THE PATIENT AS ACTOR: NOTALL IN THE CASE PRESENTATION

Cormac Gallagher

" Charcot's lectures... produced their effect primarily by their constant reference to the patients who were being demonstrated... I sometimes come out as from out of Nôtre-Dame, with an entirely new idea of perfection "

Sigmund Freud

"None of you listen..."

Lisbeth Salander, the bloody-minded heroine of the Millenium Trilogy[1], has her own way with psychiatrists: *"I will never ever talk to you or any other crazy-doctor. None of you listen to what I have to say. You can keep me locked up here until I die. That won"t change a thing. I won"t talk to any of you"*. But then she had been the victim of an internationally respected Swedish doctor who at the bidding of the state systematically abused her with psychoactive drugs and physical restraints. An atypical and moreover fictionalized story!.[2]

Just as "One flew over the cuckoo"s nest"was becoming a distant folk memory this new dramatization in one of the major best-sellers of the naughties of the plight of the mentally ill patient confronted with the manipulative power of psychiatry has done nothing to improve the credibility of the profession. Political considerations aside, the main ethical issue for these authors centres on the objectification and dehumanization of people with whose psychological distress and malfunctioning their readers – unlike the doctors - can empathize.

For many of the new "anti-psychiatrists" – as well as for some health professionals - the touchstone of this inhumane approach is the practice of displaying the curiosities of speech and behaviour of the mentally ill before an audience who know from their theoretical formation that such subjective manifestations are meaningless and that what the patient says is to be listened to only with a view to categorizing it in one of the statistically manicured boxes of the DSM 4. The tone was set more than a century ago by the founder of modern psychiatry. Speaking of a patient who is present but not invited to speak Kraepelin says that in some letters he has sent to his doctor he expresses: "...all kinds of distorted, half-formed ideas, with a peculiar and silly play on words...He begs for 'a little more *allegro* in the treatment'....and '*nota bene* for God's sake only does not wish to be combined with the club of the harmless'".[3] Then as now it is considered a waste of valuable time for the psychiatrist to show an interest in such utterances! Enough to recognize that they are signs of *dementia praecox* and to take the appropriate steps.

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[1] Stieg Larsonn , *The girl who kicked the hornet's nest*, The Millennium Trilogy III, Maclehose Press, London, 2009

[2] After summarizing a catalogue of appalling conditions in the state-run mental hospitals, the *Irish Times* of 28.12.09 adds: "Non-compliance with the rules on the use of mechanical restraint, seclusion and ECT was of concern and was in breach of the rights afforded to residents as part of the Mental Health Act, 2001" in the acute psychiatric unit of Dublin's Mater University Hospital. It is only fair to add that in a subsequent debate more than one former patient joined its psychiatric proponents in arguing for the benefits of ECT.

[3] Emil Kraepelin *Lectures on clinical psychiatry*, revised and edited by Thomas Johnstone, William Wood, New York, MDCCCCIV. I am grateful to Dr Tom Dalzell for drawing my attention to this text.

Now this exhibiting of the features of an illness has its legitimate place in demonstrating to student-surgeons or physicians the signs that will help them to identify different forms of physical illness, and indeed television presentations that demonstrate cases of blindness or paralysis caused by insects or bacteria in third world countries have become an essential tool in public education. But when it concerns an exploration of the intimacies of human existence this ruthless objectification is an unpardonable invasion of the privacy of the individual. And so it may seem obscene to suggest that far from being an exercise in public humiliation, an ethically informed psychiatic case presentation can be an opportunity for patients to strut their stuff! Up to now they have been passive, "patients" to whom things have been done: forced into hospital by concerned family and anxious doctors – if not by the authorities – confined to bed, medicated and kept under constant surveillance. But as actors in a case preentation they have their fifteen minutes of fame, or at worst their day in court, where *they* will be the active ones: witnesses appealing to an alert staff and audience of puzzled and perhaps frightened students to hear their side of the story: to listen to the history of their suffering and of the failure of well-meaning friends and highly qualified experts to do a whole lot about it.

