

ethico-religious one. The anxiety that something “human” was being lost in the spread of neuroscience, diagnostic standards, and psychopharmaceuticals can be seen as a response to the rationalization of new spheres of life. In Buenos Aires, psychoanalysis – initially brought into *salud mental* as a novel medical technique – now functioned in the service of a secular counter-modernity.

We may empathize with the criticisms of the abstracting qualities of DSM, and of pharmaceutical treatment as an element of an encroaching and sinister technicity. But the case I described earlier in the chapter – in which a doctor used powerful antipsychotics in order to make his patient amenable to group therapy – shows that we should be wary of the potential pitfalls of this desire to be human in a *social* way. It is worth noting in this regard that Lipovetsky’s defense of the use of DSM criteria was also made on ethical grounds; but it was based on an ethics of professional practice rather than one of humanistic values. DSM was not capable of providing meaning to the world it ushered into existence. But if it entered into a practice of knowledgeable care, this latter position seemed to suggest, neither did it necessarily imply the dissolution of the subject, or the technologization of the soul.

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The Lacan ward

Soon after I arrived in Buenos Aires in 1998, the physicist and science warrior Alan Sokal came to the city to promote his new book, *Intellectual Imposters*, and delivered a lecture to a large audience at the University of Buenos Aires. As expected, Sokal decried the influence of postmodern cultural relativism and anti-scientific thinking on progressive political thought. Moreover, he said, while this was merely an academic debate in the United States, in Buenos Aires, where Lacanian psychoanalysis dominated the mental health sector, it was a problem of public health. There were loud cheers from the audience.

Sokal’s accusation was echoed by several of the doctors in the men’s ward at Hospital Romero. Patients were often misdiagnosed and given the wrong medications, these doctors complained. More generally, they argued, an anti-scientific ethos presided among analytically oriented mental health professionals, such that it was impossible to adequately measure and efficiently approach the city’s mental health needs. The problem was especially acute given the effects of structural adjustment policies and economic crisis on the public sector. They pointed across the entry corridor to the women’s ward – the “Lacan ward” – as an exemplary site for such malpractice. Such criticism suggested a possible disjuncture between the resolutely pragmatic needs of the public hospital and the ethereal realm in which Buenos Aires *lacanismo* traveled. While following the collection of bipolar samples for the genetic study in the men’s ward, I became curious about this institutionalized practice of Lacanianism across the entryway. I began to spend time in the women’s ward, posing the question: how could this hermetic knowledge system be put to work in the context of the public hospital, whose infrastructure was deteriorating and which took in patients from the most marginalized social classes?

Psychoanalysis in the hospital

Hospital Romero's psychopathology service is an outgrowth of postwar psychiatric reform in Argentina, whose aim was to shift patients from overcrowded asylums back into the community by replacing life-long institutionalization with brief hospital stays and a decentralized network of care.¹ From a North American vantage, the practice of Lacanian psychoanalysis in a public hospital psychopathology ward was surprising. In Buenos Aires, this was not a particularly unusual situation—in fact such sites were privileged spaces for the reproduction of psychoanalytic knowledge and practice. There were a number of explanations for the phenomenon. Some observers suggested that *lacanismo* was simply the latest fad in a long-running Argentine fascination with psychoanalysis. Others argued that the turn in the mental health community toward Lacan's hermetic philosophical system had been complicit with the military dictatorship's efforts to depoliticize the mental health field—that this form of thought's detachment from social problems allowed it to survive the dirty war period, while more engaged movements were brutally repressed by the dictatorship following the 1976 coup. Historians, meanwhile, pointed to the structure of the city's mental health system and the organization of the professions over the previous half-century as an explanation for the rise of Lacan in Buenos Aires.²

For the first two decades after its founding in the 1940s, the practice of psychoanalysis in Argentina was located far away from hospital psychopathology wards, as a private treatment for the neuroses of the educated classes. In the wave of intellectual renewal following the fall of the Perón regime in 1955, the Argentine urban milieu nourished a thriving psychoanalytic culture.³ In this period, the growing middle class combined progressive politics with a passion for cosmopolitan cultural forms. They were ardent consumers of psychoanalysis: to be analyzed came to be seen as a necessary part of maturation, a sign of health rather than illness.⁴ By the end of the 1960s, Buenos Aires was the second most psychoanalyzed community in the world.⁵

Through this period, the Argentine Psychoanalytic Association (APA) oversaw the orthodox practice of psychoanalysis: in an office, with a couch, under the assumption of a contract between analyst and analysand. Psychoanalysts' professional identity developed in opposition to classical somatic psychiatry, which was based in the large neuropsychiatric hospitals built at the turn of the century. In the wake of the Perón regime, mental health reform and a changing political landscape provided the conditions

for the entry of psychoanalysis into the hospital. *Salud mental*, a progressive movement for reform of the treatment of mental illness, was the venue for this integration of psychoanalysis into the space of public health.

For mental health reformers, psychoanalysis was one of a number of experimental approaches used in the effort to modernize the treatment of mental illness. The main focus of reform efforts was the development of alternative institutional spaces. Psychoanalysis made inroads into the public hospital mainly through the new institution of the acute psychiatric care ward. The work of analysts in public hospital wards required a break from orthodox models of psychoanalysis: therapy was provided for free, there was no couch, and transference was potentially hampered by the difference in social class between therapist and patient. As Mariano Plotkin has noted, the setting of psychoanalysis in public hospitals raised new questions for these practitioners.⁶ The role of social and political conditions in the development of illness became central to their reflection; and even more, some analysts began to envision psychoanalysis as a possible tool for social change.⁷

Following a workers' revolt in Cordoba in 1969 known as the *Cordobazo*, political mobilization gripped the left intelligentsia, spreading quickly through the *mundo-psi*.⁸ Younger analysts and trainees reacted against the conservatism of the Argentine Psychoanalytic Association. After a struggle over whether to officially support the student and worker uprisings, a group of rebellious analysts challenged the APA's hierarchical structure, leading to a splintering into multiple psychoanalytic societies. The rebellious analysts defined themselves both as psychoanalysts and as *salud mental* "workers." They sought to bring psychoanalysis into public hospitals where poorer patients could receive treatment. One of the most distinctive features of the contemporary Buenos Aires *mundo-psi* emerged at this intersection: psychoanalysis became "public" as both a technique to be used in public institutions and a form of knowledge concerned with broader social transformation.⁹

The study group

The institutional form of the "study group" played a critical role in the widespread adoption of Lacanian thought in Argentina. Silvia Sigal has analyzed the importance of the study group as a distinctive Argentine cultural institution, whose origins were in the Peronist era of the banishment of progressive thinkers from the university.¹⁰ From the 1950s to

the 1980s, progressive intellectuals in the university were repeatedly persecuted by authoritarian regimes: whole departments were shut down; faculty were fired and replaced with ideological supporters of the regimes. The fragility of their institutional positions led intellectuals to form networks outside of the university based on shared interests. In the study group, students would pay an expert on a given topic to lead an ongoing seminar. These study groups functioned autonomously, sustaining the activity of thought until the political situation changed so that intellectuals could reenter the university. Sigal estimates that by 1966 there were about 2,000 study groups in Buenos Aires, with eight to ten members each.

Since it was a means for under-employed intellectuals to sustain themselves, the feasibility of a given study group was at least in part a question of market demand. For this reason, fashion and personality played a central role in the dynamics of the study group. The combination of a famous name and a popular theme, such as psychoanalysis, was especially valuable in the marketplace of ideas. With the help of the study-group phenomenon, the charismatic philosopher Oscar Masotta was able to spearhead the impressive dissemination of Lacanian thought into the Buenos Aires intellectual milieu.¹¹ Lacan's support of May '68 made him a hero among the Buenos Aires left intelligentsia, and by the end of the decade, Masotta's weekly seminars were drawing an audience of three hundred.

