan (as his history shows us) would have concerned himself with what I wanted, attempting to please me rather than asking questions about himself. Thus, I acted as object *a* for Keenan—as the cause of his desire, as that which inspired him to question and explore. I acted as a placeholder for his unconscious, for those unacceptable parts of himself he needed to put into words.

So what did I do? I actively listened to the letter of Keenan's language, reiterating (i.e., punctuating) signifiers that repeated and offering interpretations only when Keenan was right on the brink of a discovery. I helped him connect signifiers to his parents' discourse and aided him in reconstructing and rewriting his history. By doing so, Keenan's symbolic matrix—all of the implicit rules he had unknowingly been living by—was brought to the foreground. Above all, I situated myself as a symbolic Other, not engaging in imaginary ego-to-ego battles with Keenan. (I learned my lesson there.) I sought to bring to light Keenan's relationship with the Other, not with the many egos he battled daily. For, in the ego-to-ego battle, there was *jouissance* for Keenan. Always guiding me were the questions: What is at stake in desiring for Keenan? In enjoying? What is at stake in making a choice? And, of course, what is the fundamental structure of Keenan's desire and *jouissance*?

For Keenan to come alive—to stop playing dead—there had to be a shift in both his desire and *jouissance*. In many ways, I think we accomplished this. In other ways, I wish he had continued therapy. Perhaps there is no better way to end than with Keenan's own words: "I'm here. Speaking more freely. I have thoughts. Feelings. I'm not so blank." Keenan is more connected now to the living than to the dead. He feels less need to withhold—to go blank—when faced with the Other. He has discovered that desire and satisfaction are the stuff of life and that to hide his desire away was and always will be a death sentence.

CHAPTER FOUR

An Hysteric in Obsessive's Clothing: A Case Study of Hysteria as Differential Diagnosis

For by responding to the analysand's demand for advice and interpretation, for "understanding" of his or her symptoms, the analyst gives what he or she has ("knowledge") instead of what he or she does not have (lack, in other words, desire), and encourages the analysand to demand rather than desire, to remain alienated rather than separate.
(Fink, 1995, p. 88)

I had everything structured so that I could feel nothing but sorrow. If I had approached her, she would have said "yes," so I didn't. Now, I could approach her because she would have to reject me. There's excitement in disaster and pain.

Vincent, September 2010

Introduction

What follows is a case study of my clinical work with an hysterically-structured male patient. As in the previous case, the patient suffered from classic obsessional symptoms; however, despite this similarity in symptomatology, the prominent features of his case are in marked contrast to those presented in the previous chapter. These differences primarily revolve around the hysteric's stance with regard to desire and jouissance, his position in relation to the Other, and the hysteric's existential question: "Am I a man or a woman?" I offer this study as a differential diagnosis to the previous case study as an example of how symptom-based diagnoses can mislead and inhibit the therapeutic work; consequently, I focus predominantly on the structural characteristics that are definitive of the hysterical position, as well as the way the patient's hysterical structure guided my work with him. Before turning to the case presentation, I would like to briefly outline the obsessive symptoms with which Vincent presented that would lead most clinicians utilizing a *DSM* nosology to diagnose Vincent with obsessive-compulsive

disorder, and I would like to draw attention to the similarities between Keenan and Vincent's superficial obsessive symptoms.

Both Keenan and Vincent were distressed by intrusive thoughts and images they felt subjected to and engaged in repetitive behaviors in an attempt to neutralize their anxiety. Keenan suffered intrusive thoughts of being kidnapped and “grabbed from behind”; whereas, Vincent (as will be shown) was plagued by thoughts of the devil, his criminal nature (he was convinced he was a pedophile, despite no sexual feelings for children), and unwanted sexual intrusions. Both recognized the “pathologic quality of these unwanted thoughts [...] and would not act on them, but the thoughts [were] very disturbing and difficult to discuss with others” (*DSM-IV-TR*, p. 456). Like Keenan, Vincent engaged in many “undoing” rituals to combat his obsessive thoughts. He sought to “cancel out” any perceived “imbalances” through a variety of ritualistic actions. Whereas Keenan felt the need to turn right to cancel out turning left (making a complete sphere) or turn locks a certain number of times, Vincent often felt the need to carry around magical beads or sprinkle salt around his room to “cancel out” any evil thoughts he had. Both were excessively concerned with symmetry and the need to have things “just right.” (Indeed, Vincent often needed to rearrange the furniture in the session room before we could begin.)

Both Keenan and Vincent suffered from omnipotent and “magical” thinking—the idea that their mere *thoughts* could impact or hurt others. With Keenan, we saw how this manifested in his fear that others he fantasized about would somehow *know* or be affected negatively by his thinking. Vincent, too, was convinced of the power of his thoughts over others and also believed that others somehow knew what he was thinking. As is noted in

the *DSM-IV-TR*, both men “recognize[d] that the obsessional thoughts, impulses, or images [were] a product of [their] [...] own mind[s] (not imposed from without, as in thought insertion)” (p. 456). Neither Keenan nor Vincent was psychotic: It bothered them both that they seemed to have no control over what they termed “silly” acts or rituals. Despite their rational thinking, however, the “irrational” symptoms persisted. (This was particularly true of Vincent, who was still engaging in many obsessive symptoms when we began treatment.) Consequently, both men leaned heavily on thinking over affect, denigrating feelings and venerating intellect.

Perhaps most notable was the use of propositional language by both men. One of the criteria for OCD listed in the *DSM* is that “The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. However, these behaviors or mental acts either are not connected in a way that could realistically neutralize or prevent whatever they are meant to address or they are clearly excessive” (p. 456). Recall the wording of Keenan’s symptom: “If I don’t walk to the kitchen in *x* number of steps, someone is going to die.” Vincent, too, suffered from such propositions. I will offer one example here, as Vincent’s symptoms will be detailed below. Vincent had the recurring thought that “If *x* [didn’t] happen, the devil would come and steal [his] soul.” Consequently, Vincent used his beads, his magic rituals (including knocking on wood), and any number of other repetitive behaviors that were designed to prevent some dreaded event from occurring. He recognized that sprinkling salt around the room was not likely to actually prevent whatever terrible doom awaited; however, *he felt compelled to perform the ritual*. Coupled with frequent panic attacks and the sheer amount of time

his compulsive rituals took up, Vincent easily met the criteria for OCD. In fact, it was his *DSM* diagnosis in the clinic where I trained.

I offer this brief exposition of Vincent's OCD symptoms here to illustrate that, given a one hour intake (the standard these days), he easily would meet the criteria for OCD. Thus, given a diagnosis of a "medical syndrome," he would be treated for his symptoms thus precluding exploration of his underlying structural dynamics. Vincent clearly "had OCD," but when working from a Lacanian orientation, symptoms are simply a language to be deciphered—not a medical syndrome to be treated. Let's turn to Vincent's case history for a concrete explication of this difference.

"I Just Want to Be Loved" Presenting Problems

Vincent was a Caucasian male in his early twenties attending college and majoring in philosophy and theater. I worked with Vincent for approximately 35 months: For 20 months, he came once weekly and then began coming twice weekly. Vincent consistently attended sessions and occasionally requested additional sessions when he was feeling particularly overwhelmed. Vincent's commitment to therapy as evidenced by his consistent attendance was a strength that, from the beginning, allowed him to really engage in his therapy. Prior to our work together, he had been in counseling for a brief period following his parents' divorce at the age of 10. Vincent did not remember much about his previous experience in counseling, saying only that he remembered being "encouraged to discuss [his] emotions."

Vincent was a petite man, quite effeminate in appearance, who typically dressed casually in jeans and t-shirts. His hair was usually wildly strewn about as if he had been rushing from place to place and, indeed, this was often the case. Vincent's gaze was

intense, and at times, he engaged in a somewhat-paranoid surveillance of the environment around him. Before our first session, Vincent called to cancel his appointment because he was concerned that information garnered in session might be “used against [him].” After being assured of his privacy, Vincent decided to keep his appointment. During our first session, Vincent stated it had been over a month since he had contacted the clinic seeking psychological services (he had been put on the clinic’s waiting list), and that he felt as though the “issues” he had been having then were now “no longer an issue.” When I inquired as to why he had kept our appointment given that he felt his issues were now resolved, he quoted the Dalai Lama, saying, “A tree with strong roots can withstand the most violent storm, but a tree cannot grow roots just as the storm appears on the horizon,” and that he wanted to “grow roots” while he could. Vincent also expressed his desire to delve into an “exploration” of his life. Throughout our first session (and all of subsequent therapy), Vincent spoke grandly, often in a quite performative manner, describing his life in metaphors, symbols, and colors because he found language to be “limiting” when attempting to convey his experiences.⁷⁷ Throughout the intake, Vincent attempted to create an intellectual rapport with me, speaking of philosophical and psychological theories.^{78 79} Vincent’s demand to know what I was thinking was predominant in our initial meetings and remained consistent throughout our work together. This was evinced by the fact that he would end every statement he made by looking at me inquisitively and

⁷⁷ Vincent’s larger-than-life speech was one indicator that pointed away from obsessive structure. Schneiderman (1986) notes that the obsessive tends to avoid highly metaphorical language, instead leaning on “pure grammar.” The act of speech itself engages the subject as a participant in action—something the obsessive is loathe to do.

⁷⁸ In what amounts to a beginner’s mistake, I allowed this imaginary identification between us, believing it would strengthen rapport.

⁷⁹ The philosophy and psychology departments are closely related at the university Vincent and I attended. He saw this as a point of identity between us and focused on it quite frequently throughout therapy.

saying, “You know?” This need to check-in with me and seek my approval characterized the therapy, as will be shown.

The “issues” that prompted Vincent to call the clinic that he felt were “no longer an issue” were that he was “*having problems with the opposite gender*” and had recently noticed a recurring pattern where he would find himself attracted to a woman but “within a couple of weeks, all feelings [would be] gone.” Consequently, there had been one girl after another in his life, and this pattern was increasingly bothersome to Vincent. He also stated he believed he was “too dramatic” and “overly analytical” and he found these to be frustrating qualities. When I inquired what “overly analytical” meant for him, Vincent said he had great difficulty making decisions, often losing himself in the details. Of particular concern was his inability to decide whether to pursue a graduate career in philosophy or theater. The fact that Vincent was highly talented in both areas made his decision all the more difficult. He routinely earned top honors in philosophy and was frequently cast in many theater productions.

Vincent’s concern that he was “too dramatic” centered around his feeling that he “often bl[ew] things out of proportion.” In his estimation, he was “too needy” and believed others found him “creepy” because of this neediness. Vincent chronically worried about how other people perceived him—a feeling that pervaded the therapy from beginning to end. With great disgust, he said he was “false” and an “actor.” Vincent indicated he “felt powerless” against the need to “play a role” for other people because he feared his “true self” would ultimately be rejected by others as “ugly” and “displeasing.” Vincent worried he would never be able to overcome his need to mold himself according to others’ desires and, as a result, would remain “nonexistent.” Vincent described his

existence as “not really being [his] own” and said he felt an ever-present sense of guilt over his inability to find and follow his own desire, often disparaging his achievements in theater, stating, “I’m an actor. The thing I’m best at, I’m good at because I like the praise.” His compulsive need to please others was confusing for Vincent because he found most people to be “inane” and “ignorant,” and therefore wondered why he worried so much about being approved of by them.

Finally, Vincent’s sexuality and sexual orientation were highly-charged areas that elicited a great deal of anxiety for him—indeed, Vincent was characterized by constant anxiety. Initially, Vincent identified as heterosexual; however, he would say things such as, “I know that makes me sound gay, but I’m reasonably sure I’m not.” This type of unprovoked denial regarding his sexuality was common, suggesting very much the opposite: Vincent feared deeply that he might be gay and worried what other people would think of him if he was gay. His worries took the more specific form of a paranoid fear of being “beaten up” by “big, burly men” if they were to discover his sexual orientation. Vincent’s fear of being hurt by large, “gruff” men peppered our sessions from the beginning, and while Vincent had never been in a physical altercation with anyone, he often looked panicked when discussing his lifelong fear of “large men.” When describing his fear, Vincent disgustedly equated these “manly men” with what it meant to be masculine in contemporary society. It was obvious from our initial meetings that Vincent was deeply confused about his sexual identity and felt great revulsion toward sexuality in general. Vincent claimed what he desired most in life was “to be loved.”

