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Book Review Essay: The Parentheses Have Been Blown Apart: Misrecognition in Late Capitalism, on "Clinical Introduction to Lacanian Psychoanalysis" by Daniéle Brillaud

Review of *A Clinical Introduction to Lacanian Psychoanalysis*. Routledge, 2020, Pp. 286

The Parentheses Have Been Blown Apart: Misrecognition in Late Capitalism

Lacan is often criticized by American practitioners for not being "clinical" enough—too theoretical and involved in his elaborate cosmology to share any practical expertise. Nonetheless, he has significantly influenced clinical norms in France, Italy, Argentina, and Mexico, among other European and Latin countries (Svolos, 2017, p. 63). In the United States, Lacanian psychoanalysis has not seen the same "success" in the clinical domain. Selections of Lacan's major works have been translated into English by Alan Sheridan in 1977, and in full by Bruce Fink in 2006. While his concepts have been readily adopted in English-speaking academia by fields such as critical theory, film theory, and linguistics, American clinicians have struggled to translate the theory into practice. "I've tried but I just don't get it" are words commonly exchanged when his name surfaces at the proverbial water cooler. While Lacan considered himself a Freudian, many contemporary psychoanalysts fail to find the clinical Freud in Lacan's teachings. Thus, there have been a handful of significant efforts in English to take on the project of making Lacanian praxis and theory less esoteric to the English-speaking practitioner.

In 1999 Fink came out with *A Clinical Introduction to Lacanian Psychoanalysis*, using case studies to discuss clinical approach, the analytic relationship, diagnosis, and the role of interpretation. Also of note here is Joël Dor's *The Clinical Lacan* (1998), published a year earlier. Dor gives special attention to the structures of hysteria, obsession, and perversion.

Dr. Daniéle Brillaud's casebook is well-suited to join these teachings, beginning with a series of introductory seminars to Lacanian thought for practitioners. She focuses on differential diagnosis, marking the architectonics of Lacanian thought and offering a distinct contribution in her exploration of the group of disorders known as delusional misidentification syndromes. Drawing on her work as both a psychoanalyst and a psychiatrist in a community mental health center, Brillaud pulls back the curtain on the psychotic structure, and as it happens, the formation of the subject at large.

Brillaud's explication of Lacanian concepts leads to critiques of the state of contemporary psychoanalysis and the so-called 'mental health' landscape. In what should be unsurprising to those familiar with Lacan, Brillaud joins in the critique of ego psychology. She writes that the ego psychologists during the

development of the optical model, "…maintained analysis should proceed in several ways: the patient should identify with the analyst's strong ego, the analyst had to appeal to the healthy part of the patient's ego in the struggle to overcome defences, or the patient needed to develop a strong ego him/herself" (Brillaud, 2011/2020, p. 18). This treatment approach betrays a fundamental and irreconcilable difference in the understanding of the ego between these two schools. If we assume the Lacanian assertion that the ego is fundamentally alienating and intrinsically based on misrecognition, the idea that the patient can borrow the ego of the Other and make adaptive use of it for herself is absurd and antithetical to a Lacanian understanding of the nature of identification.

Although many ego psychologists continue to argue that their work derives from Freud, Hartmann's conflict-free ego and the adaptive goal of ego psychology are directly in conflict with the foundational Freudian conceptions of psychoanalysis as both a science of constitutive mental discord and a practice that scrutinizes the culture as much as it does the patient. Ego psychologists appeal to a "rational" part of the unconscious that is believed to help with "regulating affect," "reality testing," "impulse control" and the like. This type of therapy is a repetition of early life in which the patient is asked to sublimate and control sexual and aggressive drives to please the analyst as if they were a caretaker. These early experiences are the very thing that leads the patient to the consulting room. Thus, ego psychology is a psychology of reification. A primary technique of ego psychology is defense analysis, in which the patient is told that what she is doing or feeling is a defense against another impulse or more primary feeling. One would be hard-pressed to find an example in which an interpretation of a defense did not lead the patient, understandably, to double down on that same defense. Brillaud has a biting critique of Cognitive Behavioral Therapy as well, which has the self-proclaimed aim to "deprogram and reprogram patients by ingraining new behavioral reflexes in them, a practice that is not, in fact, unrelated to how animals are trained" (Brillaud, 2011/2020, p. 157). The therapist in this practice is positioned as an agent of social control whose task is to use Pavlovian conditioning to return the subject to a level of functioning in which s/he can again be an instrument of production and consumption.

Brillaud's second clinical bone-to-pick regards the seemingly interminable question of diagnosis. She is opposed to the reigning paradigm of the Diagnostic Statistical Manual (DSM), with its ever-proliferating labels and indifference to underlying psychical structures. In her case studies, Brillaud approaches the challenge of differential diagnosis between psychosis and neurosis, an often difficult but crucial distinction for proper Lacanian treatment. The standard request to the neurotic is to speak freely about whatever comes to mind. Asking the psychotic to free associate, on the other hand, can lead to distress and even a break. Brillaud states that the use of the Borderline diagnosis in a difficult case is an easy way out that serves to avoid the problematic of diagnostic confusion. We know descriptive psychiatry is present when a new diagnosis enters at the point of the unanswerable.