Lacan's critique of orthodox psychoanalytic practice was enthusiastically received among idealistic young psychiatrists who sought to extend their techniques from the *consultorios* of Barrio Norte to public clinics in poor neighborhoods. The psychiatrist Jacinto Armando was part of Masotta's first study group, and is credited by many as the first to bring Lacan's thought into Buenos Aires public hospitals. He is a gruff, friendly man in his fifties, with effusive gestures and a scraggly beard, who enjoys reflecting on his part in this history. What was important was the idea of a return to reading Freud, he begins: Masotta's background was in philosophy and he argued that one did not have to be a medical doctor to do psychoanalysis – that it was the “reading” and not the title that was important. The dominant group at this time, the APA, was a product of the diaspora of European analysts, he says, and had a vaguely Kleinian orientation, but it was not very “rigorous” in its training: “for them reading Freud was secondary.”

This was in the late sixties, continues Armando, during a time of great hope for a confrontation with imperialism. He emphasizes that the field was *salud mental*, not psychiatry. When members of the APA broke off

into radical splinter groups, their efforts turned toward bringing psychoanalysis into the local treatment centers “where theoretical, clinical, and ideological positions encountered one another.” From 1967 on, Masotta encouraged his students to go into hospitals and discuss what they found there. Armando rejects some contemporary critics' claims that Lacanian thought was apolitical: Lacan's thought was so influential in Argentina because it gave an authentic and renovating interpretation of “social” discourse. “Anti-psychiatry entered our thought through reading Cooper and Laing, and although Lacan was opposed to anti-psychiatry, the two were merged here in Argentina.”

In 1969, Armando went to work in the *Centro de Salud Mental #1*, whose director was the *salud mental* pioneer Hugo Rosario. “The psychoanalysts gave space to Lacan among the residents. At this point, there was room for all kinds of treatment positions: the point was to listen.” Armando finished his residency in 1972 and entered the men's ward of Hospital Pirobano as a volunteer intern. In describing the period, he does not place much emphasis on Lacanian theory – he is more interested in talking about the politics of the movement. This was under the Onganía dictatorship, he says, which was much less harsh than the later one, and so they staged many little protests in the hospital. The patients painted a sign saying “Revolutionary Army of Pirobano” on one wall. There were confrontations with “traditional psychiatry” in the internment ward – protests against electroshock, for example. They were trying psychoanalysis on psychotic patients and producing many books and articles on the experiment.

During this period, he continues, many people worked at Pirobano for free – the point was to train people, not to have a hospital career. After a few of his colleagues left, he took charge of the ward and eventually of the whole service. It was a heady time: “we were Lacanian and anti-psychiatric, in our late twenties, and in charge.” I ask Armando what was distinctive about a Lacanian approach to psychosis. “We didn't medicate,” he says. “It isn't that we listened first, then medicated. Listening was the priority. And we thought there could be a restitution of psychosis assisted by the hospital. Medication erases the delusion, but Freud said that the delusion was the restitution.”

The military coup of 1976 had a devastating effect on the *salud mental* movement, including such experiments in the public hospital. The right-wing junta considered psychoanalysis to be a subversive practice, and sequestered many politically active analysts and mental health workers. Most public hospital acute psychiatric care wards were shut down.

Analysts were forced to retreat from public space. During the dictatorship period, which lasted until 1983, a number of Lacanians led private study groups and were able to maintain their communities outside of established institutions.

When the Faculty of Psychology at the University of Buenos Aires reopened in 1983 after the fall of the dictatorship, Lacanian analysts were well placed to lead the institution. In the rapid growth of interest in psychoanalysis that accompanied the democratic transition, these instructors trained literally thousands of psychology students. Since the orthodox APA limited the authorized practice of psychoanalysis to medical doctors, many clinical psychology graduates embraced Lacanian theory as a way to rebel against the strictures of the APA and to authorize themselves as analysts without medical training.¹² Meanwhile, Lacanians attained prominent positions in the city's public hospital psychopathology wards, which became important sites for postgraduate clinical training and for the production of psychoanalytic knowledge. Hospital Romero was exemplary of this process.

The Director of the Psychopathology Ward at Hospital Romero, Alejandro Noailles, was a well-known Lacanian theorist of psychosis in the 1980s, before becoming disillusioned with the approach. His office in an upper-middle-class neighborhood of Belgrano is a serene white, decorated with Van Gogh and Cezanne, with an oriental tapestry laid over the couch. I ask about his training in the 1970s. When he began the residency at Hospital Pirobano, he says, it was the only possible choice if one wanted to work in a general hospital and was interested in a dynamic orientation. It was difficult to get into Pirobano as a resident, and the position was quite prestigious. For residents at Pirobano many opportunities were available afterwards.

Noailles had studied psychoanalysis for two years, he says, but given his Marxist background he was prejudiced against Lacan. At the time he was working with Rafael Paz, a Communist Party militant and founder of a leftist association of psychiatrists. Paz said that you had "missed the train" if you did not study Lacan. They broke with the APA, which they saw as the establishment. Noailles recalls the role of Jacinto Armando in the Pirobano residency: although he was actually just an unpaid intern, he was functioning as chief of the ward, and meeting with thirty people at a café on the corner to do supervisions and case presentations.

Lacanian thought developed on the margins of psychoanalysis in Buenos Aires, outside of the APA, observes Liliana Hirsch, a physician-analyst at Romero, in an interview in her office. The *consultorio* in her airy

Palermo Viejo loft has an antique wooden desk, a sleek divan, and bookshelves full of worn paperbacks. As she tells me about the role of Lacan in the hospital, she goes through her books, showing me various texts describing early psychoanalytic experimentation with the psychoses. Oscar Masotta was the supervisor of Jacinto Armando, who brought Lacan into the public hospital. "The institutional presence of Lacan first surged in Pirobano," she says. When Hirsch graduated from medical school in 1977, Pirobano was the only place in Buenos Aires with a psychoanalytic orientation, and it was Lacanian, led by Armando. A year or so after she arrived, the dictatorship closed the in-patient ward and ended the residency at Pirobano "with an odd mixture of authoritarian caprice and bureaucratic rationality": since the residents still had contracts, they were told to choose somewhere else to go. After the director at Pirobano was promoted and moved to Romero, all of the residents at Pirobano followed her there.

The director didn't know much about psychiatry, Noailles recounts, but she was a powerful political figure, and managed to get forty new posts at Romero by 1982. With an additional fourteen residents and seventy volunteers, it was a "mini-city." They treated patients anywhere there was space, even in the hallway. Noailles explains his embrace of Lacan's thought during this period as an expression of revolt against authority: "Around 1980 we began to be Lacanian," he says. "It was a way of talking: the old standards seemed ridiculous to us. In this repressive time, the orthodoxies of the APA seemed authoritarian, hypocritical. Lacanian thought "presented itself as a very attractive line for young people who wanted to change things, and for whom the only thing they could do was to change the place of the chair because at this moment to change the place of anything else would end your life." Everyone wanted to see what was going on at Romero, says Noailles. There was enthusiasm, a desire to work together – "the miserable practice you see today of supervising to make money did not yet exist."

They began to forcefully push Lacan, recalls Hirsch, mainly in order to be oppositional. They were fighting for "a space of thought" – it was a way of resisting official discourse. Waving the flag of *lacanismo* was combative, an institutional politics. "We judged people according to how Lacanian they were. This is the juvenile part, but there was a real part too," says Hirsch. They were treating psychotic patients, they were with "*los locos*." And the work of Lacan was the only one with a consistent logic for reading psychosis – which is not nothing, she adds. "Noailles, before he stopped being a psychoanalyst, used to say that he was trained as an analyst in the

hospital. And this was because psychosis was in the hospital, not in private offices. Lacanians taught there: Romero was the place to go for psychoanalytic training in the hospital." When well-known foreign analysts, such as Jacques-Alain Miller and Colette Soler, came to Buenos Aires, they visited Romero. "They didn't know what we were doing, but they wanted to come," says Hirsch. She had been in Chile in the early seventies under Allende when they would show foreigners around as observers of the process of socialism. "It was like this in Romero."