Family Context

Vincent was an only child who was primarily raised by his mother. His parents divorced when Vincent was 10 due, in large part, to his father's philandering. Vincent's father eventually remarried a woman who had a son from a previous marriage. Vincent remembered feeling "happy" when his father moved out but also jealous of his new stepbrother—particularly when his stepbrother would call his father "Dad." While Vincent had a few good early memories of time spent with his father, he said this good relationship changed fairly early in childhood for reasons which were unknown (and confusing) to Vincent. He described his father as largely "ignoring" him as a child. In contradistinction, Vincent recalled being very close to his mother and described her as his "safe place" growing up—a description that changed as therapy progressed. Vincent almost exclusively identified with his mother and considered his father to be an "*ignorant, large, gruff man.*"

Dad

Vincent's father had a career doing skilled manual labor and exemplified for Vincent the "typical, weak, disgusting man" who "control[led] through fear." He recalled being "terrified" of his father and feeling as though he was an inconvenience to him. Vincent's father rarely participated in his life, instead spending most of his time in front of the television set. When he did interact with Vincent, it was usually in a *dominating* and ridiculing fashion that often included arbitrary decisions Vincent found confusing. For example, Vincent once asked if he could have more milk for his cereal (around the age of four), and his father told him he could have a glass of milk but that he could not pour it on his cereal. A particularly precocious child, this made no sense to Vincent;

however, he was not allowed to question such commandments. On another occasion, Vincent spilled a soda in his father's truck, and his father began "screaming at [him] as if [he] had done it on purpose." Vincent said, "He never believed me. He always assumed I purposefully did things that were accidents." When Vincent did tell a lie to his father, he remembered "*waiting in terror to be punished.*" While Vincent's father rarely physically hit him (only twice), he would often "rough [him] up" in their play. Vincent described this "roughing up" as somewhat "violent." In spite of his terror of his father, Vincent "idolized" him until the age of six, describing him as his "hero." As previously mentioned, this idealization rapidly changed to hatred and disdain for his father for reasons which never became clear in our work together.⁸⁰

A few months into therapy, Vincent speculated, "I wonder if my father left us because of my close relationship with my mother," and further stated, "My father is the person who spoiled the relationship between me and my mother. He was the one to be feared in the household."⁸¹ Vincent's disgust at what he termed his father's "piggish" attitude toward women began at a young age (in no small part because of the discourse of his mother, as will be shown). Vincent's father talked about women in a "degrading manner," and looked at magazines such as *Playboy*, disparagingly talking about women's "titties" in a way that made Vincent feel "ashamed." While Vincent admitted he was "enthralled" by those "tabooed" magazines, he "always pretended to not be interested" because he did not want to hear his father talk about women in such a "gross" manner

⁸⁰ My guess is that, around this time, Vincent became aware of his father's extramarital affairs. Perhaps he overheard his parents arguing about his father's infidelity. This hypothesis is given credence by a memory Vincent had around age five of feeling "vindictive and angry" and *cutting off* the head of one of his stuffed bears. As will be shown, this is also around the time Vincent experienced his first compulsion. I would also hypothesize that Vincent felt responsible for his father's philandering because of his "close relationship with [his] mother."

⁸¹ As will be shown, Vincent also feared his mother.

(and, of course, because he did not want to identify with his father). When combined with his father's frequent infidelity, these "piggish" behaviors left Vincent with a repugnance for the "manly man" he believed his father personified.

In 6th grade, Vincent's father asked him if he was "getting laid yet," and this evoked both terror and loathing in him. He saw his father as "objectifying" women, only further perpetuating his distaste for his "dumb" father. Vincent's father had moved out of the family home at this point, leaving Vincent with his mother. Throughout high school, his father frequently made sarcastic comments to Vincent about how "feminine" he was, once saying, "If you're gonna be gay, please don't act like a girl!" Vincent felt he was a constant disappointment to his father because he never embodied the "masculine" traits he believed were so important to his father. Consequently, Vincent very much situated himself on his mother's side, in an "us" against "him" scenario. Vincent said that, as he grew older, he enjoyed "*putting [his] father in his place*" when he made "ignorant" comments. This "putting [his] father in his place" took the form of one-upping his "dumb" father in all areas intellectual, resulting in Vincent's father's statement: "Someday you will get your ass *beat* for being smarter than everyone else. People with muscles are better because they can *beat* smart people in the face." Vincent said, "Dad was always stronger. He always won, except intellectually."

Mom

Vincent's mother was a nurse who never remarried or dated much after her divorce. Vincent described his mother as being "sad and depressed" when he was a child and of feeling an immense responsibility and corresponding need to "take care of her." While on the one hand, Vincent called his mother his "safe space," on the other, he said

she was often “uncomfortable” when she thought “[he] needed her too much.” Vincent stated that his childhood desire was to have his mother pay attention to him and validate his needs but felt as though his emotions were mostly “belittled” and that his mother “desired to not *feel* more than she desired me.” Vincent longed to be his mother’s “most favorite thing”; consequently, he tried to stifle much of his emotion and need because it would “overwhelm” her and “break [her] heart if [he] was angry.” Vincent noted,

My mom moved too quickly. I couldn’t reason through it. She would tell me that I was wrong [as a child]. In the face of that, how could I know when I was right? I felt like she could read my mind and knew all of my thoughts. Like I couldn’t hide anything from her—no secrets. When Dad *left me*, it was like a vacuum. Mom fell apart. She felt dangerous. I needed to hold her together so that she could take care of me. I was so terrified when she was angry and falling apart.

Vincent felt he couldn’t “depend” on his mother, yet he often described her as “overprotective” and felt she rarely gave him the space to be whom he wanted. Vincent stated, “It was very important to her that I follow my own path, so long as it was in conformity with others.” This mixed message from his mother exemplified much of Vincent’s discourse with regard to his mother. On the one hand, she felt all-powerful and all-knowing, yet, on the other, she was the depressed victim of his “repulsive” father’s sexual escapades whom Vincent had to rescue.

Vincent was exposed to an almost daily onslaught of anti-male rhetoric, from both his mother and his aunt, who played a large role in his life after his parents’ divorce. Vincent recalled the two women denigrating men, calling them “disgusting pigs” who sought nothing but the objectification of women. Vincent remembered his mom being “super offended” when men would whistle at women, yelling, “WOMEN DON’T WANT THEIR BODIES LOOKED AT!” Unlike women (who were soft and reasonable),

men were barbaric users of women who could not control their lustful feelings, seeking to unashamedly *take* what they wanted from women.

In high school, Vincent's mother would "make fun of [Vincent] for liking girls," leading to feelings of anxiety around dating for him. At age 14, she told him he was "too young to be in love" and disparaged his budding relationships with girls at school. Vincent noted that his mother seemed "uncomfortable" with her own sexuality—never going on dates or having men over to the house. Consequently, it was usually just the two of them. Vincent's mother frequently shared that she would "kill [her]self" if anything ever happened to him, and she also worried that Vincent might take his own life. Consequently, Vincent "always worried about mom killing herself" in high school because she was "so depressed." Vincent's maternal grandmother had attempted suicide when his mother was a teenager, further intensifying the already anxious household. Vincent said, "Mom was always depressed and would lie and say she wasn't. So, I'm left thinking it's all me. I invested so much energy in just trying to be loved."

And Then There Were Three

Vincent was conceived on his parents' first date—an event he described as "irresponsible" on his parents' part. The spontaneity and *enjoyment* of his parents' first date was obviously distasteful to Vincent, and he felt they never "truly wanted [him]." This feeling was amplified when he learned his aunt had recommended his mother have an abortion and that his mother had *hoped for a little girl*. Vincent felt that if he had been born a girl, his parents would not have gotten divorced because then "[he] would have been lovable." He felt his father would not have been so "disappointed" in him when he did not "live up to his expectations." At the same time, Vincent said it would have been

“the worst thing to be born a girl because then [his] mother would have been even more overprotective.” Above all, Vincent viewed his parents as having never taken “responsibility” for their actions—something he felt they expected of him despite not being responsible themselves. He said he “never felt *powerful* as a kid,” and felt he had “ruined” his mother’s life by being born. Furthermore, he felt his father’s “*lust for power*” hurt others, particularly his mother, whom he felt never really had a “grip” on his father.

Personal History

To be ordinary is to be unlovable. I wasn’t loved because I was ordinary.
Vincent, 2012

One of Vincent’s earliest memories was of something that occurred at age three: He was sitting on his mother’s bed watching her put her bra on. When recounting the memory, Vincent laughed hysterically and shared that what he remembered most was his father calling the bra an “over-the-shoulder-boulder-holder.” Vincent said, “Looking back it felt as though I was seeing something forbidden.” He further noted that he felt as though his father “never really kept [him] from [his] mother,” stating, “Nakedness was normal in our household.” Another of Vincent’s memories from this time period was of his father screaming, “I’M GONNA KILL YOU!” when Vincent refused to stop teasing their dog, and Vincent feeling convinced his father meant it because “[his] parents always did what they said.”

Vincent remembered playing a “game” around the age of six in which he put coins into a piggy bank. The stakes were high: If he missed getting the coin in the slot, he had the thought that the devil would come and steal his soul. The family was not

particularly religious, with the exception of his grandmother (who told him about the devil), so this was not tied to any parental belief system. As previously noted, this was also the time period when Vincent recalled cutting off his stuffed bear's head.

Interestingly, Vincent recalled little else about his grade school years⁸² with the exception of “always wanting to be part of the girls’ group”—specifically, wanting to play *Pretty, Pretty, Princess*—a children’s dress-up board game. Vincent said he felt more comfortable with girls than with boys and liked girls’ clothing, particularly women’s shoes—a fondness that prompted his mother to say, “Oh, please don’t be a cross-dresser!”

Around the time of his parents’ divorce, Vincent began experimenting with masturbation and recalled his mother (who did not yet know he was masturbating) telling him ways to go about “getting around an erection without masturbating.”⁸³ For Vincent, this was another sign of his mother’s omniscience and he was “horrified.” Vincent recalled going to a restaurant with his mother that was owned by one of her “piggish” male friends and asking if he could go explore the restaurant. When his mother expressed reservations, her friend said, “Oh, come on! Let him *go explore*.” As he was walking away, Vincent heard his mother say, “No... You don’t think he’s... already?” It was clear to Vincent at that time that they were talking about masturbation. Vincent stated: “I was so embarrassed. I vowed right then to quit masturbating, so that when my mom asked me if I did, I could honestly say no. I thought it was wrong.” When Vincent was unable to master his masturbation, he felt “gross” and “disgusting”—two words Vincent frequently used to describe anything sexual.

⁸² This “forgetting” is typical of hysteria. Fink (1997) notes, “The forgetting of the thought, accompanied by persistence of the affect, is especially common in hysteria” (p. 113).

⁸³ What these “ways of getting around an erection” were never became clear in therapy.

During high school, Vincent was the “nice kid” and well-liked, though he credited this more to his constant adjustment of himself to others’ needs than to anything inherently likable about himself. In high school, people assumed Vincent did not masturbate because “nice guys don’t masturbate”—a statement Vincent said his few male friends often made to him. He felt a certain satisfaction in knowing they were wrong, though his chronic feelings of guilt and disgust over his masturbation remained unabated. During his junior and senior years of high school, Vincent “dated” a string of girls, none of whom he saw for more than a month. There was little physical contact with any of these girls—at most, a kiss—and Vincent seemed more interested in the fantasy of the girls than the reality. Furthermore, he often felt “ashamed” for being romantically interested in girls. Vincent said he always befriended women because he felt more comfortable with them and because “most guys [were] macho assholes.”

Throughout high school and into college, Vincent found himself intrigued by the occult. He was fascinated by death, the devil, the number 666, and black magic. He said his “fascination” with death dated back to his earliest years. The occult was associated with something dark and forbidden and meshed with many of Vincent’s “superstitions” (such as his fear of the devil coming to steal his soul). Vincent liked the rituals involved in black magic and the protective spells it offered; however, Vincent was also “terrified” of the *power* of black magic. This attraction to something that Vincent found terrifying was one that played a prominent role in his life.