The patient as teacher

Their is no doubt that a clinical interview undertaken by someone who has mastered the intricacies of the Lacan"s exhaustive essay on *The Family* can offer a patient an opportunity to explore areas of his subjectivity that previous psychoanalytic and most current psychiatric protocols leave in the dark. But this is still very close to the methods advocated by Harry Stack Sullivan in *The psychiatric interview*[4] where the charismatic neo-Freudian author demands of the interviewer that he should earn his money and demonstrate his expertise to the patient who is paying him for precisely that!

So what does the "later" Lacan add to this laudable approach of the expert putting his knowledge and skill at the service of the patient?

It was in the 1967-68 seminar on the *Psychoanalytic act* that Lacan coined the word "psychoanalyser" (*psychoanalysand*) to emphasize that the task of the analyst was not to analyze a passive patient but to put him to work. Later, he even went as far as to say that if the psychoanalyser is invited to speak freely, as Freud had insisted he should be, it is because we recognize that he can seen as a "Master" and that what he says can lead to knowledge. This is particularly the case when the person in analysis wants to become an analyst and indeed one of the major differences with psychiatry is that the analyst must first of all be someone analyzed (*l'analysé*). But everyone who undertakes an analysis must be treated as an analyser - which is not an endorsement of self-analysis - and particularly so with respect to the story of their suffering. Lacan is proud of his new signifier. In *L'étourdit* he boasts: "…it is only due to me that he is so named (but what powder-trail can equal the success of this activation)"! And as we shall see it is in this text that he makes the clearest claims for the importance of the case-presentation in demonstrating the primordial place of the "saying" of the patient in the work of analysis.

[4] Harry Stack Sullivan, *The psychiatric interview* (1954), W. W. Norton, New York/London, 1970

The case presentation in the formation of psychoanalysts

My concern is with the formation of analysts and this paper has a simple aim: to encourage those who are involved in psychoanalytic teaching to explore the resources of the case presentation, not in the Kraepelinian or DSM-inspired sense, but as it has been renewed by Lacan's theory and practice. This with a view to furthering this formation and, what is more essential from an ethical point of view, to fostering a respect for what patients actually say. My own experience is that students who are quite well served as regards the theory, and usually have access to some serious analysts and supervisors, have little or no exposure to what Lacan considered to be this crucial element of his teaching.

I am speaking primarily about the local Irish situation but I suspect that the position is not much better in other English-speaking countries. The case presentation – if it exists – is under the control of psychiatrists who, in line with the prevailing culture of their profession, look on it as an opportunity to present, often in powerpoint images, the objective facts of the patient's medical and psychiatric condition. This will usually include some elements of family history, in particular the known psychiatric pathology, but the main emphasis is on the number of admissions, the different psychopharmacological medications that have been tried and the often dismal prognosis. Given the statutory responsibilitis of psychiatrists and their vulnerability to litigation such matters must of course be kept in mind, but allowing them to dominate often means that the interaction with the patient and the subsequent discussion rarely rise even to the level of a consideration of the "psychodynamic" factors at work. And it can be easily understood why a psychoanalytic intervention and even more so, perish the thought, a Freudian or Lacanian one, is heard by colleagues as a descent into obscurantism or at best a utopic distraction.

The student psychoanalyst is thus left with the disconcerting impression of a complete disconnect between the rigorous investigations promised by the *Question preliminary to any possible treatment of psychosis* and his teachers learned articles on the disputes about the place of the Name-of-the-Father in President Schreber"s psychopathology and the stifling pragmatism demonstrated in the case presentation.

Is this simply an unavoidable consequence of the unbridgeable chasm between the practical exigencies of the psychiatrist and the esoteric reveries of the psychoanalyst? Not necessarily. A renewed awareness of the importance Lacan accorded to the case presentation and a strenuous effort, particularly on the the part of Lacanian psychiatrists, to learn some indispensible practical skills, would go far to bridging the chasm and to revealing new dimensions of exploration within reach of many psychiatrists and crucial for regaining the ethical respectability of their profession.

