

# THE UNTREATABLE

willy apollon

At the very heart of its development, all analytic experience encounters an internal limit that manifests itself in the form of what Freud called a "negative therapeutic reaction." Once it has reached a certain point, the analytic process itself flounders and seems bound to lead nowhere. The royal road of the dream becomes a kind of impasse that prevents what is at stake in analysis from finding an opening toward its representation. When Freud encounters this difficulty with the Wolf man, he does something that analysts today find shocking. He places a limit upon the experience by informing his patient of the date when he will terminate the process. But Freud thus introduces this strategy of the analyst into analytic technique, a strategy that Lacan will call the maneuver, which consists in constraining the patient to make a decisive change in his ethical position in relation to what is happening within the analytic experience.

This difficulty is internal to the very process of the analytic experience and, for obvious reasons, to psychoanalytic treatment itself. Moreover, the analytic symptom seems to be the nodal point at which this difficulty becomes a stumbling block for psychoanalyses. In fact, it is quite possible that it is the origin of many deviations within analytic technique, within the theory of the clinic, and within the history of the psychoanalytic movement. It would be fascinating to verify this hypothesis. The fact is, however, that many analytic cures fail because of this central difficulty of analytic experience. For some time, the detractors of psychoanalysis, or anyone who wishes to reproach it for being non-scientific, have been able, without knowing how or why, to rely upon the support of this internal difficulty. We must, therefore, examine the knot at the center of this difficulty, because it brings us a specific knowledge about the human whose decisive importance Lacan, after Freud, never ceased to uphold. In order to give it a preliminary form, we could say that the "negative therapeutic reaction" presents a difficulty because it pertains to an unbearable knowledge about what remains unrepresentable within the jouissance that constitutes the human subject.

## POSTMODERNITY, THE DIFFICULT MOURNING OF MODERNITY

Psychiatry and the neurosciences, which take pride in taking control of the human in order to give it a scientific dimension, assign themselves the mission of deferring the inevitable work of mourning modernity within the field of subjectivity. Science is the principal heritage of modernity.

Even as it unburdens us of the illusions of religion, it is supposed to guarantee the reign of rationality. This substitution of reason for the Other is supposed to guarantee the promise of happiness, taking charge of human destiny through the enterprise of reason. Modernity thus initiated the hope, if not the illusion, that the empire of reason and—why not? —the signifier, would make it possible to cure all the ills that derive from affectivity and its imaginary avatars. Today, we willingly believe that we have long since abandoned such illusions, shattered by postmodernity, which has accustomed us to the work of analysis, demystification, and deconstruction. Nonetheless, we have not ceased to think, along with a certain science, that all of our ills are of biochemical nature and that it will only be a matter of time before we rid ourselves of them. Advances in biochemical and neurobiological science hold out the promise of happiness. If the great ideologies have progressively assumed the place of religions, which used to found and legitimate the ideals and norms that govern our lives and civic coexistence, and they have themselves gradually disappeared and evacuated the horizon of the signifier, then one might claim that this empty place has been filled by the extreme ideology of scientism, the only thought that upholds the achievements of science as the basis for new social and historical ideals. But the appearance of such achievements is perhaps deceptive.

Instead of Western Europe, America now carries the torch of a chosen people invested with the mission either to bring the good news to all other peoples, to civilize them, or, as with the United States today, to bring them the democracy that would guarantee peace along with economic development and well-being for all. The paranoid mania, a kind of gentle madness, to believe itself superior to all other peoples and to assign itself the mission of becoming their saviors, supports all other values. Although official ideologies have no other function than politically to legitimate this madness, it is not, as we are often encouraged to think, simply the province of the extreme right. This maniacal thought permits a certain science to remain at the level of an epistemology that dates from the Christian middle ages, according to which the human spirit benefits from a share of divine thought, so that it can possess an exact representation of the world such as it is constituted in the mind of God. Our mental representations would thus not be human constructions, but rather veritable reproductions of the structure of the universe. Truth can then be conceived as the adequation of our representations to the structure of the objects observed within the universe. This schema, which has survived for centuries because it partakes of the religious justification for dominating peoples, still animates the epistemology of certain sciences and informs their experimental dimension, charged with controlling the reaction of subjects. Nonetheless, the contemporary advances of physics and mathematics, which serve as a reference point for all of these sciences, are more and more foreign to such claims about the relation between our mental representations and the reality of our observations.

