



Chapter 7

A CARTOGRAPHY OF MENTAL HEALTH

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Psychoanalysis as a clinical practice entails perspectives on suffering and mental health different from those espoused by psychiatry. Psychoanalysis, though, is on familiar terms with psychiatry, both in hospitals and in consulting rooms. Many who come to the consulting rooms for psychoanalysis are medicated, and many psychiatrists may use the psychodynamic perspective when treating a suffering being. A multitude of disturbances, some quite acute, affect people regardless of their age and ethnicity. Some maladies are characteristic of certain historical periods and their socio-cultural conditions. The epidemic of suicide among adolescents appears to be a hallmark of modern times. Autism, the manifestation of early psychosis and a lifelong disability that impairs social

interactions and communication, is another malaise. Clearly, social phenomena cannot be dissociated from our approach to mental health, in regard to both the sufferers as well as the services delivered.

Here is an example of how loss of social context may involve loss of meaning. In April 2005, a man was discovered in a suit, dripping wet, on a beach near Sheerness, Kent. He wandered around speechless, looking despondent, his hands gripping music scores. He remained an enigma for the professionals who approached him in order to take care of him. His identity was unknown. If his memory had failed him in relation to his identity, as far as music was concerned, he was a true virtuoso. When admitted to a hospital, he did not speak and the staff supplied him with pen and paper. Determined, he sketched a piano in all its detail. He was led to the hospital's chapel where he started playing Tchaikovsky's *Swan Lake*. He was baptized the 'Piano Man', who, when not having his hands on the ivory keys, was very disturbed and unsettled. The only form of communication for him was music.

Mental health services are replete with such accounts, perhaps not as dramatic but nevertheless dense and complex when examined through psychoanalytic lenses. Chemotherapeutic discoveries have made an undeniable contribution to mental health, and no one could deny the richness of classical psychiatry since the turn of the twentieth century: Kraepelin (1921) distinguished manic-depressive psychosis from dementia praecox, and Clérambault (1927) elaborated his formulation of mental automatism. Psychiatrists, however, conventionally treat manifest clinical conditions as if there was no need to burrow into the psychic meaning. Listening to a number of clinicians, one gains the impression that with the two key afflictions of our time—depression and anxiety—the clinical field is covered.

Psychiatry and Psychoanalysis: Differentiation of Approaches

Psychiatry and psychoanalysis alike are concerned with helping suffering people whose symptoms may prompt a search for help. Psychiatry for the most part considers the symptoms and the manifest phenomenological signs. Psychoanalysis approaches the symptom as a meaning to be deciphered. The significance of each symptom is subtle and unique and is to be integrated into the person's discourse which is impregnated with unconscious elements. The symptom persists; it has a repetitive character. It was after Freud's ([1920] 1940) "Beyond the Pleasure Principle" that the compulsion to repeat moved into the foreground of psychoanalysis. The symptom is no longer seen merely as a form of resistance but traversed by the unconscious and overdetermined by narcissistic investments in which the person finds gratification. Associated with profound suffering, an exacerbated narcissism can often be witnessed today in the psychoanalytical clinic entailing a resistance to the treatment.

The existence of the unconscious that propels the formation of symptoms (as well as of dreams) is addressed through the psychoanalytical process. This process has the ability to restore the importance of the singular experience and

history of the suffering person, thereby establishing new configurations in the meaning of life. This is particularly essential in the treatment of adolescents when their previous values lose their meaning and they search for answers to the following question: what do I have to do so that I can be accepted in the adult world? The peer group can be a source of reference to one's existence at this age. The adolescent may feel included in such a group, yet it can also be a source of agony if there is exclusion. Whether there is ostracism or acceptance, adolescence can still be a period of great solitude and turmoil.