The presenter and presentee

Presenting a 'case' is not as easy as it sounds. Chacot, Kraepelin, Lacan are not easy acts to follow. The case presentation is after all a performance, a demonstration by an acknowledged expert, not only of the clinical features of the illness, but also of his ability to communicate with the patient and the audience. The ideal interviewer needs the ear of a trained analyst, the clinical

experience of a consultant psychiatrist and the dramatic instinct of a David Frost[5]. There are few more embarrassing public occasions than a gauche case presentation where the couple are unable to engage with one another and the audience is exposed to a series of misdirected questions and long, painful silences.

However, there are places where serious attempts at offering Lacanian case presentations have long been in place: the 2009-2010 prospectus of Charles Melman's *Association Lacanienne Internationale* lists among the teaching opportunities open to members no fewer than six hospitals in the Paris region alone where a *presentation de malade* can be attended on a regular basis throughout the year. Some such learning experience is surely possible elsewhere provided adequate preparations are made.

Is being "presented" an impossibly stressful experience for the patient? Of course it would be if brutal and insensitive staff ignored their protestations and frogmarched them into the theatre for a public demolition of their carefully constructed defenses: "I"d prefer them to ask about the colour of my knickers than go in there and be quizzed about my binging" one terrified patient told her ward-sister. And of course patients, no less than doctors, can develop a quite understandable stage-fright either before or at the start of proceedings. But I have only twice seen someone collapse in a dead faint at a case presentation – once at St Vincent"s Hospital in Dublin and again at Sainte- Anne in Paris – and in both cases it was a student, possibly overcome with anxiety at someone who was being allowed by an expert presenter to say things that are seldom heard in polite company.

Fridays at Saint-Anne

The allusion to Sainte-Anne brings us to the heart of things, since it was there, in his weekly conversations with the patient he had been asked to interview, that I first came across a dimension of Lacan's work that is rarely taken into consideration in attempts to transmit his teaching.

Unlike Charcot's lectures there was nothing spectacular about these Friday-morning sessions which were attended by about sixty or seventy people as against the seven hundred plus at his concurrent seminars. They were neither recorded nor published. This for obvious reasons of confidentiality rendered more urgent by Lacan's interest in the proper names of the patient and his entourage. Only in 1976-77 was this rule waived and a set of typescripts for that year do exist. It may have been one of these that Stuart Schneiderman translated for his 1980 collection of clinical Lacanian essays[6]. This transcript is instructive and shows Lacan's desire to respect and reassure his patient but it is certainly not dramatic or even gripping and suffers from the need to disguise the patient's family name. The difficulty of conveying this type of encounter in print and especially in translation may account for the fact that it remains, as far as I know, a lonely

[5] These were qualities possessed in abundance by Professor Noel Walsh whose weekly case presentations formed the backbone of the clinical psychoanalytic programs developed in St Vincent's University Hospital and LSB College, Dublin in the 1980"s and 90"s.

[6] Stuart Schneiderman (editor and translator), *Returning to Freud. How Lacan"s ideas are used in clinical practice*. Jason Aronson, New Jersey/London, 1993

monument to these conversations and has been forgotten in 'the whirlwind of semantophilia' which has made Lacan so unattractive to the majority of English-speaking clinicians.
Lacan very seldom spoke in public about his case presentations but he did in fact allude to this one in his seminar on the *sinthome*, linking this 'madman' to Lucia, who according to Joyce was not ill but rather telepathic. And while he says little about her 'schizophrenia', this patient whom he had seen on the previous Friday had been driven to a suicide attempt by something 'that Joyce gives us a little taste of...that speech is form of cancer with which the human being is afflicted'. Like Lucia, this man was telepathic and could not tolerate his conviction that everyone could read his thoughts and that he no longer had any secrets.

This indication opens up perspectives that the simple reading of Schneiderman's account would never have revealed and shows how necessary it is to be inserted into the psychoanalytic discourse to become aware of the significance of phenomena that would otherwise escape us. Already when he returned to Sainte-Anne in 1971-72 in the hope of finding some trainee psychiatrists in his audience he had confided:

"Of course, for me, for my discourse, everything starts from there. Because… I heard, I heard things that were quite decisive, anyway, that were so for me. But that, that's my own business. I mean that the people who are here, confined within the walls, are quite capable of making themselves understood, provided one has the proper ears for it!"

