

What Depression? Or The Elimination of the Subjective Causality of Pain?

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Abstract: The spectrum of depressing affective disorder countries a crowd of clinical types and cases and summarizes various symptoms, criteria and phenomena that are not explained in their quality and their causality and that potentially are symptomatic events and sentimental situations that can oscillate from the neurosis up to the psychosis. It is estimated by epidemiologic researches that the 6% of roughly general population suffers from clinically diagnosed depression. The common point of subjects that suffer or have been diagnosed with depression is the pain of existence, as a complicated emotional, psychical and physical situation, and the inhibition that this involves. The psychoanalytical clinic is based in the decoding of this pain in the particular signifying chain of each subject separately, but also through the localization of mental structure that belongs to each subject. While the depression is not a structure but a hyper-structure, but neither a symptom, it is an affective painful situation which should be treated by the clinical process in its singularity. Thus, through a concise regard of pain in the depressing situations, the pain of existence in the post-modern melancholies, the moral pain of melancholy as psychotic structure, and the intense pain of loss and mourning, presenting three clinical examples, the author concludes and emphasizes the clinical and ethical importance of elaboration of subjective causality of pain and inhibition.

Keywords: Depression, inhibition, moral pain, pain of existence, pain of loss, subjective causality.

1. TO INTRODUCE OR TO POSE THE QUESTION

But in reality, the pain of existence is the real that comes forward on stage and demands the interrogation of the off-stage, without coming apart: how does someone have a pain of the self - the one that the term of depression comes to weaken and blur in a way, what is happening? [1] p. 215.

The suffering subject appealing to us, the one whose state of mentality we assess and who asks us to intervene, talks about pain, or implies the pain, the deep pain of its existence that induces a generalized inhibition and inertia. We could argue that this is the common point of all those diagnosed with depression, even if the subject appealing to us is structurally situated in neurosis or psychosis, is a melancholic subject, is a hypochondriac or a perverted masochist, a hysterical, or an obsessive-compulsive subject (the nosographic categories are subdivisions found in the psychoanalytic theory and clinic), what we hear is the deep pain of existence, as a complicated emotional, psychical and physical situation, and its inhibited activity.

Nevertheless, pain cannot be taken as a point neither as a sign, since its particular quality, its enunciation and enunciated and the content accompanying it in the therapeutic session are of major importance in regard to the structure and the state of the suffering subject from which the intervention

and the position of the analyst will depend. The pain of being within the register of psychopathology is found in a plurality that demands from the professionals in the field of mental health extreme caution on regard to its content and manifestations which are physical and mental, having consequences in the cognitive, emotional, behavioural and organic state of the diseased subject. Despite the fact that according to the psychoanalytical theory the category of pain is not predominant, in comparison with anxiety or even with the work of mourning, it still is a state for which the psychoanalytical clinic and theory is not limited in the description of its experience or in its solace or soothing, but approaches it as a complex emotional, psychical and somatic state that encapsulates or conceals other issues of the subject and of its mentality which are being put into treatment within the analytic session.

Therefore, I will pose some questions of major importance for me making my suggestions in this article for the clinical practice and ethical position of the psychologist, the psychoanalyst, the psychotherapist, and even the psychiatrist. In the first instance how the diagnosis of depression ensures the subjectivity and heterogeneity of each suffering subject and the subjective causality of pain aiming at the cure or improvement of its state, and secondly, if the term depression meshes eventually a number of mental states that require a different clinical treatment, assessment and intervention. And subsequently, which is the position of the psychoanalyst if indeed, through the grouping of symptoms and the question concerning the integrity of the phenomenological criteria an elimination of subjective causality is carried

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out? Which tool, which answer can psychoanalysis provide in the explanation of the phenomenon of depression next to the work of psychiatry and pharmacology in the contemporary social link?