It can be argued that the inclusion of psychoanalysis into sociological analysis can enhance certain areas of social research, specifically where traditional approaches have become limited (Paul 1989: 202). My clinical work in a range of countries and culturally diverse settings has led me to develop an ethnographic approach that relates to the human condition understood in an anthropological-existential sense. I shall name it 'ethnography of the subject'—a subject that is born into language and suffers its effects. It is at an early age that language crystallizes a child's symptoms. In this sense, as Jacques Lacan ([1975] 1985: 22) pronounced at a conference in Geneva on 4 October 1975, "The child will effectuate a coalescence between its sexual reality and language." Spoken language leaves its indelible marks. We have been impregnated by the way in which we heard the first words. The parental discourse pre-exists the subject. Arrival into this world as a subject implies a different status from that of a biological being: "The manner of speaking which has been instilled into the subject can certainly carry the mark of the way in which the parents have accepted this child" (ibid.).

Psychoanalysis presented itself from the very beginning as an adventure in the unconscious and the psychic, a remarkable journey through language toward the unknown. These days psychiatry builds itself on biochemical, evidence-based medicine—one would say a new organization of human subjectivity. Although psychiatry specializes in medical care, its status as a science leads to a 'repudiation' of the subject (known in psychoanalysis as 'foreclosure'). The subject is evacuated from the field of psychic causality and what comes to the foreground is the number of manifest phenomena. Depression in modern times has become a biochemical concept. There is a division in the psychiatrist's work. On the one hand we may consider that there is the 'a-subjective' explanation and, on the other, the field of the subject. In the scientific approach, the subject is still there but in a masked way. A psychoanalytic ethnography would seek to overcome this antinomy. If we consider bipolar disorders, there is the paranoid process but also the melancholic one. It is a matter of assessing the position of the subject in life—what is working, what is just working enough, and what is not working at all. It is a question that goes beyond assessment and brings forward the matter of ethics, which concerns not only the relation between the subject and the surrounding civilization but also that of the subject to his or her unconscious desire. It transcends the exaltation of social desires. The experience of culpability, for instance, is closely related to the experience of interdiction. This dialectic leads us to an ethical context.

In "Civilization and Its Discontents" Freud ([1930] 1948: 111) illustrates how peculiarly ethics inhabits human beings: "The element of truth behind all this,

which people are so ready to disavow, is that men are not gentle creatures who want to be loved, and who at the most can defend themselves if they are attacked; they are, on the contrary, creatures among whose instinctual endowments is to be reckoned a powerful share of aggressiveness. As a result, their neighbor is for them not only a potential helper or sexual object, but one who may tempt them to satisfy their aggressiveness on him, to exploit his capacity for work without compensation". The subject's relation to his or her outside world is mediated by unconscious phantasy. More important than the modification of the symptom is the modification of the subject's position in the phantasy, that is, the way the subject situates him or herself vis-à-vis his or her unconscious desire.

Karl Jaspers's ([1913] 1997, 1920) phenomenological differentiation between psychiatric and psychoanalytical approaches to mental disorders can be useful as a tool. His distinction is made in terms of "explanation or perception of causal connection" (*erklären*) and "understanding" (*verstehen*).

PSYCHIATRIC	PSYCHOANALYTIC
Explain	Understand
Symptom	History
Diagnosis	Subjectivity
Disease	Unconscious

Jaspers constructs the opposition between comprehension by the subject (psychoanalysis) and what psychiatrists used to regard as causal explanations that simply clarified what the patient already knew. The latter approach did not help to further the patient's comprehension of what was at stake. By contrast, Lacan has persistently objected to such an opposition between the field of causal explanation and the field of comprehension by the subject. As long as there is an effect of sense in the patient's discourse, the subject is at stake. That is, it is the possibility of articulation in meaning, the implication of the subject in what he or she is saying that justifies the existence of psychoanalysis. How can the subject be an object of investigation?

It was only in 1932 that Freud utilized the term 'subject', referring to it as being liable to split and to suffer cleavages: "If we throw a crystal to the floor, it breaks but not into haphazard pieces. It comes apart along its lines of cleavage into fragments whose boundaries, though they were invisible, were predetermined by the crystal's structure. Mental patients are split and broken structures of the same kind ... They have turned away from external reality, but for that very reason they know more about internal, psychical reality and can reveal a number of things to us that would otherwise be inaccessible to us" ([1932] 1940: 59). Freud states that man, in one respect or another, is divided within himself. It is in a retroactive process, a process of reorganization and 'reinscription' of traumatic and painful events, as well as of fragments of history, that a psychoanalytic knowledge is engendered concerning the splitting of the subject. The reinscription means a new signification of elements that until then could have been immobilizing, a hindrance in the subject's life. This process would lead to a new, hopefully creative dynamic.

