Diagnosis in the Clinic: From Structure to Sinthome

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I will share with you some considerations on the current state of the diagnostic question in the Schools of the AMP, based on the teaching of Lacan and of J-A Miller. My references to the current era will concern France in particular and, although we belong to the same Western world, many differences exist between your country and mine, and I look forward to learning from you how this diagnostic question arises for you today.

The clinic versus psychoanalysis

What do we mean when we talk about clinic? At stake is more than an opposition between theory on the one hand and clinical practice on the other. The Greek root of the word 'clinic'—klinē—designates what happens at the foot of the patient's bed, and as such denotes a bedside art. It is a procedure that consists of noting signs—which we call clinical signs—and grouping them into different categories. This is why Jacques-Alain Miller compares the clinic to a herbarium, a collection of different plant specimens.

Clinical practice, it should be stressed at the outset, is to be differentiated from psychoanalysis, which is primarily interested in a subject's jouissance and the symptom he presents; that is to say, in the way in which jouissance is linked to certain signifiers for him or her. Unlike behaviourist and cognitivist approaches, Lacanian psychoanalysts consider that the symptom never ceases to be written, that it is necessary and thus a part of life. We reject the idea that one's symptom can disappear, or that there is such a thing as harmonious normality or even 'mental health', as put forward by the World Health Organization. In line with Freud, we consider the symptom to act as protection in relation to jouissance.

The psychoanalyst is, therefore, interested in the singularity of each subject, rather than in fitting him into a particular category or class. Does this mean that an analyst must lose interest in diagnosis in the clinical setting of psychoanalysis, which is a clinical experience subject to transference? In what follows I will argue that diagnosis, and therefore clinical practice, are important for psychoanalysis in so far as they help enlighten the analyst in the preliminary sessions with an analysand, so that he can subsequently do without it. This will be the central theme of my presentation.

In all cases, this clinic involves meeting with a patient face-to-face; the diagnosis occurs only afterwards. This is precisely what Lacan evokes in one of his earliest texts, translated by Russell Grigg, when, regarding the Papin sisters, he writes of avoiding 'the reproach of making a diagnosis without having examined the patients myself'.[2] Rather than speak

1 Presentation at the Lacan Circle of Australia, Melbourne, Saturday April 27.

2 J. Lacan, *First Writings* (Cambridge : Polity, 2024), 84.

in terms of a diagnosis, he will talk, about his 'thesis' regarding the two sisters.

Diagnosing means differentiating and naming

All human societies, whether traditional or modern, make use of diagnoses. At its Greek roots, the word denotes a function of differentiating or distinguishing. A clinical diagnosis is always 'differential' and depends upon what a society recognizes as the norm and what it qualifies as madness.

But to make a diagnosis is to identify and thereby classify a subject, which in turn has social and subjective consequences which can vary depending on the authority which makes the diagnosis and according to what each culture prescribes as a solution. A clinical diagnosis always depends on a particular society's ideas about what constitutes the norm and what it qualifies as madness. A diagnosis of madness can lead to a subject's exclusion from the community or even to his confinement, which is a decision usually made by the police, political, or religious authority. It can sometimes lead to a ritualized treatment prescribed by a healer or a religious authority (medications, trances, or even exorcism), which can coexist with scientific, chemical or electrical treatments. Fortunately, for our desire as analysts, it can sometimes take the form of a talking treatment, either recommended to, or chosen by, the patient.

On a subjective level:

In health-care institutions, teams are often questioned about a diagnosis, for example that of 'gender dysphoria' or 'gender transition'. I have heard from professionals who come to CPCT training that some prefer to avoid naming the problem, because this type of question sometimes 'destructures the team'.

A diagnosis, then, can have a subjective effect on caregivers. This is the case with practitioners—psychologists, doctors, social workers, etc.—working in the private sector, as well as for psychoanalysts. Making a diagnosis has consequences for how the patient will be cared for as well as the conduct of the analytical treatment and the analytical act itself. Diagnosis is part of the treatment.