In college, Vincent continued his pattern of largely surrounding himself with females, though he did have three good male friends. He pursued two quite divergent paths—philosophy and theater—and, as mentioned, excelled at both. He enjoyed

philosophizing and “*beating* others at arguments.” His intellectual prowess⁸⁴ was something Vincent was quite proud of (and identified with most), and he was disdainful of anyone he deemed “ignorant” or “irrational.” Most people fit into this category for Vincent, leaving him to often feel “lonely.” The theater stage was the place where Vincent felt most comfortable, and he was often praised for his performances, which he greatly enjoyed. He took pleasure in playing roles and in the admiration he garnered from others. He kept himself endlessly busy, rushing from one thing to the next, and this included an ever-revolving door of females. Vincent found himself infatuated with a certain woman for a period of time and then, quite suddenly, would lose all interest in her. He felt “ashamed” for “obsessing” about the woman and wondered why he ceased liking her when she “became real.” Erotic activity with any of these women was conspicuously absent, something that bothered Vincent greatly. Rather than feeling sexually turned on, Vincent preferred to simply “cuddle” with women who were “warm, nice, and *dominant*.” Vincent continued to view sex as “gross,” and “repulsive,” and wondered why he did not feel more sexual toward others. It was around this time that Vincent sought therapy.

Course of Therapy

Neurotics dream about what perverts do. This is fantasy.
(Fink, 2010, personal communication)

I don't think I'm gay. It made who I am make sense to those around me.
Vincent, March 2011

Vincent entered therapy shortly after a brief encounter with a young woman that left him feeling “abandoned” when she began ignoring him. He was growing frustrated

⁸⁴ We could say that intellect represented the symbolic phallus for Vincent.

with the revolving door of women in his life and the vacillation between his rapid idealization and devaluation of them. He called himself a “miserly old man” and wondered why he did not feel more sexual toward others. He cried when saying, “Most people I find so disgusting and irritating that I don’t want to connect with them sexually.” Vincent was experiencing a crisis in *jouissance*—a disturbance in the way he typically obtained satisfaction—thus, he sought therapy with the hope of reclaiming his usual way of enjoying.

Unlike Keenan, Vincent immediately situated me as the subject-supposed-to-know. He assumed I had a certain knowledge about him that he needed if he was to “get better,” and he wanted me to provide this knowledge to him; indeed, he demanded that I do so. This immediate positioning of the therapist as all-knowing and masterful is characteristic of hysterical structure. Soler (1996) notes that the hysteric presents himself⁸⁵ as a question to the analyst and demands the analyst provide the answer to his being. This is because the hysteric overcomes separation by situating lack in the Other and then attempts to become the object that can fill that lack. We can say that the question the hysteric has never asked himself is, “What do I want to be?” instead, always asking, “What do you want me to be?” The hysteric is quite concerned with the Other’s desire—he wonders what others want and attempts to become *that*. Stated otherwise, he attempts to position himself as object *a*—as the cause of the Other’s desire. He desires the Other’s desire and, as we will see, desires *as the Other*. To place his being in the Other’s lack necessitates that there actually be a lack to fill, so the hysteric—in order to ensure his being—also seeks to bring out lack in the Other. No lack in the Other means no being

⁸⁵ In her actual writing, Soler refers to the hysteric as a “she” for reasons I have already detailed. For our purposes, I will use the masculine.

for the hysteric. Thus, the hysteric challenges the Other—seeking out knowledge (to tell him who he is)—while constantly poking holes in the knowledge of the person he situates as Master (in this case, me) so as to always maintain a certain lack in which he can situate himself as unique. Hysterics then are typically concerned with their relationships, particularly romantic relationships, and spend the majority of their therapeutic time discussing these relationships (Fink, 1997).

This was certainly the case with Vincent. Over the course of the three years we worked together, I found it difficult to keep track of the multitude of women who played roles in Vincent's life. Vincent idealized women—he thought they had access to something he did not because he possessed a penis. Indeed, within the first month of therapy, Vincent's ambivalence over his sexual identity took center stage. He wondered if he might be gay and felt ashamed admitting this to me. Moreover, he was "terrified" that, if he did discover he was gay, he would be *beaten up* by those "manly men" he so dreaded. He rationalized his fear by talking at length about our homophobic society; however, Vincent's terror went beyond the rational and was, indeed, quite paranoid. Vincent had yet to mention any type of sexual attraction to a man, and given his addition of a new woman almost every week, I wondered why he thought he might be gay. He said that because he was so feminine, *others* were constantly telling him he was gay and he wondered if they might be right. Yet, Vincent seemed to have no erotic feelings for men or women. When I attempted to discuss sex with Vincent, he became quite uncomfortable and said, "Sex and kissing are taken up too glibly in modern day society. Language uses too broad of strokes [*sic*] and cannot capture the beautiful moment of a

kiss.” Vincent felt that social manners and graces were a thing of the past and he became easily angered by how “lewdly” people talked about sex.

Vincent’s pattern during this time was to meet a new woman, put her up on a pedestal for something he deemed other’s found desirable (e.g., she was the best singer in the school’s choir), spend a day or two with her, and then find some reason why she was unworthy. He would come to session and talk feverishly about each new woman, only to arrive at the next session depressed and anxious because he was “always going to be alone.” Vincent was attracted to women whom he perceived had *power* over him and was *repulsed* when he realized that many of the women he found attractive resembled his mother. He decided he was “gay” about seven months into therapy, despite his lack of sexual contact or interest in any men. He “agonized” over telling others about his new sexual identity, in spite of the fact that they “likely already knew.” Each coming out was a performance of sorts for Vincent, after which he felt better for a short period of time. Coming out to his father was accompanied by both acknowledged enjoyment and terror (unacknowledged enjoyment); however, after talking with his father, he decided maybe he “wasn’t fully gay” anymore.

Vincent was chronically dissatisfied, constantly in limbo, and unable to make decisions. He felt “false”⁸⁶ and worried he would never be anything more than a “being for others.” He simultaneously worried that he was “different” and did not fit in with others and that he was “ordinary” and “just like everyone else.” In his words, “I can’t decide whether I am worried about being significant or insignificant.”⁸⁷ He “hated”

⁸⁶ This is a common complaint of neurotics—particularly hysterics—and points toward the very alienation that is constitutive of the subject. See Verhaeghe (2009).

⁸⁷ In the imaginary register, “the subject cannot act because it is plagued by the idea that it may be black [different]. In other words, it fears that there is a part of itself that does not coincide completely with the

himself for being gay (despite his lack of sexual feelings for men), engaged in self-punitive behaviors (such as picking his fingernails until they bled), and complained incessantly about the “shitty state of the world.” He blamed others for almost everything, but particularly for “not understanding” him. He was sullen, dramatic, and enjoyed making me enemy number one. Everything I said was “stupid” and “sounded silly.” (Didn’t I know Freud had long since been discredited?) He found me particularly distasteful when I refused to tell him what to do and who to be—which was during every session. He cried, cajoled, quit therapy, and pointed out how “unfair” it was that I knew things about him but that he nothing of me. In short, Vincent was uncomfortable not knowing what I desired him to be. How was he supposed to situate himself with regard to me as an Other without knowing what I wanted him to be—without knowing what I lacked? In this sense, I kept my desire enigmatic—never allowing Vincent to ascertain what I desired—because to do so would have left him trapped in his world of “being for others” rather than forcing him to really make himself a question. I wanted him to ask *what he wanted*, not what I wanted. In other words, rather than being stuck in the demand (the imaginary), I wanted Vincent to begin questioning his desire—a shift that would indicate his move toward the symbolic.

Demand is always a demand for love and recognition from the Other and marks a place of fixation, whereas desire indicates a dialectical movement that shakes up the patient’s psychic economy freeing him from the inherent fixation of the imaginary. In *Seminar I*, Lacan (1975/1988) tells us that, “This meaning [of his being] must not be

other. One of the predominant features of the neurotic subject is this division between its demand to be like all the others and its fear that it is different” (Samuels, 1993, p. 20).

revealed to him, it must be *assumed* by him” (p. 29, italics added). And as Soler (1996) indicates,

In the case of the hysteric, a change must also be obtained from the initial position. [...] The position of the hysteric in relation to the subject-supposed-to-know is: “Please tell me something about myself. Please give me an interpretation.” The subject, divided by [his] symptom, addresses someone else, a supposed master, a master from whom the subject can demand knowledge. “What do I have? What am I?” The hysteric has a demanding position and you have to obtain a change. You have to make the subject perceive that *[he] is the one who has to produce the answer.* (p. 276, italics added)

Vincent sought recognition and approval from me. My refusal to give in to his demands produced frustration in Vincent and allowed to come forward “the signifiers with which [his] frustration [was] bound to reappear” (Lacan, 1975/1988, p. 244).

This frustration with me (or “negative transference” in common parlance) increased the more I steered Vincent away from his complaints about “the shitty state of the world” and toward a discussion of his sexual fantasies. In *Seminar I*, Lacan (1975/1988) remarks,

Freud would say that one encounters greater and greater resistance the closer the subject comes to a discourse which would be the ultimate one, the right one, but one which he absolutely refuses. (p. 22)

It was far easier for Vincent to volley criticisms at me and tax me for endlessly failing him in therapy than to reveal his sexual fantasies.⁸⁸ I knew Vincent had an active fantasy life. He said, “Fantasy is always, well, most of the time, more satisfying than real life. It’s shiny, not gray. Like sprites and fairies.” Vincent described his fantasies as “pure” and told me he “didn’t want [me] to touch them.” Vincent’s revulsion at even saying the

⁸⁸ Unlike some therapies that see transference as the ultimate aim of therapy and as something to be elicited, Lacan identifies how transference can, at times, be an avoidance of therapeutic work: “It is within the movement in which the subject acknowledges himself that a phenomenon which is resistance appears. When this resistance becomes too great, the transference emerges” (Lacan, 1975/1988, p. 41). See also Lacan’s *Seminar VIII*. This was certainly the case much of the time with Vincent.

words “sex” and “masturbation” pointed toward a fantasy life that clearly did not fit with Vincent’s ego-ideal. This was supported by Vincent’s confession that he didn’t want his fantasies “to *be* [him].”

About 16 months into therapy, an encounter with a woman occurred that began to lessen this reticence to discuss his fantasy life. Vincent was at a party and found himself attracted to a woman whom he knew had a boyfriend. This was not a desire to “cuddle”—this was wholly new to Vincent. He found himself wanting to “steal” her from her boyfriend and said he felt “masculine” for the first time. In his words,

I felt powerful. I had this primal desire, like a hunt. I wanted to take her. I [felt] like I could do something. I had the thought, *she’d be better off with me.*

Vincent described the pain of the situation (not being able to have her) as “like having someone bite [his] lips”—a pleasure in pain. Vincent said, “I could approach her because she would have to reject me. There’s excitement in disaster and pain.” In other words, there was satisfaction in *remaining unsatisfied*. To maintain an unsatisfied desire allowed Vincent to keep desiring—a hallmark of hysterical structure. Vincent’s enjoyment—his *jouissance*—came from sustaining dissatisfaction through deprivation. Thus, his statements, “I always feel so dissatisfied” and “I desire desires” began to take on different meanings, opening up previously unexplored avenues.

This encounter shifted something for Vincent. He identified his feelings of masculinity and *power* with his father’s degradation of women; however, rather than exclusively rejecting such feelings, he instead began exploring this “masculinity.” He wondered about the origin of his idea of masculinity and whether there were other ways to be masculine. New signifiers began to pepper Vincent’s language. He spoke of “carnal

desire,” “lust,” “Machiavellian *power*,” and “aggression.” He would frequently refer to himself as “we” rather than “I,” stating, “We are wicked and enjoying it.” He also shared his first masturbation fantasy which entailed him and other men (that was all he would initially say). He was quick to add that, “There was no S&M shit” as that stuff “freak[ed] the shit out of [him].”

It was at this time that Vincent, with great shame and anxiety, revealed his obsessive symptoms to me. He described his symptoms as “that crazy place [he] could go,” and worried what I would think of him if he shared them. Vincent described his overwhelming fear that the FBI were going to show up at his apartment because he had been looking at a pornography website for the past few years, but had only recently read the fine print on the screen that said it was a *crime* to do so from his particular area code. He spontaneously showed up at the clinic where I worked in the middle of a panic attack, his feeling of terror was so great. He carried around beads as a way of “protecting” himself and would often sprinkle salt around his room as a protective barrier—a way of keeping *evil out*. On another occasion, Vincent snuck a bottle of whiskey into a university function and “accidentally” left it in a bag that also contained materials for the function. Rather than go retrieve the illicit bottle of whiskey, he instead suffered another panic attack and spent the rest of the evening worrying about what would happen to him if he was caught. Similarly, he smoked marijuana about a month before taking a drug test and became convinced he would be caught, resulting in a compulsive need to knock on wood. The most predominant of Vincent’s obsessions during our work together was his fear that he was a pedophile. He was “terrified of getting near children” because he worried what he might do. This particular obsession bothered Vincent the most and was the most

difficult for him to admit. Finally, Vincent recalled that, as a child, he would set up propositions around masturbation, such as “If x happens, then I can masturbate.”⁸⁹

A loosening of Vincent’s rigid ego identifications⁹⁰ and an increased capacity to talk about sex resulted in Vincent’s admission of his love for cross-dressing—something he only did in private at the time. He loved the feel of women’s clothing, particularly women’s hosiery, and said he felt “most comfortable” when dressed as a woman. Vincent longed to dress as a woman publicly and felt he had been born the wrong sex. His fear of being “beaten” by “manly men” kept him from satisfying his desire, which provided him ample reason to feel dissatisfied. When an opportunity arose that made it socially acceptable to cross-dress publicly, Vincent described how much he enjoyed the compliments he received for his “costume,” and how “comfortable [he] felt in his own body.” He longed to make it a more regular occurrence; however, he feared someone “grabbing [his] junk” if he wore a skirt around others. When I said, “Or maybe you’d like it...” he responded, “I’m scared of that feeling.”

