Symptom and fantasy, two clinical dimensions

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Abstract

The paper uses a clinical vignette to discuss Lacan's re-working of Freud's conceptualisation of "symptom." It traces the relationship of symptoms seen at the beginning of an analysis, and the original fantasy traversed in its final stages.

Introduction:

Freud (1923) defines psychoanalysis as a method to investigate unconscious mental processes, a method for the treatment of neurotic disorders and a set of theory obtained on those lines.

The post Freudian psychoanalytic movement developed into different approaches and theories. Those post Freudian developments centrally used in New Zealand include Ego Psychology, Object relations theory, Kleinian Psychoanalysis, and other less formalised, eclectic approaches in psychotherapy.

Within this context, my practice as a psychoanalyst in New Zealand has always been coloured by a sense of marginalization. I am not planning to elaborate about this in detail; however, the issue of marginality seems to be the effect of some demographic factors like my being a foreigner or English being my second language, but also it seems to be related to more fundamental issues like my offering a foreign type of approach in New Zealand: the Freudian field of psychoanalysis. In my opinion, and within the psychotherapy field in New Zealand, clinicians and institutions are more interested in psychotherapists getting on with each other, rather than reflecting on any of the mayor discourses in psychoanalysis: Sigmund Freud, Heinz Hartmann, Rudolf Loewenstein, Donald Winnicott, Melanie Klein, Jacques Lacan, to name just a few.

Well established institutions like NZIPP[1] or new ones like Centre for Lacanian Analysis (CLA) are instigating the introduction of the major paradigms in Psychoanalysis in New Zealand. The CLA was created last year, as an attempt to address the issue of marginality by trying to bring the marginalized Freudian field to a more central position. In conjunction with an amazing group, within the Lacanian orientation, of people moved by the same passion for the Freudian field of psychoanalysis, we created the CLA, with members from both clinical and academic fields. The activities of the

CLA include research seminars, aimed at addressing issues related to clinical and/or theoretical psychoanalysis.

Lacan proposed a return to Freud, a return to Freud's works, with the intention of re-stabilising the Freudian field in psychoanalysis. Lacan's initiative facilitated the development of psychoanalysis along with other sciences i.e. linguistics, anthropology, philosophy, topology, etc. There is therefore no Lacanian psychoanalysis, but the Freudian field of psychoanalysis.

Our clinical practice shows us that usually people ask for psychoanalysis when concerned by their symptoms. Symptoms are always present at the beginning of an analysis. The notion of the beginning of analysis raises the question of the logical progression of an analysis, and what is expected at the end of an analysis.

I am introducing the idea that an analysis has a logical progression, a notion that is not always taken for granted. An analysis has a beginning and an end. The logical progression includes preliminary interviews, the establishment of transference and beginning of analysis, the analysis of speech; understanding the meaning of symptoms, unconscious tendencies and repetitions, drive, identifications, fantasies. Then, change in the analysand's subjective position by passing through the original fantasy and lastly the end of analysis. The end of analysis is defined, within the Lacanian orientation, as the subject's passage through his original fantasy. Therefore we talk about symptoms at the beginning of analysis, but we talk about fantasies at the end of an analysis.

The clinical division between symptoms and fantasies was first introduced in Lacan's last public seminar in Caracas, in July 1980. Jacques Alain Miller, among other psychoanalysts, followed this issue up, stating that the division between symptom and fantasy is essential in the direction of psychoanalytic treatments. The proposal of this paper is to define the concepts of symptom and fantasy in psychoanalysis, and to reflect on their differential status in psychoanalytic practice.

Symptoms

Referrals and preliminary interviews are usually about symptoms. The more common symptoms that people bring to therapy are: anxiety, depression, anger, relationship problems, intimacy problems, difficulty sleeping, consequences of trauma, anorexia, bulimia, self harm, among others.

The subject enters into psychoanalysis presenting symptoms. The beginning of an analysis is an invitation to explore them, to talk about the suffering associated with symptoms, and also about the feelings and emotions related to those symptoms. The subject, at the beginning of analysis, structures his

demands around symptoms. In terms of the logical progression in an analysis, we can say that at the beginning of analysis we find a demand structured around the subject's symptoms and those symptoms are displayed in transference.

Regarding the western medical knowledge, symptoms are perceptible manifestations of an underlying illness that might otherwise remain undetected. The symptom establishes a distinction between surface and depth, between phenomena and the hidden cause of those phenomena. Examples of medical symptoms are fever, high blood pressure, pain, etc. The traditional western medical knowledge tends to make an assessment, to establish a diagnosis and to administer a treatment. It usually prescribes treatments that will suit every human being, which usually compromise human individuality. Traditional western psychiatry operates in a similar way, formalising the diagnosis around the DSM-IV, and individuality is also generally compromised.