These days, a diagnosis is often presented directly to the patient. From the patient's perspective, it is sometimes a relief to receive a diagnosis and to recognise oneself—and one's enigmatic jouissance—in it. It gives it meaning. A melancholic patient who identifies with waste may be soothed by a diagnosis of social phobia. The diagnosis can sometimes confer a form of identity that the subject can claim: 'I am bipolar', 'I have a post-traumatic syndrome', 'I am a drug addict', etc. Other times the patient might reject the diagnosis entirely: 'I was called schizophrenic', or 'I was called an alcoholic', 'but it's nonsense!'

Some adolescents are quick to recognize themselves in one of the more publicized diagnoses—bipolar, school phobic, ADHD, early onset, etc.—which they often pick up on social networks and from influencers. Today the 'right to self-determination' and to self-diagnosis is a growing demand, which summarizes a subjective position as "I am what I say."[3] It is the new dogma, be it 'I am trans', or 'I am autistic', or 'I am skinny', or 'I am a sex bomber', or even 'I am what I want'. Marie-Hélène Brousse stressed that this contemporary movement of self-description of the body's mode of jouissance is an 'attempt to manufacture an ego where there is a lack of being'.[4] What presents itself as the affirmation of the intimate truth of the subject is in fact a demand for recognition of his singular mode of jouissance, which on the one hand maintains segregation and on the other hand closes the door to the unconscious. The subject then becomes a pure object of the superego's jouissance, or the jouissance of an Other, immune against dreams and slips of the tongue which could lead to desire. It should not be overlooked that this self-designation can be an attempt by the subject to make a name for him or herself and create a symptom, and in this sense it should be welcomed and respected.

Diagnosis from Freud to Lacan

In his early work, Freud relied on the neurological and psychiatric knowledge of his time. For example, in his first letters to Fliess, he speaks of cerebral hysteria (1888), periodic depression, anxiety neurosis (1892), and neurasthenia, which he quickly qualified as sexual neurosis (manuscript B. of 1893).

In his 1932 thesis, where he presents the Aimée case, Lacan discusses at length the 'diagnosis' of his patient, based on the psychiatric nosography of

3 Theme of the 52nd Journées of the École de la Cause freudienne, November 2022.

4 M.-H. Brousse, Interview in J.-N. Donnart, A. Oger and M.-C. Segalen (eds.), *Adolescents, sujets de désordre* (Paris : Éditions Michèle, 2017), 165

the time, and finally proposes his famous 'paranoia of self-punishment'. This is not a diagnosis per se but what he calls a 'clinical type',[5] which is based on an analysis of the 'development of the subject's personality'. Subsequently, he only occasionally uses the language of diagnosis, such as in his seminar on *The Psychoses*, when he notes that 'we must insist upon the presence of these disorders [at the level of language] before making a diagnosis of psychosis'.[6] Elsewhere he mentions the 'diagnosis of perverse structure'[7] or even 'the correct diagnosis' of phobia[8] in relation to a case of exhibitionism.

Diagnosis involves classification and this can lead to a kind of dictionary. We can evoke what Michel Leiris, a structuralist writer and friend of Lacan, wrote:

> A monstrous aberration makes men believe that language was born to facilitate their mutual relations. It is with this aim of utility that they write dictionaries, where words are catalogued, endowed with a well-defined meaning (or so they believe), based on custom and etymology.

Lacan, for whom 'to understand patients is a pure mirage', is more interested in 'clinical structures' than in classifications, dictionaries, and so on.[9]

Structural diagnosis

Freud's famous reference from 1933 to the metaphor of the crystal suggests something of this concept of structure:

If we throw a crystal to the floor, it breaks; but not into haphazard pieces. It comes apart along its lines of cleavage into fragments whose boundaries, though they were invisible, were predetermined by the crystal's structure [*Struktur*]. Mental patients are split and broken structures of this same kind.[10]

The crystal therefore breaks along the fault lines that structure it.