And he went on to reflect on how it was a psychiatric patient who had led him to psychoanalysis "In a word, and to pay tribute to her for something that she is not at all personally responsible, it is, as everyone knows, around this patient to whom I gave the name Aimée – which was not hers, of course – that I was drawn towards psychoanalysis. She was not the only one of course. There were some others before, and then there are also a certain number whom I allowed to speak. This is what they call my case presentations consist in...this presentation consists in listening to them, which obviously is not something that happens to them at every street corner. It sometimes happens that in speaking afterwards to some people who were there to accompany me, to pick up whatever they could, it sometimes happens, in speaking about them afterwards, that I learn about them, because it is not immediate…"[7]

A remark which throws light on his reflections on the comparison between Lucia Joyce and the patient he had seen.

One of my own recollections is of the occasion when the *Chef de Clinique* – the psychiatric tutor - set Lacan the problem of diagnosing a woman who had worried the team with her suicidal and homicidal delusions. In the course of their discussion she did indeed speak, among other things, about wanting to stuff her father down the rubbish chute of their apartment block and of the pleasure she got from planning how she would go about it. But at the end of a very florid half-hour Lacan simply wished her well and then asked the tutor about his reasons for suspecting a psychosis. I cannot recall the details of the interchange but I clearly remember Lacan's final remark: "Look, that is a case of what I have been describing for years as a hysterical discourse". This no doubt was a valuable lesson, not only for the young psychiatrist in question, but for all

[7] J. Lacan *The knowledge of the psychoanalyst* (1971-72), trans C. Gallagher, 6.1.72

the would-be clinicians in the room. And God knows how many "psychotics" have been saved from the back wards of French and other psychiatric hospitals by remarks such as these.
But does it convey the essential of what Lacan was at in these presentations? Showing aspiring diagnosticians the value of the newly minted categories of the Four Discourses and how they and other elements of his teaching could be applied to concrete cases was indeed a worthy aim and one that that Lacan in no way undervalued. But he was also pursuing a much more subtle and provocative goal that had become clearer as he felt obliged to go beyond, without in any way abandoning, the oedipal clinic and which had finally become focused on the obscure but crucial distinction between *le dire* and *le dit*, "saying" and "said".

From an operational point of view I take this to mean that it is not a matter of situating the patient objectively, on the basis of what is said by him, in terms of developmental stages or the discourses or any other theoretical framework. Nor is a matter of getting him to recognize where his progress has stagnated or become fixated at a particular point of his sexual history. I think that Lacan's goal was to pick up on his dreams, slips of the tongue and other formations of the unconscious in order to 'relaunch', in Christian Fierens happy expression, his subjective voice, his 'saying'.[8] Or as he had put it in the Rome discourse: '...to attain in the subject what was before the serial articulations of speech, and what is primordial to the birth of symbols...'[9] - the little bit of freedom and of the real that has escaped the nets of language.

L'étourdit

Just how vital he he saw his Friday sessions to be can be gauged from the fact that Lacan framed what is arguably his most opaque and comprehensive text with a twinned reference to them and to his own style of of drawing a teaching from the interaction with patients while apparently doing no more than following the traditional medical and psychiatric norms. The first words of *L'étourdit*[10] are of ones of gratitude to the clinical director of Henri-Rousselle, a section of Sainte-Anne, for having been granted the privilege of access to his patients for the previous ten years. This had allowed him to extend the teaching of his public seminars and to show how the the truth of what he was saying in them was confirmed by what the mentally ill were able to say, in his presence and that of his students, and so demonstrated the experiential foundation and the practical implications of that teaching.

"By contributing to the 50th birthday celebrations of L'hôpital Henri-Rousselle for the favours that my friends and I have received there in a work which I will show has been able to go beyond presentation, I am paying homage to Dr. Daumézon who gave me permission to do it."