According to Lacan, neurosis is a question that Being poses for the subject. The fundamental question (for the hysteric it is the question of sex) is never satisfactorily resolved. Thus, the subject must make an unconscious decision between neurotic obsession, psychotic resolution, or perverse disavowal. In descriptive psychiatry, the diagnosis comes to fill the hole of the question that insists. In this way it works as a fetish object, substituting for the absent maternal phallus, disavowing the castration that comes with the feeling that we, the subjects supposed to know, cannot instantaneously know the patient's diagnosis. The idiomatic signifier is tossed aside in favor of the sanitized institutional signifiers and preconceived identifications. When symptoms are treated as discrete, the labels stack up quickly. The reliance on dual diagnoses in the contemporary clinical field is extensive, bringing to mind the statement Holland makes in his preface regarding the "unhealable cut between psychiatry and psychoanalysis" (Brillaud, 2011/2020, p. xi). To put it in Lacanian terms, medical speech is a master-discourse, irreconcilable with the discourse of the analyst. The cut exists between psychotherapy and psychoanalysis as well. On this point, Brillaud writes, "We could say, and not only in jest, that psychotherapy makes you better by 'blinding' you, and psychoanalysis lets you 'see' more clearly, which can actually make you feel worse" (p. 157).

These are two practice examples of Lacanian disputes with the paradigms of popular psychology. Ramifications for treatment also exist at the level of the institution. Brillaud comments on community psychiatric care in France. She explains that in France when a patient moves to a new residence, the psychiatrist is forced to move the treatment to a clinic in proximity to the patient's new location. As most analysts believe that transference is fundamental to being able to make progress with patients, this custom indicates a failure to understand the conditions that need to be met for treatment to occur. Brillaud writes, "This misunderstanding of symbolic *transference* leads to the real *transferral* of the patient to another clinic" (p. 38).

In New York-based community mental health clinics practitioners face a variation on this issue. The transfer of patients within the clinic is frequent. Therapists often leave as their caseloads are high, the pay is low, and employee health insurance is non-existent—a recipe for burnout. In addition, and perhaps more disturbing, patients are encouraged to request a transfer of therapist if they no longer want to work with them. They have only to ask management for the change and are not encouraged to discuss it with the treating clinician. While every patient is certainly not the "right fit" for every clinician, this policy bars the possibility for a negative transference to unfold, for resistances to be resolved, and for conflicts to be worked through. Moreover, this policy may disempower the therapist to make certain difficult interventions and empower the patient to pursue repetition. Simply put, it creates an environment that favors repeating over remembering. This incurs a great waste of time, as the patient will often reach the same point with the next clinician and on and on.

These are the signs and symptoms of particular psychoses and perversions in the psychological sciences, the field merely a sketch of larger contemporary confusions. There exists in our society an unknotting of the symbolic, the real, and the imaginary, and a resulting 'unquilting' of the signifying chain. Brillaud discusses what it means to live in a "perverse society." Desire is positivised and the lost object that originates lack is framed as attainable (Brillaud, 2011/2020). Elsewhere this has been referred to in terms of culture that refuses to mourn. The loss of an object is never processed, we are encouraged not to grieve, and thus we become melancholics in the Freudian sense (Leader, 2009). In consumer society, the symbolic signifier has come to refer directly to an imaginary signified. The metaphorical substitutions and metonymic elisions inherent in language are lost, and a psychotic literalness takes hold. Charles Melman offers a Marxist perspective regarding the perversion of brand name clothing, where symbolic value takes on greater significance than use value, thus transforming clothes into fetish objects (Melman, 2002).

Brillaud regards the call for transparency as a symptom of social perversion. She argues that absolute transparency ends in voyeurism and exhibitionism (Brillaud, 2011/2020, p. 227). Beyond voyeurism, an ironic defense against seeing, the demand for transparency is a paradoxical defense against knowing. It is sign and symptom of a rejection of the subject supposed to know in the transference. Transparency is demanded as an extension of the fantasy that if we know all there is to know about the Other, the position of the master will be undone. Consequently, we live in a society of confession, in which we can never confess enough. This fantasy operates on several strange assumptions about the relationship between power and knowledge. For instance, the idea that we gain power through demanding a confession of the Other's motivations as if this were a thing that could even be known and told. The operating belief here would appear to be that "ulterior motives" are the cause of social stratifications, and if we could get rid of them and the specific people that harbor them, we would live in an egalitarian society. The campaign against concealed knowledge can only be a defense against knowing ourselves, and a defense against the horror of encountering the void in the moment in which we pause interrogating the Other.

Brillaud's seminars use Lacanian concepts to gain perspective on how disturbances in language, the optical model, and the transference, manifest on clinical and social levels. Of utmost importance is Brillaud's emphasis on the idea that all recognition is misrecognition, and furthermore that all knowledge is based on this misrecognition. If we take this to be true, it deeply problematizes popular beliefs about social identifications and interpellations. Simultaneously, it sheds light on the insatiability we find at the heart of contemporary demands for recognition. Brillaud's case studies, in which recognition and identification break

apart, allow for inspection of both mechanisms. Her clinical illustrations provide a cipher for the apparatuses behind the psychotic, perverse, and melancholic in the cultural psyche, which lead respectively to concrete identification, a fetish for the image, and cathexis to the lost object. Thus, it is worth our time to think about social bonds as formed by systematic misrecognitions and incomplete cuts, which painfully separate us, yet don't sever us, from the object that sets desire in motion.

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