Lacan created a new version of the traditional notion of the subject by transforming the subject of consciousness into the subject of the unconscious. He conceptualized the logical and philosophical notion of the subject—of a divided subject—in the context of his theory of signifier. Notably, a signifier is an element in the chain of free association or in the analysand's discourse that represents the subject to another signifier. In order to continue the mapping in terms of this specific conceptualization of the psychoanalytic field, I will take into account three distinct axes. These axes interact with each other and shall be considered in their interplay.

First, there is the environmental axis on which the subject depends for his or her growth. There are cases of migration due to a totalitarian regime, political dictatorship, torture, or political persecution that have led people to depart from their homeland into exile with severe consequences for their mental well-being. In acute cases, such as in autism, we observe how the environment plays a decisive role in promoting or halting the evolution toward this disorder. The exact causes of autism remain unknown, but cases of it and related conditions such as Asperger's syndrome (ASD), known as autism spectrum disorders, have increased in the past two decades. A recent study suggested that the rate can be as high as 116 ASD cases per 10,000 children in some Western countries. The statistics, though, are not significant of the qualitative dynamic process of the psychic and of each individual suffering. There is also the hypothesis that older fathers are more likely to father autistic children. This study advocates that fathers also have a biological clock and that older fathers have almost nine times the risk. Parenting, however, is also influenced by the socio-cultural environment and varies across societies and over time.

Second, there is the symptomatic axis. A psychoanalytic symptom is distinct from a symptom as articulated in medical-psychiatric diagnosis. By diagnosis I mean a questionnaire or mental examination. The diagnosis masks facts that are unknown to the patient and, paradoxically, imposes on the patient the disclosure of symptoms already known to him or her. Psychoanalytic practice distances itself from the diagnosis, if by the latter we understand the operation that consists of ticking on a chart the presence or absence of certain signs before addressing the subject's psycho-social history. Considering the perspective of a psychoanalytic ethnography, the symptom, with correlated complaints and suffering, is to be considered as a formation of the unconscious. Despite the fact that the subject may perceive the symptom as being something foreign to him or her, it results in unconscious gains that lead the afflicted to cling to his or her diseases and correlative forms of suffering. The symptom is therefore another instance whereby the subject finds unconscious satisfaction. It is an intimate aspect of one's being. As Freud ([1917] 1946: 385) points out: "Dealing with a conflict by forming symptoms is after all an automatic process which cannot prove adequate to meeting the demands of life." The symptom is also a fulfillment of an unconscious desire.

Third is the structural axis. The strategies utilized by the subject in the formation of the symptoms, whether knowingly or not, obey a certain structure. It is also through this structure that the subject relates to the organization of the unconscious phantasy. The phantasy mediates the relation between the subject

and the world. The Freudian phantasy described in “A Child Is Being Beaten” (Freud [1919] 1947) illustrates the importance of the presence of another child, who not only witnesses the punishment but will also suffer it in its turn. The child places itself in different subjective positions, swinging from passive to active. Following Freud (ibid.: 180): “This phantasy, a child is being beaten, was invariably cathected with a degree of pleasure and had its issue in an act of pleasurable auto-erotic satisfaction. It might therefore be expected that the sight of another child being beaten at school would also be a source of similar enjoyment. But as a matter of fact it was never so... however the experience of real scenes of beating at school produced in the child who witnessed them a peculiarly excited feeling which was probably of a mixed character and in which repugnance had a large share.”

This phantasy consists of three phases:

1. *A child is being beaten.*
2. *I am being beaten by my father.* The relation here is dual. The act of being beaten already entails an element marked with erotism.