## THE ILLUSION OF TREATMENT<sup>1</sup>

This censured and implicit epistemology today dominates the domain of practices in the health sciences. Within the field of mental health, in particular, all of our ills are supposed to become the more or less long term object of the best care with the best results, thanks to the now irresistible advances of science and, especially, of neuroscience. The question of treatment introduced by psychoanalysis is thus often confused with the problematic of care that dominates the field of medical practice. Doctors and hospitals have plenty of treatments to offer, using the best means placed at their disposal by the health sciences. They treat physical troubles whose biochemical and neurological causes and consequences are clear, well known, and experimentally demonstrable and verified by third parties. On the one hand, there is thus a structure for physical and medical treatment that implies that the caregiver will intervene on the level of the cells, tissues, organs, and systems or functions of the organism that becomes the object of care. On the other hand, the treatment revolves around a relation, structured and framed by an institution, between a team of caregivers and the patient, along with his friends and family. The act of giving care is conditioned by these structures and cannot be abstracted from them without affecting its results. Within the limits imposed by the object of its intervention, such an act cannot do without a minimum of involvement on the part of the patient. But it remains fundamentally the intervention of a technician or a specialist upon the organism of a client. This intervention is clearly delimited and makes it possible to calculate a result that has been predicted and agreed upon by everyone. In everyday discourse, if not official discourse, this dispensation of care is more and more often confused with what psychoanalysis evokes with the concept of treatment. This confusion has grown to the point that it tends to make the incurable indistinguishable from the untreatable, sustaining the illusion that treatment is possible in milieus dominated by the administration of care. Moreover, this confusion is repressed in the English language, as if it were the object of an interdiction upon thought, especially within milieus where the human is regularly reduced, from an epistemological standpoint, to its biological functioning.

Indeed, care is not treatment. When we speak of treatment within psychoanalysis, we are in an entirely other register than that of care. Psychoanalysis delimits a domain of application in which the concepts and practices of care are hardly applicable. One will thus say that a psychiatrist cares and that a psychoanalyst treats. An interesting French idiom allows us to underscore this difference. When one says of someone that he is *intraitable*, this means that he is *intractable*, that he refuses to compromise his principles. In more Lacanian terms, one could say that he refuses to give up on his desire. The notion of psychoanalytic treatment is of this same order. Contrary to care, which centers on the action of the caregiver or the team of caregivers, the notion of treatment is centered on the relation between the subject and something without which his

very existence would no longer matter to him—that which, in psychoanalysis, we call his desire. This notion of treatment requires a radical experience on the part of the subject that calls into question his relation to something that is as important to him as the apple of his eye [*la prunelle de ses yeux*]. It thus calls for a rethinking of the very foundations of a being's existence and his relations to others. In order for it to be considered a treatment, its particularity must reside in the analyst's desire to constrain the subject to assume an ethical position with respect to the knowledge derived from the experience. The problematic of treatment implies that the objective is to assume the consequences of such a knowledge and thus to take ethical responsibility toward oneself and toward others. This ethical constraint upon the position of the subject with respect to the knowledge derived from the experience and its consequences is the very object of psychoanalytic treatment. This position led Freud to recommend to Tausk that he terminate the analysis of a patient whose ethics seemed to him clearly insufficient. Treatment consists therefore in undertaking a radical experience that gives access to a knowledge; and the analyst expects that the first consequence of this knowledge will be a mutation of the ethical position of the patient.

With respect to such a perspective upon treatment, the practices that psychoanalysis might introduce into mental health are far removed from the practices of health care envisaged by medicine or even psychotherapy. On the one hand, psychoanalytic treatment is not an intervention; on the other hand, its domain of application is not the organism, nor the social link, nor the history of the patient. With its treatment, envisaged as an ethical constraint upon the position of the subject in relation to certain mental representations, psychoanalysis seeks to act upon the decisions of the subject himself. For this reason, it suggests that the cause of mental trouble is to be found, not in the organism, which only registers the consequences of this trouble, but rather in the response of the subject to some mental representation. Psychoanalysis thus reintroduces the whole problematic of subjectivity, which science had rejected and excluded, into the problematic of treatment that pertains to mental health care. Moreover, the subject cannot be accessed either experimentally or scientifically; nor can the mental representations that provoke the responses in the subject that we are calling "mental trouble." This dimension, which has been reintroduced by psychoanalysis, renders illusory any attempt to care for the subject, his ethical position, and the mental representations that overdetermine the social, cultural, or historical receivability of his responses. Health care is thus structurally inadequate, because it evidences what, from its own standpoint, can only be thought as incurable. All of our scientific approaches, as they are promulgated today, which reduce the subjective dimension of the human within mental health, necessarily encounter the limit of the incurable that becomes perceptible within the problematic of psychoanalytic treatment. The misunderstanding that we are analyzing can only deepen to the extent that the reduction of subjectivity to its neurobiochemical dimension continues to dominate so-called scientific approaches to human troubles.

## THE INCURABLE WILL SOMETIMES ALSO BE UNTREATABLE

This is the case with psychosis, with many situations of perversion, and, in particular, with femininity. What is presented as incurable by psychiatry and the neurosciences will remain incurable from the point of view of psychoanalysis. Nonetheless, the perspectives opened by Lacan's advances, along with the results of our own ethical and clinical advances, which have sought to rebuild Freudian metapsychology on the basis of the clinic of psychosis, allow us to think that the incurable in psychosis is sometimes treatable. Psychotics enter into psychoanalysis, progress to a certain endpoint, when they decide to enter into the social link as fully participating citizens. Such results remain unthinkable within the framework of care and psychotherapy. Therefore, we must rethink the relation between the problematic of the treatable and the incurable. In fact, what psychoanalysis treats has no common measure with what medicine and psychiatry care for. By all accounts, the real at stake in psychoanalytic treatment is no more susceptible to medical intervention than to suggestion or psychotherapeutic advice. Often this real can appear in the form of the incurable, mobilizing the resources of the entire being to express itself through profound neurophysiologic troubles or accidents. This point would be worth serious examination.

