



## ARTICLE

### *Transference: private practice, institutional practice*

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**Abstract:** The present realities of transference and psychoanalysis are examined in light of a visionary text by Lacan: *Psychoanalysis and Medicine*. The void left open by the incorporation of medicine in contemporary sciences displaces the physician and his position as subject-supposed-to-know. The anonymity in which the physician finds himself today is coherent with the place, neither exclusionary nor marginal, that the psychoanalyst can take charge of today. The analyst will not be anonymous, and he will take a position in which it is possible to make the subject-supposed-to-know operate.

**Key words:** Transference; analyst's place; demand.

**Resumen:** La actualidad de la transferencia y del psicoanálisis es examinada a partir de un texto visionario de Lacan: *Psicoanálisis y Medicina*. El lugar dejado vacante por la incorporación de la medicina a las ciencias contemporáneas deja desplazado al médico y a su lugar de sujeto supuesto saber. El anonimato en que el médico se encuentra hoy es coherente con el lugar no de exclusión ni de marginalidad que el psicoanalista puede tomar a su cargo hoy. El analista no será un anónimo, y tomara el lugar donde es posible hacer operar el sujeto supuesto al saber.

**Palabras Claves:** Transferencia; lugar del analista; demanda

Transference is a broad concept in psychoanalysis. Usually we link transference to other concepts, such as interpretation, repetition, drive, unconscious, etc.

Freud's early works demonstrate two faces of transference in psychoanalytic cure. One face is the engine, a necessary requisite to the analytical work. The other face is that of the obstacle, obstruction, deviation, a sort of turning away from analysis.

Freud defined transference as a phenomenon installed in the core of the relationship between the psychoanalyst and the patient. Transference was also present

in many other human relationships. Freud states that transference is a sort of “remake”, repetition or second edition of the relationship with the parental figures, the imago of the parents.

Freud said it was always difficult to work with that part of the transference because the patient does not talk about it; without knowing it, he or she just acts it, like a kind of performance.

Back then, Freud was on the alert for the silent side of transference that shows one modality, one certain way of the subject relating to the Other.

The post-Freudians emphasized feelings of love and hate and defined negative and positive transference, though the core of analytical work was countertransference. Following Freud, Lacan’s teaching emphasized the mistake of the concept of countertransference; he rejected it. Moreover, he shed light upon the structural character of resistance. Lacan said countertransference emerged as a conception of analytical work as a relationship of inter-subjectivity.

Allow me to make four remarks on definitions of transference in Lacan’s teaching:

1 – “The appearance of permanent modes according to which the subject constitutes his objects” (*Intervention sur la transfert*); Jacques Alain Miller said this formula is an outline of the *jouir* mode (paradoxical satisfaction of suffering).

2 – “Transference is acting (performing) on the unconscious reality”. It follows Freud’s thesis of transference as repetition or reproduction of the subject’s relationship with his parental figures (we can call it the partner-symptom).

3 – Lacan proposed the Subject supposed to know as the core or engine of transference. Regarding today’s clinical work, I think that this point has changed notoriously due to changing the old regime of the Name-of-the-Father. Nowadays, I find that subjects have less or no supposition; it seems very difficult to install it.

4 – Years later (1967- Proposition of the Pass), Lacan said “the subject supposed to know is not real”, which leads us to conceive interpretation and transference in another direction.

There is a difference regarding what we have to concern ourselves with here today – and it’s not very clear. In fact, the answer has become more imprecise over time. I am referring to the issue dealing with “clinical practice” in institutions where patients who have entered the facility—either voluntarily or committed by their

parents, a judge, their spouse or someone else—have the opportunity to meet with a psychoanalyst and start working on their malaise, concerns and suffering.

Secondly, we have what is referred to as “private practice”, which has been so-named because it makes up part of the daily work of the so-called “liberal professions”. We should stop and think about the state of their practice to see if society regards it the same way today as when it emerged or if it is changing. It appears that the meaning of “private” has become more damaged and threatened due to stricter governmental regulations throughout the world and requests of external agents who seem to intervene in our practices where, one way or another, patients come to see us. In both instances—institutional or private—we must consider the possibility of installing transference.

