EDITORIAL:
THE INSUFFERABLE SYMPTOM

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The incurable indubitably interrogates the ends and limits of psychoanalysis as a clinical practice and discourse. Freud certainly encountered a vast array of obstacles in his quest to treat his patients. He exhausted his faculties, in the end, over the dilemma of the "negative therapeutic reaction," his patients' paradoxical defense against the cure and its entailments. After continually butting up against this "resistance against the uncovering of resistances," Freud was met with "the central difficulty of psychoanalysis": treating the symptom that satisfies. The precise function of the analyst and even psychoanalysis as a clinical enterprise were radically called into question insofar as Freud was solicited to provide the antidote for something that went beyond the bounds of what was clinically possible. By Freud's assessment this was the monumental impasse of castration. Continuing to conceptualize the objective nature of this incurable excess, however, is a central task for maintaining the specificity of psychoanalysis, and the ethics of its cause.

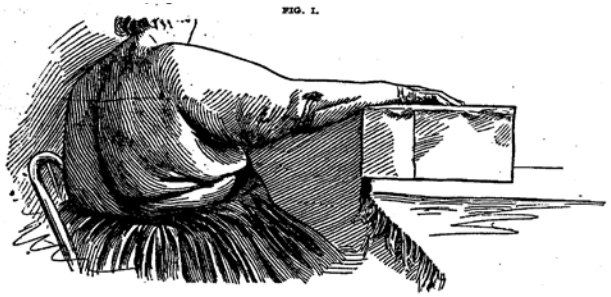
Given the status of the incurable as a negative entity we can only hope to approach it obliquely. The clinic of psychoanalysis is exemplary in this regard, given the fact that the style of its theory and practice is modeled after the very object of jouissance that it questions. One need only consider the psychoanalytic understanding and treatment of the unconscious production of the symptom in order to appreciate the importance its practice places on following the detours, and half-sayings, of signification. Accepting that symptoms only allude to something, somewhere, that is structurally failing, Freud came to consider these pathological elements as variations on a universal theme: the inconsistency of the subject's relation to sex. Intrigued by what the source underlying and supporting their construction might be, Freud was ultimately compelled to disconnect his clinic from the standards of all previous discursive regimes. Thus he established his own principles and, with them, psychoanalysis' proclivity for contesting the very criteria used for circumscribing and constituting the real.

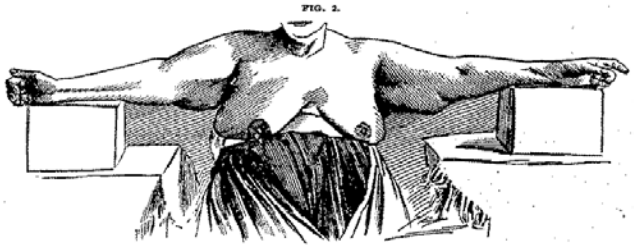
Although the symptom brings psychoanalysis into contact with medical discourse at the level of the word, it essentially distinguishes psychoanalysis from science at the level of the concept. The political and social consequences of analysis' conjectural act are not to be ignored, and more importantly, beg for further elaboration. As the subject outside of psychoanalysis is more and more mistaken for merely a biological entity, a rampant medicalization of the symptom has ensued. Such anesthetizing practices are indicative of a general push, within contemporary discourse, toward the de-subjectivation of society. The symptom, in this epoch, is typically viewed as a hapless neurological accident whose effects must first be quantified and then silenced as efficiently as possible. For psychoanalysis, however, the symptom is conceived as the encasement of the truth of the subject. At its core, then, the symptom is taken to be a meaningful invention, the inaugural attempt to contain an unwieldy sufferance. This is to say, ultimately, in opposition to other medical practices, psychoanalysis asserts that the silencing of such symptoms would be to irremediably sever the subject's relation to desire.