This being beaten is now a convergence of the sense of guilt and sexual love. It is not only the punishment for the forbidden genital relation, but also the regressive substitute for that relation, and from this latter source it derives the libidinal excitation which is from this time forward attached to it, and which finds its outlet in masturbatory acts. Here for the first time we have the essence of masochism and the ego is strongly accentuated. We may ask how far the subject participates in the action of the one who aggresses and beats. It is the classical sado-masochistic ambiguity. This second phase, the child being beaten *remains unconscious* as a rule, probably in consequence of the intensity of the repression and can only be *reconstructed* in the course of the analysis. (Freud [1919] 1947: 190)

3. *“My father is beating the child; he loves only me.”* In the third phase, the phantasy becomes sadistic. Freud emphasizes that only this form of the phantasy is sadistic because the unconscious satisfaction (in Lacan’s terms, *jouissance*) that is derived from it is masochistic. “All of the many unspecified children who are being beaten by the teacher are, after all, nothing more than substitutes for the child itself.” In this phase of the phantasy, however, there are three characters: the agent of the punishment, the one who suffers the punishment, and the subject who has the phantasy. The one who suffers is someone whom the subject of the phantasy hates and therefore sees as being rightfully excluded from the parent’s preference. The subject who has the phantasy sees him- or herself as being in an exclusive position in relation to the father’s affection, as being the father’s preferred child, as being the one who has the privilege that the beaten child has forfeited. The subject creates the tension and causality between the other two characters in the phantasy. He or she animates and motivates the action between the other two and also is the instrument of communication between them.

Another illustration of the reconstruction of the phantasy is Freud's clinical case of a five-year-old, 'Little Hans'. While the initial symptom is the fear of being bitten by a horse, Hans's phantasy goes from the transformation of this bite to the unscrewing of the bath. The founder of psychoanalysis writes: "After all, Hans' phobia of horses was an obstacle to his going into the streets and could serve as a means of allowing him to stay at home with his beloved mother. In this way his affection for his mother triumphantly achieves its aim. The content of his phobia was such as to impose a great measure of restriction upon his freedom of movement and that was its purpose. Beyond his hostile and jealous feelings towards his father, his phobia was a powerful reaction against the obscure impulses to movement which were especially directed against his mother—They were sadistic impulses (premonitions, as it were, of sexual relations of some kind) towards his mother" (Freud [1909] 1941: 138).

In his seminar *La relation d'objet*, Lacan ([1956–1957] 1994) analyzes the traversing of the phantasy. Essentially centered on the mother and the mother's desire, this seminar evokes the mother in her capacity as a woman. Lacan refers to female castration—the mother as a subject defined by the lack of an object. In 'Little Hans', the mother was originally an opaque, threatening power, becoming in Hans's phantasy the mother that comes and goes—and with her the whole household (an additional fear of Hans was that the house would collapse). The phantasy then proceeds to the unscrewing of the bath by the plumber. At this stage, in the reconstruction of the phantasy, it is no longer the whole household that is at stake, that is, at risk from the departure of the mother. The metaphoric object in question is a bath that supplies a place for Hans, as Freud ([1909] 1941) comments, "a bath according to his wishes, a bath into which his behind fits perfectly."

Implications for Treatment

As we get referrals from psychiatrists, it is important to situate the differences between the psychoanalytic approach and the psychiatric one. In contrast to the psychiatric treatment, the aim in our psychoanalytic clinical approach is not the removal of the symptom but rather a change concerning the relation that the person has with his or her symptom, which can manifest itself far from its causes. In obsessional neuroses, for instance, the uncertainty of memory is used "to the fullest extent as a help in the formation of symptoms" (Freud [1909] 1941: 233).

Through treatment we aim for the symptom—which at the beginning may have been immobilizing and overwhelming to the point of becoming the person's identity and the fundamental part of his or her life—to be less overwhelming. The symptom becomes just one of the many phenomena that are present in everyday life. The subject ceases *to be* the symptom in order *to have* a symptom (Volich Eisenbruch 2001). Through a psychoanalytic approach, instead of focusing on the symptom, we focus on the unconscious phantasy and on the singularity of each history, with subjectivity taking precedence over diagnostic categories. Finally, instead of speaking of the psychic disease, we

speak of the unconscious whose analysis allows meaning to be created by the analysand. This understanding of experiences and suffering—spoken, elaborated, and signified by the patient during the treatment—is of fundamental importance. The dimension of subjectivity, of one's history, is distinct from that of the symptom.