Just a few years ago, in France, a law was proposed that would go as far as limiting which professionals a patient could choose to see. Furthermore, upon admittance, a “qualified” professional would decide what type of specialist would treat a specific problem. Based on the logic of the specialization and the type of symptom (speaking in very broad terms), a certain specialist would be recommended before a specific treatment. To stop this bill in its tracks, Jacques-Alain Miller created a new movement and put it into action.

In Florida, unlike France, such legislation has not yet been proposed; however, the fact that a patient can freely consult us could become threatened. It is very common for professional codes to require that certain pathologies be treated by certain specializations. For example, for sexual problems a sexologist is recommended. This alerts us to the fact that we must preserve what we consider the minimum conditions for carrying out the work of psychoanalysis throughout the world. One of these conditions is the freedom to choose the professional we want to treat our malaise. However, if the government or a third party decides that our practice is useful for certain pathologies and not for others, then patients do not even get a first encounter with an analyst. This does not mean that as analysts we do not make referrals, inter-consultations, etc. However, to make our practice possible, we must preserve the right of patients to choose whom they want to see.

Let’s take another look at the difference between “private” practice and institutional practice. In institutional practice, a mechanism has already been set in place whereby a third party intervenes between the patient and the psychoanalyst. The analyst who works as a professional must comply with a specific undertaking that is

not always an individual consultation. More and more, analysts are involved in different types of programs—not just outpatient programs. Many times analysts work with groups, families, emergencies, etc.

In these cases, analysts work with what is called applied psychoanalysis, which we have brought to the attention of the world in order to carry out this mode very carefully, thoroughly and with great detail. At WAP over the past few years, many of the meetings, seminars and activities have been devoted to bringing before the public (public opinion, scientific community) all aspects of our practice outside of “private” practice. To bring our work into the public view, today there is material available (in at least five different languages) that includes hundreds of cases and clinical clippings, which bears witness to the work of psychoanalysts and lends itself to Lacanian orientation in a variety of institutions: hospitals, emergency rooms, schools, mental health centers, detention centers, jails, etc.

The therapeutic effects of applied psychoanalysis have been documented. Psychoanalysis for Lacanian orientation is not a practice that is excluded from these various spaces. Its purpose is to determine—in each of the cases written about in the hundreds of articles that I mentioned—that it is precise; it is formalized, argued and considered. It is a fascinating work in progress.

The results are surprising. Applied psychoanalysis is extremely effective to the extent that this term is understood today. Let's not forget that effectiveness is one of the voices of the modern superego. Without responding to this requirement, yet not ignoring it, we see that the application of psychoanalysis causes therapeutic effects, sometimes very quickly, and—what people do not seem to know—with great consequences in terms of the cost of treatment. Relapses are often reduced and, more often than not, the expense of medication is greatly reduced.

In the last few years, an attempt has been made to bring this type of analysis into the institutions where Lacanian-orientated psychoanalysts practice. This work refutes, questions and reevaluates a series of prejudices disseminated at American universities today regarding what psychoanalysis is. This is not an extremely costly practice. It does not take long periods to see therapeutic effects. While psychoanalysis is very rigorous and varied, it is very effective for a variety of pathologies and problems. In addition, it is very cost-effective for institutions and, above all, it is very contemporary. (Hiring Lacanian analysts is very cost-effective!)

Let's not forget to distance ourselves from modern imperatives and the requirements of the era, keeping in mind what these institutions want and require of us and other mental health professionals. We must think about the definitions of requirements such as so-called effectiveness, which, to us, does not reduce therapeutic effectiveness.

Nearly six years ago, between February 10 and 17, 2001, in Paris, Jacques Alain Miller once again posed the question regarding the relationship between pure psychoanalysis and applied psychoanalysis. Remember that he is in the heart of the institution (The School) that created Lacan in order to join analysts together. In the text of the Foundation Act, Lacan set up three pillars or areas of psychoanalysis: pure psychoanalysis, applied psychoanalysis and Freudian analysis. From the perspective of applied psychoanalysis, Borromean topology is one of the three rings that make up the foundations of The School. This has great consequences since applied psychoanalysis in institutional practice is not some type of second-hand psychoanalysis. Placing it as one of the pillars of The School means it has a central role, essential to The School itself.