We might even say that the symptom begins, for the subject of psychoanalysis, where science fails—the exposure of a necessary limit internal to the scientific method of paranoid critical disclosure. Witness the hysteric—that most unmanageable subject—finding strange comfort in using her body to signify the very ignorance of the scientific Other, who vainly searches to know the cause of her affliction. Psychoanalysis does accept that science, in the form of psychiatry and its discursive bedfellows, may produce knowledge, but asserts that none of it will properly correlate with the reality of these symptoms. The intensity of their effects will only strengthen

when mitigated sheerly with a combination of feigned certainty, in the form of prefabricated knowledge, and the reckless drive to cure. To use Freud's phrase, there is an inevitable "lacuna in the knowable," which suggests that the standardization of care, at its core, is an epistemological failure. What these sciences overlook is the bare fact of singularity, or more specifically that a singular, displeasing satisfaction is the square root of these symptomatic formations. Science will not accept into the circuitry of its discourse the knowledge that something of the subject goes against life. The process of psychoanalysis, by contrast, could be conceived as a work of reduction solely intended to bring one to encounter this element. That is, rather than demand that this element be purged, the psychoanalytic clinic elevates it to the dignity of a unique knowledge, accepting it on its own terrain.

Our wish to reinscribe the obscure sense that is the incurable within the field of discourse requires the transfiguration of the subject's symptomatic insistence. In the very repetition of its presentation, something is hit upon that signals a brush with the real. The analytic act does not entail a dismantling of the particularity of each symptom, but the realization that each—in the end—is a singular bid to signify something wholly dissimilar to signification. There is a form of knowledge locked within the symptom that is essentially incommunicable, marking the limit of what can be said, while at the same time manifesting the insufferable and "forbidden jouissance that is the only valuable meaning that is offered to our life."[1] Thus, while the impotence of castration was the end point of Freud's clinical theory of the incurable, it is the constitutive impossibility advanced by Lacan that rearticulated the limit of the psychoanalytic project. The impossible, much like the return to the inanimate that Freud pondered, can only be hypothesized, given that it is strictly unaccounted for

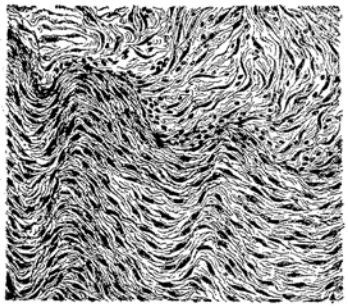




within the symbolic. Nevertheless, to the credit of psychoanalytic discourse, such a point can and must be inscribed in a structure. The ethic of the psychoanalytic clinic is to be located in this very act of positioning this impossibility at the heart of its practice. Such a constitutive failure in determining the subject is the affirmation of the fundamental fact of the subject's existence: its non-coincidence with itself. It is impossible for one to directly approach, or possess, this incurable truth. One can, however, suspend and even seperate oneself from its incendiary effects. All that psychoanalysis and its epistemological allies demand is that this impossibility be formalized, that is, that one seek to establish a discourse that coheres while still containing a non-signifying element. Heeding this demand comes from the realization that it is the logical way out of the subject's metonymic slippage between the remedial semblances that contemporary life readily traffics.

1. Jacques Lacan, "Of Structure as the Inmixing of an Otherness Prerequisite to Any Subject Whatever," in *The Structuralist Controversy*, eds. Richard Macksey and Eugenio Donato, (Baltimore: Johns Hopkins, 1970), 195.

FIG. 4.



Microscopic drawing from portion excised from right arm, upper third, showing embryonal connective tissue. (Bismarck-brown).—Drawn by Dr. Allen J. Smith.

FIG. 3.

Diagram of the outer aspect of the right arm, the shaded portions represent the areas in which at a recent examination no response was given to the æsthesiometer. In the white patches sensibility was present though not fully up to normal, It should be stated that at the time of making the examination the patient was just recovering from one of her attacks of pain.

TABLE OF MEASUREMENTS OF THE ARMS.

	Right arm measured Dec. 1st, 1887.	Right arm measured July 11th, 1888.	Left arm measured Dec. 1st, 1887.	Left arm measured July 11th, 1888.	Left arm rubber bandage applied 1 hour.	Left arm muslin bandage applied 4 hours.
	Inches	Inches	Inches	Inches	Inches	Inches
Circumference of shoulder measured vertically through axilla	21	21	21	21	21	20¾
Around arm at axilla	17½	17	17½	17½	17	16½
Greatest circumference, middle of arm	21	20½	19½	20½	19½	19
Circumference midway between greatest circumference and elbow	19	19½	19	19	19	18½
Circumference at elbow	13	13½	12½	12½	12½	12½
Greatest circumference of forearm	11½	11¾	11	11	11	11½
Circumference of wrist	7	7¼	7	7	7	7
Circumference of metacarpus	9	9¼	8¾	9	9	9