What happens in psychoanalytic treatment? On the simplest level, the analyst invites, then constrains the subject into an experience that confronts him with his interior demons and that engages him in a process whereby he profoundly reworks his entire life. Such a position is radically different from what one expects of a doctor or a psychotherapist. It supposes a manifest change in perspective upon what causes the human and certain of its troubles, and upon its mode of functioning with respect to that cause and those troubles. Such a perspective does not in any way invalidate the medical or psychotherapeutic perspective; but it does dramatically manifest their insufficiency, their incompleteness, and their inadequacy when it comes to treating the positions and responses of the human subject with respect to certain mental representations. In the same way, the psychoanalytic perspective will appear inoperative, inadequate, and illusory when situations or troubles arise that have to do with the malfunction of cells, tissues, organs, or properly biological systems; or with psychosocial situations that require appropriate care and/or psychotherapy that are foreign to the perspective of psychoanalysis.

The psychoanalytic perspective turns upon the affirmation that the human being is always grappling with pure mental representations, to which it responds, and in relation to which it organizes all of its thoughts, its actions, and objectives—that is, its entire personal and social existence. The principal characteristic of these representations is that they are intimate experiences that cannot be repeated and thus cannot be made accessible to others—neither by observation, nor by experimentation—unless the subject decides to establish them in speech. Herein lies the theoretical justification for the radicality of the signifier and its irreducibility to interpretation. Such representations constitute, to an essential degree, the real of subjectivity that is the object

of psychoanalytic knowledge. Therefore, in order to gain a clearer understanding of the difference between the object of care in medicine and psychiatry and the object of psychoanalytic treatment, one must have a more detailed sense of the stakes of these pure representations at the heart of subjectivity.

What we are designating as a pure representation, drawing upon a Kantian problematic, concerns representations that do not correspond to anything that can be contained within the limits of reality and of the pleasure principle. Nothing can be grasped within the limits of the space-time that defines reality and conditions pleasure for the biological and social beings that we are. Accordingly, in order to grasp the scope and importance of these representations, it is necessary to begin with the concepts of hallucination and imaginary numbers. Why these concepts? It is simply because they correspond exactly to what is at stake in the question that interests us here. It would, of course, have been possible to start with other concepts of the same nature. This point of departure already entails an entire series of questions that we will only mention briefly, not doing them justice, because they would take us too far from our main topic. But the stakes of these concepts are no less determining for the question of the distinction between treatment and care. Hallucinations are not, for us, mental representations in the same sense as imaginary numbers. As human beings, we have the capacity to produce mental representations to which nothing corresponds in our internal or external environment. Thanks to them, however, we can create strategies of intervention or means of action within this environment. In a sense, they deserve to be called tools as much as the tools that we construct in reality in order to intervene in the world of our environment. What we call *spirit* refers to this properly human capacity to produce and to manage such representations and their consequences.

The neurosciences, modern psychology, and psychiatry consider such representations as false representations, because they do not correspond to anything that exists within the limits of realities that science can verify or construct. And the discourses that open with these representations are evaluated as delusional. Within the same perspective, behaviors that are elaborated on the basis of such representations are obviously at risk of being judged pathological, unless these behaviors accord with the characteristics of what has been deemed receivable within a given society. From 1915 to 1925, Freud was preoccupied with his discoveries about the way in which the action of these representations impact the clinic that he had set to work under the name of psychoanalysis. The unconscious, which was the invention of his new psychology, upholds these very representations, firstly, as the veritable cause of a human sexuality that profoundly subverts the function of reproduction, and secondly, as the foundation of desire and speech. It is, in a sense, the mathematical place of these representations. The Freudian unconscious thus introduces subjectivity as a veritable mutation that displaces the responsibility and intentionality of the human act outside the field of conscious perception and of the space-time defined by the neurophysiologic limits of pleasure and reality. This rupture introduced by Freud wounds all of

our conceptions of the human being and its undertakings, from aesthetics to science, going by way of erotics and the religious, leaving only mathematics and very little else unscathed by its subversive action. This rupture, that Lacan sought to re-open and to keep open, is a continual target for all the revisionisms and repressions within psychoanalysis itself, which do nothing but provisionally ensure the repeated unsuccesses of psychoanalysis, to the great satisfaction of its detractors.