The School has a very important function (but not the only one), and that is to guarantee the continuity of the existence of analytical discourse. Lacan said that it is a place of refuge and an answer in a time of cultural unease. Thus, applied psychoanalysis is one of the essential fronts in the pragmatic sense, that is, what analysts do in the city.

At the same time, WAP is a thermometer that is continually progressing and being put to the test: the contrast between our theoretical devices, our theoretical corpus, and the actual practice, the clinical work. It raises new questions and advances in terms of answers to new problems that arise every day. Everyday symptoms present themselves in new ways and every day there are new problems dealing with subjectivity.

Recently, in a research group led by Alicia Arenas and Liliana Kruszel, my colleague Fernando Schutt recalled how Lacan, in an article entitled "Psychoanalysis and Medicine" (1966), described three positions which psychoanalysis occupies along with medicine. The first position is rather marginal, that is, similar to the role of paramedics, a bit of external help, which is the arena occupied by most institutional therapists who think in terms of medical and psychiatric discourse.

The second position to take is what Lacan called the “extraterritorial” position, which would consist of the position taken by some psychoanalysts that are divorced from medicine. Lacan does not agree with either of these positions. He has his own position, which we could say occupies a void left by a contemporary change regarding the diagnosis of the doctor and his “classic” function within society.

Lacan says that medicine itself is undergoing a change, a type of movement, leaving behind what he calls a personage – a social level with a certain supposition of knowledge and recognition somewhere within society – who applies some of his knowledge and lack of anonymity. However, due to the scientific movement in recent decades, which has placed the role of medicine in a different place, doctors have not voluntarily made this change, a change dictated by the logic of the era and by the introduction of modern science. Thus, doctors have had no option but to take an almost completely anonymous position required by scientific medicine, the physiologist.

As you can see, this has serious consequences regarding the position of the subject supposed-to-know, since machines now verify what the doctor says (his words have no value) and this implies changes regarding the transference phenomenon. Yet, this does not operate by anonymity, but by personage. Doctors have abandoned the place that Freud says causes the human transference phenomenon, which flows between the doctor and patient. The recent void that scientific medicine has left open allows, more than ever, for the convenient accommodation of psychoanalysis.

Lacan proposes a third option that is neither extraterritorial nor marginalization: “what I say regarding the place that the psychoanalyst can occupy is currently the only place where a doctor can maintain the originality of his position, that is, what he has to know, although this can only be done by directing the subject to reverse his thinking to make this demand.” The position of being the one who takes care or takes charge (the demand) corresponds to the space of supposing knowledge of the truth about what happens to a subject. Today, this place is emptier than ever.

We can deduce that the foregoing makes the psychoanalyst’s practice more necessary than ever if this position is empty. Our work is to take this empty space and lend somebody (different from a machine) to occupy it; this place is the basis of transference.

Another consequence of the above discussion is that contemporary science, which relates to what is real, seeks to twist, modify and alter it in particular ways,

serving the ideals and imperatives of our era. Well, Lacan said this movement in scientific medicine is convenient, coherent and permissive in analytical discourse. In other words, it is not exclusive of psychoanalysis; in fact, this leaves the door open to accommodate it in this era.

Lacan adds, "At the end of this demand, the function of the relationship with the subject supposed-to-know reveals what we call transference. More than ever, this is the means by which science has the last word and the myth of the subject supposed-to-know is sustained. This permits the existence of the transference phenomenon because it leads to the most deeply rooted desire to know."

By this viewpoint, in 1966 Lacan shed light on what institutional work really is and how institutions respond to the demands of the age, such as the demand for productivity, a major inscription of the role of medicine under this regime; given that the subject does not stop making his demand in relation to the *Jouissance* of the body, greater space is to be occupied by the psychoanalyst. (This refers to a Lacanian future!)

Thus, we are not opponents who systematically question institutions. This is not in line with the ideals or imperatives of those who serve institutions all the time. Our position will be that of finding those holes that the machinery of standardization leaves behind in order to accommodate the subject in them, receiving his demand in a different way from the classification that encourages imaginary identifications or systematic exclusions that favor segregation and refusal to take responsibility for his *jouissance* – non- responsibility.

It is the possibility of recovering the dimension of transference that can find someone, not just anyone, but someone who takes on the issues that affect the subject's suffering today, someone to listen to what the subject has to say about the enigma of his suffering.