At this point, recounts Noailles – the mid-eighties – they also began to teach at the Faculty of Psychology at the University, in the "Department of the French school" – Masotta's department. This was university-based psychoanalysis, he says – "a new species was born." Their students from the Faculty of Psychology also came to Hospital Romero – as many as a hundred at a time. "All of this turned us into celebrities," he says, "we entered the structure of power."

In 1986 Noailles won the post of chief of the women's ward at Romero, and physician-analysts there began giving post-graduate courses at the hospital, which were attended by large crowds of students. "With all these students around, you become a megalomaniac," says Noailles. "It was like Bioy Casares' novel *The Diary of the War of the Pig* – killing off everyone who was not Lacanian. We were like Stalinists." Noailles recalls this period as "the acme of my Lacanian delusion" and the beginning of his disillusionment, mentioning the name of one famous analyst who said that you had to know about Borges and the tango to do psychoanalysis. They thought that psychosis could be explained outside of any organic foundations, says Noailles. The base of the whole thing was the idea that the foreclosure of the Name-of-the-Father could explain everything. Now this is the most difficult thing to maintain. "We created an entire frame of reference around a theory that was only relevant for around 5 percent of the patients."

Noailles' shift in thought coincided with his accession to power in the hospital – he became Director of the ward in 1990. "Something began to happen to me that had never happened before, which is that it is very easy to criticize power but when one has it – this crappy little bit of power ... and one begins to say, 'let's see if the patients get better or not.' My personal impression is that this began to change when I began to get bored of psychotics. They stopped being a marvelous world of madness, poetry and who knows what and began to seem a squalid world of the loss of things, of extreme pain, of poverty ... The impression I had was this: that schizophrenia is a terrible illness, that it screws people up, that it

begins to screw people up at a very early age, that many patients do better with drugs and that the explanation of foreclosure seems totally insufficient."

"It worked at first, and then it didn't work any longer," says Hirsch. Why not? "Well, there were *desencuentros* with reality. For one, our techniques weren't as effective as we had hoped. And it subverted the institutional order – we would do things you just cannot do." There were the "exits," for example: teams would go out of the hospital on excursions with patients – "we did all kinds of things." Hirsch remains a passionate advocate of hospital psychoanalysis, but she also seems to sense a battle lost, the end of a golden age. "We psychoanalysts occupied a respected position at Romero, where people were trained. Given Noailles' objectives after his rupture the situation is more difficult now. We are 'bothersome' characters. Romero used to be full of people who wanted to be taught; it no longer is."

The medical order

The official function of the in-patient ward at Romero was one of risk-prevention: in making decisions as to whether to intern or to release patients, doctors had to balance the threat of suicide or violence – which was the justification for hospitalization – against the institutional logic of limited hospitalization times. While doctors were instructed to move patients in and out of the ward – in Lorna Rhodes' phrase, to produce "empty beds" – and there were attempts by the municipal government to audit the length of patient stays, these remained considerably longer than in comparable institutions in the United States.¹³ In the women's ward, patients were sometimes hospitalized for as long as four or five months at public expense. If a case seemed to be intractable, the patient might then be transferred to the city's main psychiatric hospital for women, Moyano, labeled a *manicomio* (asylum) by the analysts at Romero.

Such requirements formed part of what physician-analysts there called "the medical order" – the set of bureaucratic demands governing institutional action.¹⁴ As Alicia Fiorentino, one of the physician-analysts at Romero, put it: "In the hospital, we have to operate within a specific juridical discourse in which we diagnose and medicate the crisis, and then control it." Doctors in the ward saw their real work as analysts to be in tension with this administrative imperative. They occupied an ambiguous position: on the one hand, they were authorized to direct the

institution because of their official certification as medical doctors within the order of a public hospital. But their formal status as physicians often came into tension with their professional identity and self-formation as psychoanalysts: the filling out of forms, medication decisions, and patients' somatic complaints interfered with what seemed to be more crucial work on patient subjectivities.

Public hospitals in Argentina provided both steady (if very modest) incomes and a source of prestige for doctors since they remained central sites of medical training and knowledge production. But employment in a psychopathology ward carried the danger of being associated with "psychiatry." While membership in the analytic community connoted cosmopolitan sophistication and political progressivism, analysts associated psychiatry with the medical-penal order, with violent techniques such as shock treatment and lobotomy, and with the authoritarian space of the asylum. For this reason, physician-analysts resisted any ties to biomedical psychiatry. If one was both employed in a psychopathology ward and politically progressive, to insist on being an analyst – and *not* a psychiatrist – was one way to avoid the stigma associated with the asylum. In Hospital Romero the distinction was publicly visible: the urbane, professorial habitus of the analysts contrasted with the harried disrepair of the self-consciously biomedical psychiatrists of the men's ward.

There were twenty beds in the women's ward, and patients slept in parallel rows of wooden cubicles that led toward a meeting room in the back. The open-door policy of the ward meant that patients could move about the hospital grounds during the day but had to have permission to go beyond, into the city. Doctors came in only during the morning, while nurses, residents, and voluntary interns managed the patients the rest of the time. In the afternoon, the doctors typically returned to offices in more prosperous Barrio Norte or Palermo where they saw private clients, often working twelve to fourteen hours per day. The staff gathered at least once a week to discuss the progress of the patients. A computer was used, sometimes to track patients, but also to look up references from a complete index to Lacan's seminars.

Meetings, workshops, classes, and patient presentations provided some solace from the din of the ward itself. One psychology resident called it "the trenches," a term that called attention to the difficulties of defending a sheltered space of thought from the disorder of the ward. In these gatherings, however, the medical order would often impinge from outside: insistent banging on the door by patients, babies' cries, visits from hospital administrators or pharmaceutical company representatives. And it was

also within: the patients under discussion had typically been hospitalized either by judicial order, because of suicide risk, or due to questions about the source of somatic syndromes. On particularly chaotic mornings, the head of the ward, Jorge Gitel, would do his best Robin Williams imitation, calling out "Good Morning, Vietnam!" in English. Dark humor was one way to deal with the ironies of the situation: "Another success for psychoanalysis!" he would exclaim when patients failed to improve.

In this context, with neither contract nor couch, there was no question of treating patients with orthodox psychoanalysis. Nonetheless the hospital was a space for generating analytic thought and practice. This was a challenge given that patients in the hospital were far from ideal analysands. The practice of analysis was accomplished through a strict differentiation between the work of the doctor and that of the analyst, which mapped onto a separation between the body and the subjectivity of the patient. Medication played a crucial but unspoken part in maintaining this distinction, as the means for managing symptoms so that subjectivity could be investigated.

Structuralist dualism

"What I can't explain is how you could have a theoretical construct like *lacanismo* and medicate heavily without having your head explode." Alejandro Noailles was musing about the seemingly contradictory practices of his colleagues in the women's ward. The issue in the ward was not whether or not to use medication. Patients who are hospitalized in a psychiatric ward are not those who raise the question of "cosmetic psychopharmacology," because their suffering is quite obvious and severe.¹⁵ But the everyday use of medication was not much discussed in staff meetings, perhaps because it was not especially interesting: transformations effected by medication did not provide material for analytic conversation.

In the biomedical model, psychotropic medication is understood to restore reason and agency to the subject by directly treating the chemical pathology that has disrupted normal mood or thought. But this is not the only way for experts to understand – indeed, to use – such medication. For physician-analysts in the women's ward, medication did not act directly on the site of disorder. Rather, it worked in an indirect way to help sustain what was simultaneously the object of psychoanalytic knowledge and the source of its authority – patient subjectivity. In this setting, the production

of subjectivity practically depended on, but remained conceptually autonomous from, the effects of medication. Physician-analysts considered psychopharmacology to be part of "psychiatric" discourse, an element of the normalizing medical order. This did not mean that they were averse to using medication, but rather that psychoanalysis and pharmacology could not be in dialogue. They might coexist, each in its proper sphere. "Medication works on the symptom, but not on the subject," explained Gabriel, a young psychologist who worked with the patients to develop their narratives. "The neuron is the medium of subjectivity, but they are not the same." It was not that he was against psychiatry, said Norberto Gomez, one of the staff doctors: he was interested in psychiatry and psychopharmacology, he just did not agree with the erasure of subjectivity. "They are different realms," he said: "to medicate a symptom does not require one to stop investigating subjectivity."