For instance, beyond the question of cyclothymia, the oscillation of extreme affects, there are other essential issues, such as a subject's symbolic place in the family and the place of a child in the unconscious desire of a parent. These are constellations that are constructed during the analytical treatment through the subject's place in the unconscious phantasy. Therefore, the discourse of psychoanalysis accentuates the unconscious phantasy and the subjective implications that it entails. Psychoanalysis has as its primary aim to deal with suffering by accessing the unconscious manifestations that are revealed through transference. The analyst's presence is the repository of the analysand's free associations. The demand is constituted as the word is addressed to the analyst, with the subject demanding an answer for what he or she lacks. Love in transference is what the analysand imaginarily assigns to the analyst as the one who would have what the subject lacks, a supposed knowledge about the analysand. It is fundamental to consider situations on a case-by-case basis, according to each subject's psychic universe, according to the logic of each phantasy that is at stake.

It is noteworthy that the Kleinian and the Lacanian approaches have in common the wish to grasp the phantasy and unconscious life beyond the biological-evolutionary framework of understanding. Construction and traversing of the phantasy is what affords mobility to the subject, giving way to changes in the subject's life. For Lacan, the phantasy is inscribed in a significant structure, such as is illustrated above in the 'child is being beaten' phantasy and the case of 'Little Hans'. Considering the diversity of phantasies of each subject, the traversing of the fundamental phantasy by the patient is also an indicator of the efficiency of the analysis. The modification of the subjective position in relation to the kind of defenses maintained and the unconscious gains and satisfaction found in the symptom are other markers that guide us.¹

Depression is not necessarily a psychiatric illness. Whereas in medicine the symptom shows up as a dysfunction, when diagnosed according to the classification in DSM-IV or in ICD-10,² psychoanalysis approaches the symptom as an enigma—imbued with a particular meaning—and addresses the place of depression in the logic of the unconscious. The two systems therefore utilize different methods of treatment. While selective serotonin reuptake inhibitors (SSRIs), acting on neurotransmitters, is one of the preferred psycho-pharmacological approaches for the treatment of depression, psychoanalysis addresses the question of how the subject is implied, which position he or she occupies in this depression. There is a certain omission of responsibility for one's destiny when one chooses the path of medication, whereby the subject's alienation is reinforced in a chemical effect. Cognitive sciences place cerebral functioning at the origin of knowledge. Psychoanalysis is a process in which the source of knowledge is the symbolic dimension of the unconscious and its implication in one's destiny.

Let us consider another aspect, namely, dissymmetry between paranoia and melancholia. From the very beginning, in his correspondence with Fliess (manuscripts G and K), Freud refers to melancholia as loss and paranoia as mistrust (Masson 1985). He describes melancholia as a bitter regret of something that has been lost, a loss that takes place in the instinctual life. Less focused on the psychiatric approach of the melancholic state, Freud did not identify melancholia with depression; rather, he considered melancholia as a subjective destiny. In his essay "Mourning and Melancholia," Freud (1915) conceived melancholia as a pathological form of mourning. If in the work of mourning the subject succeeds in progressively separating himself from the lost object, in melancholia, on the other hand, he feels guilty about the death, denies it, believes himself to be possessed by the corpse, and identifies with the lost object to the point of losing himself in the infinite despair of an irremediable nothingness. "In melancholia the object perhaps has not actually died, but has been lost as an object of love ... This would suggest that melancholia is in some way related to an object loss which is withdrawn from consciousness, in contradistinction to mourning in which there is nothing about the loss that is unconscious" (*ibid.*: 245).