Lacan, too, made reference to structure in a 1931 article, published prior to his thesis, entitled 'Structure of the paranoiac psychoses', and published in *Early Writings* (*Premiers écrits*). According to Éric Laurent, Lacan here uses the term 'structure' 'in a phenomenological sense, as the specificity of an existential experience conceived as a whole'.[11] Linguistics was key to Lacan's rereading of Freud, allowing him to isolate the symbolic dimension of the signifier, as well as the imaginary phenomena that preoccupied other post-Freudians. It was this that led him to think of psychic processes in terms of structure.

In his 1954 seminar on *The Psychoses*, he emphasised the necessity for any approach which aims at scientific rigor, to detach itself from the phenomena in order to understand, beyond them, the structural constants. It is from here, he stressed, that the analyst 'shall proceed […] setting out from the subject's discourse'.[12] Structure, then, for Lacan was understood as 'a manifestation of the signifier', so that 'the notion of structure and that of signifier [appear] inseparable'.[13] The structure, then, orders all the effects produced by language. The divided subject is the effect of the signifying structural logic and Lacan defines the subject as 'what the signifier represents […] to another signifier'.[14] The subject disappears under the signifier which represents it.

The word 'structure'—stemming from the Latin 'struere'—refers to the idea of a construction, of strata where one element cannot move without the others being displaced. Lacan speaks of 'reciprocal references'.[15] The anthropologist Claude Lévi-Strauss situates structure as 'a system of oppositions and correlations which integrates all the elements of a total situation', as 'a whole where everything fits together'.[16] It's in this sense that the myth of Oedipus is a structure: it is an effect of the relationship of the speaking being to language, and it is according to this structure that desire will be ordered.[17] Indeed, it is by

5 J. Lacan, *De la psychose paranoïaque dans ses rapports avec la personnalité* (Paris: Seuil, 1975), 347
6 J. Lacan, *The Seminar, Book III, The Psychoses, 1955-1956*, trans. R. Grigg (New York: Norton, 1993), 92.
7 J. Lacan, *Le séminaire Livre IX L'Identification, 1961-1962*, 2 May 1962, unpublished.
8 J. Lacan, 'The direction of the treatment and the principles of its power', *Ecrits*, trans. B. Fink (New York: Norton 2006), 510.
9 J. Lacan, *The Psychoses*, 6.
10 S. Freud, *New Introductory Lectures on Psychoanalysis, Standard Edition* (London: Hogarth, 1964), 59.
11 E. Laurent, oral presentation, Val de Grâce Hospital, September 2005.
12 Lacan, *The Psychoses*, 61.
13 Lacan, *The Psychoses*, 183-84.
14 J. Lacan, 'Position of the Unconscious', *Écrits*, 708.
15 Lacan, The Psychoses, 184.
16 C. Lévi-Strauss, Anthropologie structurale (Paris: Plon, 1974), 218.
17 Cf. M. Safouan, Le structuralisme en psychanalyse (Paris: Seuil, 1968), 17.

transgressing the prohibition of the murder of the father that Oedipus gains access to the his mother's jouissance. For Freud, these two crimes—parricide and incest—comprise 'the paradigm of the psychic structure'.[18] With the matheme of the paternal metaphor, where the father and the mother are signifiers with a function, Lacan will move the Oedipus complex from myth to structure. The structure then indicates that 'there is some symbolic in the real'.[19]

Although Lacan was closely associated with the structuralists, they nonetheless rejected his concept of structure because of the way it integrates the dimension of the subject, which they reject. Miller notes that in Lacan's first teaching, 'the ancient clinical classes inherited from a tradition appear as so many structures'.[20] These clinical classes are neurosis and psychosis—each of which has subclasses (phobia, hysteria, obsessional neurosis, paranoia, schizophrenia, autism)—and perversion.