Vincent gradually grew more comfortable wearing women’s clothing in public; however, he always did it in the context of a “joke” or in a performative manner that canceled out how serious he actually felt about it. He discussed the possibility of undergoing a sex change operation because of his belief that he was meant to be a woman. Vincent said women were “sacred” and were the ones who “got to be taken care of.” Furthermore, he said, “*Girls can manipulate themselves into being lovable. They can manipulate love out of people by being feminine. By being pretty. They can dress themselves up.*” Vincent felt women had the luxury of “expressing themselves with their

⁸⁹ This is only a handful of Vincent’s many obsessions; however, it provides a representative sample.

⁹⁰ Vincent said: “There’s a shell I have to keep up for this world. It breaks down when I come in here. I need it. I have many fronts.”

bodies” in a way that men did not, and consequently, that they had a special *power* or freedom available to them. Vincent said there was a feeling of “correctness” for him about being a woman, though he also expressed how much he “like[d] [his] penis.”

During this time, Vincent began visiting gay nightclubs; however, he found flagrantly gay men distasteful. He didn’t understand why they needed to *flaunt* themselves that way. He began to actively desire oral sex from women—a desire he found “disgusting.” His admission that he longed to have intercourse with a woman one day led to further feelings of repulsion and guilt. In a particularly poignant session, Vincent discussed how troubled he was by his desire for girls and how he “replace[d] people in fantasy.” Vincent preferred his fantasy life to any actual engagement with real people in his daily life. He said, “What if I’m like my father? OH MY GOD! I AM MY FATHER!” Even *wanting* a woman was linked in Vincent’s mind to his “ignorant, macho, objectifying” father.

Two years into therapy, Vincent was finally able to begin putting words to his sexual fantasies, as well as his masturbatory activities. Vincent’s fantasies revolved around torture and punishment in which he almost exclusively played the submissive role. They involved being tied up by women and “beautiful women forcing [him] to do things [he] really wanted to do anyway.” In some, men were giving him “blow jobs”—something Vincent found quite erotic. In another fantasy, he was having sex with the devil and the devil was male. As he grew more comfortable talking about his fantasies, they grew more graphic. He fantasized about being raped, bound, and “*dominated* by a man,” and confessed that his favorite way of masturbating was to dress in women’s clothing and “cum on [his] own face.” He detailed fantasies of being cooked alive,

thrown on spikes, and stabbed. He grew simultaneously frightened and fascinated with movies where people were being tortured, mutilated, and dismembered, stating they made him feel “terrified of being helpless where [he couldn’t] fight back.” Vincent would visibly tremble when discussing such “horror” films; however, he said there was a “safety in pain.” In all of Vincent’s fantasies, he was being humiliated in some way, and he almost exclusively occupied the role of the woman. In his words, “My fantasies are about me being *utter object*. The feeling of shame is arousing. The pain is intoxicating. Being degraded is intoxicating.” Vincent further shared that he felt “all of [his] fantasies [were] about wanting to be taken care of,” and that he felt everyone always expected him to be the “dominant” one in real life.

As we worked through these fantasies, Vincent often longed to run out of the session room or hide from me. He wondered whether I thought about him outside of therapy and whether he was “special” to me. He asked whether I thought he could be “blamed” for this Other that existed within him, and how he could “possibly be responsible for it, as it didn’t seem to be a choice.” When I asked what “it” was, he said the “grotesque, dark” part of himself of which I now knew. He felt “constant horror” over someone having *power* over him and said “[he] did all kinds of things to keep [himself] safe from death.”⁹¹ This statement led us back to his fear at age six that the devil was going to steal his soul. When I asked what came to mind around the devil, he said, “alluring, aloofness, suave, control, clean lines, no worry, security, mischief, and *con artist*.”

⁹¹ Sexuality, jouissance, power, and death are intimately related; however, such an exploration would take us away from the main point of this dissertation. I will confine my comments to saying that Vincent’s life-long fascination with death and his abject fear/wish to be “dominated” point to this connection. For a more thorough exploration, see Verhaege (1999, 2009).

As we entered the last six months of therapy, Vincent's demand of me lessened in some regards. He had moved to lying on the couch—a move that only occurred with great anxiety for Vincent, as he feared “not being able to see [my] face.” The move allowed Vincent the freedom to just *wonder* without the need to scan my face for approval. Consequently, he began questioning more and demanding a little less. He continued to long to be a woman, while also saying he felt he would “lose meaning” if a girl he was romantically interested in did not like him. The ambiguity around his sexual identity greatly distressed him, and he sought to find a label for himself that “fit.” He also wondered why he “couldn't allow [him]self to have fun.” He described “feeling bad for being happy, like [he was] supposed to always be sad,” and said he feared that if he “let [him]self out, it would be *too much*.” He would have “too many needs.”

In our last four months of therapy, Vincent met a woman and, at long last, had sex with her. He described it as “less impressive than [he] thought” and said, “Mom wouldn't be okay with me having sex. Dad would be happy I was getting one over on her [mom].” He complained that his new girlfriend did not dress properly and didn't seem to care what others thought about her appearance. He described her as “blobbish, frumpy, soft, repulsive, and disgusting,” though he said he enjoyed that, “She look[ed] like a woman.” He liked that she was curvy and not too thin. He vacillated between his “pure love” for her and his denigration of her. He began exploring a more sadistic side of himself with this new woman, enjoying handcuffing her to the bed and playing a more *dominant* role. He dreamed of raping her with a knife—a dream he found pleasurable.

In therapy, Vincent's paranoia and obsessive symptoms lessened. He said he could not remember the last time he had worried he was a pedophile and pondered that

this symptom had “just disappeared.” Rather than disowning the “Other within,” he now said he felt his fears and compulsions were just “distorted desires” and that they were “all [him].” He punctuated this himself, saying, “Maybe I wanted the devil to come take me as a child.” Finally, Vincent said, “I’m trying to leave behind performance and embrace passion. I want to be rid of demands because when you’re too busy saying, ‘give me this,’ you can’t see all the different parts available.” His demand was ever-so-slowly giving way to desire; however, “the idea of having a desire that [couldn’t] be completed” terrified him.⁹²

The final two months were a combination of great insight and regression for Vincent. With our impending termination came a return of his hyperfocus on me at the expense of his therapy. He demanded to know (again) why he could not know more about me personally, saying, “I find it hard to know what your perspective is on things. You don’t make me feel comfortable and you seem to make no attempt to do so.” His desire to be the object of my desire was patent: He hoped we could be friends after termination and assumed this would be the case. He longed to be the center of my world and frequently left sessions telling me how “dissatisfied” he was: “I FEEL DISSATISFIED! UNSATISFIED! THERE IS NO SATISFACTION!”⁹³

Transformative moments came when Vincent acknowledged that dressing as a woman felt like “real enjoyment” and really began questioning why he did not allow himself to enjoy. He was just beginning to explore how he “avoided pain by creating

⁹² Fink (1997) notes, “Demand is, of its very nature, repetitive. The patient’s insistent, repetitive demand for an instantaneous cure gives way to something that moves, that is intrigued with each new manifestation of the unconscious, that attaches itself to each new slip and explores it; in a word, the patient’s demand gives way to desire” (p. 26).

⁹³ Miller (2011) writes, “In articulating the loss, in symbolizing the lost phallus, we are symbolizing the fact that part of us is alienated, not desired. It is our instinct perhaps to remedy this situation by regaining the desire of the m/Other” (p. 101). This was clearly the case with Vincent and the return of his transference to me toward the end of therapy.

pain”—in a word, how he orchestrated his own *jouissance*, particularly in his fantasy life. He was also growing bored with his fantasies, saying, “I don’t want to move toward fantasy. I think I’ve had my fill.” Vincent felt he was less controlled by others’ opinions and was growing more comfortable with disappointing people when he “didn’t perform.” He was also becoming genuinely curious about the symbolic Other (rather than the imaginary other) and wondered how communication was possible given the polyvalence of language. He also wondered whether his goals were his own or someone else’s. In one of our final sessions, Vincent said, “I am distinct from some. I am not all humans. We are not all unified. There’s great value in not being understood.” He was beginning to recognize difference and slowly needing the reflection of the Other less.

These are the things Vincent was pondering when our work together ended. I transferred him to a different therapist who was also of a Lacanian persuasion. Though he had made great strides in therapy, he continued to struggle with the question of whether he was a man or a woman, and he continued to blame others for much of his suffering. I saw Vincent once more when I obtained his signature for IRB purposes. It was only for 15 minutes, but I found what he said to be noteworthy:

I realized [after our last session] if I could live through the end of something so big, I could live through anything. It made me more comfortable with my own death.

Case Formulation

For the male hysteric, woman constitutes the object par excellence that allows him to get his bearings with regard to possession of the phallus.
(Dor, 1999, p. 63)

Vincent clearly desired to be the cause of desire—object *a*—for those around him. To be the unique, special object that could both evoke and fill the Other’s lack guaranteed

his being, and his symptoms functioned in a variety of ways to ensure this. Vincent was a chameleon of sorts—becoming what others wanted him to be—performing and changing at the drop of the Other’s hat. His feeling of always being “an actor” illustrated not only that he longed to be object *a*, but also that he came to desire what the Other desired—in other words, that he desired *as the Other*. At times, Vincent desired as his father and, at others, as his mother. Furthermore, he maintained his desire as unsatisfied as a defense against jouissance—both his own and the Other’s.

Freud posited that the hysterical subject feels an aversion—a *repulsion*—toward early sexual experiences that results from a fear (whether real or fantasized) of having been the intended sexual object of an early seduction. The hysteric therefore accuses the Other and attempts to resist or reject jouissance. Soler (1996) writes,

There is an aversion to pleasure in hysteria [...] Aversion does not mean that the hysteric cuts off every relationship involving jouissance. There is a defense against jouissance in hysteria, but there is also a failure. [...] This failure gives rise to symptoms. Logically, therefore, jouissance is present in the symptoms. *The hysterical subject defends against this jouissance.* (p. 253, italics added)

Vincent was clearly “disgusted” by his “needs” which he thought were always “too much.” He escaped into intellectualization to avoid this encounter with his jouissance, and instead maintained his desire and jouissance via his active fantasy life. Consequently, Vincent’s own enjoyment was hardly in the picture. His question toward the end of therapy of why he felt so averse to pleasure was a pertinent one.

Similarly, Vincent’s obsessional symptoms served the purpose of placing limits on his jouissance and his sexuality (which are, of course, intimately connected) by attempting to invoke the law. Fink (1997), following Freud, notes that hysteria is characterized by a propping up of the weak father—as a propping up of the law. Recall

that the No! of the symbolic father is what places limits on the child's jouissance, and while this occurs in hysteria, it is not firmly pronounced. Symptoms arise then to further limit what is experienced as overwhelming need. Short of a father that attended to him and firmly separated him from his mother, Vincent developed obsessional symptoms. Schneiderman (1986) notes that, "Obsessions signify the effort to bring his desire [...] under his control" (p. 40). Examining Vincent's symptoms closely, we see that they all entail a restriction of jouissance by invocation of the law. Vincent's fear of the FBI after looking at pornography, his panic attack after sneaking whiskey into a school function, his need to knock on wood after smoking marijuana, and his fear of being a pedophile all revolved around his fear of being caught, or rather, his *wish* to be caught. They also all involved some form of sexuality or pleasure. Likewise, his proposition that "If *x* happens, then I can masturbate..." was a way of setting limits around when it was okay to experience pleasure. If there were limits, then perhaps he could enjoy. To "protect" himself, he carried around beads, and he sprinkled salt around his room to "keep *evil* out." The "evil" here from which he needed to be "protected" was his own jouissance—his own drives.⁹⁴ His symptoms functioned as a defense against jouissance. In this vein, Vincent talked about feeling as though he had committed a *crime*—one for which he obviously felt the need to be punished.