Medication took form in the ward as an element of a disciplinary technology: it worked on the body, in order to help produce the subject as a speaking being. As Alicia Fiorentino told me, whereas "neuroscientists give medication so that patients don't speak, I give it to help them speak." Liliana Hirsch echoed this: medication "helps when it accompanies speech." Patients were medicated in order to be calm and manageable enough to engage in some form of talk therapy. "When a psychosis is unraveling," a psychology resident told me, "medication is a necessary intervention – in order to be able to work by using speech."

Gitel explained the division of labor between pharmacology and words in the following way: "I think that psychopharmaceuticals operate to lower the threshold of sensitivity of the stimulus response, but do not operate on the reader. So I can medicate and change the hormonal or neural equilibrium of the apparatus, but the reader, who is the producer of the delusion, is an effect that I don't think is regulated by the neurochemical but is this subject. The delusion comes from here" – from the subject. For Gitel, medication treated only the symptoms, not the structure of the illness. To do work on the structure it was necessary to distinguish problems of the organism from questions of subjectivity.

Gitel described the relation between the organism and the subject as "a dualism, not idealist but structuralist, in which there is no suture between the apparatus of the central nervous system and the reader." The physician treated the brain with molecules, while the analyst dealt with the patient's psyche. I asked Gitel, who is a jazz musician, if it was difficult to reconcile the two roles of physician and analyst. "It is like listening to a concert in two or three planes: on the one hand you listen to the harmony, and on the

other you listen to the melody, and on the other, you also listen to the texture. But yes, you have to be a good musician to hear so many planes."

"Psychoanalysis listens for the particularities of the patient," said Cecilia, a psychology resident, "while the pill is for everything. In this point the two discourses are incompatible: in how to understand the subject. Psychiatry thinks it knows and the patient doesn't, whereas psychoanalysis says the patient is the one who knows." But what if the patient claims to have a certain disorder? I asked. This was a knowledge that was difficult to access, she said: "unconscious knowledge is a knowledge that is unrecognized [*desconocido*] by the patient." Patients could not act as experts about their own condition, since unconscious structure could emerge only in the therapeutic encounter. Patients who claimed such authority were often considered "contaminated" either by analytic categories or by biological ones. I was especially interested in moments when the models of the patients came into conflict with those of the analysts.

In one case, a woman had to perform a long sequence of rituals in order to avoid contamination. She washed her hands repeatedly, for hours at a time, including at the hospital. Fiorentino thought that it was a very grave case: "there is no subjective commitment," and so no possibility of transference. While the attending therapist, Cecilia, tried to work on the rituals, the doctors were more interested in the problem of contamination, in the idea underlying these symptoms. What kinds of objects were contaminated? What was the significance of the number of stages of contamination? "Putting oneself in the symptoms won't do anything," advised Gomez. In doing so, "one is sustaining the pleasure of the symptoms." The psychologist should work instead on questions of subjectivity: "what is the structure?" he asked.

"We could arm the rituals," someone suggested. That is, if it was a psychosis, the intervention might involve using the rituals to reinforce the patient's delicate defenses.

"The rituals take five or six hours," Cecilia pointed out. "Maybe we can 'arm' something else?"

"The only observation, in the psychoanalytic sense, would be not the rituals but the obsessions," said Gitel: one should focus not on specific behaviors but on the question of contamination.

But the woman seemed to be more interested in talking with the psychologist about her current symptoms than about her past. "She doesn't talk about her history," Cecilia said. "For her what's going on is genetic, organic." The patient was, it seemed, something of an expert in psychiatric semiology. She claimed to have obsessive-compulsive disorder,

and said that it was an organic condition. "She speaks of Henri Ey and manic-depression, about the genetic sources of her illness."

Lacan was explicit that the analyst should not take seriously the patient's self-description. Understanding was not the point of the analytic relation: "If I understand I continue, I don't dwell on it, since I've already understood," he wrote in his seminar on the psychoses. "This brings out what it is to enter the patient's game – it is to collaborate in his resistance. The patient's resistance is always your own, and when a resistance succeeds it is because you are in it up to your neck, because you understand. You understand, you are wrong."¹⁶

"If we go that way," warned Gitel, "we won't get anywhere. We need to look at the life of the signifier. She cannot reside in speech if she thinks it's genetic. She is not going to talk to you if she doesn't know that it is overdetermined by speech."

"She says that it's a chronic illness, that it needs to be medicated," said Cecilia. "This is a match," Gitel responded. "She is a calculating subject: she is the genetic, and you are the psychologist. Unless she is neurotic the match is equal – genetics versus speech."

Human specificity

For the analysts, the human was defined by language and subjectivity, as opposed to the animal-like body. Their objection to biomedical psychiatry was to its refusal to admit that humans are distinctive, and therefore require a special kind of technique for knowing. As Fiorentino explained: "The subject of desire is what is left out of psychiatry, and is what psychoanalysis concerns itself with." Whereas psychiatry's emphasis on the biological threatened to erase subjectivity, psychoanalysis was concerned precisely with bringing it out.

Analysts argued that their site of investigation was beyond what "objective" science could approach. Gitel defined the epistemological status of psychoanalysis as a "conjectural science" based on the premise that "man is an incarnate being, differentiated from animals by his use of speech." Language placed human psychic phenomena outside of the realm of the natural sciences.¹⁷ "In medicine they look at the sign, and are not interested in hearing the patient speak," said Fiorentino. "Psychoanalytic symptoms," on the other hand, "are read through words."

The human transcended the organism, and subjectivity was what was universal within the human individual. "Psychoanalysis points at

something irreducible in human being which is subjectivity," said Gomez. "Subjectivity is of each one, it is the most personal of each one. What one tries to read in the discourse of the patient is not the history of the patient, but the impressions of subjectivity in the history of the patient – these points of rupture in the story. The posture of each one in front of his own story."

The specificity of its object – human subjectivity – lent psychoanalysis its characteristic of being a science of the individual, whose logic was distinct from the biomedical. As Fiorentino told me, "Psychoanalysis differs from psychiatry because it is interested in the individual case as its clinical object, not in generalized diagnostic categories. Each madness has its own logic."

How does one come to know this object, characterized by its singularity? In asking whether or not psychoanalysis should be considered a science, philosopher John Forrester argues that psychoanalysis is an example of "thinking in cases."¹⁸ In its practice, a set of paradigmatic cases form exemplars that serve as models for analysts' encounters with their patients. These cases come from Freud's founding texts: Dora, Schreber, Little Hans. According to Forrester, this way of thinking forms a distinctive "style of reasoning" within the sciences, as opposed to deductive logic or probabilistic analysis. Importantly, sciences of the case not only study individuals, but also participate in their production. In hospital psychiatry, for example, the patient's file is not just a source for understanding the patient's past, but in fact produces that past in concrete form, in the written traces left by consecutive doctors and therapists.¹⁹

In the women's ward, individual cases were produced around practices of writing and metaphors of reading. The thick folders of repeatedly admitted patients contained psychiatrists' changing diagnoses, the notes of various analysts, medication histories. And the process of coming up with an understanding of the patient's psychic structure was spoken of as a "reading." But in the hospital one did not encounter texts but patients, and they were generally in bad shape, not immediately willing to provide adequate narratives. They were often silent, or crying, sometimes heavily sedated. In order to do psychoanalytic work with such patients, they had to be assimilated to discursive needs. This meant finding analyzable stories in the patients' utterances, stories that pointed toward an identifiable structure such as hysteria, phobia, or melancholia. "Interesting" patients were those whose stories were available, and who made an analytic reading possible.