This 'beyond presentation' is his own elliptical way of stating his goal. We may find some sense of what he means in a commentary on this passage taken from Christian Fierens' *Reading L''étourdit,* even though he seems to take Lacan's remarks on the case presentation as referring principally to what should happen when an individual approaches a psychoanalyst in a non-institutional setting:

[8] For a discussion of 'saying' and 'what is said' see C. Gallagher *Laytour, latetour, l'étourdit,* The Letter 41, pp....
[9] J.Lacan, *Fonction et champ de la parole et du langage* (my translation), Paris, Seuil, 1966, p 320
[10] J. Lacan *L''étourdit,* Translation C.Gallagher. (c.f. The Letter 41)

"Far from being a simple presentation of a sick person, which would be limited to just the case, the work of analysis always presupposes a double presentation and therefore a re-presentation. The individual only enters analysis, only becomes an analyser in so far as he goes beyond his simple presentation and allows himself to be presented a second time by his slips, blunders, symptoms and dreams: by his unconscious. The subject in analysis, the analyser, is circumscribed by a double discourse. He is presented and presented again: he is re-presented. "The subject is what the signifier represents for another signifier". To be sure, the patient presents himself in his own words; he only becomes an analyser if what he says is not what he means to say; if his words say something other than what they meant, if his words become signifiers (one signifier for another signifier, S_1 S_2). The subject only exists by this double turn of the signifier.

… (I)t may be tempting to consider the patient as the object of a treatment in which the analyst would be the subject acting… [but]…from the side of the "patient", it is never a matter of an objective case or a clinical illustration of a specific problem (case presentation). The analyser is nothing other than the activation of the unconscious in the practice of the signifier which is all he is invited to; he is therefore subject, represented by a signifier for another signifier. In other words, analysis from the outset goes beyond the case presentation and goes on to the representation of the subject by the signifier. The object of study of psychoanalysis thus proves itself to be this strange twice-presented subject…[11]"

The last lines of *L'étourdit* leave us in no doubt that this subtle work of analysis is not confined to the couch and the privacy of the consulting room:

"I salute Henri-Rousselle because …I do not forget that it offers me a place to give a clinical demonstration of the interplay between what is said and saying. *Where have I have better made it sensed* that it is by the impossible of saying that the real is to be measured – in practice?"

An insistence, as the phrase I have italicized makes clear, that nothing better displays the fruit of Lacan's forty plus years of teaching and practice than the so-often neglected words of the inmates of a large public psychiatric hospital.

The formulae of sexuation and the case presentation

This does not leap to the eye and people have written, in Schneiderman"s book for example, that "Lacan does not teach here". It has taken a long time for the lessons of this clinical teaching to be articulated and it seems to me that this has been most coherently done in Guy Le Gaufeys rather uninspiringly entitled *Lacan's notall*[12]. The unique value of this work is that it first uncompromisingly spells out the emergence of the formulae of sexuation and thus provides a solid base on which to establish the elements of a renewed clinical practice of psychoanalysis. The chapter entitled "Some clinical consequences of the logical difference between the sexes" owes much of its force to having been preceded by rigorous historical and logical discussions. Like Fierens he does not explicitly deal with the case presentation but his articulation of the formulae to clinical practice and his critique of the naive "clinical vignette" throws an invaluable

[11] Christian Fierens, *Lecture de l'étourdit, Lacan 1972,* Paris, Harmattan, 2002
[12] Guy Le Gaufey, *Le pastout de Lacan: consistence logique, conséquences cliniques*, Paris, EPEL, 2006

light on the elements that should be kept in mind in a 21st century clinical interview that takes full account of the present state of psychoanalytic knowledge.

By way of leading up to the clinical consequences of the formulae of sexuation, let me review what we have already seen about the way in which an interviewer may approach a patient that he is presenting.

The typical psychiatric case presentation focusses on the illness rather than the patient in a way that is typical of the pre- or indeed anti-Freudian approach. The presenter thus such treats the patient's depression, for example, as a particular manifestation of the general concept of depressive illness. This in accord with the Aristotelian-style syllogism: "Depression is characterized by certain signs; this patient displays displays those signs; therefore this patient is depressed." And the illness is subsequently treated in accordance with the best scientific methods that have been found to deal with conditions of this type.

The Freudian case presentation based on the traditional Oedipal model takes the singularity of the patient and of his family history much more seriously and may, for example, uncover the fact that the paternal imago, or the Name-of-the Father, has been subjectivized in such a way as to result in a crushingly oppressive superego and a pattern of self-punishment that has given rise to a clinically depressive picture. And the analysis that is therefore indicated will keep this role of the father very much in mind.