The crimes for which Vincent felt responsible were (at least) three-fold: his sexual being, his male sex, and his belief that he had "ruined" his mother's life by being born. Vincent never felt loved enough by his mother and longed to be the object she desired; however, Vincent was male. The combination of his "disgusting, ignorant" playboy

⁹⁴ Lacan speaks at length about jouissance as a real bodily substance with materiality. It is something experienced in the real of the body. See Soler (1996) and Verhaege (2009).

father and his mother and aunt's pervasive anti-male discourse combined to create an environment in which having a penis was equated with ignorance, *dominance*, and *unrestrained lust*. Men were nothing more than objectifying "pigs" who ogled women's bodies and *degraded* them. For Vincent, to be masculine thus meant identifying with his father as a "macho, manly man" who philandered and denigrated women. Vincent found his father to be both someone who seemed to be unable to limit his mother's interference in his life, as well as a *terrifying* figure that his mother "couldn't get a grip on." Thus, any identification with his father was consciously shameful for Vincent and represented a betrayal of his mother; indeed, to be masculine created extraordinary conflict for Vincent.

Vincent's belief that his mother was omniscient—and therefore "knew" when he masturbated—reflected an incomplete separation from her that prohibited recognition of Otherness and sexual difference. Schneiderman (1986) writes, "Otherness is introduced at the moment the child realizes that his parents do not know all his thoughts. The Other is introduced as having a defect, a blind spot, where something escapes his knowledge" (p. 26). Vincent did not perceive this defect in his mother; in fact, he did not perceive it in women generally. He idealized them and believed they had something "special." Women were placed on a pedestal as the ones who were "lovable" and "pure" and who *did not want their bodies looked at*. The idea that there was something wrong with his masculinity and sexuality was further reinforced by his mother's admonitions of his early masturbation and her belittling of Vincent when he began expressing romantic interest in girls in high school.

Vincent was caught in a trap: To identify with his father was to betray his mother and to be seen as a sexual brute; however, to identify with his mother was to give up

sexuality. Given his father's early departure from the family for another woman and Vincent's subsequent rejection of him at an early age, he sought to become the ideal object for his mother—someone she could see as “lovable.” Recall Vincent's statement that if he had “just been born a girl” he could have been loved. Given this context—this symbolic matrix—Vincent identified as a woman and rejected his sexuality, feeling *repulsed* by it. However, it was impossible for Vincent to completely identify as a woman—he had a penis, one he *liked*—and this created great ambivalence for Vincent. Thus, his question: Am I a man or a woman?

Vincent identified women as having the phallus—as being the signifier of the Other's desire (Lacan 1958/2002, p. 279). Vincent's identification with and idealization of women can be viewed as his attempt to enhance his own prestige via a woman: Because Vincent did not experience himself as having the phallus (recall his statement that he never had any *power* as a child), he aligned himself with those he perceived did. Dor (1999) notes that hysterics are “militantly engaged in having the phallus” (p. 74) because they perceive they have been unjustly deprived of it. Vincent was adrift in a sea of ambivalence over just who had the phallus in his family: On the one hand, he felt his philandering father had deprived his mother of it (Mom couldn't get a grip on Dad—he had the *power*); while on the other, he identified woman as possessing the phallus insofar as she was the object of man's desire and was the one who “got to be taken care of.” Furthermore, his mother and aunt's discourse portrayed women as special and “above” men. Dor writes, “It is easy to see how, on this level of the oedipal dialectic, every ambiguity, every ambivalence on the part of the mother and father concerning exactly where the phallic attribution is to be situated can be conducive to the organization of the

hysterical process” (pp. 73-74). Vincent wasn’t quite sure who had the phallus; he only knew that he did not.

Consequently, he sought it out in any number of women he idealized as perfect and desirable. Though Vincent felt deprived of the phallus, he believed it was still available to him through a woman—that “brightly shining object in the *gaze* of others” (p. 64). Such idealization was quickly replaced by rapid devaluation when the chosen woman displayed any form of lack or desire—an indicator to Vincent that if she could *want*, she must not possess the phallus. Vincent’s relationship to the feminine other was alienated from the outset in his representation of the feminine as inaccessible, placed upon a pedestal. Such idealization functioned as a way of keeping feminine objects at a distance—Vincent could avoid a confrontation with sex precisely because it would ruin that “specialness” only available to women. This was evinced by Vincent’s Victorian speech about how “lewdly” sex was taken up and how no words could capture “the moment of a kiss.”

Vincent’s cross-dressing, as well as his fantasies, signified his desire to enjoy as a woman, to be the “shiny *object* of the gaze”—in other words, to be the center of attention, the object cause of desire. By cross-dressing, he could perform and offer himself to the other’s gaze, embodying the ideal object of desire. This, of course, was fraught with anxiety for Vincent: He simultaneously enjoyed it while also worrying about the judgment of the Other.⁹⁵ This Other for Vincent encompassed both of his parents. Recall that at the age of 11, Vincent’s mother said, “Please don’t be a cross-dresser!” Vincent’s cross-dressing thus functioned as way of separating from his mother by

⁹⁵ This fear of judgment by the Other is what situated Vincent as an hysteric rather than a pervert. Vincent said, “There’s always an unseen panel judging my actions.”

refusing her demand. Lacan (1961/2002) writes, “Ultimately, by refusing to satisfy the mother’s demand, isn’t the child requiring the mother to have a desire outside of him, because that is the pathway toward desire that he lacks” (p. 252)? Likewise, Vincent’s cross-dressing served as a refusal of his father’s request that “if [he] was going to be gay” to “please not act like a girl!” While Vincent presented his cross-dressing as a symptom that was distressing, he obtained great *jouissance* from it precisely because of the disapproving opinion from others it garnered. Dor (1999) notes, “Since make-believe is always sustained by the gaze of the other, it enables the subject to enjoy, in fantasy, the supposedly disapproving or hostile opinion the other has of him” (p. 102). Cross-dressing provided the opportunity to present his body as a show—as an object—perhaps the object that would capture his father’s attention the way those women in *Playboy* did. Perhaps Vincent could be the woman who stole his father’s attention—attention he felt he never received as a boy. Perhaps he could be the object cause of his father’s desire?

Vincent’s fantasies of punishment, torture, and humiliation support such a formulation. The discourse that shaped Vincent’s ideas of masculinity and femininity suggested that men *dominated* and *humiliated* women, making them nothing more than *objects*. Almost exclusively, Vincent played the role of the woman in his fantasy life—often being *beaten*, bound, tied, raped, and *dominated*. He was *powerless* in his fantasies, something he felt “horrified” by. Such horror points toward the *jouissance* of the real—that pleasure in pain Vincent so loved. Vincent noted that in all of his fantasies he was “*utter object*.” Again, we can surmise that this was the object he perceived his father desired. Vincent had described his early play with his father as “violent” at times—something that reappeared in his fantasy life. Furthermore, in situating himself in the

submissive role, Vincent was able to give up his “feelings of responsibility” and succumb to *power*—something he had always felt unable to do in his daily life. Recall that Vincent felt he “always had to be dominant” to make up for his parents’ careless “mistake” on their first date. Fink (1995) writes, “Fantasy stages the position in which the child would like to see itself with respect to the object that causes, elicits, and incites its desires” (p. xiii). Vincent was the degraded object in his fantasy life, deserving and receiving punishment. He was powerless in fantasy, despite his conscious “horror over someone having *power* over [him].” Such horror suggested his terror of his own drives and his fear that they would be “too much” and “overwhelm” him. In his daily life, he projected such fears outward—making everyone a “predator” or fearing being *beaten up* by “manly men”; however, in his fantasy life, he allowed himself to be *powerless* and submissive to his drives. There was no need for obsessive symptoms to limit his jouissance.

Vincent’s horror and fascination with torture films that involved mutilation and dismemberment, as well as dreams he had of this nature, signified his desire to escape the rigid confines of his ego. Boothby (1991) suggests that fantasies and dreams of mutilation point toward the fragmentation of the real—the body before the mirror stage and a drive toward difference over unification.⁹⁶ (Note that these fantasies and dreams did not come until the end of Vincent’s therapy—around the time he began to really explore and articulate his sexuality.) Furthermore, in “Aggressiveness in Psychoanalysis,” Lacan (1948/2002) notes that “[i]magos of castration, emasculation, mutilation, dismemberment, dislocation, evisceration, devouring, and bursting open of the body—in short, the imagos that I personally have grouped together under the heading ‘imagos of

⁹⁶ Boothby (1991) notes, “It is because aggressivity represents a will to rebellion against the imago that aggressivity is specifically linked in fantasy to violation of bodily integrity” (p. 39).

the fragmented body,” represent “aggressive intentions” (p. 13). Such fragmentation and aggressiveness was a source of jouissance for Vincent, increasingly one he was able to discuss in therapy rather than simply entertain in his fantasy or dream life. His fascination with dismemberment signified to me a change in his stance with regard to his desire and his jouissance—a willingness on his part to explore the “grotesque” parts of himself rather than repress them.

Conclusions

Nothing other than this is at stake in analysis—recognising what function the subject takes on in the order of the symbolic relations which covers the entire field of human relations, and whose initial cell is the Oedipus complex, where the assumption of sex is decided.

(Lacan, 1975/1988, p. 67)

Vincent’s burgeoning interest in what it meant to be “masculine,” as well as the awakening of a longing for oral sex and sexual intercourse with women, represented a shift in his psychic economy. It indicated a move from his exclusive identification with women and his enjoying as a woman to a tentative exploration of all of those features of his father he believed would make him undesirable. To *lust*—to sexually want a woman—was inscribed in his very being as wrong; thus, he rejected it and played object *a* for his mother at the expense of his sexuality. We can see then that Vincent played both parts: object *a* for his father by being the degraded object in his fantasy life and object *a* for his mother by being the little girl she had so badly wanted when she was pregnant. We can also read the inverse, something Freud repeatedly reminded us to do: Vincent identified with his father by cutting women down in his fantasy life. Initially, this was something he could not openly wish for, so he instead positioned women as humiliated and denigrated in fantasy. Vincent wanted to do to women what he perceived his father

did to his mother. His mother's discourse taught him that all men were users, and this is what he sought to become. Later, when Vincent was better able to symbolize this, he began playing it out consciously with his new girlfriend—cutting her down to size by calling her “blobbish and dumb,” and enacting sadistic sexual play with her in “real” life. This movement was only able to occur once Vincent had begun to explore his *lust*, *dominance*, and all of those other signifiers he associated with “masculinity.” As a result, he began to feel that he had had his “fill of fantasy”—he was exploring things with another person now.

Vincent also identified with his mother and the other women in his father's life by playing the role of the degraded object in his fantasies. He wished to be used by Dad like Mom was. He wanted to be the object that would cause a man's desire. This was present in Vincent's cross-dressing, as well. He longed to be the object of the Other's gaze, while also feeling great anxiety about it—a feeling that implied considerable jouissance for Vincent. While Vincent's situating of himself in both the male and female roles was certainly complex, what is clear is that, in both scenarios, *he desired as the Other desired*, his own desire always being mediated by someone else's desire. While, on one level, Vincent's identification as a woman functioned to please both of his parents (recall his statement that, had he been born a girl, they wouldn't have gotten divorced), it also served as a refusal of their jouissance. As a teenager, both of Vincent's parents implored him to “please not be a cross-dresser” and to “please not act like a girl!” By refusing these demands, particularly through his cross-dressing, Vincent created a space for himself outside of his parents' desires. This was the crux of many of Vincent's issues: He could not decide whether to please the Other or just say, “Fuck you.” For three years he

vacillated between his need to be the pleasing object for all and his desire to leave the “people pleasing” behind. Vincent could never be sure that he had the phallus—indeed, he wasn’t quite sure whether it was his mother or father who had it—and this kept him trapped in a loop of indecision and terror.

