

IS THERE A CASE IN A CASE PRESENTATION?

For a start, my answer to such a question could be quick: alas, Yes! Explaining why requires a little more time.

The clinical vignettes invaded the Lacanian field at the end of the seventies and I was prompt to react to that, because it looked to me as an unbearable reduction of what I then expected from psychoanalysis, even if my feelings about that were rather mixed, and even sometimes confused. At the beginning of the eighties, with some friends, we tried to launch a working group entitled “La fabrique du cas”, to problematize, precisely, the making of a case into the psychoanalytical frame. I must confess that it turned to be a complete failure, and during years and years – decades in fact – I was very uneasy about that. On the one hand, I have always appreciated reading short stories, and when a case presentation is well written and constructed, it can be a pleasure to enter into a little piece of life. But, on the other hand, after a little while of reading or listening, I almost always felt the same: what the hell are we doing here, and I insist on the “we” because, even if I am alone in my reading, I strongly feel I am part of a “us”, the story is very obviously addressed to an audience, and that disturbs me, not for ethics reasons, but for technical reasons we will approach later on.

Before all that, I had been an attentive reader of Foucault’s *Birth of the Clinic: An Archaeology of Medical Perception* in the mid-sixties, and I did have in mind what were the bases of Medical clinic. It rested on three different points: first of all, there were the pathological signs produced at the level of the sick person, especially when this person belonged to a series where identical signs could be found in quantity inside the new clinical hospital created in the middle of nineteenth century.

In front of these natural signs, stood the clinic director who is supposed to know perfectly the different theories about such and such illnesses, but who has learned to appreciate their relevance according to each case, paying attention to a lot of another signs; and, finally, there is also the young residents, the ones who are supposed to distinguish better between the universality of the natural law governing the illness, and the singularity offered by the case itself.

All of these three different points are necessary to justify the word “clinic”. On this way, indeed, are distinguished the universality and the singularity or, if you prefer, the generality of the knowledge and the particularity of what has to be called “the case”. But what remains unquestionable is the fact that the signs are produced at the level of the sick person, independently of the clinic director and the young residents.

It is precisely what is missing in the psychoanalytical case. One has to trust the account of the facts, whatsoever they can be. And at first: why not? But let's pay attention to the various possibilities present at that level. Most of the time, the storyteller is the analyst herself/himself; sometimes, the story is given by the patient himself, writing down what has been his/her treatment. I know only one case into which both of the couple analyst/patient worked altogether: when Robert Stoller published the case of "Belle", she had corrected his text. But this is very very uncommon and Stoller's text is not at all a "clinical vignette" (100 pages).

The one who is in the position of the storyteller is not considered here as a professional, or even an occasional liar; s/he just speaks as everybody, and technical terms do not make any difference. But regularly, after a while, it gets harder and harder to swallow the tale itself: the obviousness of the clinical signs is more and more dangerously missing. In the medical clinic, these same signs can be difficult to reach at first glance, but they eventually come out, on the skin or on a screen; they are never reduced to a narrative.

So: what is going on here when we pretend not to make such a difference between what would be called in Peirce's vocabulary "icons" and "symbols", that is : signs that actually and directly indicates something else, like the weathercock, and signs that build a signification, and through this way refer to a referent that can be easily missing in the process of meaning?

As far as we are ready to take into account this maybe too sophisticated question, I would like to introduce a brief Freud's quotation. It comes from the 27th Lecture entitled "On Transference". This lecture is strangely constructed. Despite the very clear title, coming after "Libido theory and narcissism", during seven pages (the conference itself is only 17 pages), the word "transference" does not appear even once. And then, out of the blue, Freud writes: "And now for the facts". (*Und nun die Tatsache*). It is rather well done because Freud always liked to present the discovery of transference as a "coup de théâtre". All was going pretty well, despite a lot of difficulties and resistances more or less satisfactorily surmounted when, all of a sudden, looms up the transference itself. After having described and admitted the phenomena of transference as a sudden love addressed to the analyst, Freud concludes: 'An admission of this sort surprises us: it throws all our calculations to the winds. Can it be that we have left the most important item out of our account?' And then the sentence I want to stress now:

And indeed, the greater our experience the less we are able to resist making this correction, though having to do so puts our scientific pretensions to shame.

Und wirklich, je weiter in der Erfahrung kommen, desto weniger können dieser für unsere Wissenschaftlichkeit beschämenden Korrektur widerstreben.