Lacan's case presentation, as he describes it in *L'étourdit*, is based on the proposition fundamental to the formulae of sexuation that "there is no sexual relationship", and their subsequent development demonstrating that his previous assumptions about the role of the Father as exception are false, and that hysterics in particular bear witness to the fact that "notall" speaking beings are subject to the oedipal law of castration. And the style of analysis that results will focus on the relaunch of the subject's 'saying' as mentioned above.

Logic for beginners

This is where our progress becomes more difficult and where I have to confess to my own limitations as a *passeur*.[13] Talking about any kind of logic demands a precision of expression demanding years of study and practice and I am not sure that even today I could explain in technical language the flaw in a pseudo-syllogism I heard many years ago: "Either it's raining or it's not raining; but it's raining; therefore it's not raining." Frankly, these are the sort of word-games that put many beginners off logic and it is only Lacan's repeated urgings to his listeners to familiarize themselves with the field that has made me realize that the formations of the unconconscious often hide their secrets behind a logical facade and that to resolve psychopathological structures a good deal of logical sophistication is required.

Much of Le Gaufey's logic is beyond my grasp. References to such recondite theories as the Duhem-Quine principle and the demonstration of its relevance to Freud's treatment of "A case of paranoia running counter to the psychoanalytic theory of the disease " are still beyond me. But

[13] The *passeur* is traditionally the one who guides a novice across the treacherous defiles of a difficult frontier. Lacan's choice of the term in the context of the *passe* is well known.

I am convinced of the relevance of what he has to say to the grounding of the renewal we have to undertake and of the value of coming to terms with it . But I want to suggest to the readers I have in mind who have not had the benefit of the year of philosophy French students enjoy, that it is possible to acquire some basic notions that will encourage them to tackle his text and to allow the effort to reach up to it to progressively change their habits of thought.

First then some remarks on the how our way of thinking logically, which is so fundamental in scientific work, has been influenced by the dominant position accorded to the 'universal' in the traditional logical square. This is at the root of the most of the syllogisms attributed to Aristotle: "All men are mortal, Socrates is a man, therefore Socrates is mortal". A major, a minor, a conclusion.

Now, as we have seen, in the science of psychiatry the major usually articulates a general proposition that has been established by many observations, experiments and trials rather than by an *a priori* axiom like mathematics. Every subsection of the DSM 4 which lists the features of a category of mental illness may be thought of as a major, and a conclusion about the particular Socrates who is being treated can be reached if certain conditions are met. This is what we can call the clinic of the "minimal particular".

The defects of the minimal particular

In his earlier essay on the logical development of the formulae of sexuation, Le Gaufey had highlighted the decisive moment of the 20th century formalization of the distinction between two forms of 'particular' – the minimal and the maximal - and their very different relations with the 'universal'. He discusses in great detail the relevance of this distinction to clinical work. Here is an sample of what he has to say:

"…the particular affirmative is only a partial instantiation of a universal truth (in the universe of the chosen discourse, the scientific one par excellence which, in its search for universal truths, is only interested in minimal particulars)."

This scientific way or reasoning is, he points out, at variance with our usual way of thinking about "all" and "some":

"If I learn that some passengers have lost their lives in an air crash, I will not for a single moment imagine that, because all have been lost, I am being told that at least some have been."

This simple example illustrates the confusions in the apparently straightforward relationships in the traditional logical square which is made up of a universal and particular affirmative on the left, and a universal and particular negative on the right. If all are positive, some are positive and if all are negative, some are negative. This apparently incontrovertible piece of commonsense reasoning has from all time been shown to exhibit inconsistencies and the invention of quantifiers and functions in the 19th century was intended to clearly identify and remedy these.[14]

[14] Lacan, surprisingly for a Frenchman, takes as his most authoritative reference the work of two Oxford logicians: William and Martha Kneale, *The development of logic*, Clarendon Press, Oxford, 1962. [c.f. 21.06.67]

Le Gaufey explains how the flaws in the logical square were tackled by focussing on the particular existent rather than the universal, how this concerns clinicians and why it forces a radical re-think about how theories of psychopathology are applied to individual cases:

"…the approach through the particulars presents first of all the interest of showing us how the logical square which seems to inspire respect by its perfect order, is itself defective… the Venn diagrams proved, for their part, to be incapable of representing separately the two types of particulars, which in logic earns them the qualification of 'troublesome propositions' in the measure that the senses that they distinguish refer to affirmative and negative universals that are sometimes contradictory and sometimes equivalent."