In psychoanalysis, when we talk about neurotic symptoms, those are understood as unconscious mental processes. Freud defined symptoms in topological terms, as a compromise between two factors. An unconscious desire and a defence, not less unconscious, from the ego. Psychoanalytic treatment is specific, different and individual for every human being. In Freudian psychoanalysis we ask the patient to talk and to free associate. The starting point is usually a manifestation of the unconscious; parapraxis, dreams, etc. These free associations will show us the way to unconscious desires and tendencies, as well as the defence mechanisms against those tendencies. Symptoms will have a reason and logic. Freud talked about a primary and a secondary benefit of symptoms. Paradoxically, psychoanalysis does not treat symptoms; however, it is expected that the symptoms will disappear during psychoanalytic treatment, by making conscious the unconscious, hidden material.

Lacan's conceptualization of symptom evolved during the course of his teaching; he started following Freud in affirming that neurotic symptoms are formations of the unconscious, and that they are always a compromise between two forces. In 1953, Lacan introduced the use of the concept of signifier in psychoanalysis. He used tools developed by the discipline of linguistics; "the symptom resolves itself in an analysis of language, because the symptom is structured as a language"(p. 59). In 1955 Lacan identified symptoms with signification "the symptom is itself signification, truth taking shape"(p. 320). In 1957 Lacan described symptom as a metaphor (p. 157). In 1961 Lacan says that the symptom is an enigmatic message which the subject thinks is an enigmatic message from the real instead of recognising it as his own message (p. 149).

By Free association, from word to word, from signifier to signifier, the subject will show us the window through which the unconscious can be read. In analysis we find that the subject speaks about his symptoms, the subject talks about his dreams, slips of the tongue, jokes. Even subjects presenting inhibitions have no problems in talking about their inhibitions. The subject finds no difficulty in talking and complaining about his symptoms. But usually fantasies are his hidden treasure. The subject talks about his symptoms, but cannot talk about his fantasies. Freud considers the existence of a shyness of fantasies. The neurotic subject is in general embarrassed by his fantasies, basically because his fantasies contradict his moral values. In general the neurotic subject borrows from the discourse of perversion the content of his fantasies, which does not mean the he is a perverted subject.

Clinical vignette:

Let us consider the initial presentation of a patient talking about his symptoms. Some relevant demographic data: New Zealand European, male in his early 40's, only child.

I have been in psychotherapy for 20 years. I am a very angry and unhappy person. Sometimes I find myself screaming while driving my car. Sometimes I wake up screaming in the middle of the night. I have no friends. I don't tolerate anyone. Nobody likes me anyway. I don't sleep well at all; I have been taking sleeping pills and Prozac for years. Anger is my main problem. It has been always like that, we addressed It in therapy over and over again, I still have the same problem.

I go through periods; I've got times of low, dark mood and anger and I feel miserable. I also have times when I start feeling good. Then, when I realize that I am beginning to feel good, I know that my mood will change, and suddenly I feel bad again.

This patient presented complaining about 20 years of psychoanalytic orientated therapy, where he worked hard by talking, associating, making conscious unconscious tendencies, etc, etc, however his symptoms remain. He said that he sometimes makes progress; he functions normally for a while and sooner or later his symptoms return, most of the time as a new version of his old symptoms.

From 1980 we can see some rectification in the way of reading the writings of Jacques Lacan from the conceptual mistake of supposing that "everything is signifier" and that psychoanalysis could be reduced to the work done by free association. In psychoanalysis not everything is a signifier. We found that symptoms are the effect of a structure and therefore they have a reason and a

logic. Treating symptoms by the method of free association is not enough; the logical progression of an analysis implies the consideration of something that does not belong to the field of the signifier: fantasies.

Lacan's discovery was not "the unconscious is structured as a language"; this was his starting point. His true discovery was the object "a", and its status claim that in the psychoanalytic experience not everything is signifier and therefore psychoanalysis is not a unified field. In 1957, when Lacan introduced the concept of original fantasy, the object "a" began to be conceived as the object of desire. Later, in Seminar 20(1975), Lacan presented the object "a", as an object that can never be attained, which is the cause of desire rather than that towards which desire tends; therefore Lacan termed the object "a" the object cause of desire.