I am based on one of the most important principles of psychoanalysis to approach the questions of this article: it is not enough to classify the symptoms of the subject through diagnostic criteria, but to interpret them in their relation with the unconscious and hear them as a modality of subjectivity. Also guided by the Freudian theory and the Lacanian teaching it is not possible to understand and approach the nosographic categories as simple groupings of symptoms, but I will be directed by the structural diagnose, which does appreciate the affective, emotional, psychical and physical states of the subject. (The nosographic categories, mutually excluded for Lacan, are: neurosis, perversion, and psychosis. Understandably these are not groupings or classifications of symptoms, but three strong positions of the subject in relation with the Other. Each structure is characterized by a different mechanism: Neurosis by repression, perversion by the disavowal of the motherly castration, and psychosis by foreclosure. It is clear that this is a categorical system of mutually excluded positions based on a non-continuous order. As one of the fundamental axioms of psychoanalysis is that of the critical period of definition of the subject, it becomes evident that the clinical structure is consolidated after the critical period and it not ever possible for it to change and transform [2]). Even more so, it approaches the emotions and the affective states as results of the structure and the discourse of the social link in which it lives. Each mental state has its own causality. I am referring to the pain of existence not only as if it an emotional state, but also as a sentimental trace or affective situation (Affekt), which is reduced to a previous incident or experience (Ereignis).

Based on epidemiological researches it is estimated that approximately 6% of the general population suffers from clinically confirmed depression. One in twenty persons will be diagnosed with depression at one point in their lives. According to data studied by the World Health Organization in collaboration with the World Bank of the UN, based on the index burden in one's personal, professional & social life, five out of ten diseases with the highest index are mental. According to the World Health Organization, depression holds the 4th position globally from the aspect of loss of life, disability and social dysfunction, while it is estimated that it will rise to the 1st position in the Western countries in 2020. Depression is a significant contributor to the global burden of disease and affects people in all communities across the world. Today, depression is estimated to affect 350 million people. Depressive disorders often start at a young age; they reduce people's functioning and often are recurring. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability. The demand for curbing depression and other mental health conditions is on the rise globally. A recent World Health Assembly called on the World Health Organization and its member states to take action in this direction. Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or re-

current and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life [3].

Is depression in fashion? as Soler says – since this is what publications coming from the psychiatric environment show, and since its concept, having crossed the diagnostic borders tends to include the concept of melancholia [4] p. 69. The modern pharmacology has effects in the classification of symptoms and in nosography, but also in the conception of the quality of the disease. This is due to the fact that the term affective disorder embraces the melancholia which is a particular clinical entity, and even mourning, which tends to become pathological since it includes elements and characteristics approaching those of depression, as depression is defined in the manuals of clinical psychiatry or, according to some theorists and clinicians in the process of mourning we can locate features of depression as one of its stages [5]. I consider that the term of depression, or otherwise the term depressive affective disorder gathers under its umbrella plenty of clinical types and cases and sums up different symptoms, criteria and phenomena, inexplicable in their quality and causality, and which are probably symptomatic manifestations and emotional and affective states that can range from neurosis to psychosis.

2. PAIN AND DEPRESSION IN PSYCHOANALYSIS

It is now acknowledged in psychoanalysis that pain cannot be separated in physical and psychical. Even though in psychoanalytical studies pain is designated by an adjective to be separated from a pain that would be purely physical or organic for a medical doctor, psychoanalysis essentially metaphorizes the pain in order to be able to deal with a series of issues pertaining to subjectivity. Besides, as Assoun notes every pain – worthy of that name – is radically physical. The anxiety of existence does not escape this rule... [1] p. 217.

If the principle of pleasure is responsible for the operation of the unconscious, and subsequently the operation of the human mentality and the psychic apparatus is based on the avoidance of pain and the pursuit of pleasure [6], as Freud teaches us, what could pain be? It is manifested as an affect that spreads to the entire being affecting at first the body – as every pain is physical since the discontentment it emanates is basically instated as a physical sensation [1] – under the form of pain, fatigue, mental agony, sorrow, desolation, sadness, inhibition, that at times have no object or cause in the real of the body (in the sense of a medically locatable damage) but cannot be doubted nevertheless. Is it an excessive tension? [7]. Or, equally, as Freud says in his *Metapsychology*, what becomes a physical pain is what should and could give birth to a mental pain? [8]. Following closely the Freudian theory, pain is a residual state that does not refer to the principle of pleasure/unpleasure and to the principle of reality [9]. Later on, Freud will connect pain - as well as the depressive state – with the loss of the object and the deregulation of the libidinal cathexis [10].