To the extent that psychoanalysis lets itself make common cause with therapies of all kinds and neurosciences that favor medical care for the inevitable troubles provoked by this dimension of being that Freud called the unconscious, it is doomed to fail. These troubles as such are necessarily incurable; they cannot become the object of care. Even if their consequences within the organism can become the object of the best medical care, they still remain untouched to the extent that their profound cause has not been addressed. This is precisely what we demonstrate in our clinical practice with psychotics.<sup>2</sup> Of the five-hundred patients that we have treated over the last twenty years at the “388,” our center for the psychoanalytic treatment of psychotics in Québec City, clinical observation has shown that those among them (60-65%) who really pursued long-term psychoanalytic treatment eventually returned to social life to participate as a full citizen. Nonetheless, they did not lose the radical critique, bordering on the global refusal of society, that characterized their subjective position in psychosis. They seem rather to have acceded to an ethics in relation to their psychosis and to an ethics of collective responsibility, in which they are active participants, for the fate of humanity within society. More disturbing, but also more positive, is the fact, the possible causes of which are being studied in the clinical observatory, that 35-40% of cases end in failure. The best supported hypothesis until now is that, in most of these clinical cases, around 20% of them, it is possible to discern a refusal of analytic treatment and its effects upon psychosis, either in the form of frequent interruptions of the treatment or its simple termination. And all of these cases present specific symptoms that accompany the interruption or the termination of analytic treatment. In other cases, the progress observed, or the appearance of failure, are not significant enough or well enough documented to be classified as successes (or failures) of treatment. These clinical facts allow us to propose the provisional conclusion that the incurable can sometimes turn out to be untreatable. But they leave intact the question whether the incurable must necessarily be treated. This is, in fact, the most important question introduced by psychoanalysis since Lacan; and it leads us to revisit metapsychology on the basis of all the knowledge that we have drawn from the psychoanalytic clinic of the psychoses.

### **A MISUNDERSTANDING TO DISPEL ABOUT JOUISSANCE**

A total misunderstanding underlies the conception of psychoanalysis as a therapy, an extension of health care, whereas psychoanalysis is fundamentally an experience that calls into question our ethical practices. This misunderstanding is maintained on a theoretical and even a clinical

level, but it is, in fact, a symptom; and, as such, it sustains a hidden *jouissance*. What is the concept of *jouissance* introduced by psychoanalysis? Freud laid the foundation of the concept in 1905 with his “Three Essays on the Theory of Sexuality,” where he posits a hallucinated real that perverts biological functions and, in particular, sexual functions. Later, in 1920, with “Beyond the Pleasure Principle,” the concept is fully developed, as it articulates the drive in relation to a death foretold, foreign to the natural aims of life. *Jouissance* thus refers to the upsurge of a pure mental representation that provokes an effraction in the living being that disregards the limits of pleasure and reality. Or better, *jouissance* is the insistent work of this effraction, which subverts the conditions of conscious perception, pushing beyond the limits of reality and pleasure. For the first human beings, as for the child who can’t yet speak, this effraction of space propels the being into time, subjects it to something else, a real, which the perception of reality, or the acute consciousness of the limits of pleasure, could never contain. *Jouissance* refers to this fundamental experience that makes beings into subjects of a real that turns them definitively away from the reality of their biological and social roots. As such an experience of an effraction into being caused by the object of hallucination, *jouissance* constitutes the being as unique, cut off from others and his environment, thrown into an absolute solitude where the other is the stranger.

Under these primordial conditions, that the psychotic knows very well, and the analysand at the end of analysis encounters with the emergence of the *object a*, there is no possible society. Also, the creation of language does not found the social link upon the mere possibility of communicating this primordial experience, which is, in any case, untransmissible, and founds the unicity of the subject. Language institutes the social link by defining the receivable, the visible, the audible, along with the interdict and the ideal, against the subject’s pure mental representation and against hallucination. No matter the fascination, attraction, or passion that can be inspired by the mental object, the signifier posits itself against the desire that opens beyond the perceptible and the conscious, the visible, and the conditions of the social link. The feminine subject, the pervert, and the psychotic hold onto a force that seems to inhabit their conviction of being in the truth. Contrary to all appearances, the feminine subject manifests her lack of faith in language; the pervert displays contempt for all the justifications of the established order and the affirmations of the common good; and the psychotic is possessed by a will to reform language so that it can reconcile the social link with the incursion of *jouissance* and its cause. In all of these exemplary cases, an intimate exigency commands that experience come first, before its interpretation, and before its contested, if not impossible, representation.

The staging of the social link within language is organized as an interdict upon hallucination and is structured as an interdict upon thought. But being does not stop responding to the effraction of *jouissance* or to the hallucination that causes it. Both this effraction and this hallucination remain inaccessible to the other’s perception and to the control of consciousness; and they thus escape

all reproduction or verification, experimental or otherwise. Accordingly, the being's response to them, the drive itself, remains in some sense mythic. As Freud wrote, the drives are our myths. We have no idea what they respond to, or what they consist of. But we cannot deny either the strangeness of their presence, nor their anxiety-producing insistence, nor their disjunction from our environment and our social situations. Indeed, what the drives respond to, this *jouissance* that marks the effraction of the hallucinated object, projects us outside what is deemed receivable in the social link. The visible, no less than the ideal, even if they are supported by the symbolic order of things promoted by language, cannot resist the signifier that erodes and hollows out this order by evoking the work of *jouissance* within being.

The real of this *jouissance* thus imposes itself and insists as what causes the being as a subject of speech and of a desire that singularizes him or her. If, indeed, the subject takes a position within language that is contrary to the receivable, and if the subject requires something that is beyond the visible and that contests the ideal, it is because the object of an experience that corresponds to his most intimate exigencies, and that makes him ultimately untreatable, is a real that causes the desire that speech can evoke at specific moments. In the formulation of a fantasy, this real imposes the logic of a non-negotiable *jouissance*. But it can also subvert the logic of a being's neurological and even biochemical functioning to the point of affecting the structure of his systems. As an effraction to which the being responds, the real of this *jouissance* cuts a memory of its occurrence into the being's neurochemical and genetic structure and thus profoundly modifies it and constructs its body as the writing of a subjective history that detaches it from the logic of the organism. The psychoanalytic clinic has thereby rediscovered the foundation of the psychoanalytic symptom, in which the being responds to a *jouissance* that the superego withholds from all norms and ideals. More often than not, those who today seek medical, psychiatric, or even psychological advice want to put an end to the ravages of such *jouissance*.