Miller provides another insight when he argues that 'what Lacan found in structure is an answer to the question of the real […] which led him to pose that what is real and what is cause in the Freudian field, is the structure of language'. This means that 'the concept of structure adds the [notion of] cause to the class',[21] the notion of cause as the element of the real. This leads Miller to say that 'for Lacan, the unconscious is a structure, that is to say knowledge in the real'.[22]

Beyond structure

Lacan goes on to develop his concept of discourse by way of four modalities of discourse—the master, the hysteric, the university, and the analyst). Each of these modalities, expressed by Lacan via mathemes, corresponds to a modality of jouissance and to a certain type of social link. Each discourse has four elements which permutate in four places: the barred subject, the master signifier S1, the other signifiers S2 and the *objet a*. Following this, we can surmise that the notion of structure is cashed out in terms of the four discourses.

The concept of structure is therefore based on its 'combinatorial character' or 'its potentialities of displacement', according to Miller. A limit to this concept appears with Lacan's logical proposition that the 'sexual relation' is impossible to write. As a consequence, the jouissance of the subject then appears to be One, 'idiotic and solitary', and therefore it 'does not establish a relationship with the Other by itself'. This, says Miller, 'limits the concept of structure'.[23] If the sexual relation cannot be written, 'there is a relationship [which is] given over to contingency, removed from necessity', while the structure is something which is written and which 'presents itself as a necessity'.[24] In fact, Miller proposes, the structure should be understood as containing holes; it is in those holes that 'there is room for invention'.[25]

In 1998, Miller proposed the notion of 'ordinary psychosis' which expanded the concept of structure. 'Ordinary psychosis' cannot be objectified in measurable behaviours; it manifests itself neither by a major disorder nor by anti–social behaviour. In the absence of any trigger, it can be considered where there are other signs pointing to a psychosis: language disorders, a body that is poorly or not-so-poorly constructed, body phenomena, or even more ordinary, more discreet signs. It can be a feeling of weirdness, a life of wandering, sometimes the absence of symptoms other than the need to be conforming, normal, often accompanied by a feeling of emptiness. Miller, quoting Lacan, speaks of 'a disturbance that occurs at the inmost juncture of the subject's sense of life'.[26] He refers to small clues of foreclosure to look for, such as the adjustment of one's life to imaginary identifications.[27]

The 'ordinary psychosis' hypothesis does not exclude the possibility of a structural diagnosis when we consider the possible mode of decompensation of this psychosis. Rather, its main purpose is to help

18 M.-H Brousse et J. Miller, 'Le criminel et son crime', *L'Âne*, no. 8 (1983), 36.
19 J.-A. Miller, *Cours, Le lieu et le lien*, 14-28 November 2001.
20 J.-A. Miller, Cours, *Choses de finesse en psychanalyse*, 10 December 2008.
21 Miller, *Choses de finesse*, 10 December 2008
22 J.-A. Miller, *Cours*, *L'Un tout seul*, 26 January 2011
23 J.-A. Miller, 'Six Paradigms of Jouissance', *Psychoanalytical Notebooks*, no. 33 (2019).
24 The 6th paradigm of jouissance proposed by J.-A. Miller
25 J.-A. Miller, 'The Six Paradigms of Jouissance'.
26 J. Lacan, 'On a Question Prior to Any Possible Treatment of Psychosis', *Ecrits*, 466.
27 J.-A. Miller, 'Effet retour sur la psychose ordinaire', *Quarto*, nos. 94-95 (2009), 45.

refine the diagnosis of psychosis where there is no apparent triggering, therefore making itself useful in overcoming the impasse of the pseudo-diagnosis of borderline state.

