Acting out and the Analyst's Responsibility.

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There is no doubt that in Psychoanalysis, the concept of the clinic is very different from the one that springs from the medical nosology, in which a symptom is considered a morbid configuration if it responds to a previously established set of pathological criteria, the sign of a disturbance that has disrupted an equable.

Psychoanalysis, as Porge (2008)[1] argues, has renewed the approach to the clinic by proposing among other things a clinical view that relies on structural considerations rather than on deficit and deviance. The clinic based on structural considerations implies emphasizing the symptom as a configuration that reveals the manner in which each subject position him or herself in relation to the demand and the desire of the Other, a sort of subjective strategy through which the subject deals with the problematics of desire and jouissance.

Additionally, within the psychoanalytic clinic the analyst through transference takes part in the constitution of the symptom, and he or she is included in the functioning of the unconscious of the analysand by becoming the *Other* term that unconscious' chain of signifiers addresses.

[1] Porge, Erik. Des Fondements de la Clinique Psychanalytique. Paris: Éditions érès. 2008.

The way the analyst is included in the frame of the cure is not without consequences; part of this inclusion obeys constrains that has to do with the structure that each patient presents; but another part of this inclusion signifies that the manner in which the analyst responds and intervenes could become an opportunity through which something new in the cure might emerged.

In this respect, I am interested in following some of Lacan's teachings in his Seminar Anxiety (1962-63), in which he comments on a series of texts regarding the issue of counter-transference written by female analysts. In general Lacan rejects the term countertransference because of its over emphasis on the mirroring effects of transference conceived in the form of a 'two body psychology'; nonetheless he appreciated some of these writings for having introduced the question of the necessary implication of the analyst in the cure, pointing out – unknowingly- the relevance of the analyst's desire in the psychoanalytic process. Moreover, he praises female analysts in this respect for having said something interesting "regarding the function of desire in love."[2]

One of the articles that Lacan comments on in the seminar concerns the clinical case of Frieda, a patient of Margaret Little whose clinical material she discussed in the paper entitled "R- The Analyst's Total Response to his Patient's Needs" (1956). The article would draw Lacan's attention not only because it addressed the issue of the analyst's responsibility vis a vis his/her

[2] Lacan, Jaques. Seminar X: Anxiety. Edited by Jacques-Alain Miller. Trans. by A. R. Price. Cambridge, UK. Polity Press, 2014. Pag. 124.

patients, but also because through the term “counter-transference” Margaret Little seemed to be underscoring the role of the analyst’s desire in the direction of the cure.

Frieda was an adult female patient whose analysis lasted ten years; her symptom was characterized by a dangerous form of acting out that consisted in robberies and kleptomanias, as well as other form of impulsive behavior, especially when her mother was around. In light of her symptoms, Margaret Little views the patient as having a “character disorders”, a diagnosis which constitutes a sort of “borderline diagnostic category” of patients who are neither classical neurotic nor truly psychotic.

Lacan however, will reject as problematic that way of classifying patients, primarily because it implies a clinic issuing from a “psychiatric gaze”, that is, a clinic in which the clinician – supposedly an “objective observer”- makes a diagnosis outside the transference relation. Instead, he proposes to read those clinical manifestations as falling within a “relational zone in which acting-out is prevalent”.

> *“In short, a good many problematic attempts at classification are developed around this when in reality it is not about a sort of subject but* ***a relational zone in which what I have been defining here as acting-out is prevalent***.”[3]

[3] Lacan, Jaques. Ibid. 142.

In my view, the fact of designating certain clinical manifestations as falling within a “zone” has the advantage of not only avoiding a categorization that is too reliant on the medical discourse and its objectifying tendencies; it also stresses the importance of the relational space constituted by the subject and the Other, in which acting out could be conceived as an unconscious, subjective strategy aimed at “showing” something to the Other.

Indeed, these patients confront us with special difficulties, especially in the initial stages of the analysis known as the “entrance into analysis”, which implies setting up the analytic transference relation. Part of the problem is the fact that acting out appears to be a “demonstration” addressed to an Other, a wish to flaunt something to whomever occupies its place, and thus it gives the appearance of summoning an interpretation. However, it is not certain whether interpretation is possible, especially since the action involved in the acting out does not have a repressed dimension addressed to an analyst symbolically placed in the transference relation. Indeed, even if acting-out is “the manifestation of an unknown desire” whose meaning is lost to the subject, it is also the testimony of a wild transference which involves the problematic of its handling, and thus it requires a certain maneuver on the part of the analyst to domesticate its unruliness.