Plus en effet notre expérience s'amplifie, et moins nous pouvons nous opposer à cette correction si humiliante pour notre scientificité.

« Our scientific pretensions »... We must remember here that it is precisely the reason why Freud, in front of the ethical question : “Are we allowed to give any publicity to what is confided to us?”, had already answered: for scientific reasons, yes, it is part of our duty to tell to the world what we know about the psychological life of humankind and, to do so, we must pass on details that only a case presentation is in capacity to offer.

We must not forget that, from *Studies on hysteria*, he had a strong medical legitimacy in this kind of exercise. But we must not forget either that, at a moment, he confesses:

I have not always been a psychotherapist. It still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own.

So: on one side, we are legitimated to give a case presentation, and on the other side we are supposed to be ashamed of because it does not fit with the rational game that we thought we were engaged in. There is undoubtedly a problem here, even for Freud himself, and even if he was not inhibited by that.

The first reaction could be, given the supposed “nature of the subject” : OK, let’s include transference itself in our description of the case, not only the one coming from the patient but equally the one coming from the analyst, and the case will be ‘complete’, we will have surmounted our scientific shame in widening the scope with the new data: transference.

Unfortunately, here is the point where the problem worsens, where honesty, sincerity, perspicacity, humor, self-criticism, whatever you like as a truth-maker is no longer trustable. And not because of human weakness, but because of the laws of speech.

In transference, the analyst is the addressee – no doubt about that, at first glance. But if transference becomes one of the topics of the case the analyst is constructing, s/he no longer is a second person as is, grammatically speaking, an addressee, but a first person talking about not that much herself/himself, but about this another person onto whom the patient is transferring. This splitting is unavoidable because there is no reason why the analyst as the object of transference would be the one who tells the case in his/her presentation of that case.

So: let’s sum it up. If transference is just put outside the case, we are no longer in a psychoanalytical frame. We are playing at psychology, psychopathology, psychiatry, or, worse, bad medicine in resident’s room, the sick people confined in their wards or their neurosis, the “clinicians” gathered altogether on the sane side of the street.

But if we bravely put the singularity of the case (because, yes, there is a case!) into its natural medium of transference, the case itself blurs and loses most of its pertinence because what is said becomes dependent, more and more obviously, from an enunciation more and more dubious.

The best I ever read about transference in the establishing of cases is Susie Orbach's book *The Impossibility of sex*¹. But listen: the six cases she presents in this book are all invented. They are decidedly short stories, written as such by Orbach, with the help of other writers, obviously with all Orbach's experience as an analyst, but nevertheless totally invented. She succeeded in being right about transference evacuating the actuality of the cases themselves. And that is very informative: only fiction –good and very learned fiction– can carry off such a task: speaking convincingly of transference.

I can already hear the criticism about the viewpoint I try to support. You are too demanding! Clinical vignettes are not so pretentious! They just try to give a brief account of a treatment, so that other analysts can appreciate (or not) and have a glance to the practice of other analysts, creating through this way the group of so welcome "colleagues". What are you looking for with such excessive requirements?

My main problem is not about the fact that we would put patient's confidences in the open (that can be done cautiously), but about the "we" created in this way. On that point, I encounter again the splitting I am talking about from the beginning: this "we" is partly unavoidable because there are necessarily analytical communities – isolated analysts do exist, but if you look closer, they are, one way or another, related to a community. But if the "we" takes too much consistency, what is threatened is the consistency of the third person at stake in the treatment.

That will be my main and final point: transference is the mean through which the third person is constructed in the analytic treatment, and that is why "everyone of us" has to be extremely careful about the consistency s/he gives to this "person". This "person" is a mix of little other and grand Other, so that it is at the same time somebody real and somebody imaginary, both framing the symbolic field. It is fiction *and* non-fiction. How is it possible to manage between these two opposite values in respecting the analyst's solitude *in front* and *inside* transference?

The interest of case presentations begins when the narrative itself (here is the unavoidable 'case') succeeds in losing its own consistency (it is not so easy) and makes legible, audible, this gap between fiction and non-fiction, truth and forgery. It is one way to deconstruct the usual belief in the referent that is made to kill the life of the fantasy, the one "we" are made of – analysts and patients altogether.

¹ Susie Orbach, *The Impossibility of sex*, Allen Lane, The Penguin Press, 1999.