To the extent that a psychoanalytic practice takes into account the true stakes of the real of *jouissance* as cause, it will necessarily be oriented by an ethical problematic. Indeed, the question for such an analysis is the position of the subject in relation to *jouissance*, the work of the object as it breaks into being. The effects of such work, on the level of the body and on the level of the social, undermine the relation to oneself and to others, depending on the ethical position of the subject in the fantasy that determines his relation to *jouissance*. The subject might, for example, prefer to abandon himself to some Other rather than take responsibility for his position. In the place of this Other, he could also address himself to any willing doctor, therapist, or—why not?—spiritual master. The psychoanalytic clinic has taught us how this recourse to the Other, in which the subject abandons his ethical responsibility, factors into the persistence of the symptom, no matter how much suffering accompanies such a position.

## AN UNTREATABLE REAL

The request for medical care to counter the ravages of *jouissance* inevitably encounters obstacles inherent in the illusion that it is possible to manage this real, which unfolds outside the limits imposed by the space-time of reality and pleasure, with the means and techniques of biology and its laws. In psychiatry, medicine, and now psychology, one tries to use new chemical compounds in order to manage hallucinations and delusions. And, in the wake of their failure, one always promises even newer, better, and more effective cures, with the distinctly scientific certainty that each new failure represents progress toward eventual success. One thereby never perceives that what one seeks to cure cannot be situated within the domain of care, despite the scientifically practical obsession to reduce the human to the biological. When one considers how partial it is, this obsession itself starts to seem delusional. Indeed, a large portion of human beings openly function on the basis of delusional discourses founded upon hallucinations. It could well be that the number would include over half of human beings alive today. Far right, fundamentalist, or even merely conservative religious discourses, whose foundations lie upon the centuries-long practice of controlling populations, seem for obscure reasons to achieve more credibility than the discourses of certain patients, which are immediately ascribed to a mental pathology. That which, on the individual level, is relegated to biology so that it may become an object of therapy and physical treatment, shows itself, on the collective level, as something that lies beyond all illusion of therapy or care, and as a historically decisive ethical and political matter. This real is thus an unavoidable figure of the untreatable.

Two very important logical moments in analytic experience will clarify the dimension of the untreatable that characterizes the real, which Freud calls a “psychical reality,” instituted by *jouissance*. These moments correspond, in fact, to two presentations of the rupture in which a being, as the object of a censored *jouissance*, becomes the subject of a desire and a speech that would evoke this *jouissance*.

## THE REEF OF THE SYMPTOM

The first logical moment that we will evoke concerns a relatively advanced stage in an analysis. For a certain period of time, the analysis of dreams has given the analysand access to the other scene where what is essential for him gets decided, that is, the essential part of what happens to him and troubles his attempt to order his life in terms of the rules and values of the social link. He can, in some sense, begin to measure how little importance is attached to what he believed to be his thought, his will, and even his conscious desires and his goals in life. He begins to discover that the motives for his illnesses and his symptoms are not to be found in the circumstances of his life, nor in the accidents and detours of his history. Instead, they seem wedded to the more or less perverse contours of his infantile fantasies, whose consistency probably still seems

doubtful to him. In particular, it is obvious that the importance of the repetitive and insistent symptom that led him to analysis, no matter its physical dimension, inheres in the knowledge that it provides about the patient and his ethics of life than with the difficulty of providing him with appropriate care.

Access to the unconscious has the effect of calling into question the Other of seduction, or even of leading to its collapse. To wish and to imagine oneself as the object of the Other's love and attention can help a child to limit, or even to nurse the illusion in him that he has escaped the ravaging and anxiety-producing effects of *jouissance* within his imaginary and within his body. This defines a precise position for the child in relation to the effects of *jouissance*, which can now be imputed to the Other. He hands himself over to the Other. As the analytic clinic shows, this infantile position does not depend upon age, or upon psychological development. The satisfaction of the Other's demands, the concern to keep his love, the complaint about his indifference, or the resentment and hatred provoked by his lack of love, the entire range of imaginable responses, do nothing but fuel the fantasy that supports the logic of this dependency of the being upon the Other. The normal development of the cure leads analytic experience to discover this other scene, where, far from consciousness and the stakes of the social link, the logic of such a fantasy does its work. As the dream interprets the responses of the being to the Other, it unerringly stages the logic of this ethical surrender.