The complex labor of shaping interpretable narratives was performed by psychology residents and student-interns, trained in what to look for by

academic study of the classic works, and finding in the hospital an opportunity to bring these texts to life in the clinic. The psychologists' theoretical background from the university was usually psychoanalytic; study groups and courses in the hospital continued this training in the light of experiences they were having with patients. Most psychology residents told me that they chose to come to Romero because of its reputation: it was known in psychoanalytic circles for its Lacanian orientation. Given the lack of employment opportunities for psychology graduates, entrance to the residency was highly competitive. Of twelve hundred applicants, only twenty-five received posts. More generally in Buenos Aires, a major reason that it was possible to do psychoanalytic work in the hospital setting was the oversupply of psychologists in the labor market. In many public hospitals, psychologists worked for free, to gain experience and in the hope of attaining a rare paid post.

Let me give an example of how patients' stories were elicited in order to generate clues about psychic structure. A 53-year-old woman was interned in the ward after attempting suicide with a pair of scissors. She suffered from both hallucinations and depression. Carla, a psychology resident in her late twenties, described the situation to the staff in the women's ward: the woman claimed to hear the voices of birds telling her to kill herself, but Carla was skeptical about the "reality" of the hallucinations. Because they were inconsistent, Carla suspected that the patient was simulating, feigning delusion in order to convince her daughter to move back into the apartment with her grandchild.

Gomez disagreed, suggesting that the hallucinations tranquilized her fear – that the delusion was a "restitution." It was crucial to know whether the delusion was real or simulated because the psychic structure would determine Carla's approach. The immediate problem, for Carla, was that the patient refused any psychotherapeutic interventions: she would not even speak to Carla. Sebastian, a psychiatry resident who was working with the same patient, had an explanation for the patient's frustrating silence, but one that was not taken up by the analysts: that the side effects of the powerful anti-psychotic medications she was taking had made it physically difficult for her to speak – that she was "neurolepticized."

Several weeks after the patient's admittance, there had been little progress. In the hospital they were at a standstill. I accompanied Carla to her supervision with an analyst in Barrio Once, Mariano Cavelli, who worked with many of the psychology residents at Romero. Cavelli is tall and thin, in his early forties, with the requisite analytic goatce and a poker face. A front room in his upper floor apartment, with high ceilings, oriental

rugs, and a single bed as divan, functioned as his office. Cavelli listened to the story that Carla had reconstructed from the patient's file, which included the notes of a long series of physicians and psychologists. There were several key incidents from the woman's past to recount. When she was a child she had fled political repression in the provinces with her family. There was the story of a rape attempt, her troubled early marriage, her son's departure for the Malvinas War. Carla then told Cavelli about the voices of birds telling the woman to commit suicide. She complained that she had yet to get anything to work with: she didn't know what to do – the patient would not speak, she would only make gestures, balling up her fists. Carla said that she was embarrassed about not having done anything – the patient tired her, she seemed impenetrable.

After listening to the case, Cavelli focused on the early incident – the family's flight from political repression – and began to construct a narrative. "I'm going to make a hypothesis, to invent a meaning," he began. "Hypotheses are images made in order to intervene." His hypothesis was that there had been some kind of catastrophe, perhaps a bomb that fell, leaving a hole – an *agujero*: There was an event, he mused, a moment: the three days of the 1955 "Revolution of Liberty," in which people had to flee.²⁰ In this period there was a saying, "the birds are coming," which referred to the navy's planes, coming with bombs.

"You could call this a coincidence, but I don't believe in coincidence," said Cavelli. "She has lived through a situation – a trauma, not in the classical psychoanalytic sense, with the father and genitalia, but a catastrophe, something concrete that happened in the Real. What we call trauma is the hole that the bomb leaves." Cavelli's analysis was "divinatory" in the sense that Carlo Ginzburg indicates: a form of detective work that involves gathering traces and symptoms into a singular and meaningful case.²¹ "Where do we take this, transferentially?" asked Cavelli. The patient was not associating; the case was not yet showing itself as a catastrophic hole. "But the gestures – the fists, the hair – these are signs, hieroglyphics." Carla listened intently. "She is sitting like a baby with these gestures. I will make another hypothesis," he continued. This one was a warning. "A sign is not nothing. Killing herself would be the highest expression of staying put, in the place with the *agujero*," the hole. "In psychoanalysis," he said, "one tries to bring the subject near the catastrophe, to the Real, whereas she is trying to flee the catastrophe."

How, then, to bring her out of this? Cavelli suggested that Carla construct a text with the patient: "The position is to accompany her toward the construction of a history. The analyst takes notes, is the one who writes

this catastrophic bond with her. What can we do in order to join with her in making an *historia* – a letter to the city? Why don't you try to write something with her?" When Carla asked if it was possible to make a diagnosis, Cavelli said: "what matters is the making of an *historia*."

Authorship

Scholars of scientific knowledge production have recently turned to Michel Foucault's classic lecture, "What is an Author?" to frame questions about the historical and contemporary role of authorship in both validating and rewarding scientific creation.²² In the lecture, Foucault argued that, during the early modern period, there was a reversal in the respective role of the author between science and literature: scientific discourses no longer had to be linked to their author's name in order to carry authority, whereas literature now required an author in order to circulate. In the lecture, Foucault noted the recent invention of a different type of discourse – one that fit the model neither of literature nor science. These were evolving forms of knowledge that nonetheless remained linked to their founders' names. The founders of such discourses continued to be present in subsequent transformations of the field of knowledge, even as new authors came into the fold. Psychoanalysis and Marxism were exemplary of these author-centered discourses.²³ In the lecture, Foucault outlined a possible research program that would follow the trajectories of such discursive formations "according to their modes of existence" how they "vary with each culture and are modified within each."²⁴ The discourse of Lacanian psychoanalysis in the women's ward provided an optimal site for such an inquiry.

I spoke with members of the staff about the role of these founding texts, of key cases like Schreber or Dora, when patients in the hospital were so unlike these classical figures. Their responses complicated Forrester's analysis somewhat: for them the exemplary case, the "paradigm," was both the condition of possibility and a potential hindrance to psychoanalytic understanding. Freud as the founding author was present, but instructed *against* the automatic reproduction of his texts. The exemplary case was a convention, but one that had to be overcome.

AL: When your patients are not the typical psychoanalytic patients of Freud's couch, and yet the founding texts speak of such patients, how can one improvise a method? In the

encounter with patients, what is your relationship to these texts?

Jorge Gitel: One has a tendency to make references to "the cases" all the time. For instance, in psychosis one is always referring oneself to two or three or to one above all, which was the Schreber case which, okay, it is a written text, we know that he never met with an analyst, he was never analyzed. One always tends to refer oneself to these typical cases. But it seems to me that the movement would be to be able to leave this permanent reference. If not, you cannot listen, you have completely stopped listening as a result of having taken a reference. This, it seems to me, is a daily clinical challenge for us. I think it is a question of daily practice.

Liliana Hirsch: In general, the cases that Freud published – four or five of them in all of his work – have been converted into paradigms. This makes it easier to think the clinic, and is also an obstacle to thinking the clinic. It gives us the chance to know how Freud thought about a clinical case, and gives us the stereotype that . . . all the hysterics are like Dora or that all the phobics are Little Hans and all the psychotics are Schreber. This is a prejudice that training gives rise to when one has just begun. It seems to me that to break with this is part of the work of those who participate in the training of the analyst, and is part of the work of the analyst himself, to make his own clinical course. I would say: to make of his case one in itself, something that for the patient results in a *writing*. If ever a paradigm for psychoanalysis arrived it would be welcome. The truth is that there are few cases like this, so typical. The cases continue to be singular. And this is what Freud taught, beyond whether or not hysterics are like Dora. That one has to be able to read the singularity of a case.