The wound thus is not always visible and real, yet we hear about this wound in the session of analysis. It is therefore the competitor of pleasure or an internal objection to the

economy of pleasure? [1]. Is it the pain of loss, or the moral pain going as far as the delirium of unworthiness?

The pain is singular and differs depending on the structure and the situation of a subject; it is a subjective index of a deregulated mental and physical state. Subsequently, pain is different in melancholia, pain is different in mourning, different is the pain of the subject in neurosis or in perversion, and different the pain of a subject facing a to the limit state like for instance the diagnosis of a chronic organic disease, but we must also approach pain differently in post-modern melancholies, although all these could be diagnosed as depression.

The position of the psychoanalyst is opposed to the flattening of subjectivity by obsessing only on the semiological and classifying diagnoses and listens to the depressive words in order to decode them since, like Soler says depression is not a direct result of castration but emerges mainly from the particular solutions that each subject is trying to give to it [11] p. 132. Freud, and Lacan, use very seldom the term depression, and never in its psychiatric sense. They do not make of it a specific entity. It does not belong to this or that clinical structure, nor does it qualify it; which implies accounting for it starting from structural coordinates from where neurosis, perversion and psychosis are distinguished. Beyond these phenomenal manifestations, the practice of psychoanalysis consists in making emerge the bottom of the truth it conceals, the real it touches, and in each case, in what does it appertain to a causality that must be delimited [12]. We could say that for the psychoanalytical theory and practice the depression does not have precisely substance [12], while importance has no the nomination of syndrome or a disorder but the individual and particular elements that constitute it. These elements - proportionally their quality - they indicate and elect the structure of subject and its position. For instance importance has if the subject hurt because of a loss or a continuous category of the ideal ego. This is the crucial point in order to be clarified at the analytic session.

Let's continue with a brief reference to the variations and varieties of pain in an attempt to discern the pain in depressive states, the overwhelming moral pain in melancholia as a psychosis, the pain of loss in the process of mourning, but also the in the post-modern depression of the contemporary subject as an objection to the capitalistic discourse.

3. PAIN IN MELANCHOLIC/DEPRESSIVE STATES

The pain of existence or moral pain is not only a privilege of the melancholic. Every speaking being, every parlêtre (Lacan's neologism) sooner or later will be unable to escape the pain of self-awareness or the pain and grief of division itself. Every subject goes through a melancholic-depressive state to the degree that it recognizes within that state that it is constituted from a loss, but contrary to the melancholic subject, it does not reject the unconscious. These are the depressive emotions and the affects of sadness, pain, desolation of the desiring subject that penetrate even its body and perhaps eventually reach the point of somatization. The melancholic state - or the depressive one to use the modern term - does not confine itself to one emotion or sentiment. Thus, our subject speaks about an internal pain, a grief, and even uses physical images to express the mental in which it finds itself.

The subject is often hemmed in and remains in such a state for a long period of time refusing to take up action, to renew its thought and reaches points of obsessive regurgitation, generalized inertia, physical decline, sadness and non-pleasure. The psychoanalyst then listens to images of ossification and obstructed movements [11] p. 131 when a subject attempts to describe the pain of existence it experiences.

The main characteristic of this pain thus is inhibition, a state to which modern psychiatry attributes a particular importance as well, since inhibition is one of the index points for the diagnosis of depression.

Freud considered this depressive state - although the term depression is lacking - and the inhibition that accompanies it as a consequence of the splitting of the ego and/or interpreted it as a defense to the return of the repressed or as continuous punishing and merciless prohibition of the hyper-ego whose effect is - in one case or the other - the segmentation of investments and cathexis and the exsolution of instincts. In 1923, he will speak about the exsolution of instincts, which can have crushing results on the subject. On "the Ego and the Id" mainly he talks about the disconnection of instincts and its destructive consequences. This exsolution concerns the disconnection of the death instinct and the life instinct to a degree that it excludes any transition of the impulse into something psychically economic for the subject, but also into the exclusion of the expression of the death instinct as a tendency of aggressiveness or destruction towards the external environment in a controllable - if possible - manner. Freud demonstrated that the exsolution of the instincts can become extremely dangerous - main examples are sadism, and the case of melancholia and obsessive-compulsive neurosis where the impulse of death becomes an aggressive movement towards the self and the subject [13]. The depressive state induces inhibition like anxiety, but in a global manner, freezing and ossifying the libidinal functions [10].

