



CLINICAL STUDY DAYS 2 DISCUSSION OF CASE

“Why is the devil chasing me?”

(by Tracy Favre)

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I believe that answering the questions the analyst poses in this case is fundamental to understand what makes this treatment possible.

In transference, which role did the patient give to the analyst?

It seems that she is chosen by him among other possibilities in the institution, for some reason, he felt he could be safe with her.

Nevertheless, it doesn't prevent the analyst of the risk of becoming a persecutor, and she is aware of it. Some of the interventions show this direction, also the difference of orientation with other professionals who thought that the best for him would be a behavioral change (like making eye contact as one of the goals in his treatment plan), the analyst said: *My suggestion was to make eye contact when he would feel ready.* She didn't install a demand coming from her; she didn't have expectations about what he had to do.

Usually, when a patient makes noise tapping on his leg, the DSM would say that it shows anxiety, however, instead of labeling him, the analyst used the tapping as a sign to establish a particular way of communication. She offered him a place for a singular way of interpreting.

The analyst offered herself as a secretary that notes the patient's evolution, giving place and underlining his own constructions. Time is really important, and she lets him decide when the time of the session is over. So, she doesn't force him with the time, with the treatment goals, or labeling him with a diagnosis.

This kind of direction allows the continuity of the treatment; therefore he can talk about his thoughts, trust her and feel safe. The *jouissance* invades him but being in the analyst office stops it. It helps regulate the invasion and sets a limit at least while he is there, which is of a great importance for a patient who can't deal alone with this real.

When a patient like this one communicates his thoughts, it is necessary to verify if there are hallucinations.

He related them as thoughts, but how can we make a difference between thoughts and hallucinations? An obsessive patient also has raising thoughts and sometimes we can see paranoid ideas too.

If he takes his thoughts as coming from somebody else, from outside, the thoughts are invading him. He says: "*Die, you damn BASTARD you Devil leave me alone & bother someone else with these thoughts!*", he talks like if another person is bothering him. He can't say " I don't know where this thoughts are coming from and are all over my head", he is positive about the *certitude* of having the devil inside.

On the one hand he says "I am the devil" but in the other one he says to the devil: "leave me alone", then he is not. The devil is inside-outside him. Nevertheless, the devil could die and he could continue being alive.

Another contradiction is that he doesn't recognize the words as belonging to him, at the same time, he gives continuity to them, he continues the sentence.

We should as well analyze why he identifies himself with the devil, which ones are the delusional thoughts and verify if those thoughts are or not verbal hallucinations, so we can make a more precise diagnosis.

He says: "*I have dozens of thoughts like being a suicide bomber , a rapist or other bad sexual thoughts, being an arsonist, a child molester, homicidal, suicidal, racial, about peoples height, weight, disabilities, giving counterfeit money to cashiers, having a gun not being afraid to use it, having candy to offer to kids to molest them, thinking that Koby Bryant the basketball star lives in my house so I can attract kids to my house so I can molest them.*"

He wants to kill, molest, without being afraid, at the same time, he is afraid. But these contradictions aren't at the level of the obsessive doubt; they affect him in a way that doesn't point out to a conclusion. For him, there is something impossible to

symbolize, to organize, to give order to. What was refused from the symbolic returns from the real.

He wants to have power over the Other, but there is a drive that goes after him. We have to remember that he tried to commit suicide, and it is necessary to be precise about this event. What did he want to answer by doing it?; he wants to be a suicide bomber, while killing the others he dies too. It is a way to stop suffering.

"Johnny stresses one event he considers was the start of the disturbing thoughts: his admission to a medical unit due to a bleeding ulcer. At that time, Johnny's step-mother died in the hospital. Johnny became delusional and started having the thoughts. In the hospital, Johnny got suicidal; he stayed almost a year in the hospital."

The surgical intervention in his body plus the death of his step-mother could be the trigger for his crisis. There is an impossibility to respond to it, to symbolize it. He found himself confronted with the emptiness under the modality of the hole. He didn't have a signification to respond to this facts and the solution was separation from reality. First, by trying to kill himself, then, in a second moment, by having the invasive thoughts.

Johnny explains his identification with the devil back from his hospitalization in 1995, where a black patient told him that *"13MZ was written in the Bloodshot lines of my eyes, I think he said 13 was for the 13th Disciple M, was for Man & Z was for zero! & I see the*

13 MZ in the bloodshot lines of my eyes, he tried to say I was the Devil!"

He tried to give an interpretation to what happened to him, but it appears to him as an enigmatic statement which he tries to give some sense without being able to. There is language on him, but without order, he is outside of discourse. There is significance with no meaning and he makes an effort to give one to it, of course he gives his own meaning, his delusional meaning. After he defensively separated from reality he attempted to recuperate something by constructing his delusion, but it is still fragile.

One of the analysts questions is: *What could be behind Johnny's demand for treatment?*

The psychotic demand to the analyst is intent to limit the *jouissance* of the Other. This *jouissance* is usually located in the body in schizophrenia, and present in the thoughts of the paranoiac.

Another question she poses is: *How to receive and address what Johnny is experimenting?*

Johnny feels lost in the “Bermuda triangle”, he needs a limit to the horror the *jouissance* of the Other produces him. What can work as a limit for the Other?

The Lacanian theory teaches us that delusions are a way to organize the internal chaos and an attempt to reconnect with reality in the patient’s subjective way. Only, it has to find a “point de caption”, a point where he can sustain himself in his relationship to the Other, a kind of link to the Other. Johnny should be able to solve the contradictions of his ideas and construct his interpretation of his subjective position toward the Other.

There is something else that may help; this patient has shown to the analyst his interest for the paintings as a way of link with the analyst, as a way to speak of himself to the Other. Could it be for him a way to take away from himself the gaze of the Other?, could he offer the paintings to the gaze of the Other instead of his own body?. The analyst will have to verify it in the direction of the treatment, carefully, as she has done up until now, may be a “point de caption” is emerging.