Authorization

In the women's ward, the role of the founding psychoanalytic authors was not only to provide exemplary cases that might help in the interpretation of patient narratives. Their ongoing importance in the hospital was signaled by the decoration of the staff meeting room, where doctors, residents, and nurses met to discuss the progress of their cases: along with a chart listing

the histories of the interned patients there were two framed black and white photographs, one of Sigmund Freud and the other of Jacques Lacan. What were these authorities doing on the wall, and how did their lingering presence relate to what was being said before their eyes? The question concerned the kind of discourse that was being practiced in the ward: was it scientific, aesthetic, or something else?

For Freud the invention of psychoanalysis heralded a scientific revolution that hinged on the discovery of the unconscious – a discovery he had made through a rigorous practice of analyzing his own dreams. He announced this discovery as a third blow – following Copernicus' restructuring of the cosmos and Darwin's reordering of the animal world – to human narcissism, to the notion of man as an autonomous, divine being at the center of the universe. The discovery was of the inevitable inscrutability of the self, that the ego "is not even master in its own house, but must content itself with scanty information of what is going on unconsciously in its mind."²⁵

If knowledge of the unconscious was not directly accessible to the self, the question then became: how could one access and work on that which is hidden from view? Was there an instrument or device that could make it appear? And how could one guarantee the veracity of such knowledge? Philosopher Isabelle Stengers compares psychoanalysis – at least in its origin – to the experimental sciences, which are based on techniques of verification and purification. For Freud, the disappointment of hypnosis had been that it produced false witnesses, created artifacts. In his invention of the analytic scene, Freud sought to purge the artifact of influence through the technique of transference, which would transform the neurosis into an artificial illness so that it could be worked on in the "laboratory" of the analytic relation. The relationship between analyst and analysand was the crucial site of work, the laboratory in which the unconscious became manifest.²⁶

Freud and his followers gave detailed instructions as to how the analytic scene should unfold – such as the position of the couch with respect to the analyst, the length of the session, and so on. The effort to standardize this process has been a subject of considerable discord within and among psychoanalytic institutions.

While Freud's discovery of the unconscious was the result of an individualized process of self-analysis, the fecundity of psychoanalysis then depended on the capacity to reproduce this process in others. Here the analytic institution has played the role of guarantor, through the standardization of procedures and an ongoing "genealogical" link to the founder.

My question for the analysts at Romero was whether the hospital could function as a site for the reproduction of psychoanalytic knowledge. Was the women's ward performing the role of an analytic institute? Although they acknowledged that Romero had once been a site for training, the analysts emphasized that authorization involved an experience of self-transformation that was distinct from the work I was following in the ward. This experience occurred in the intimacy of the relation between analyst and analysand. The key term, in their response, was "transference."

Alicia Transference is a concept and it is also a practice. The
Fiorentino: transmission of psychoanalysis includes the question of
transference. That is, one listens to one's masters in a
particular manner . . . I don't know how to explain this
because it is understood . . . It is not only to go to read and
learn, but also to be taken by the experience. Because of this,
to be an analyst first one has to analyze oneself.

Only their own experience of the analytic scene could lead to authorization as an analyst – that is, to the validated capacity to access the subjective structures of others:

Liliana The personal analysis, I would say, is what most differentiates the
Hirsch: practice of analysis from any other practice . . . This experience is
what puts one in the position, in the condition of saying of oneself
that one is an analyst . . . And it does not have to do with what she
has read or with what another tells her or with what a title
authorizes her to do, but with her own experience of analysis, of
having located in her analysis the routes of her own subjectivity.
This brings her to position herself as an analyst for another. In
this sense, it is totally different from any other practice where the
subjectivity of the analyst is not included in the practice. In ours, it
is included in order to be able to exclude it.

The centrality of this subjective experience to the capacity to access truth distinguished psychoanalysis from other sciences. As Norberto put it, "Without any doubt, methodologically, science necessarily tries to exclude subjectivity. In the scientific method subjectivity cannot be brought in, which doesn't mean that science is not useful. But in the field of psychoanalysis, this logic doesn't have any space."

Unlike the natural sciences, psychoanalysis does not have a "nonascetic subject of knowledge."²⁷ The capacity to access truth remains dependent upon the self-work of the knower. Only in going through the self-analysis,

in discovering one's own "routes of subjectivity," does one become qualified to become an analyst. And one cannot speak authoritatively about psychoanalysis until and unless one has had this experience. Psychoanalytic authorization thus has characteristics of both *askesis* and revelation: it requires the discovery within one's self, through work on oneself in the analytic scene, of the truth of Freud's discovery of the unconscious.

According to Stengers, by making access to knowledge dependent on the experience of the analytic scene, psychoanalysis claims the privilege of not needing to give an explanation. "At the heart of the analytic scene there appears to function a very curious 'black box': the analytic scene itself."²⁸ As opposed to the black boxes of "hard" science, which are devices that confer meaning on certain facts, "the analytic scene appears to create those who will have the right to speak about it, and therefore operates in itself as the foundation of right."²⁹ As Alicia said to me, somewhat pointedly: "You have to be included in this experience to think about the question of transference and the relation with the masters."

Thus, although Lacan proclaimed, "the psychoanalyst is authorized only by himself," this work can be accomplished only in relation to a master, and the passage has a pre-given structure.³⁰ The technique of transference – institutionalized through the reproduction of the analytic scene – connects one to "the founding experience of the initial "author," making it possible both to know one's own subjective trajectory and also to create an *historia* for others.

Psychic structure

In order to decide what sort of intervention to make, analysts had to know what they had before them. The psychic structure indicated the position of the subject, which in turn directed the strategy of the analyst. The initial task, then, was to locate the patient according to one of the basic structures outlined by Freud. This was quite different, analysts emphasized, from making a "psychiatric" diagnosis, which was done only for bureaucratic purposes.

The most important structural distinction to be made was between neurosis and psychosis. This distinction structured the analyst's approach to the patient. Whereas with neurotic patients one could work with the tool of transference, there was no possibility of achieving transference in psychosis. Freud explained the difference between the two structures in

terms of the site of psychic conflict: "Neurosis is the result of a conflict between the ego and the id" – that is, an internal psychic conflict – whereas "psychosis is the outcome of a disturbance in the relations between the ego and the external world."³¹ The split between the ego and the outside world accounted for the separation from reality that marked psychosis. The resulting delusion, wrote Freud, "is the patch that covers this breach in the relation between the ego and the external world." At a basic level, then, the presence of delusion was an indication of a psychotic structure. Moreover, the implication of the theory was that such delusion performed an important role in allowing the psychotic patient to function despite his or her "loss of reality." This made it a delicate problem to work with psychotic patients: one did not want to strip patients of their defenses.

For Lacan, translating Freud's spatial scheme into linguistic terms, psychosis was characterized by a failure to enter the symbolic order. He described a process of "foreclosure" in which an unwanted thought or image was expelled rather than repressed, a refusal of symbolization that had catastrophic effects. Lacan located the emergence of the psychotic delusion in this inability to internalize the superego, or "Name-of-the-Father" function through repression: "It is the lack of the Name-of-the-Father in that place which, by the hole that it opens up in the signified, sets off the cascade of reshapings of the signifier from which the increasing disaster of the imaginary proceeds, until the level is reached at which signifier and signified are stabilized in the delusional metaphor."³² Cast outside of the symbolic order, the psychotic remained in a condition of ontological otherness, unable to enter into inter-subjective relations.

In a lecture to a group of medical students, Gitel outlined his approach to psychosis. Psychosis is not an illness, he said, but is, rather, the patient's position in front of reality: "hallucination is the lived language of the subject." The patient's delusion is an attempt to restore lost ties with reality – a "restitution." And since there is no transference in psychosis, one cannot work with the tools of traditional psychoanalysis. In fact, Gitel warned strongly against treating psychotic patients as one might treat neurotics, by trying to use the technique of transference: in doing this one might unleash the psychosis further, destabilize it. It was thus important to identify the structure early on. Neither medication nor psychoanalytic treatment could cure the psychotic. "Delusion is not medicable," said Gitel, "because, fortunately, there is no idea that can be changed by a pharmaceutical. What lowers is the level of anxiety, of anguish, and the productivity that this generates."