Lacan, in his Seminar entitled *L'angoisse*, will clearly state that the depressive desolation is not stress, but on the contrary it is a sentiment (senti-ment(ment=to lie, in French)) that lies and deceives in regard to the cause. It is not a structure, nor a symptom, but an inter-structural state that is not related to stress but still participates in the various forms of inhibition [14]. What is the cause then of this painful inhibition, this desolated and sad inertia? Even if the pain of existence is connected with the loss of the object according to Freud, or even with the common logic that connects depression with a loss, in our opinion the cause of a depressive state is not castration, i.e. the loss of the Thing (das Ding) through the speech and the language to which all speaking beings pertain, at least all those who move within the spectrum of neurosis. At this point the author follows the Lacanian teaching by considering that if there is something that animates the cause of desire and makes it regain its dynamic, that something is castration. The function of castration is connected with anxiety and not with depression and the pain of existence that inhibits and ossifies the subject. Subsequently, these are states that - even through their polymorphism - signify an interruption of the cause of desire, a painful lack of desire for life and target-setting on desired objects.

For psychoanalysis nevertheless, the pain of existence and the impending inhibition and inertia that exists within as a main ingredient in the depressive state is also an ethical issue. Lacan talks about the error of existence, in *Remarques sur le rapport de Daniel Lagache* [15] and he will refer the pain of existence to the unjustifiable of the existence, meaning that the being ex-ist in the *Other*. For purely structural reasons, the pain of existence out of psychosis is not usually crushing and fatal. In 1973, on *Télévision* [16] p. 39, Lacan will talk about desolation and sadness not as a state of psyche or a dysthymia, but as a cowardice, as a sin that lies in the moral error and fault of breach of the duty of *well speaking*, where the subject in failing does not find the outcome in regard to the unconscious, in regard to the structure. Certainly, in melancholia, this error can even induce death when cowardice reaches the rejection of the unconscious, probably with the most absolute manner, by taking action, i.e. by committing suicide. Sadness [...] we call it depression, giving it psyche for support, or the psychological tension of philosopher Pierre Janet. But it is not a state of psyche, it is simply an moral error, as Dante said, and perhaps even Spinoza: a sin, which means a moral cowardice, which lies in the last resort only of thought, that is of the duty of well speaking or of recognizing itself in the unconscious, in the structure [16] p. 526.

It is a pause of the desire for a painful lack of desire for life that is expressed in the frenzies of pain, in the spectacular at times indifference to life that reaches unwill. From the extreme of castration that founds desire designating the object as cause-treasure of desire in the extreme of the rupture of the relation with the word, where the melancholic becomes an object-waste himself. In between, the depressive states, where the subject, despite all the opportunities to feel well, it shrinks on the base of its castration refuting any causal object, any object-aim, complaining that nothing is worth anything. A spectrum that starts from the weakened and doubtful desire of the neurotic that goes as far as ossifying it, until the invalidated desire of the melancholic who hates himself. And even if we speak of a circularity of depression, it is the appearance and disappearance of the cause-object of desire, isn't it? There is a debate on the circular character of the affective disorders: For the neo-bios, the reason is the pulsation of the living. For psychoanalysis, it is caused by language parasitism. It is a fact of structure linked to the pulse of the significant chain, on the background of the presence and absence of the object. [12].

If desire constitutes the only defense and barrier against jouissance [17] p. 56, then here comes the time of jouissance. Depression is a matter of the death instinct (I use the term instinct to translate the trieb, the life and death drive guided by the editors of Standards Edition of the Complete Psychological Works of Sigmund Freud), i.e. of jouissance, this painful pleasure that leads the subject to its ossification, and even its extermination through the act of suicide. Nevertheless, we can not generalize but approach each particular and unique depression on the elements that constitute it and as a special way for each subject to deviate from or engage in the process of castration in an absolute manner.