The shadow of the object falls on the ego, which becomes, according to the subject, devalued, impoverished and worthless. This form of perpetual lamentation is at the same time the expression of a rebellion at the thought of annihilation of oneself as well as the most extreme manifestation of the unconscious desire for this form of annihilation linked to the loss of an ideal. At the end of his essay "The Ego and the Id," Freud ([1923] 1940) reflects upon death anxiety played out between the ego and the super-ego. It is in melancholia that death anxiety, as a reaction to an internal danger, exposes itself the most. In melancholia we find a ferocious super-ego, a torturer of the ego that is overwhelmed by oppression and can be cornered to the point of committing suicide. The super-ego ceases to be protective and instead becomes a pitiless persecutor to such an extent that the ego feels threatened by it as much as by the most extreme external danger. This dynamic engages the melancholic subject in a genuine feeling of real death.

The subject is the point of emission, as well as the point of reception, of accusations. It is the self-reproach. On the other hand, the paranoid places fault on the side of the 'Other'. Phenomena that assail him or her are assigned to the Other. We can also oppose the melancholic stasis, a certain inertia, to the paranoid sthenia, an excessive mental power of production. Both melancholia and paranoia have an attribute of certitude that does not check for proof. Lacan names this certitude as the 'return in the Real'. Hallucinations, for instance, would be a 'return in the Real' of what could not be resignified by language, of what is not integrated in the system of signifiers. Lacan used the concept of *Verwerfung* (in French *forclusion*, translated in English as 'foreclosure' or 'repudiation') to denote this process. Lacan borrowed this term from Freud, who utilized it in relation to the treatment of a young, wealthy Russian, also known in the psychoanalytic literature as the 'Wolf Man', who came to him for analysis. The process involved in his hallucination of the cut finger was explained by Freud through the concept of *Verwerfung*. It is this term *Verwerfung* that Lacan translates as foreclosure.

In the absence of symbolization, of signifiers that are expelled or not integrated into the subject's unconscious, hallucinations occur in order to represent what is taking place in the subject's life—hallucinations that can represent a default in language. In neurosis, on the other hand, the subject may not have immediate access to certain signifiers. They are however there, behind repression, in a latent way. Forgetting when one is about to enunciate an idea, for instance, may be due to the process of repression that acts on the signifier.

Based on Freudian theory, Lacan makes a diagnosis of the need of a subject. He conceptualizes a logical notion of the subject by elaborating the subject of the unconscious, the subject of desire. This subject is then submitted to the Freudian concept of splitting. The individual and his or her acts are a product of repression, of the splitting between the ego and the subject of the unconscious instance. One may suffer a breakdown, and at this moment, this splitting and articulation between these two aspects of life—the conscious and this other scene that is the unconscious—become even more evident. Freud's metaphor of the crystal mentioned above shows how a structure can be revealed.

The inability of a person to form social bonds in psychosis is a great challenge for the family and the community. Is psychosis out of the therapeutic reach of psychoanalysis? Freud did not believe so. It was through his questioning, derived from his work with psychotic patients, that further psychoanalytical contributions to this field were made. Paranoia, in particular, offers a particularly 'open-cut view' into unconscious processes in a way more accessible to comprehension than other forms of disturbance.

Lacan came across the evidence that psychosis is not a deficit but a psychic organization, another order of the subject. Rather than a deficit, this process is to be considered an enigma. The 'Piano Man' would have been an illustration. In August, four months after his admission to the psychiatric hospital, his identity was revealed. He was a German citizen who, under pressure of unemployment in Paris, traveled to England where he decided to portray himself as a mentally disturbed person. The man used to work with mentally ill patients and is thought to have copied some of their characteristics to convince psychiatric doctors that he had a mental illness (Jacob and Roche 2005). Here is also an illustration of the limits imposed by one's history and constitution. Paradoxically, the means he found to make himself heard was to isolate himself in a deafening silence.

The unconscious is the voice of repressed truth. It is the path through which the truth expresses itself once oneself and others have refused to listen to it. Analysis is instrumental in this process of lifting repression. Painstaking as it might be, it shows a path out of the fatalistic position by encouraging each of us to make an effort to assume responsibility for the unconscious's production.