A footnote explains the historical reference: "Taking up again the initiative of Leonhard Euler (1707-1783), who wanted to educate a princess by explaining syllogistic reasoning to her with the help of intersecting and non- intersecting circles, John Venn (1834-1923) generalized them in the form of "Venn diagrams"…"

The new logic and psychoanalysis

Lacan's concern was that a reliance on defective logical paradigms was leading to disastrous systemic consequences in the work of psychiatrists and psychoanalysts and to correct these deviations engages with some of the most up-to-date thinking of logicians in their subversion of the traditional square. The key point, once again, is the notion that the 'some', or particular existing individuals, are not to be subsumed under the general concept of the 'all'. In the contemporary shorthand of logic that Lacan adapts to psychoanalysis, when it comes to speaking beings the fundamental starting point is $\forall x.\Phi x$ but $\exists x.\overline{\Phi x}$.

This brings us to his the logical square in which he presents the formulae of sexuation and attempts to take into account a number of relationships, and non-relationships, which help us to see how tunnel-visioned our perceptions have been:

$$\forall x.\Phi x \qquad \overline{\exists x.\overline{\Phi x}}$$

$$\exists x.\overline{\Phi x} \qquad \overline{\forall x}.\Phi x$$

This square is primarily designed to articulate the consequences of his 'There is no sexual relationship' between men and women by contradicting the requirement that all the individuals that fall under a concept – 'Man', 'Woman' - should be treated as a unity having the same features possessed by that concept. The very important practical truth that logicians have been formalizing for more than a century is, as Le Gaufey puts it, that 'such an implication of the universal towards its particular only takes up the minimal particular, and that this type of logical functioning cannot claim to be the only rigorous one'.

The alternative to the minimal is the "maximal particular" which had been set to one side by Aristotle and the 2000 year tradition that followed him. This simply states that a particular case may object to its affirmative or negative universal. In psychoanalysis it means that despite the universal law that all speaking beings are subject to the chicanes of Oedipal maturation and

castration there exist some that are not so or that notall are so**.** To clarify this Le Gaufey falls back on the logical rule of *modus ponens*, which points out that "if A then B is true, and nothing more…nothing follows from it". As long as the existence of A is not affirmed, the statement conveys a certain knowledge but this knowledge remains abstract and ineffective. In practice this means that: **"***The trait that the … individual presents, and which allows him to be ranged under a particular concept, is not of the same nature as the trait present in the concept*."

This distinction between the traits of the abstract concept, and the existence of these traits in the individual – all men are mortal, etc – is ignored in the minimal particular. But in affirming existences that do not fall under the concept, as in the maximal particular, precedence is given to existence and, without in any way attacking the conceptual order itself, sees it as a map tempting me to situate myself too easily in the overcomplicated world of my perceptions.

This highly condensed paraphrase of Le Gaufey is scarcely intelligible as it stands. If the assertion of the right of the individual not to be classified as simply a particular instance of paranoid psychosis, for example, is provocative enough to send the reader to the original text, my goal will have been reached.

On the vignette style case

It is however important to mention briefly a contribution of Le Gaufey's which though explicitly referring to the way psychoanalysts report their cases also has a bearing on how a Lacanian-style psychiatric case presentation might be conducted. Here again I find his arguments innovative, even revolutionary, and far too subtle to be summarized or abbreviated. His fundamental thesis is that psychoanalysis still depends to an enormous extent on Freud's discoveries and that all roads lead back to him, Consequently:

"Each generation of analysts must... 'learn its lessons' by reading Freud, most often through the spectacles of some lineage of commentators. A major part of analytic literature is thus composed of exercises in learning the Freudian language (Lacanian, Kleinian, Bionian, etc.), which have scarcely any ambition to innovate, but serve as a step at the entrance of the corporation."