The symptom thus comes into its own dimension, that of supporting the ethical position of a subject. It encodes, in a sense, a point that the subject will not negotiate. The fall of the Other would thus have two consequences. On the one hand, it leaves the subject in solitude, faced with the void implied by the absence of any recourse in relation to the effects of *jouissance*. On the other hand, the subject, deprived of the Other, is constrained to change his position. The depression that can accompany this moment will define the response of the subject. But it is important to grasp the scope of what has been playing itself out until this moment of rupture. No matter what the symptom was, its function was to encode the scene of a *jouissance* that must remain censored, unsaid, or somehow maintained outside the signifier. All the care designed or obtained for the symptom then reveal itself to have had the specific function of reinforcing the symptom. It maintains the recourse to the Other—no matter whether it is a doctor, therapist, spiritual director, or guru—who is reassuring and redoubles the coding of the subject's surrender. But, at the moment when this coding is overturned, it also becomes clear that the suffering exposed in the symptom cannot be dissociated from the *jouissance*, embezzled from the Other, as it were, and invested in the fantasy.

Indeed, *jouissance*, as the work produced by a hallucination as it breaks into a being, projects the subject outside the limits of reality regulated by space and of pleasure regulated by time, confronts the being with death as the absolute limit of this work. The symptom is what raises the

question of the limit of the censored *jouissance* of the fantasy. To what point can the subject accept the suffering of the symptom in order to sustain the hidden *jouissance* derived from imagining himself as an object of the Other's desire, love, or even hatred? This is a question occulted by the very coding of this *jouissance* in the symptom. Therein lies the basis of the primary masochism that seems inseparable from the secondary benefit of the symptom. Everything unfolds as if the suffering caused by the symptom were never enough to justify abandoning the silent *jouissance* of the fantasy. The fascination with the object of hallucination that provokes the ravages of *jouissance* is always stronger than the being's reaction against suffering in order to preserve his life and thrusts the subject further into the fantasy. Indeed, in the end, there is no response to the question of how far a being can go into the suffering of his symptom so that the subject can continue to enjoy his fantasy in silence. This is one of Freud's central discoveries in "Beyond the Pleasure Principle," which he takes further in "The Economic Problem of Masochism"; but it is also a crucial experience in every analysis that gets to the point of traversing the symptom.

It is also one of the strangest and most unavoidable difficulties of psychoanalysis as such. The position of the subject who seeks treatment in relation to the intimate *jouissance* that motivates all the troubles of which he complains, is a position coded within the symptoms that articulate these troubles with the signifier. The lifting of the symptoms is strictly coordinated with the moment when the logic of the fantasy gains access to the subject's speech, to the extent that such an access to speech makes it possible to "say well" the *jouissance* at stake in the fantasy. The difficulty of this logical moment within any analytic cure is essentially bound up with the subject's ethical decision. Indeed, only a change in ethical position in relation to *jouissance* can dissolve the mortgage of primary masochism and come to terms with the benefit derived from the symptom. The psychoanalytic clinic of the psychoses makes quite evident how little help psychiatric care is at this logical moment in the clinic of the symptom. Such care encounters the decisive obstacle of primary masochism, in which the object of care becomes the ethical position of the subject in relation to the *jouissance* that causes his troubles. Neither the approach of physical medicine nor that of psychotherapy can have the least effect upon such a position.

#### **THE UNTREATABLE: FROM THE TRAVERSAL OF CASTRATION...**

Another decisive logical moment demonstrates to what extent, in the analytic cure, the ethical position of the subject is fundamentally what determines the ill that he complains about, and to what extent this ill resists any form of care. As such, it is incurable, but it is very precisely the object of psychoanalytic treatment. This logical moment in analytic treatment assumes capital importance in the analytic clinic because, in fact, it pertains to the object that sustains the desire of the psychoanalyst in the process of analytic transference. In order to grasp this logical moment in any analytic cure, it is necessary to refer to the psychoanalytic concept of castration, as it is understood in metapsychology today. Since castration is actually a concept that has been

cobbled together from an accumulation of misunderstandings, it is not surprising that most of the theoretical and clinical deviations of psychoanalysis fuel the misrecognition of this concept.

Within the perspective that we are developing, castration is an unavoidable effect within the human, due to the mutation that language causes within the human species. Referring to the givens of evolution, we have suggested that, early in history, the upsurge of a hallucination or a pure mental representation within the environment of the *homo sapien* breaks into his consciousness and in the biochemical order that regulates his relation to the environment, giving him a taste of something other than reality or pleasure. The human being is thus effectively turned away from the conditions for survival within his physical and social environment, in such a way that he invests a world of objects that have nothing to do with survival or with the environment. The investment in hallucination then gets the upper hand over survival itself, much as it does for the child or the psychotic. Because of this fundamental trait that constitutes the specific difference of the human, society is not possible, nor is the social link—which is not the case in the animal world. It is what accounts for the meaning and structural necessity of the mutation of language. Thanks to the signifier, language creates the social link, defining what is visible, what is audible, what is receivable, and what is desirable in opposition to the stakes introduced by hallucination, and it articulates the relation to the Other in terms of the interdict and the ideal. The space-time thereby constituted through the signifier redefines perception-consciousness and the limits of reality. The signifier institutes another place, another space-time where subjectivity is rejected, riddled with holes by the action of the hallucinated object, and left hanging upon the real of the incursion into being by this object. Castration is precisely this rejection of the subject in relation to the signifier that institutes the social link; and it results from the incompatibility of language with the irresistible quest instituted by the object of hallucination. Cut off from the ego that represents a being upon the social scene overdetermined by the signifier, the subject remains knotted to its quest for the object that causes it. This division between a being and its ego, redoubled by the more radical division between the subject and the object, installs a permanently irreparable cut, which is the effect of the seizure of being by language and becomes the source of an exquisite suffering. The concept of castration thus refers, on a theoretical level, to this structure that constitutes the difference of the human that divides the being from itself with an unhealable wound, which tears it from its roots, and renders it foreign to its own survival.