From singularity to sinthome

Lacan's concept of sinthome, put forward in his late teachings as he is developing his theory of the Borromean knots, 'erases the boundaries between neurosis and psychosis'.[28] What operates is the real-symbolic-imaginary knotting and the sinthome is what creates the knot, a knot that endures. The paradigmatic exemplification of the sinthome is James Joyce, a subject who eludes all classification and who exists outside the clinic, having never done a psychoanalysis. His case is absolutely 'singular' (which is to be differentiated from a 'particular' case which is susceptible to comparisons and can be attached to a class). The clue to Joyce's case is the episode of the beating he suffered at the hands of his school mates. Joyce responded to this event with indifference, his body then appearing like an empty envelope.[29] In a logic of knots, this moment is characterized by a shift in the imaginary that 'clears off'.[30]

A sinthome will come to the place where the knot fails. In the case of Joyce, Lacan proposes, 'his desire to be an artist who would keep the whole world busy'.[31] As a consequence, his own name, his proper name, came to represent 'a way of suppletion for the fact that the three registers were never knotted together'.[32] It was also a way, for Lacan, of 'compensating for the fact that his father was never a father to him'.[33] The ego will reconnect the imaginary with the real and the symbolic.[34] The diagnosis, if we can still refer to it as such, boils down to identifying when and how the knot has come undone, and also how a sinthome 'makes it possible for the symbolic, the imaginary and the real to continue to hold together'.[35] This Borromean reading does not, however, prevent Lacan from referring to a more classic conception when he speaks of Joyce as 'de facto foreclosed',[36] thereby raising the question of whether he was mad.[37]

We can ask ourselves whether a sinthome is only valid for psychotic subjects as a singular solution in the absence of the signifier the Name-of-the-Father. Among neurotics, the signifier the Name-of-the-Father, means that there is no obligation to find a singular solution. That said, the Name-of-the-Father is only one possible version of what holds RSI together—the Oedipal suppletion being only one among others. As such, each subject does not have the same Name-of-the-Father, and so, in our era of 'the Other who does not exist', the Name-of-the-Father function is often inoperative. That is to say, it never achieves a perfect knot.

From diagnosis to singularity

The sinthome, then, is 'the singular concept par excellence'.[38] It introduces the idea that each subject must invent their own solution to make the knot hold. As a concept, it allows for more focus on what might constitute such a solution for a subject, rather than on what a subject lacks in relation to a supposed normality. The sinthome comes in place of the relationship to the unconscious, which we no longer try to decipher.

This leads us to a revised sense of the clinic that is no longer structuralist; it is discontinuous, with no clearly differentiated classes. It is a Borromean clinic of a continuum, which focuses on the study of deformations or ruptures of knots. If we consider that in neurosis it is the Name-of-the-Father that acts as the quilting point, and that in psychosis it is something other than the Name-of-the-Father, then, as Miller has noted, 'We can speak of neurosis as a subset of psychosis, mainly for ironic purposes'.[39]

28 J.-A. Miller 'Choses de finesse', 17 December 2008.
29 See J. Lacan, *The Seminar of Jacques Lacan, Book XXIII, The Sinthome (1975-1976)*, 128-29.
30 Lacan, *Sinthome*, 131.
31 Lacan, *Sinthome*, 72.
32 Lacan, *Sinthome*, 131.
33 Lacan, *Sinthome*, 88.
34 Lacan, *Sinthome*, 152.
35 Lacan, *Sinthome*, 94.
36 Lacan, *Sinthome*, 89.
37 Lacan, *Sinthome*, 87.
38 J.-A. Miller, 'L'inconscient et le sinthome', *La Cause freudienne*, no. 71 (2009), 74.
39 J.-A. Miller, in IRMA (ed.), *Conversation d'Arcachon* (Paris:Agalma, 1997), 256.

It was a similar thought that led Lacan to say that 'everyone is mad' or 'delusional'.[40] In so saying, Lacan removed any reference to a norm, even if everyone has his singular way of being crazy and invents his own solution to confront the hole, the absence of any guarantee in the Other, S(A).

Rather than thinking in terms of a binary structure—whether or not there is psychosis, or more precisely, whether or not the signifier the Name-of-the-Father is present, for example—it is interesting to consider this signifier, or another operator than the Name-of-the-Father, as an apparatus enabling one to treat jouissance, more or less, in degrees. We thus arrive at the notion of a continuum clinic, whose paradigm might be the reed that bends in the wind, unlike the oak which resists or breaks.[41] It is also possible to locate in this clinic the proposition according to which we are all autistic, since at the heart of each speaking being there is an autistic jouissance which constitutes the dark side of the symptom. It is this jouissance which is the very core of any treatment oriented by the teaching of Lacan. The Analysts of the School (A.S.'s) bear witness to this autistic jouissance—impossible to nihilate—and to its destiny during and after the treatment.