Gitel described the temporality of psychosis, based on a moment of rupture. He drew a schema of the history of a psychosis, in which there is a before and after the unraveling: "this episode represents a break with reality." It could take several months for the patient to take on this history, a process that included notes on therapy sessions, weekly staff meetings, perhaps a workshop, and the therapists' external supervisions with senior analysts.

How did this theoretical understanding of psychosis relate to the pragmatic task of dealing with psychotic patients in the hospital? What did a psychoanalytic approach look like in a situation in which the technology of psychoanalytic cure – the transference relation – was explicitly inoperative?

"Psychosis is a limitation of psychoanalysis," admitted Liliana Hirsch. Psychoanalysis "is a tool that helps me to think the subjective position of the psychotic. You cannot apply the same thing to a neurosis as to a psychosis. One does a 'deconstruction' with psychoanalysis. People criticize the use of psychoanalysis in psychosis with the idea of using a couch – this is not done, it would be an outrage [*una barbaridad*]."

"In psychosis a cure through therapy is not possible," said Gabriel, "but one can stabilize it." As opposed to neurosis, the treatment is not based in interpretation. The object is not to expand the delusion further by talking about it, but to deflate it. In fact, the act of therapeutic intervention can have a dangerous effect on the patient. "Speech can perform an unraveling," explained Gabriel. "One has to be careful with psychotics," said Rosana, a staff psychologist. "It doesn't help to listen to them."

Since transference was impossible, the idea of "arming" – or reinforcing – the patient's delusion was an alternative technique for treating psychotics in the hospital. Analysts tried to help such patients "construct a fiction" that would enable them to manage in the outside world.

A psychiatrist in the men's ward, Gustavo Rechtman, argued that the rigid distinction between neurotic and psychotic structure produced a group of marginalized others. "This question of the psychic structure," he said, "is fatalistic, conservative. In this culture if you call someone psychotic they are marginalized as a completely outside group: 'We are the neurotics, and they are the psychotics.'" Rechtman cited the results of mood-stabilizing medication to illustrate the problem of this way of classifying patients: "If you just give a bipolar patient sixty milligrams of lithium, one who might seem really crazy, he will be normal, like you or me." One may *seem* crazy but not *be* crazy, and it is the effect of the drug that provides the evidence. For Rechtman, this was an ethical question: in the act of diagnosis, the psychiatrist had the power to decide whether to include or exclude this person from the collective of the "normal."

The status of bipolar disorder was a source of controversy among doctors with differing theoretical orientations at Hospital Romero. In the men's ward, the condition was widely diagnosed and was the subject of the transnational genetic study that I described in Chapter 1. Within a biomedical framework, bipolar disorder is an organic problem of mood regulation, in which the patient alternates between states of intense agitation and heightened sensibility and periods of serious depression and withdrawal. Unlike schizophrenia, the disorder does not necessarily have a dire prognosis; it is potentially treatable – though not curable – with mood stabilizers such as lithium. There is even speculation that the disorder is linked to particularly creative personalities, to well-known artists and writers like Van Gogh and Edgar Allan Poe.³³ But the disorder is threatening to psychoanalytic epistemology since it has the potential to disrupt the strict differentiation between neurotic and psychotic structure. This is because in the manic phase of bipolar disorder, the patient may suffer delusions and hallucinations, but then, when stabilized with medication, these recede.

While Freud wrote of mania and melancholia, these cannot easily be assimilated to the biomedical concept of bipolar disorder. Freud explained mania in terms of the life history of the subject and a dynamic theory of psychic energy:

In mania, the ego must have got over the loss of the object (or its mourning over the loss, or perhaps the object itself), and thereupon the whole quota of anticathexis which the painful suffering of melancholia had drawn to itself from the ego and "bound" will have become available. Moreover, the manic subject plainly demonstrates his liberation from the object which was the cause of his suffering, by seeking like a ravenously hungry man for new object-cathexes.³⁴

DSM-based psychiatry, in contrast, emphasizes general descriptions that can be answered by a brief questionnaire. From the biomedical vantage, the content of delusion is not important to the diagnosis or treatment of bipolar disorder – since it is a question of mood, rather than thought, it is the patient's bodily chemistry rather than the subject and its history that is the source of pathology. Moreover, the use of the presence of delusion to distinguish between neurotic and psychotic structure no longer makes sense when the presence of delusion in the patient is unstable – that is, dependent on alterable neurochemistry.

Bipolar disorder was thus a dubious category for the analysts in the women's ward. Liliana Hirsch implied that the diagnosis had been invented

to help sell psychopharmaceuticals. "The fashion of bipolarity is winning because it is something so objectifiable," she said. "The politics of psychiatry is correlated to the consumption of psychopharmaceuticals: 'bipolarity' justifies an exaggerated quantity of pharmaceutical consumption." Gitel had a more complex view. He accepted the existence of bipolar disorder but did not see it as commensurable with the analysis of patients in terms of their subjective structures. He considered bipolar disorder to be a physical condition that could exist parallel to either of the Freudian structures of neurosis and psychosis. He could thus speak of mania in the psychoanalytic sense and bipolar disorder as two distinct aspects of a patient. For instance, Gitel and Rosana, a staff psychologist, discussed a patient who had stopped eating, who became obsessed with death following a car accident. "She doesn't think she's ill," explained Rosana. The patient was an insomniac, disturbing other patients at night. "It is a mania, in the more Lacanian sense," explained Gitel, "the accident produced a question in the Real. And she's also bipolar."

Noailles attacked the notion that one could distinguish medication issues from structural questions. Each contaminated the other, he said: structural analysis was often used to make medication decisions. Physician-analysts diagnosed psychosis in structural terms, then prescribed anti-psychotic medication to alleviate the symptoms. This meant that delusional symptoms in bipolar disorder led inexorably to the use of anti-psychotics – and in Argentina, this usually meant the cheaper, older generation drugs whose side effects, such as parkinsonism, could be devastating – and could mimic the symptoms of schizophrenia. Noailles thought there was a public health disaster in Argentina, in which large numbers of patients were kept sedated and unnecessarily institutionalized through misdiagnosis and the wrong medication. This, for Noailles, was the scandal of treating hospitalized patients psychoanalytically: "If you're Lacanian you always diagnose psychosis," he said. "There's no choice, because the texture of the theory brings you to it. It is inevitable: 'the elemental phenomenon, non-dialectizable,' and then you go and you give halpidol or olanzapine."

According to Noailles, the effect of mood stabilizers on his patients had forced him to rethink his theory of the human subject. He found that a number of the patients that he had diagnosed as psychotic could be given mood stabilizers and function well, could even achieve transference in analysis. If apparently psychotic patients could be brought back to normality through lithium treatment, the otherness of delusional structure was called into question. As he told me:

If foreclosure didn't function for me anymore, and if there was an entity that more than 1 percent of the population had, and I gave drugs that worked, how could I think that this was purely the oedipal constellation? It is like having an enormous abscess in your thorax and supposing that it is because of a conflict, and taking antibiotics and the abscess goes away and supposing this is because of the analytic interpretation. It began to seem very obtuse to me.

What happened when these different positions encountered one another? It is illustrative to look at the case of a member of the Argentine bipolar patient support group (FUBIPA) who was hospitalized in the women's ward in a manic state. The young woman, Marta, initially tried to educate her doctors about bipolar disorder, giving them literature from the support group and asking for lithium treatment. She was a particularly difficult patient, with many outbursts requiring attendance by the residents and tranquilizing medication. And although she was given mood stabilizers and other drugs, her condition seemed to worsen during her stay the hospital.