The subjective experience constituted by an analytic cure thus revolves around several unavoidable clinical moments that determine the logical unfolding and clinical consequences of this experience. Each analysand must discover and clinically traverse the structure that makes legible the unconscious position of the subject in relation to jouissance. In his experience of the clinic, each analysand traverses the phase of castration according to a logic that pertains to him alone and is determined by a certain fantasy. The clinic of the symptom shows the subject that he must change his ethical position in relation to the jouissance of the fantasy from which the symptom

derives its secondary benefit. Without the subject's ethical decision to submit the *jouissance* at stake in the symptom to full speech, the analytic experience will turn indefinitely in circles and nothing will constrain the subject to face castration. Submitting the fantasy and the *jouissance* at stake in the symptom to the signifier leads to the collapse of the Other of seduction. There is no one left to surrender to, nor to reproach, nor to depend on for help. In fact, the analytic experience logically constrains the subject to face the evidence of his solitude in relation to the agency of decision in his unconscious. He has the experience of this other place within him where the decision gets made that determines his most important choices, as well as his most serious illnesses, his most debilitating errors, and his most encouraging successes. As the experience progresses, the background painting of the subject's life is sketched out for him, where he finds already depicted the events, which he thought were the fruit of chance, that have articulated his history. He thus begins to think that, somewhere within him, a logic has imposed itself that is unrelated to what he had, until then, attributed to the good- or ill-will of others.

The unconscious thus takes the form of an implacable fantasmatic logic, functioning independently of the conscious will and affirmed choices of the subject, definitively cutting the being off from the places where the clearest aspects of his life have been decided. His illnesses, his intimate preferences, his hidden *jouissances*, his hatreds, his friendships, even the intimate details that mark the form of his body, along with his social and professional choices, his tastes and his attractions, everything that he had until then considered as his essential personality escapes his reason and turns out, in an uncanny manner, to refer to this other scene that he discovers within himself. But the most somber aspect of this logical moment in the experience is the subject's anxiety and solitude in relation to this discovery of the division of his being. The experience, which might occur in a moment of profound depression, of a temporary loss of all points of identification, which might lead the subject to seek psychiatric or psychological help or psychotherapeutic rescue, now appears to him to be a structural state that no specialist's intervention can do the least thing about. He discovers the extent to which the symptom that encoded his *jouissance* had the function of keeping him far from discovering his profound implication is his own misfortunes.

### ... TO THE CONSTRUCTION OF THE *OBJECT A*.

The subject must then face his ethical responsibility in relation to something irreducible that he discovers within himself, his unconscious that is the untreatable source of all his ills, which stymies all possible therapy. This unconscious is neither the depot nor the memory of the traumas and tragedies of his personal history. Nor is it the ensemble of psychic traces of the twists and turns of his psychic evolution and the obstacles or parental constraints that marked this evolution at each of its stages. Much more radically, it is an unavoidable and structural dimension of his being as a speaking subject exiled within his desire, in search beyond language for an object that is unrepresentable in terms of the signifier. With the analysis of *jouissance* and the masochism at stake within the symptom, he discovers the vanity of his relation to the Other when it is compared to the importance of his responsibility and his ethical position in relation to this lethal *jouissance*—which had, until

then, been ascribed to the Other, but which is at the heart of all his choices and all his ills. He takes the disquieting measure of his quest, which seems so strange against what may be presented within the social link and in reality. The object of his quest then reveals itself to be the object of all his misfortunes. He can neither rid himself of it nor require that it be healed, unless it is by the negation of his very existence as a subject. Also, he is no longer in a position to act as if he knew nothing. Only two options remain to him. Either he assumes responsibility for this knowledge, or he gets what he can out of a protected jouissance in the form of a symptom that will put an end to the analytic experience. It is necessary to recognize the practical side of this second solution, because it seems the option favored by the end of many analyses. It would not be surprising if it lay at the basis of many of the schisms that have shaken up the history of analysis. In any case, it does not bear witness to a misrecognition of castration, but rather to an ethical choice taken in relation to castration that is one of the possible ends to the analytic experience.

I would say that what characterizes or should characterize Lacanianism from a clinical point of view is the exigency to go further with the ethics of the analytic experience. Such a characteristic is not without consequences for the theory of the clinic as well as its results. In any case, this exigency is a necessary condition, even if it is not a sufficient condition, to lead the cure of a psychotic beyond what psychiatric care and psychotherapy can hope for, there where the experience of the psychotic revolves around a properly untreatable real. For every analysand who accepts that it is necessary to confront the difficulties of this logical moment in an analytic experience, the question is simple, but maddening. Is he ready, and with what resources, to assume ethical responsibility for what plays itself out and gets decided within the other space of the unconscious, with all the consequences that it will entail for him on the social scene, his family life, or his professional and civic engagements? The traversal of the fantasy of castration that leaves the subject alone to face the structure that causes him can only lead the subject to the exigency of responding without further ado to this question. He can no longer flee in the face of the troubling knowledge that, what causes him as a subject of speech and desire, and that motivates and modulates all of his undertakings, is also in large part what causes all of the intimate trouble and the suffering that occasion his complaints.