The psychoanalyst faced with the diagnoses of our time

Today, diagnoses are increasingly common, particularly in child and adolescent psychiatry. These diagnoses tend to ignore both the subjective dimension and that of the symptom; both are reduced to behavioural disorders—Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorders, transidentity, etc.—likely to be re-educated or treated with medication. Signifiers such as 'dysfunction', 'disability', 'harassment', 'victim', and so on, are more and more common. Questioning the applicability of these terms to a child's or an adolescent's parent will often arouse hostility. 'Brain-mania' also invades the media space and reduces an entire pathology to neurological causality that must be treated with drugs or microsurgery.

Miller emphasizes that 'the legalization of jouissance is paid for by non-symptomatization'.[42] However, he says that 'zero symptom is the return to the inanimate'. He adds,

> Contemporary de-pathologization is not only the consequence of the dissolution of the clinic due to the DSM and the promotion of medicine as the universal key to 'mental disorder' but is also a consequence of the deconstruction of the normal, classically opposed to pathological.[43]

Once the normal is deconstructed as a 'male norm', he says, 'the pathological deconstructs' and 'the pathologies of yesteryear are doomed to become "lifestyles"'. There are also diagnoses which function as a plug, such as incest. We can also question the function of alcoholism or drug addiction diagnoses. They may have a social role but they say nothing about the structure of the subject.

What, then, should the psychoanalyst's relationship to diagnosis be?

Clinical diagnosis is a relevant part of the analyst's training—as distinct from the analyst's formation which occurs in his or her own analysis. It is also relevant to the patient's discourse, in so far as we often refer to neurosis, psychosis and perversion, as well as to their subclasses. Likewise, we evoke the Freudian and Lacanian concepts like castration (which can be denied, refused or foreclosed—Verleugnung, Verneinung, Verwerfung) as well as the presence or foreclosure for a subject of the signifier of the Name-of-the-Father and its corresponding phallic meaning.

The mathemes of the discourses allow us to approach the diagnosis of structure in an even finer way. This logical reduction has a very practical implication. Rather than seeking to make a classic diagnosis by placing the subject in a particular category, it is possible to ask how this subject is situated in relation to the four elements of discourse. How is the subject articulated by way of the signifying chain and the *objet a*? Moreover, is the subject we receive divided or not? Is there a master signifier, S1, that emerges from his words? Is this master signifier alone or can it be linked to other signifiers, to a signifying chain? What, then, is the subject's relationship to

40 J. Lacan, 'Lacan pour Vincennes', *Ornicar?* Nos. 17/18 (1979), 278.
41 See IRMA (ed.), *Convention d'Antibes* (Paris: Agalma, 2005).
42 J.-A. Miller, 'Présentation', *Enfants violents* (2019).
43 J.-A. Miller, 'Trois questions à Jacques-Alain Miller', L'Hebdo-Blog no. 326, 5 février 2024.

knowledge, S2? Is he frozen in certainty about knowledge, or does he have access to a dialectic, even to doubt, which mobilizes the signifying chain? Beyond this, we might ask, is the object housed in the Other? Alternatively, is the object of enjoyment found 'in the pocket' of the patient (as Lacan suggested), who then often feels targeted by a wicked Other or reduced to the state of waste? The answers to these questions will guide the conduct of any cure or treatment.

The continuum clinic, the clinic of the sinthome and of knots, has its place because it is this clinic that allows the analyst to be oriented towards what is singular and towards the real of jouissance, as that is what is incomparable in his patient. It does not, however, eliminate the structural clinic. The Lacanian orientation is to make use of it, and then to be able to do without it.