Vincent’s complex uncertainty as to his sexual identity was perhaps best exemplified by his favored masturbatory act of dressing in women’s clothing and then ejaculating on his own face. We can see in this act his embodiment of both the masculine and the feminine: He’s the male ejaculating on the woman’s face (perhaps on Mom’s face?). Whether identified as male or female, Vincent’s desire was to be the object that could fulfill the Other. Though his own *jouissance* came to the foreground later, it was barely in the picture at the beginning of therapy. His concern was always with the Other. Vincent’s case was particularly complex because he simultaneously idealized women and degraded them, identified with/hated his mother and his father, and routinely played both roles; however, if we return to his presenting complaint and the early discourse that shaped him, we can perhaps more readily disentangle this complexity.

Vincent sought therapy because he was “*having problems with the opposite gender.*” In light of Vincent’s history, we can now understand the wording of his presenting problem in an entirely different manner. Vincent, indeed, had problems with the opposite gender—he could not figure out which he was and all of his symptoms led back to this confusion and to the hysteric’s question: Am I a man or a woman? Unbeknownst to Vincent, the preconditions for his desire were established by the signifying chain that commenced in the discourse of his parents and conditions that existed before his birth (his very own conception, for example)—in other words, in his

symbolic matrix. Vincent's signifiers, his very language, contained the keys to his symptoms.⁹⁷ To be masculine was associated with being a *user, lust, power, domination, degradation, objectification, ignorance, and sexuality*. Because Vincent blamed his father for hurting his mother (and him) through his philandering, he rejected these things; however, as we have seen, they continued to operate for him unconsciously. Given his mother and aunt's anti-male discourse, to have embraced the only notion Vincent had of masculinity was to betray his mother by identifying with his father. What resulted were paranoid fears of being "beaten up" by "manly men" and a turn to intellectual pursuits in contradistinction to his father's blue collar work. We can recollect Vincent's father's warning that he would one day be "beaten up for being smart," and see how this discourse structured Vincent at the level of the real. He was "terrified" and "horrified" at the idea of being "beaten" by such "manly men." In such fears was a wish to inhabit this place that he could not consciously claim without identifying with his "disgusting" father.

Women were *sacred, lovable, special, unique*, and above all, *desirable*. They "didn't want their bodies stared at" and were placed on a Victorian pedestal of purity by Vincent. By idealizing women, Vincent could remain safe from any encounter with his own sexuality or jouissance. His idealization served to keep the feminine object at a safe distance where he could imagine she had the phallus, therefore, providing him the vehicle by which he could enhance his own prestige through identification with her. He desired via her, and as has been shown, longed to *be her*. His mother's discourse about men did not provide Vincent with any idea of a way a man could have a sexual relationship with a woman that was not objectifying or dominating, and he certainly did not see it modeled in

⁹⁷ Schneiderman (1980) writes, "What are the signifiers that inscribe the subject in the Real and define [his] destiny" (p. 6)?

his parents' relationship. Similarly, his father's discourse about masculinity and what it meant to "be a man" was so restrictive that Vincent felt he must not be a man.

These conflicting desires manifested themselves in Vincent's symptoms, dreams, and fantasy life. More importantly, they were present in his language—in his very choice of signifiers. It was not surprising that the words Vincent used in the beginning of therapy to describe his father (such as "lust" or "dominate") were the words he used later in fantasy when the repression of his own sexuality and masculinity began to lift. Though the question of his sexual identity still loomed large for Vincent upon termination, he had made some progress toward demanding less and desiring more—a shift from the imaginary to the symbolic. This was due, in large part, to his increasing ability to accept the inherent unfulfillability of desire—in other words, his budding acceptance of his own castration and subsequent structural dissatisfaction. He was also able to symbolize his fantasies rather than manifesting them in obsessive symptoms. He had also begun to wonder about his own pleasure rather than exclusively focusing on the Other's. Finally, he had allowed himself to desire a woman—the very verboten thing his mother found so devastating and that he knew would give his father pleasure. Vincent, who had remained mobilized by desire for his mother, was separating from her, thus allowing for the emergence of his sexual desire.

Therapeutic Aims

As with Keenan, my aim with Vincent was to invite him to become a question for himself and to assist him in separating from the Other's desire. I punctuated signifiers and made interpretations that pointed toward unrecognized desire and jouissance and asked Vincent to wonder about who it was that desired within him. I will not repeat all of

the therapeutic aims I detailed in the previous chapter here; however, I want to emphasize a few things I did differently with Vincent because of his hysterical structure. Firstly, I invited Vincent to lie on the couch so that he could not see my face. He was excellent at scanning my face and situating himself in response to what he believed he read in my facial expressions. He was terrified of not being able to see me, though once he overcame his fear, he enjoyed having the space the couch afforded him to not always be attending to someone else (me). Secondly, I frustrated Vincent's demands much more readily, so as to foster his separation from my desire as Other. With Keenan, I was lucky if I could get him to ask for anything, much less demand. The hysteric demands an answer—tell me what is wrong with me!—to avoid doing the work himself. (The obsessive refuses to do the work himself but in a different way—by playing dead—or he works hard through conscious thinking, but resists remembering his dreams and fantasies.) This also functions to induce a lack in the knowledge of the therapist (as Master), something at which Vincent excelled. By refusing his demands, I invited him go past his demand to his desire. Thirdly, in conjunction with this, I kept my desire enigmatic, never allowing Vincent to quite nail down what it was I wanted from him. In so doing, he could not situate himself as object *a* for me (though he tried repeatedly). This proved highly frustrating to Vincent, often resulting in his quitting therapy or yelling at me about how “unfair” everything was (the accusation of the Other so familiar in hysteria).

He particularly found my scolding of sessions to be troubling, often telling me he felt “obliterated” when I would not speak or interpret, instead scolding a session. Finally, I strictly limited any knowledge Vincent had of me as a subject in the room. Indeed, I attempted to be as much of a placeholder as possible. With Keenan, I had to constantly

remind him I was in the room; consequently, I interrupted him more and spoke more often. This does not mean I shared personal details, only that I made my presence known much more often. The opposite was the case with Vincent. Because he frequently focused on me as a way of avoiding his own work, the transference—more often than not—served as a hindrance to the therapy rather than as something that facilitated it. Thus, I gave Vincent my lack—my love—my pure desirousness that he come into being as a subject on his terms rather than as the object everyone else wanted or needed him to be. This is where our work together ended—with Vincent wondering about *his* enjoyment and desire and the question of his sexuality.

CHAPTER FIVE

Clinical Implications and Concluding Discussion

The challenge Lacanians accept is that of inventing ways in which to hit the real, upset the repetition it engenders, dialectize the isolated Thing,⁹⁸ and shake up the fundamental fantasy in which the subject constitutes herself in relation to the cause.

(Fink, 1995, p. 92)

The point to which analysis leads, the end point of the dialectic of existential recognition, is—*You are this*. In practice this ideal is never reached. The ideal of analysis is not complete self mastery, the absence of passion.

(Lacan, 1975/1988, p. 3, original italics)

In this concluding chapter, I detail the project's findings, specifically focusing on the clinical presentation and treatment of obsessive structure, as well as articulating how Lacan's diagnostic approach goes beyond the apparent symptoms to the underlying structure of the subject. I highlight how such an approach guided my case formulation and therapeutic work with two patients who presented with similar symptomatology, thus allowing for shifts in each patient's psychic economy rather than superficial symptom reduction. In this context, I discuss my historical experiences with various therapeutic modalities for the treatment of obsessive-compulsive disorder and how these experiences contributed to my eventual embracing of Lacan. Next, I discuss the case study and psychoanalytic interview methodologies I utilized and how these methods proved particularly useful in articulating the *how* of a Lacanian-oriented psychotherapy. Within this context, I discuss the inevitable limitations of this work and some of the issues I struggled with while writing. Finally, I discuss implications for future practice and research, including a brief discussion of the impending publication of the *DSM-V*.

⁹⁸ Object *a*.

Clinical Findings

For in the work he does to reconstruct it *for another*, he encounters anew the fundamental alienation that made him construct it *like another*, and that has always destined it to be taken away from him *by another*.

(Lacan, 1953/2002, p. 42, original italics)

The aims of this dissertation have been to detail a Lacanian-oriented approach to working with obsession and to illustrate how a Lacanian approach looks beyond apparent symptoms. By examining a variety of theoretical treatment approaches, we have seen that “obsession” takes on very different meanings depending on one’s theoretical position. Our theoretical models deeply influence us; indeed, they prescribe the very way we view the patient and how we formulate treatment. “Obsessive-compulsive disorder”—as described by those of a CBT or neurobiological orientation—is something quite different from the “obsessive personality” as described by dynamically-oriented therapists such as Nancy McWilliams or Glen Gabbard. Then we have the work of David Shapiro, who speaks of “obsessional styles,” where “style” is a product of drives and stimuli plus the “mental organizing capacities” of the individual” (1965, p. 5). In this view, rather than focusing on superficial traits, styles are linked to underlying psychological structure—what Shapiro terms a “matrix.” Shapiro thus identifies symptoms as “problems of character” that are more general than any specific mechanisms that can be inferred from them. Symptoms are viewed as a result of a style of functioning. We see a progression from the symptom taken at face value—defined as a type of medical illness—to a personality organization largely based around the defensive structure of the patient, to a first step toward a structural approach, one that attempts to locate a symptom within the person’s underlying “matrix.”

Lacan takes us even further—suggesting that it is the very symbolic matrix of the patient that must be articulated and brought to light in order for movement to occur. Lacan brings to the table the very question of *human desire* and how this desire structures the patient at the deepest levels of her being. Obsession is not a set of symptoms—anyone can have obsessive symptoms—it is a structural position with regard to the Other. It is the stance the patient takes with regard to desire and jouissance. To “treat” the neurotic is, therefore, not to treat a set of symptoms, but to bring her to a point of confrontation with the symbolic Other so that the very constellation of signifiers that have conditioned her desire may be articulated—the gaps and holes in her signifying chain reorganized, reconstituted, filled in. In so doing, the therapist attempts to bring about a shift in the patient’s subjective position, which is based on desire. The therapist assists the patient in her movement toward subjectification, “whereby the [patient] moves from being the subject who demands (as well as being subject to the Other’s demand) to being the subject who desires (as well as being subject to the Other’s desire), and then to being the subject who enjoys (who is no longer subject to the Other)” (Fink, 1997, p. 65).

What Lacan offers that is truly unique is his emphasis on the linguistic structure of symptoms and the unconscious. The patient’s desire is evident in the words she uses—her desire is displayed in the signifying chain. Thus, the work involves fleshing out the symbolic matrix, drawing into awareness the “symbolic constellation dwelling in the subject’s unconscious” (Lacan, 1975/1988, p. 65). Signifiers repeat and point to where the patient is fixated—to the real and the trauma of repetition it engenders. That which has never been symbolized repeats.

Keenan's life was on "repeat." *Nothing ever moved.* His presenting problems were that he was bored, dissatisfied, and unmotivated. He "feared" social interactions and longed for friends and love, so long as he did not have to *lose his own independence.* Keenan did not want to have to *give up* anything. He wanted companions, yet he also wanted to maintain his position of superiority over the "conformist sheep" of society. Lacan's formulation of the obsessive's question as "Am I dead or alive," allowed me to situate Keenan's symptoms within the larger symbolic matrix that constituted his desire. In other words, I was able to ascertain from Keenan's words his position in the symbolic order. Guided by the question, "What is at stake in desiring for Keenan?" I was led to a greater understanding of how Keenan's symptoms functioned as a response to his existential question. For Keenan, what was at stake in desiring was the very *giving up* of his being in the face of the Other's desire. This traced back to his mOther's early engulfing desire, and Keenan's subsequent withdrawal. Faced with his mother's overwhelming lack, Keenan chose to play dead—to deny his own lack and desire, as well as the Other's. Thus, the wording of Keenan's symptoms—that he was "taking up space," "non-existent," "empty," and "excluded"—were directly tied to his mother's discourse and early experiences. Indeed, we saw that Keenan's emphasis on rational understanding over expression of his feelings for fear that the latter would *swallow him* structured him at the level of both his desire and jouissance. We saw how Keenan "never developed an appetite" in response to his mother's voracious appetite—her overwhelming jouissance—and how his feeling that he was "taking up space" signaled the lack of symbolic space he was provided as a child to come into being as a separate subject. We were thus able to tie Keenan's symptom of withholding to this larger constellation—identifying in it his desire

to *retain* a position for himself by *giving up nothing*. Indeed, Keenan felt he was “nothing.” By being “nothing,” he could, paradoxically, maintain a place for himself. By enjoying “nothing,” he distanced himself from the *jouissance* he associated with his mother that felt overpowering. This was particularly illustrated by Keenan’s guilt the day after he “successfully” masturbated—he felt pleasure initially, but had to run from it afterwards.