This knowledge can also provoke a certain enthusiasm and a profound liberty, as analysis regularly shows when an analysand decides to assume the ethical responsibility that falls to him at this precise moment, which, in the theory of the clinic, we call the traversal of castration. The testimonies in the cartels of the *Passe* go in the same direction. The subject constantly wants to know how this paradoxical cause that, within him, without him, decides what he is, what he thinks, what he suffers from, and what he enjoys, while he has never taken the least part in this decision, unless it is to take full responsibility for it after the fact. The solution of this paradox quickly becomes an ethical exigency for the analysand. From a certain moment onward, he will enter into this exigency with all the resources that his unconscious and his experience of the logic of its functioning have put at his disposal. In the attempt to find everything that could help him articulate his unconscious position within the fundamental fantasy, he will then go back to the key signifiers of his analytic experience and to the letter where jouissance inscribed itself within his

body at the moment of effraction, the response of the drive, and the work of the symptom. It is in the midst of this search for unconscious markers of what underlies subjectivity that a hitherto unsuspected representation of the unrepresentable object will impose itself upon the subject and justify the search itself. The work of the subject to grasp what then presents itself as cause will plunge him into a work of construction, which, as its forms impose themselves, will reveal how the object taking shape in the work had, at the various stages of the process, as well as in every aspect of his life, always been at the heart of the logic that articulated his being in relation to a jouissance that he never did and never will be able to control. The attachment of the subject to this real then becomes the motor of his very existence.

Nonetheless, it is this real, without which he is nothing and everything seems to him lifeless and useless, that was also at the heart of all his ills. At an initial moment, he would hope that a psychoanalysis envisioned as therapy would cure him of this real and the illnesses entailed by its effects. But, once the work of producing the object shows him to what extent his subject position is implicated in this real, he can only want to gain an uncompromising view of this implication. The insights and observations of analysts at this logical moment of the end do not contradict the testimonies of analysands in the cartels of the *Passe*. But the former differ from the latter in a remarkable way. The analysts, as privileged witnesses of these enthusiastic conclusions, always confirm with the same surprise what they knew right away: what was invoked and underscored from the beginning as the ill to be dislodged, and as the object of therapeutic, medical, or psychological failure, reappears at the end as the very place where the subject must go to assume full ethical responsibility for what happens to him. Once again, these analysts confirm anew that psychoanalysis is not a therapy, but an ethical practice. As for the analysands, they grasp that this real is not the object of therapy or care, but is rather that which they cannot live without.

When all is said and done, science will not stop trying to find the curable causes of our psychic illnesses with the best means they can create and deploy. We must count upon these means, because psychoanalysis is not a therapy, but an ethical practice. The modification of the subject's ethical position in relation to effraction, hallucination, jouissance, and their consequences, does not suppress their neurobiochemical or genetic effects that prolong their inscription within the being. Nonetheless, what for science remains incurable still enters the field of what is treatable for psychoanalysis. On the other hand, analytic experience shows that what science might posit as the object of care or therapy can remain untreatable for psychoanalysis. In all cases, the experience of the subject is the only credible criteria. They are the only ones who know what they suffer from, what they are dying from, and what causes them to enjoy, beyond the debates between the specialists that do not go beyond their own givens and the practices that they serve to justify. But the real of subjectivity that psychoanalysis brings to light is still the object of ethics, not of care, and it will always resist any attempt at therapy, because it is fundamentally untreatable.

1. The argument that follows depends upon a clear sense for the distinction between several related French terms: *soins*, *guérison*, *traitement*, and *cure*. To a certain extent, it is difficult to translate these terms in a way that renders their distinction clear enough. *Soins* refers largely to the regime of what we call “health care,” although, in many instances, it could also be understood to refer to medical or psychiatric treatment. Nonetheless, to accord with the displacement that this essay seeks to effect, the English word treatment has been reserved as the translation for *traitement*, which refers specifically to psychoanalytic treatment. Likewise, *guérison* means both the healing and cure that constitute the goal of medical care; but, the English word cure has been reserved to translate the French word *cure*, which refers to the singular work of

psychoanalysis under transference. That said, it is also important to distinguish between psychoanalytic *treatment* and a psychoanalytic *cure*. At the “388,” the center for the psychoanalytic treatment of young psychotic adults that Apollon will mention later in the essay, “treatment” refers to the ensemble of the ways in which the center receives and engages its users, whereas “cure” refers to the specific work that takes place when these users become analysands. [Trans.]

2. More information about the “388” is available at <<http://www.gifric.com>>. See also Willy Apollon, Danielle Bergeron, Lucie Cantin, *Traiter la psychose* (Québec: Éditions du Gifric, 1991). [Trans.]