Responding to External Trauma

Is such a view always true? Can assuming responsibility for the unconscious occur in every circumstance? How can one not be fatalistic in cases of natural disasters? The Indian Ocean tsunami of December 2004 was one of the most

devastating natural disasters of our times, claiming hundreds of thousands of lives. In addition, millions of people and entire populations experienced trauma (Ashraf 2005). A remarkable human solidarity could be witnessed after the tsunami had struck. Another disaster brutally exposed US racial divisions. In late August 2005, Hurricane Katrina hit Louisiana, one of America's poorest states, creating in the process squalid conditions, homeless populations, and lethal floods (CDC 2005). Many of the already disadvantaged in the society became refugees; up to half a million people were left homeless. New Orleans gasped for life beneath the water. The scale of devastation and horror was worsened by the armed looting and anarchy. When the water retreated, there was the question of recovery. How does life become viable again for those afflicted by a terrible natural disaster?

It is fair to assign this form of traumatism to a reality that assails from the exterior in the face of which a person is impotent. Terrorist acts many driven by fundamentalism are another element in the list of traumatic events of the present young century. While the field of traumatism is undoubtedly vaster, psychoanalysis can have an impact on efforts to improve the human condition in response to external trauma. The psychoanalytic clinic shows that experience does not acquire its traumatic character merely through intensity as measured on a 10-point scale. Two people can be exposed to the same disaster, leading to traumatization for one but not for the other. The difference depends on how individuals respond with their own phantasy to the catastrophe that affects them. A psychoanalytic ethnography would accentuate the function of the phantasy and the subjective implication in the catastrophe.

The phantasy is a response by the subject to a rupture that has affected the continuity of the subject's history as well as that of his or her community. The phantasy adjusts the convictions, vital expectations, and reactions of individuals. The phantasy is mobilized each time that the subject is affected by anguish. External real danger becomes traumatic when, under the sway of the phantasy, this danger becomes internalized and highly significant for the subject. In other words, traumatism may be one of the possible faces of the phantasy.

Many of those affected by the tsunami interpreted it as a punishment by God. When they comprehended that it was a natural catastrophe in the face of which they could or could not find resources to cope with, they started taking steps to protect themselves and rebuild their lives. This meant that taking on a certain responsibility for their future helped them, if only on a minor scale, to face their anguish and mitigate it. For the affected, the need to reclaim control of their lives and to overcome the feeling of impotence was essential. The tsunami was by no means part of a destiny dictated by the unconscious. No one in the affected areas could have anticipated this natural disaster.

There are instances, however, when one could speak of a destiny in which the unconscious has something to say. We may take as an illustration certain journalists who choose to work in war zones, in countries with a history of kidnapping, or generally in high-risk areas. It is a human tragedy if, like the victims in their reportages, they are themselves kidnapped and subjected to atrocious and squalid conditions, sometimes with fatal consequences. We venture into new fields with

an unconscious knowledge that is not always accessible to us. Our unconscious desire will never lose its mystery or its allurement. Its dynamic profoundly affects the direction of our lives. The entire dynamism of the unconscious affects our choices as well as our symptoms. Our capacity (or incapacity) to listen and intervene makes the essential difference.

Conclusion

There is the important and obvious fact that many who could benefit from psychological treatment do not have access to resources. Many forms of intervention are needed to address this problem. Psychoanalysis can make a special contribution in overcoming another form of inaccessibility by addressing the unconscious causes of human suffering. A psychoanalytical ethnography or applied psychoanalysis is especially equipped to open up paths concerning in-depth experiences. It can contribute to human mental well-being across diverse existential conditions through fieldwork in areas affected by natural disasters, war, and poverty and in everyday life. In considering the diversity of contexts as well as the adversities that affect our civilization, it can help bring about a precious understanding. This dynamic process requires the relinquishing of paralyzing doctrinaire positions that are oblivious to the realities of the human unconscious.

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Notes

1. As mentioned above, this unconscious satisfaction is also known in the French school of psychoanalysis as *jouissance*.
2. DSM-IV refers to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which is published by the American Psychiatric Association. ICD-10 refers to the tenth edition of the *International Statistical Classification of Diseases and Related Health Problems*, which is published by the World Health Organization.

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