Keeping in mind Lacan’s formulation of the obsessive’s question, we were able to situate Keenan’s obsessive symptoms and childhood nightmares of being kidnapped as responses to this question. His symptoms served two functions: to deny lack and to express his repressed hostility toward his mother. Keenan’s need for symmetry and his “canceling out” behaviors pointed toward his inability to tolerate any form of lack. His frustration with me when I did not repeat his exact words back to him likewise pointed toward his inability to tolerate lack—the very lack intrinsic to language and subjectivity. His dreams of being kidnapped, fears of stepping on a crack lest he *break his mother’s back*, his need to walk a certain number of steps to the *kitchen* for fear that something “bad” occur (death), and his sneezing and belching compulsions all displayed his unconscious hatred toward a castrating mother who “stabbed sausages,” yelled “PENIS!” in restaurants, and humiliated Keenan time and again. His obsessive symptoms manifested his question of *being*: To be or not to be when faced with a woman who took great pleasure in mutilation and humiliation and a father who did *nothing* to limit her. Keenan chose death. This was best exemplified in Keenan’s dream of his dead grandmother who died *waiting*.

As a therapist, I was better able to understand Keenan's deferral of action, superiority complex, withholding, and his obsession with time and subsequent *waiting for something to happen* within the context of Lacan's theory of the role death plays for the obsessive. By playing dead, Keenan felt he could perhaps escape death. By waiting for the master to die, he was able to escape any responsibility to the Other—to escape having to make a *choice*. To say what he *wanted* would have made Keenan vulnerable: It would have implicated him as an engaged participant in his life. To risk such a move was to risk an encounter with the Other. This was at the crux of Keenan's presenting problems: his fear of social interactions, his dissatisfaction, his lack of motivation, his feelings of boredom and repetition. They all served as defenses against desire and jouissance—both his own and the Other's. His symptoms were plugs, as it were—satisfactions that sustained him in his position with regard to the Other. And, as Keenan said in our initial interview, he would rather maintain the status quo than *lose himself by conforming to Others*.

The work with Keenan, therefore, required a hystericizing of him—opening him up to the Other whom he feared would eclipse him as a subject. By my punctuating his unacknowledged desire and enjoyment, Keenan was able to see how playing dead functioned for him and was able to tie it to his past discourse. In so doing, he began to fill in the gaps and holes in his signifying chain, shaking up his psychic economy, resulting in a dialectization of his desire. We saw that, toward the end of therapy, Keenan had slowly begun to ask for things, to make “long-term” plans, and to question what he *wanted*—something that before had remained *impossible* for him. Keenan maintained his desire as impossible so that *nothing would ever move*, the very thing he “feared” the

most. We have seen just how complex this “fear” was for Keenan, and how his symptoms served as an answer to his question: To be or not to be? Am I dead or alive?

Differential Diagnosis

I chose the case of Vincent as a counterpart to that of Keenan to specifically detail how symptom-based approaches leave out the very question of desire and jouissance. Had we only paid attention to the obsessive symptoms present in both Keenan and Vincent, we would have altogether missed another register—the symbolic register, including the unconscious, language, the law, and desire. We would perhaps also have missed that, though alike on the surface, Vincent’s obsessive symptoms served a different purpose than Keenan’s. Part of the problem with CBT and neurobiological approaches to obsessive-compulsive disorder is their failure to view symptoms in their singularity—to identify how the symptom functions as a source of jouissance and as a response to the neurotic’s question. Keenan’s obsessive symptoms, as I have just discussed, were tied to his *existential being*: They covered over lack and expressed repressed hostility toward his mother. Indeed, his dreams and his compulsive symptoms were death wishes toward his mother. Vincent’s obsessive symptoms, too, were tied to his question; however, the hysteric’s question is different than the obsessive’s: Am I a man or a woman? What we learned from careful examination of Vincent’s symptoms was that they all involved an attempt to limit his jouissance and his sexuality. They served as a defense against jouissance (Soler, 1996). Vincent feared (wished) *being caught*. The FBI was coming to get him for looking at pornography. He was going to be *caught* for the illicit bottle of whiskey he smuggled into the school function and the weed he smoked a month before his drug test. Vincent needed to *protect* himself from “evil” (his own drives and

enjoyment). Vincent's obsessive symptoms signified his struggle with his *sexual being*, while Keenan's signified his struggle with his *existential being*.

Furthermore, at the level of desire, Vincent situated himself on the side of the object—becoming object *a*—the cause of desire. He was a chameleon, an actor, situating himself to fill the Other's lack. He maintained his being by being the desired object. Vincent's symbolic matrix—his early parental discourse, as well as the conditions that pre-existed him—turned his sexual being into a source of immense complexity and confusion. His questions all revolved around his relationships with Others and whether he was approved of and desired by them. Despite similarities in symptomatology, we thus can identify radical differences in Vincent and Keenan. Keenan dealt with his alienation and separation by nullifying the Other and denying lack. He plugged up his own division with any number of objects that were not connected to any human *person* per se (recall the disembodied penis). Cut off from his own desire, he felt bored, monotonous, *dead*. Vincent avoided full separation by eliciting lack in the Other so that he could then be the object that filled that lack. He therefore complained of feeling “false” and “like an actor.” Both men had somewhat similar early experiences: fathers who were largely ineffective and mothers who dominated their lives; however, their “choice of neurosis” to use Freud's term, differed. To neutralize the (m)Other, Keenan played dead and Vincent became what she wanted—her little girl.

Without Lacan's formulation of the signifying chain, I could never have understood the role each patient's symptoms played, nor would I have known how to position myself in the therapy. This is one of the things that draws me to Lacan: His diagnostic structures imply a corresponding therapeutic stance. I made myself irritatingly

present in Keenan's case. (He so longed for me to just disappear.) In so doing, he could not evade the Other as he had done his whole life. With Vincent, I did the opposite. I more readily refused his demands, forcing him to make himself a question rather than simply demanding I provide it for him. My therapy revolved much more around questions of time, death, and inaction with Keenan; whereas, with Vincent, we almost exclusively focused on his sexuality. This is not to say that sexuality was not a focus with Keenan (we saw that it was) or vice versa; however, the questions they brought with them to therapy remained largely consistent with Lacan's formulations.

With both, I listened for the beyond of discourse, punctuating signifiers that repeated and polyvalent language in an effort to assist them in articulating and reconstituting their histories. I attempted to intervene at the level of the real—to shake up that which had never been symbolized—by making interpretations that were meant to be surprising and evocative. I attempted to place myself in the role of the symbolic Other so that each patient's subjective position with respect to the Other could be brought to light and explored. To further enable this, I kept my own desire enigmatic—never allowing them to know what I *wanted* so that, instead, they could have the space to confront desire and perhaps find a place for their own to manifest. Fink (1997) writes,

The ultimate struggle in analysis—that of getting the analysand to assume responsibility for his or her castration instead of demanding compensation for it from the Other—is played out between the analysand and the analyst, who stands in for the Other (and the lost object [object *a*] at the same time. (p. 70)

I saw my role as directing the treatment, not directing the patient. It was neither my desire nor my place to tell either Vincent or Keenan (or any other patient, for that matter) how to live their lives, how to be “more productive,” or to impose a value system upon them.

My genuine desire was for each of them to come into being as they saw fit. This was also my initial draw to Lacan: Rather than seeing therapy as an adaptive process—one that seeks to adjust the patient to society—Lacan emphasizes the singularity of each person and views the role of the therapist as assisting the subject in separating from the Other’s desire.

I am a long way from the days of forcing someone to sit on a public toilet seat in order to overcome her “contamination fears.” I have arrived at a place—a human place—where symptoms reflect positions with regard to desire and enjoyment. This is a complex place, not readily reducible to a serotonin hypothesis or a “negative automatic thought.” I have utilized those modalities. I would even say they work sometimes; however, they leave the patient further alienated from herself and her desire. They require that she objectify parts of herself and “manage” them, rather than integrating and accepting them all—even the most “grotesque,” to use Vincent’s word. My experience working with “obsessive-compulsive disorder” was always that, as soon as one symptom was relieved, it would manifest elsewhere (driving therapists nuts). I have heard many therapists say they do not like working with people with obsessions because of their refractory nature.

Let me make it clear that I did not explore Vincent or Keenan’s symptoms with them with the intention of either of them “gaining insight” or “understanding” them. Instead, I punctuated the wording of their symptoms. When Vincent discussed his fear of being a pedophile, I simply asked what he associated with “pedophile.” When he said, “wrong, *disgusting*, perverse,” and so on, I punctuated “disgusting.” This led to his discussion of how “disgusting and repulsive” he felt when he masturbated as a child, and how he tried to “master” it so that his mother would not find out. We can recall Vincent’s

comment toward the end of therapy that he “could not remember the last time [he] worried about being a pedophile.” Stated otherwise, I aimed at what was driving the symptom—the repressed sexuality and the signifiers that fixated the symptom and held it in place—rather than saying, “Well, I think you fear you’re a pedophile because it represents your belief in your own badness and your unconscious desire to be punished for it.” What would that have offered Vincent other than some heady Freudian abstract theorizing that he would undoubtedly have found fault with and then challenged me on? By simply allowing Keenan and Vincent the space to verbalize that which had never been spoken, a reordering occurred that shifted their symptoms and desire *without their conscious knowledge or insight*. By listening at the level of the symbolic and aiming at the real, I was able to facilitate this via my punctuations and interpretations. The other therapies I have utilized in the past—even psychodynamic ones that focused on the relationship or the patient’s affect—never escaped the register of the imaginary, which, as we have learned, is structured by ego-to-ego relations. In such therapies, the patient is hopelessly linked to the reflection of the therapist, thus preventing the very separation a Lacanian-oriented approach seeks to engender.⁹⁹

Case Study Methodology and the Psychoanalytic Interview: Benefits and Limitations

My decision to utilize a case study methodology, with particular focus on the psychoanalytic interview, provided me the opportunity to 1) articulate the role Lacan’s theory played in my clinical practice, 2) explicate Lacan’s theory via concrete case examples, 3) illustrate the *how* of psychotherapy—what actually occurs in the session

⁹⁹ Lacan (1953/200) notes that the unconscious is never exhausted or totally emptied out, but rather, a new relationship between the drives and the ego and superego are established such that future repressions need not occur.

room—with specific attention paid to the patient’s words and the interpretations and punctuations I articulated as the therapist, and 4) to highlight manifestations of the unconscious as a valid form of knowledge in itself. Employing this methodology provided both benefits and a few drawbacks.

Firstly, by utilizing a case study methodology, I was able to tell a story in a way that I hope was reader-friendly. I was able to share parts of the patient’s speech verbatim, thus highlighting the importance of signifiers and their place in each patient’s signifying chain. Furthermore, I was able to offer a view of what occurred in the actual session room—something that is of great help to clinicians and that is sorely lacking in the literature. By necessity, I was forced to pick and choose what material to share. I saw each of these men twice weekly for over two years. This produced a wealth of information, and most certainly, what I chose to share was, in part, guided by the particular Lacanian concepts I was attempting to articulate. This is to say that, had I been focusing on other concepts, different parts of the story would have been highlighted. As I hope to have shown throughout this work, there is no way to fully encompass everything; there is, indeed, always a lack. I did my best to present the material I believed was relevant to the ideas I was attempting to communicate; however, it is inevitable that there were things left out that could have proven beneficial.

Secondly, the material I chose to share reflected, in many ways, the material I felt most comfortable working with. Lacan is difficult, and as mentioned in my initial chapter, there is much I still have to learn. My case presentations thus reflect my current knowledge of Lacan, and I chose to work with concepts on which I felt I had a fairly good grasp. Were I to reformulate these cases a year from now, they would likely be

more nuanced, reflecting my own further understanding of Lacan. Nevertheless, I believe what I present here offers the clinician who has an interest in incorporating Lacan into his or her practice a nice starting point, particularly with obsessive patients.

Thirdly, I struggled with many concepts and formulations as I wrote—learning all the way through—and I believe this shows in the cases. It is difficult to formulate such complex cases, and I found myself wondering at times, for example, what the difference was between object *a* and the phallus. Consequently, my articulation of them is somewhat sketchy. I do not believe this confusion about the phallus and object *a* is exclusive to the novice Lacanian—it is likely a conversation had amongst the most sophisticated Lacanians. I found myself wishing I could be more clear and concise in these areas; however, I also wanted to remain true to the aim of this dissertation, which is clinical in nature. I love a good theoretical exposition, and I had to continuously remind myself that this was not the purpose of this particular piece of work. I did attempt to point the reader in the direction of written works that were theoretically denser for those (like myself) who enjoy the theoretical part. I found myself somewhat limited in this respect; however, Lacan's corpus is so extensive, there is no possible way I could have provided detailed analyses of all of his major concepts.