After these remarks, let’s go back to Frieda’s clinical material. She was referred to analysis as a result of stealing and other impulsive and risky behavior, but it would take her more than a year to speak about these behaviors. Here are some important points about the case as referred to by the analyst:

"Frieda's childhood in Germany had been a very traumatic one. Her parents were Jewish… Her father was a very brilliant man, but vain and selfish… Her mother was possessive, mean and prudish"[4] The analyst also relates how the parents severely and physically punished Frieda: *'her father would punish her –mainly induced by the mother-- by beating her with his riding crop, especially when she obstinately refused to say she was sorry for disobeying her mother. Her mother punished her by hitting her, dragging her upstairs by her long hair, and locking in the dark broom cupboard. When she was about four years old she was 'cured' of masturbation by being put into a cold bath for fifteen minutes at a time."*[5]

Concerning the development of the analysis, Margaret Little would report that for the most part during the time of this ten year-analysis, no major changes in the patient's symptoms occurred. No matter how much she tried at "making the transference real to her in any way", no matter how much she attempted to throw light onto her symptoms by giving transference interpretation, her efforts were unsuccessful: "*her emotional attachment to her mother was unchanged, and her mourning for her father never reached".* [6]

We can raise a first interrogation as to whether these types of "traditional transference interpretations" doesn't already indicate a failure corresponding to the analyst's position – concerning her desire as analyst-- in attracting a real transference relation, and whether her

[4] Little, Margaret. (1958) 'R' – The Analyst's Total Response to his Patient's Needs". International Journal of Psychoanalysis IPJ. Volume 38. 246.
[5] Ibid. 246
[6] Ibid. 247

already preconceived knowledge in the form of "classical transference interpretations" might not have acted as a resistance to her listening.

Whatever the case, things were to remain relatively unchanged for seven years, giving the analyst the impression that the patient was inaccessible to her analytic efforts: "*It seemed that the key to her own locked door was lost beyond our finding*", Margaret Little says.

This status quo changes abruptly when the analysand comes to the session one day, crying inconsolable when she announced the death of her dear Ilse –a person from her childhood, with whom Frieda had maintained a meaningful and loving attachment.

Following this news, there is a period of acute distress that goes on for several weeks, despite the analyst's efforts to reduce them through the interpretation of its transference links: *"I showed her her guilt about Ilse's death, her anger with her, and fear of her; I showed her that she felt that Ilse had been stolen from her by me; that she was reproaching the world, her family, and me; that she wanted me to understand her grief as Ilse had understood her childhood unhappiness, and to sympathized with her. None of this worked*."[7]

Finally, as the analyst admits to being at a loss and fearing a suicidal risk should the patient continue in that fragile emotional state, the analyst ends up simple telling the patient how deeply sad it was to see her like that.

[7] Ibid. 247

This intervention surprised the analyst by producing positive effects in the mood of the patient, and was revealed to be the beginning of a real breakthrough in the cure.

The analyst thinks that what had been effective about the intervention was the fact that she was expressing "real and authentic feelings" to the patient. Whereas for Lacan what had taken place –unwittingly, he says and not without some release of angst on the part of the analyst- was the emergence of something that could serve to designate the place of lack in the analysis, that is, the constitution of an opening through which the patient could perceive herself in the form of "being a lack" for someone and being missed by someone, through which she could experience herself as having a causal relationship with the desire of the Other.

"The intervention showed the patient that the analyst has harbouring what is known as anxiety [angst]. Here we are standing at the limit of something that designates the place of lack in the analysis. This insertion, this graft, this marcotting, opens up a dimension that allows this female patient to grasp herself as a lack, when she was absolutely unable to do so in her relationship with her parents."[8]

Lacan points out that for this patient the function of mourning was hindered due to the particular position she occupied for the primordial Other(s): the mother was cold and

[8] Lacan, Jacques. Ibid. 143.

egotistical, unable to make of her daughter anything more than a narcissistically extension of herself, and for whom her daughter was very far from having a causal relationship with her desire. A similar relationship characterized the patient's relation with the father, and for this reason, she was never able to mourn his death.