Marta's disturbances could be read in various ways. Sebastian, the psychiatry resident who was treating her, saw her as a "resistant bipolar," that is, a bipolar patient for whom the standard medication indications did not work. For him this implied that one should experiment with other drug combinations – perhaps an atypical anti-psychotic combined with a mood stabilizer. "Nothing can be accomplished here through chemicals," responded Fiorentino. "One can medicate for bipolarity," she said early on, "but not for hysteria." For her, to call the patient a "resistant bipolar" was to ignore the singularity of the case. "This is the thing about human beings," she told me, "they talk. And they thus become unique – you cannot place them in clear categories."

Marta's symptoms had different possible meanings: if she spent too much money, this might be a characteristic of bipolar disorder, or else she was "performing" its symptoms, since she knew the disorder's characteristics so well. Alcohol abuse? Again, it could be part of the bipolar symptomatology or else an identification with her father, who was an alcoholic. The questions that were posed among the staff had to do not with medication, but with her personal life: Why did she identify with men? What had happened in her love relations? Why did she think the hospital staff were uninterested in her? Because she reported hearing her dead father's voice, the possibility was raised of a psychosis. The psychologist noted that the first episode of her illness had come not long after her father's death, and so the problem of unfinished mourning became an axis of reflection in the case.

Gitel distinguished Marta's bipolar disorder from the "structural" issues involved in the case: there was perhaps a problem with her central nervous system, but the real question had to do with the subject. "It is a problem with love," he said. "She is bipolar, but what is the structure here?" he asked. "There is something more than being bipolar, it is a Freudian mania." As for medication, he wanted to be "empirical." "Let's go with a classic," he proposed – an anxiolytic and an anti-psychotic.

Like her father, Marta was a poet, and the analysts saw her writings as a possible place for "building a sustainable fiction" in order to construct a workable subjectivity and come to terms with her ambiguous sexuality. But the case became less hopeful as time passed and her actions grew more extreme: she attempted suicide twice within the hospital grounds, once by cutting her wrists with sharp rocks, and later with an overdose of medication. She routinely created scenes in the ward by throwing herself against the walls and furniture, and the staff physician-analysts instructed residents not to speak with her, but to directly inject tranquilizing medication.

"She doesn't have anguish in a Lacanian sense, something one could work with," Fiorentino worried. "this delusion, this mania, what can we do with it?" Eventually the staff agreed to describe her as having a "borderline personality" – a structure between neurosis and psychosis.³⁵ A psychology resident told me: "the bipolar disorder is child's play compared to the personality disorder she has."

Eventually a bureaucratic problem arose: Marta had been interned more than sixty-nine days, and special paperwork was required to keep her longer. In the space of the clinic, such demands came from the administrative rationality of the medical order, oriented toward reintegrating patients into society. As Fiorentino told me, "they think that by limiting internment times they can make psychotics into normal people," but it was impossible: "there is no social space for the psychotic."

"Maybe she needs a change," someone suggested. As the crises continued, the staff prepared to give up, and began the process of transferring her to the infamous woman's asylum, Hospital Moyano. "But what can they do for her in Moyano?" someone asked. There was no answer. "There just are patients like this," said Fiorentino to console Marta's psychologist.

Then, quite suddenly, Marta improved, and was released by the end of the month. Sebastian attributed the change to the correct medication formulation – valproate and clozapine – while the psychologist thought it had to do with a change in the therapeutic strategy, which had enabled her to face the problem of mourning in a new way. Marta left as she had

arrived, without a definitive diagnosis or course of treatment. It was not clear whether her improvement was due to the medication, to the psychologist's approach, or to the threat of a transfer to Moyano.

In the women's ward, the distinction between neurosis and psychosis worked to differentiate normal from pathological, as Gitel noted in his lecture: "Eighty to ninety percent of us have neurotic structures. The rest are psychotic or perverse." Bipolar disorder and its treatment raised the question of whether a patient could move, via pharmaceutical intervention, from one state to the other, from psychotic to neurotic. Whether or not medication – in this case, a mood stabilizer – transformed the person, or rather what kind of transformation it effected, depended upon what stance the expert held *vis-à-vis* the configuration of the human person.

Given structuralist dualism, the pharmaceutical altered neither the delusion of the patient nor the knowledge system of the doctor. As Gitel said, "there is no idea that can be changed by a pharmaceutical." Bipolarity and psychosis could exist, side by side, in the organism and the subject respectively. The pharmaceutical worked on the organism so that humanness, as language – that which is impervious to chemical intervention – could emerge. It enabled the subject to speak. But then when the patient spoke, it was often in the language of neuroscience and genetics. The "match" between genetics and speech was a contest not only over how to name disorder, but also over who would be in charge of applying the medication, and to what end.

The question of the task of the healer and the role of the drug hinged on where to locate disorder. Was it in the organism or in language? If it was in language, treatment demanded an art that could never be encompassed by neuroscience. The attempt to make psychiatry a science was doomed, for Lacanians in Romero, because humans are a particular kind of being, "differentiated from animals by their use of speech," as Gitel put it. Or as Fiorentino said, "a mouse can have heart disease but it cannot be hysteric."

Structuralist dualism was a solution to the difficulty, in the public hospital, of being both a physician and an analyst. It allowed the realm of subjectivity to be bracketed off from the medical order, and medication mediated this function. The danger, as Noailles warned, was that in devoting themselves to the task of being analysts rather than physicians, they might produce more harm than good.

Referring to the Sokal debate, Rechtman told me: "We shouldn't be worrying about postmodernism here in Argentina – we need to meet basic health needs." He was pointing to the country's ambiguous status between developed and underdeveloped, and arguing that certain kinds of questions

were not relevant in the space of the Buenos Aires public hospital, given the very palpable differences between health infrastructures in Argentina and in the North. This issue was clear when the doctors in the women's ward shut the door to the clinic and began to talk – not only about Freud and Lacan, but also about Spinoza, Hegel, Derrida: you could almost forget that you were in a crumbling hospital in a marginal sector of the city, with patients that were often illiterate and outcast. In this context, the analysts' distinctive use of medication – to sustain subjectivity rather than to transform pathology – made the hospital a place where one could remain an analyst, despite the exigencies of the medical order.

4

Living with neuroscience

"This is for your fieldwork," remarks Pablo Velicovsky as he hands me a copy of the municipal hospital bulletin, which features a story entitled "The Psychoanalysis of Hunger." For Pablo, the bulletin is a typical example of the assumption, within the Buenos Aires *mundo-psi*, that psychoanalysis is a panacea for all social problems. I am sitting at the Hospital Romero cafeteria with Pablo and his colleague, Gustavo Rechtman, two psychiatrists in the men's ward. The turns of the conversation reflect the different priorities of these two colleagues. Gustavo describes the institutional structure of Romero: the hospital takes in many patients from the *villas miserias* (shanties) surrounding Buenos Aires, and from the provinces, since rural health care is quite poor and the hospital is located at the edge of the city. Meanwhile Pablo grabs a napkin and my pen to sketch a description of a behavioral genetics experiment involving chickens that he has just read about: scientists in the United States have transplanted genes from one chick to another and then studied its behavior profile, as mapped by three cameras in a closed dark box in which the chick's beak was painted fluorescent. Pablo is an enthusiast of all things "neuroscientific." He is editor of a new journal that tries to bring the latest news from North American neuroscience to Argentina. Gustavo is more skeptical about the immediate benefits of such scientific developments, and prefers to talk about problems of poverty and underdevelopment in Argentina.

As we get up and head toward the psychopathology service, I ask Gustavo what he means by the word "underdevelopment." "You're about to see it," he says, pointing ahead. A few moments later, as we walk through the men's ward, past rows of cubicles, Gustavo gestures around at the dilapidated surroundings: "See what I mean?" The head of the service, Alejandro Noailles, has been meeting with contractors to arrange the renovation that will be done with funds from the genetic