The need for someone who can take charge of the demand is more commonly verified in answers that lead to the policy of prevailing evaluation that is so frequent today.

Lacan says, "The common issues in psychotechnique research practice, in which the answers are determined by certain questions, are themselves registered in a utilitarian plane. They have a price and their value is marked by defined limits that have nothing to do with the background that is in play in the demand of the sick."

If the policy of evaluation and classification today causes us to consider every word carefully, then this constitutes the course of action, a measuring tape to measure the size of the space left by the displacement that Lacan anticipated. Evaluation and classification do not accommodate the demand itself; it is not the place for transference and proposed fixed interpretations; more and more is unknown to the professional in his clinical know-how. In other words, bureaucracy has displaced clinical work.

Nowadays are days of forgetfulness in clinical work such as the work of a professional who supports determined knowledge, be it particular or universal to every case. We might say that today's psychoanalyst holds the position of someone who tries to extract subjectivity from universal effects, one detail that helps the psychoanalyst with the subject's historization process. Clinical analysis has been forgotten in institutions and has been replaced with information collecting.

I previously mentioned that there is a third party between the psychoanalyst and the patient in institutions. We must always carefully consider and calculate the effect of this third party on the issues at hand in the psychoanalyst-patient relationship. To the psychoanalyst, this third party sometimes has the role of facilitator; at other times, the third party creates obstacles to the analyst's job performance. More often, they have the resources necessary to the course of the cure. I will give you an example so that you can better understand this third option: Institutions assign a certain period of time to each session. This is something we know that at certain times is true to our concept of language and the position of the analysis is different from the chronology. That is, we operate with various amounts of time for a session (it is prejudicial to say that as Lacanians we make our sessions shorter); we follow the patient's speech, which is a precise form of intervention that we have in the time cut. The cut, remember, is the logical consequence of the signifier itself, because it creates a misunderstanding that leads to a new meaning of the words that someone just said. The subject starts to listen to what he/she said.

The cut is also coherent with the concept of drive and of how to intervene in the act dealing with the silence of the drive that is present in transference. The analyst, obedient and respectful of the institution's policy, thus finds a very punctual solution in a session where what a patient says requires a cut. To implement it, the session is cut short after fifteen minutes and, in accordance with the institution's requirements, the analyst proceeds to let the parents in to help fill out the paperwork and sign the

documents required by the institution. Initially, the analyst may see this as an obstacle. However, it soon becomes a resource for psychoanalysts to carry out their work in institutions, keeping in mind the transference phenomenon at play and our form of intervention. This is merely an example of the small interventions we must make.

Sometimes, the third party creates insurmountable obstacles. Recently our state health system underwent a change; where there were once three institutions, now there is only one institution that must respond; there is no other option. The state is now implanting so-called HMO's that administer the resources that the institution used to administer and collect from a state institution.

At the time of the change, there was a series of movements whose common factor was the radical ignoring of transference and its importance in therapeutic mechanisms.

Theoretical considerations of the so-called behavioral therapies are responsible for this since they propose a system of standard treatments for each diagnosis and are unaware of the unique element in each case. They always work with techniques and technicians who apply techniques according to a given diagnosis.

The application of a technique is the fundamental goal, while the actor or agent of this function (the therapist) has been erased. Studies have proved that this logic, which is more published than ours, is less effective. At any rate, within this logic it is possible to move quickly from one applied technique to another or from one re-educator to another regardless of the consequences on the treatment.

This is how abrupt changes at the macro level require the patient to go from one therapist to another. The change of plan is translated to a change of therapist (and sometimes to a change of programs) without considering the clinical effects it could have.

As you can see in the previous example, the logic of effectiveness created an obstacle to the transference, which becomes unknown, nearly denied or foreclosed (Foreclosure). Transference then takes on another name (empathy) and becomes unknown.

We can intervene in this type of situation and show that lack of acknowledgement has its consequences and financial costs: re-medication, patient relapses and further consultations.

Our real business card is our institutional clinical work that produces transference and its effects, such as a new patient coming to the institution and asking to see Mr. X, therapist, and not someone anonymous. Not acknowledging transference does not mean that transference will not show its effects. What we then have is clinical work forgotten in favor of bureaucracy, measuring and classification. We have forgotten transference in favor of standard treatment.

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