The death of Ilse --who was someone with whom the patient had maintained a loving relationship, and for whom Frieda had been a "lack" in the sense of occupying the position of the missing object for someone-- opened up the dimension of loss that had been up to then blocked for this patient. The intervention of the analyst –albeit unwittingly- permitted a shift in the transference, from the analyst occupying the position of the mother, to the analyst attracting the transference that had corresponded to Ilse.

In the seminar, Lacan alludes to the process of mourning in the context of the constitution of *object a,* whose loss opens up the possibility of the emergence of the subject of desire. This is a "structural loss" of jouissance that configures *object a* as object cause of desire, eliciting the subjective constitution as well as the constitution of the drives.

We can say that this is a structural loss thanks to which we can access the dimension of love and desire. In fact, every love relation is structured around this lack, representing an attempt to fill an empty space. The relationship we maintain with our love-objects permits us to "clothe" our own lack in a manner that echoes the narcissistic constitution of our self-image, the imaginary representation of our body which functions as veiling *object a*.

This is the reason why the relationships with our loved ones are also narcissistically structured, and why the loss of a loved one is also a narcissistic loss. The love and affective

links with the object allows us to confer a certain imaginary representation to our lack, which as such is non-representable.

The task of mourning, as Darian Leader (2009) has argued, confronts us with the need to distinguish these two dimensions separately: one dimension pertains to the original and structural loss of *jouissance* that is embodied in the object a, which causes desire; this is a non-empirical loss that nonetheless is apprehended psychically with the different experiences of weaning. The other dimension is constituted by the different objects invested symbolically and imaginarily that come to occupy that voiding place, and whose real loss in reality –by death, for instance- might trigger a mourning process.

In the case of Frieda, Lacan hypothesized that the parents were seemingly unable to offer her a place of love and desire. The precondition for this requires that the Other is capable of transmitting his/her own experience of loss and relationship with lack, allowing the child the possibility of constituting an object, the detachment of which anticipates separation. Because that was not the case, because Frieda was confronting an Other seemingly unaffected by loss or unencumbered by any form of lack, her acting out in the form of kleptomania was a fruitless attempt to "snatch" an object that the Other was unwilling to lose.

> *"I am showing you an object I've stolen, by hook or by crook, because somewhere else there is another object, mine, the* a*, which deserves to be considered, to be allowed to*

emerge for a moment. This function of isolating, of being-alone, is in some way the pole that is correlative to the function of anxiety." [9]

It is important to highlight that the analyst's intervention was effective not because –as she seemed to believe-- she was able to show herself as having "real feelings", but rather because taking place from the analyst's desire it made present the dimension of the lack in the Other.

Moreover, the development of the case shows that it was only after the intervention took place that the analyst was able to introduce effectively and beneficially the function of cutting, producing a cut in the dimension of *jouissance* that had sustained the symptom.

Indeed, the analyst had, in two previous opportunities introduced a form of cutting: one time, after the patient was for the hundredth time relating her problems with the mother, the analyst told the patient that she was bored hearing these stories that were leading nowhere; at another time after the analyst had done some decoration in her office and was tired of hearing her patient's comments, she cut Frieda short when she began to offered hers: "I don't care what you think about these decorations", the analyst had replied.

However, it was only after the analyst had succeeded in attracting the transference by isolating the function of *object a* in the analytic space --the lacking object from which the analyst takes its semblance-- that her interventions could serve as real limit-setting that would effectively reduce the manifestations of the acting out. [10]

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[9] Lacan, J. Ibid. 145

[10] Indeed, as the report of the case shows, Margaret Little starts to establish serious limit-settings with the patient, such as refusing to write legal certificates for her and even threatening her with ending her analysis should she

If one reads the case carefully, the beginning of the breakthrough in the analysis points out to the manifestation of the analyst's desire insofar as she was able to detach herself from a preconceived theoretical knowledge, a knowledge concerning transference-interpretations which very likely had been unable to resonate with the experience of this patient.

However, the intervention that started the breakthrough was not without its perils, since it seemed to be produced at a time where the analyst felt a bit lost and experiencing the limits of her own resources, insinuated a state of angst on her own part which, properly speaking, should had fallen on the side of the patient.

Concerning this issue, we should recall what Lacan says at the end of Seminar on Angst: *"The analyst ought to be the one who, however little, from some angle, from some line of approach, has merged his desire back into this irreducible* a *sufficiently to offer the question of the concept of anxiety a real guarantee*."

Lillian Ferrari, 2018.

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continue to allow her mother's visits. It should be recall that the acting out behavior would be more frequent when the mother was around.

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