Our practice shows us that the symptom corresponds to the beginning of analysis and it is structured as a language. It is regulated by the signifier. The fantasy plays a role in the end of an analysis, and it is regulated by the object "a", by the object cause of desire. We should not reduce our practice to dealing with symptoms, instead we should keep in our mind the existence of fantasies and the existence of what is called an original fantasy.

Fantasies

The concept of fantasy is central in Freud's work. The origin of psychoanalysis is bound up with Freud's recognition in 1897 that memories of seduction are sometimes the product of fantasy rather than traces of sexual abuse. The assumption seems to imply that fantasy is opposed to reality, a purely illusory product of imagination, and stands in the way of a correct perception of reality. The change of Freud's ideas in 1897 does not imply a rejection of the veracity of all memories of sexual abuse, but rather the discovery of the fundamental discursive and imaginative nature of memory. Memories from the past are constantly being reshaped in accordance with unconscious desires. Freud uses the term fantasy to denote a scene which is presented to the imagination and which stages an unconscious desire. The subject always plays a part in that scene, even though this is not immediately apparent. The fantasy may be conscious or unconscious.

While Lacan accepted Freud's formulation on the importance of fantasy and on its virtual quality as a scenario that stages a desire, he emphasised the protective function of fantasy. Lacan (1994) compared the scene to a frozen image in a cinema screen; just as the film may be stopped in a certain point in order to avoid showing a traumatic scene which follows, so also the fantasy is a defence which veils castration (p. 119-120). Fantasy is characterised by

a fixed and immobile quality, and at the same time that fantasy does not stop being repeated.

Lacan (1960) stated that beyond all the images which appear in dreams and elsewhere there is a "fundamental fantasy" which is always unconscious (p. 127). During psychoanalytic treatment the analysand reconstructs the original fantasy in all its details, however the treatment does not stop there, the analysand must go on to "traverse the fundamental fantasy" (Lacan, 1977, p. 273). The analysis must produce some modification of the subject's fundamental mode of defence, some alteration in his mode of jouissance. The original fantasy will reproduce an original, oedipal relationship between the subject and the significant Other, marked by a particular relationship between the subject and the object "a", the object cause of the subject desire.

The subject finds in his fantasy a resource, a consolation against his symptoms. Freud calls this phenomenon "day-dreams". Freud investigated fantasies in "Beyond the pleasure principle," where there is a dimension of jouissance, and the fantasy appears as a way to articulate jouissance with pleasure. Lacan called Jouissance the enjoyment that goes beyond the pleasure principle. Beyond this limit pleasure becomes pain, and this painful pleasure is what Lacan called jouissance; the term jouissance expresses the paradoxical satisfaction that the subject derives from his symptom. This is what Freud (1920) called "primary gain from illness".

If we think that we can do something to cure the symptoms it is because of the signifier articulation; we postulate the same principle for all the formations of the unconscious. But when we deal with fantasies, we have to address the relationship between the subject and the object "a". Now, the object "a" is also present in the symptom, as a "plus of jouissance", therefore we cannot reduce the symptom purely to its signifier function.

Clinical Vignette:

I remember being always criticised for being a bad boy when I was just trying to be myself and to play and have fun with other kids. I was sent to live with my aunt and uncle when I was around 5 or 6; I didn't know why at that time, but I remember feeling guilty. I hated living with my aunt and uncle; I desperately wanted to go back home, I remember feeling very strong about that. I was demanding it every time I could. I didn't understand why I couldn't be home. One day after wanting it so much, and when I thought I'll finally go home, I was told that my mother had died.

Fantasies made conscious during treatment

The end of analysis is defined, within the Lacanian orientation, as the subject's passage through his original fantasy. The statements that follow are an expression of this analysand's original fantasy.

> *If I am happy something very wrong will happen, my mother will die. If I want to be happy something very wrong will happen, my mother will die. If I want to be myself something very wrong will happen, my mother will die. If I feel miserable, sad and angry, it's fine. I don't want to take the risk.*

Regardless how much effort we put into analysing his symptoms, the structure of the fantasies will be reproduced as a symptom, since they are articulating an oedipal fantasy. The fantasy protects the subject against his desire, under the pretence of protecting him against having his mother and being happy. His original fantasy protects him against his own castration. As long as he is not happy, he will not have his mother and his mother will not die. The end of analysis, defined as the subject's passage through his original fantasy seems to be, in this particular case, attached to the statement

> *I don't want to take the risk*

The analysis must produce some modification of the fundamental mode of defence; some alteration in his mode of jouissance. The change in his subjective position must articulate something along the lines of taking the risk, adopting a different mode of jouissance.

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(Endnotes)

[1] New Zealand Institute of Psychoanalytic Psychotherapy