Despite hundreds of pages of notes, I sometimes worried that I was not presenting either Vincent or Keenan in the way they presented in certain sessions. There is, of course, an inherent fallacy even in this thought, for the way Keenan and Vincent presented in sessions was already mediated through my own perceptions and hearing. Both as a therapist and as a writer, I try to really listen to the patient to the letter and to re-present them to the letter. This is why much of the case presentations detailed actual

conversations. Rather than simply formulate the cases in Lacanian terms, I wanted to share the actual conversations that occurred. This served the purpose of not only attending to the patient's signifiers and transference, but also of allowing the reader to see how I sometimes responded as well as the mistakes I made. There is something to be learned in the mistakes therapists make, and I believe sharing them is an important part of this work. It was largely because of my early failings with both Keenan and Vincent (when I was making suggestions and functioning as an imaginary other) that Lacan entered the picture for me. What I was doing was not working, and I wondered why. I was following affect, interpreting transference, creating rapport—why was I being met with such resistance? As much as patients demand that we tell them what to do, they really do not like it much. Even the obsessive, who lives by the Other's rules, secretly enacts his opposition to such rules. I learned this through experience, and it is this experience—mistakes and all—that I seek to share.

Finally, my interpretations are just that—mine. They are informed by Lacan's formulations, but they are still my own. For example, there were most certainly multiple layers to Keenan's dream of the dead grandma; however, I focused on the interpretations I felt were most relevant to the case. The wonderful thing about dreams is how complex they are and the rich material they provide. I, in no way, completely analyzed any of the dreams presented. Even today, I find new meanings in Keenan's dreams. Such is the nature of the unconscious. It provides us with something beyond conscious insight—something that, just because we cannot quantify it or fully “understand” it—shouldn't preclude it from our discourse. The unconscious needs to be taken seriously, and the psychoanalytic interview does so. It places importance on the pauses and stumblings in

the patient's speech, the negations, the sentences that trail off, the slips of the tongue, and the bungled actions. All of it points to something—something beyond—something that is often difficult to articulate in words. Language is limiting in this way: It never fully expresses what we long to express, for this is structurally impossible. In my writing, I have been forced to (once again) accept my castration here, my lack. Like Keenan and Vincent, I have had to struggle with the incompleteness of language, the lack in the Other.

I believe the case study methodology and the psychoanalytic interview invite clinicians to share their stories—successes and failures—in a way that allows us to consider alternate ways of treatment. Rather than presenting patients as numbers on a graph or detailing “outcome measures,” the case study provides a glimpse of the immense human complexity that is inevitably part of every patient we see. I hope this is something that every mental health care professional, regardless of theoretical orientation, can agree upon: the sheer intricacy of the human species.

Implications and a Call to Ethics

This is the saddest moment in my 45 year career of studying, practicing, and teaching psychiatry. The Board of Trustees of the American Psychiatric Association has given its final approval to a deeply flawed DSM 5 containing many changes that seem clearly unsafe and scientifically unsound. My best advice to clinicians, to the press, and to the general public - be skeptical and don't follow DSM 5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication.

Allen Frances, Chair DSM-IV Task Force, December 2012

My primary goal throughout this work has been to articulate Lacan's clinical approach to obsessive structure. Implicit in such an aim is an exposition of the difference between a descriptive or symptom-based approach and a structural approach. The latter

has been my secondary aim because of its ethical implications. I worry when I hear people reduce their everyday human experiences to biological malfunctions and chemical imbalances. I worry when I see children taking psychiatric medications for throwing temper tantrums or exhibiting what used to be considered typical kid behavior. In short, I worry about the medicalization of human distress that is occurring. As mentioned in the introduction, political and economic motives have contributed almost exclusively to the shift toward the biological perspective in psychology with its concomitant proliferation of psychopharmacology. People are no longer “sad,” they *have depression*. They no longer “feel moody,” they *have bipolar disorder*. People are no longer “exuberant,” they *have manic episodes*. We have become objects—further alienated from our human experiences by this medicalization of distress. There is no longer an *I*, there is a “me.” Everyone is outside of themselves looking down—never in the moment experiencing—always observing. Our culture is an obsessive one. We are spectators rigidly defined by labels that the Other affixes to us. The Other in this case is often the world of psychologists, therapists, social workers, psychiatrists, and mental health professionals—in a word, clinicians.

Allen Frances, the chairman of the *DSM-IV* has been among the most vocal of the critics of the impending *DSM-V*, due to be published in May 2013, precisely because of its biological ideology. Frances (2012) notes that over fifty mental health professional organizations petitioned for an outside review to provide an independent assessment of its supporting evidence. He further notes that professional journals, the press, and the public have “express[ed] widespread astonishment about decisions that sometimes seemed not only to lack scientific support but also to defy common sense.” The APA refused to

conduct any independent review, and final approval was given to publish the *DSM-V*. Psychiatric diagnosis has far-reaching implications: It determines whether an insurance company will pay for patient treatment. It decides what drugs a person will be placed on. It determines eligibility for benefits and services, and it stigmatizes—branding people with labels that often carry great weight. These are but a few of the powers psychiatry wields. I note them to highlight that, as clinicians, we are ethically implicated not only in our patient’s lives and what happens in the session room, but also in the larger social repercussions that occur when we fall into line with this ideology. Let me be clear: My intention here is not to demonize psychotropic medications. They have their place. The problem is, *they are currently all over the place. Their place is everywhere.* So it goes when everything is considered to be a biological disorder. And when you can medicate it, everything somehow ends up being a biological disorder. For example, in the new *DSM-V*, temper tantrums in children will be called “Disruptive Mood Dysregulation Disorder.” “Excessive” eating twelve times in three months will now constitute “Binge Eating Disorder.” (What will we all do from Halloween through Christmas?!) Normal grief (e.g., over the death of a loved one) will become “Major Depressive Disorder.” I could go on, but it’s more of the same. Behaviors are being regulated down to the tiniest degree. “Disorders” are rapidly proliferating, and the medications to treat them are growing even faster (even if the majority of disorders are still treated with the same handful of psychotropic medications).

Perhaps what is most troublesome is that people *believe in* these fantastical diagnoses and fear they are irreparably damaged—doomed and determined by biology. Why bother trying if you are already determined by biology? Such a view leaves little

place for talk therapy, no matter what your theoretical persuasion. Furthermore, it prevents precisely what a Lacanian-oriented therapy aims for: subjectification and assumption of one's history and a responsibility to the Other. When Vincent pondered why he should be responsible for the "Other within" because it seemed like he had "no choice," imagine if my response had been, "You're not responsible. It's just bad genes. Sorry kid." We need a counter discourse. We need a dialectization of thought because we are currently fixated—stuck on repeat to the tune of, "*Everyday I wake up and I take my medication and I spend the rest of the day waiting for it to wear off...*"¹⁰⁰ I can think of no better counter discourse within the therapeutic community than that of Lacan, not only because he offers a diagnostic schema that focuses on human desire and the relation to the Other (i.e., *human experience*), but because his is a therapy that aims at something greater than social adaptation and conformity: It aims at the very realization of the subject *as difference*. Isn't this fundamentally what has been detailed in this work? A move from the necessary submission to the Other of language, to the necessary objectification and alienation of the self in the mirror stage, to the anxieties of separation and the demand for love and recognition characterized by the imaginary, to an acceptance of lack and the structural unfulfillability of desire characterized by the symbolic, and finally—hopefully—to a subjectification of one's own particular *jouissance* and one's place in the symbolic order: an identification and acceptance of the very impossibility of perfect unity and wholeness, perhaps even an embracing of the difference that constitutes us all. Recall Vincent's comment that "*There's great value in not being understood.*"

Indeed, there is. I am reminded here of Lacan's (1957/2006) well-known reformulation of Freud's "*Wo Es war, soll Ich werden*"—usually translated as "Where

¹⁰⁰ Spiritualized ©1995, Dedicated Records

the id was there the ego will be”—as “Where It was, there I shall come into being.” The subject must come into being “in that place where the Other’s desire—a foreign, alien desire—had been” (Fink, 1995, p. 62). The neurotic must thus be brought to a place in therapy where s/he accepts the Other within and establishes a new relationship to the drives and the satisfaction they seek. This is not a socially adaptive agenda. This is a creative embracing of the very lack that constitutes our existence. It is a joyful acceptance of that which cannot structurally be changed. It is, in the end, a radical envelopment in difference, singularity, and the sheer beauty of human complexity.

Concluding Thoughts

I have completed my dissertation. I have formulated my cases. I now have the luxury of hindsight. I find myself asking different questions now than at the beginning. I wondered then why I felt capable of writing a Lacanian clinical dissertation given my limited understanding of Lacan and my status as a simple Lacanian-oriented therapist rather than an analyst. These are no longer questions for me. I have realized that the answers to these questions lay in my patients’ speech. If I just followed the signifiers and paid close attention to the signifying chain, the gaps—the lack—in their histories were there in plain sight, waiting to be discovered. Perhaps even more so than when I began this project, I believe Lacan is desperately needed in our current biologically-minded cultural climate. Our culture is one that suggests that “normalcy” or “maturity” is a developmental stage that is somehow attained and never again lost. It is reminiscent of the idea of a “genital stage”—that if one could just reach it, it would mean the world would be glorious and one would finally have arrived “there.” Wherever “there” is. The truth is, for Lacan, there is no “there,” no final resting place where all is right in the world

and blissful satisfaction reigns. It is structurally impossible. There is no magical place of “normalcy,” no firmly instated line between “normal” and “pathological.” Development does not follow a linear progression but is always a back and forth, an exquisite dialectical movement that characterizes life and illuminates the beauty of the human condition with all of its commensurate flaws, dissatisfaction, and imperfections. Beauty does not lie in attaining some form of socially-defined “normalcy,” it lies in finding and subjectifying one’s own particular kind of *jouissance*. People are not “normal” or “abnormal,” they just *are*.

Looking back at the case presentations, I am reminded of the many ups and downs that both Keenan and Vincent experienced during our work together. There was no movement from “childishness” to “maturity.” There were strengths that were present from the beginning and regressions that happened until the very end. Such is the nature of being human. Lacan recognized this. It is not always easy to present a case in its full circuitous complexity: It can make it quite difficult for the reader to follow. I realize, reading the cases now, that in some ways, they do not quite capture the often rapid vacillations that occurred during the therapeutic process. Rest assured, both Keenan and Vincent’s therapies were anything but a straight trajectory from “unhealthy” to “healthy.”

My role throughout our work together was not to gage what “stage” either was in, but to listen—actively listen—punctuating signifiers and polyvalent phrases, helping each rewrite and reconstruct the rejected, lost parts of their histories. I offered evocative interpretations when they were just on the brink of a new discovery, circling around it, not quite able to find the word. I offered them my lack—my pure desirousness—in order that they might lay claim to previously unavowed desires, and in so doing, find

themselves a little less alienated from those desires. I did not draw socially normative comparisons in an attempt to reassure them of their similarity to others, but instead offered them the space to glimpse how their differences could be liberating and even life-enhancing. I invited them to become questions for themselves and to explore freely the various answers to those questions. Answers they provided, not ones enforced upon them by socially-driven norms. Their therapies were not aimed at adapting them to society or helping them become more “productive” members of society, but at freeing them to ascertain for themselves their desires and enjoyment.

The end of this dissertation is a bit like the end of a Lacanian analysis: It is over when a patient decides he or she is ready to move on, that he or she no longer needs the therapist. The therapist falls away as the subject-supposed-to-know, and the patient acknowledges the Other within. There is no grand culmination where the patient is “cured,” only a place arrived at where the patient feels life is worth living. There are always more questions and more work to be done. The questions are what keep us moving forward, igniting our desire so that we do not become fixated and stagnant.

In preparing this dissertation, I have probably failed to answer certain questions the reader may have hoped would be answered. I have come to terms with the fact that I cannot cover everything, cannot speak masterfully about all of Lacan. Many of the questions I began with have been answered for me through this writing. New questions have been engendered that concern how to practically disseminate Lacan’s work to an audience that has been so thoroughly indoctrinated into the medical model approach. I hope that this dissertation provides a first step. I am left to wonder what the next step will be. And it is in the very posing of that question that I continue to move forward.

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