In all of these different schools the writing-up and even the publication of portions of clinical material is considered important on the grounds that psychoanalysis is based on concrete experience and Freud's case histories form the bedrock of his theory. 'If Freud did it, why should we not do it, we who want to be Freudians?'

The reader will be able to follow in his text the arguments adduced by Le Gaufey to show that apparently objective reports of cases are in fact riddled with logical and epistemological contradictions as they attempt to attach particular clinical details to fragments of the theory they have espoused. He gives the example of a writer who concludes a graphic case history as follows: "It thus appears to me that, in the Winnicottian perspective which I hold to, the phobic manifestations described here can be completely understood as so many means Pauline used to protect herself against this threat of a collapse, 'a danger that one looks for in the future even though it took place in the past'".

This clinical vignette is based in an unsuspected way on the minimal particular which reduces the existence of the individual to a particular instance of a general theory and the greatest offenders, for Le Gaufey, are certain Lacanian analysts. These are unwitting agents of a philosophical realism and centralized political control which aims at producing an organization in possession of a professional mastery based on the legitimacy of the founding text – all elements of the most successful post-Lacanian empire.

Le Gaufey highlights their naive use of the 'anchoring points' mentioned by Lacan in the early 1950's as giving "the minimum number of fundamental points of attachment between the signifier and the signified necessary for a human being to be called normal and which, when they are not established, or when they give way, produce the psychotic". This soon-abandoned idea that a minimal number of unmistakable signs could facilitate the diagnosis of a particular mental illness continues to be used and predisposes clinicians to miss out on some of Lacan's fundamental intuitions.

These were only fully articulated in the 1960's and 70's and are the fruit of his thinking about the importance of the maximal particular in the non-relationship between the sexes which culminated in the formulae of sexuation. Again I can do no better than quote Le Gaufey

"'There is no sexual relationship' marks a disparity between the sexes such that, far from reducing sexual difference, amplifies it to the point of making them incommensurable; now this is only obtained by basing oneself from the start on the maximal particular, which invalidates the universal affirmative, which therefore right away puts a spoke in the wheel of the case [vignette] which would be content to illustrate the veracity of a theoretical statement.'

In fact the realism of the vignette has lead to a medicalizing of analytic knowledge and this brings us back to our point of departure with the objectification of patients in psychiatric classificatory systems. No one doubts the advances in scientific knowledge captured in the concepts generated in psychoanalysis by Freud, Lacan, Klein, etc and the parallel psychiatric discoveries by Kraepelin, Bleuler, Ey and others. But fundamental ethical and epistemological problems can be shown to arise from the failure to formalize the applications of these theories in rigorous logical terms. This leads them to therapeutic sterility in the service of pragmatic political goals..

Conclusion

By the time he came to write the preface to the second edition of *The interpretation of dreams* in 1909 Freud knew that he had failed to reach his intended audience of psychiatrists and neurologists and directed most of his future work to the new audience of his followers and other 'educated and curious-minded readers'.

By contrast, Lacan, committed Freudian though he was, never yielded on his position as heir to the great French psychiatric tradition and to address psychiatrists as his preferred audience. He cites the remark of one of early masters astonished at the range of the authors referred to in his thesis on paranoia; "If you have read all that, I pity you". And his reply: "In fact I had".

He contributed to psychiatric congresses throughout his career and despite his unstinted admiration for Freud's treatment of Schreber's testimony, he could state that he did not have to depend on 'the wreckage of the memoirs of a dead man' to develop his formulations on psychosis. And at his Friday meetings, in the despised format of the case-presentation, he repeatedly proved this point before his students and peers.

Irish psychoanalysts have benefited enormously from their insertion into the department of psychiatry of St Vincent's University and in particular from the opportunity to attend the weekly case presentations. But is it not time for them to give something back to psychiatrists by demonstrating the relevance of Lacan's unrivalled teaching to the practical clinical problems they are faced with and the ethical dilemmas they confront. And how better, as he himself has written, than by showing that psychoanalysis reveals a beyond of presentation which allows the real of the mentally ill subject to be heard.

END