We could indeed consider even of the post-modern melancholies or depressive states, where the pain of existence marks the subject through its provocative indifference to-

wards all objects – supposedly the desire that the capitalistic discourse perpetually presents. The politically imposed equalization of the subject with its organic substrate through the modern practices of the body, but also through the practices defined and promoted by the capitalistic market, contributes to the creation of an asphyxiating frame for the subject. A frame that annihilates it and gives it the possibility of escape, not on the register of metaphor, but on the register of metonym, to the extent that the on the limit states appear as a desperate possibility of existence, a trademark of the post-neoteric subject, the auto-poetic of a body, a way of recognition by the Other, where a recognition on the symbolic would have been achieved. What is the raise of psychosomatic disease, the self-injuries, the suicidal addictions, the eating disorders, but the manifestation of the deepest pain of the post-modern existence sinking in depression?

The return of jouissance imposed by the market pushes the subject into a manner of management of the jouissance and of reversal of the imposition. The subjectivation is henceforth carried out on the level if the organic substance leaving perplexed the Discourse of the capitalist and of medicalization since this real escapes knowledge and concerns more the truth and its localization since henceforth, the Discourse of the capitalist, with the way it imposes the perpetual circulation of the object a puts also truth in the more general process of circulation of the market.

What is the post-neoteric subject? A body without form or a form without body? A contemporary homo sacer, i.e. a residual and non-reducible naked life, the life that has to be excluded in death as such – as Agamben says? [18]. It is lead to death without the symbolic framing of a ritual, without the imaginary meaning of a sacrifice... In other words, it is lead to being a body negated in the real. A contemporary homo sacer divided on one hand from being a body without form and on the other hand from also being a form without existence as imposed by the bio-power. The contemporary subject is the individual on which it is been imposed to have a body defined on the requirements of bio-politics.

This body from which the subject feels deprived - since anyway, who can have a body when it is imposed on him/her to be a body? – will become the field of an ultimate escape of resistance, even if it rushes onto death. Because in the end, isn't Death and resignation as a subjective choice that moment that escapes power? Because eventually, the real of a painful and absolute inhibition medicine and power cannot predict nor control, except perhaps only give it an empty name, isn't it an ironic grimace towards power?

The restart of a subjectivation through pain! Could it be that Lacan, like a Cassandra, predicted in 1969 a series of new pathologies by saying that anyone would die from the desire to know how it would really feel if it really hurt [19] p. 206 where the devastated subject carries out an ultimate subjective procedure of objection and resistance against the complete Other of its personal story which appropriates and submits its body confining it in the unswerving order *enjoy!?* The post-modern pathologies bring to us new challenges and we must consider: Are these solutions isolated and particular inventions allowing the bonding (nouage) of the real (jouissance), the symbolic (language) and the imaginary (body)? Are they objections against the Other or do they mark an annihilation of the subject, as the capitalistic

discourse dictates? [20]. Can the subject that suffers live through its disease or does it make a lethal jump by protesting?

4. MORAL PAIN IN MELANCHOLIA

Freud showed the gradations existing between the normal mourning, the pathological mourning (whether the individual considers him/herself guilty for the death of the object, whether it denies it, whether it thinks that he has been affected by the disease that lead the object to death), and melancholia. We could say briefly that the pathological mourning is characterized by the ambivalent conflict, while melancholia represents an extra stage: the ego identifies itself with the lost object [21] p. 133.

Back in 1915 already, Freud in his *Essays on Metapsychology* had attempted to demonstrate the differences between Mourning and Melancholia – prompted by Karl Abraham who had argued about the similarity between mourning and melancholia in 1911 already – and according to him melancholia includes something more than mourning. He considers that the relation with the object is complex and complicated with an ambivalent conflict [8]. What's more, melancholia is not only due to the real loss of the object, but to the threat of loss that derives from similar experiences [22] p. 44.

A lot has been written on moral pain in Melancholia which is a separate clinical entity that Freud has included in the narcissistic neuroses, i.e. in psychoses. In Mourning and Melancholia the difference between the melancholic subject and the bereaving subject is introduced, underlining the ghastly and painful emotion of unworthiness, the constant self-reproach and ambivalence, clarifying that the melancholic subject is identified with the lost subject, without for that matter knowing the value of the object or what in particular it did lose by losing the object, as opposed to the bereaving subject who aches but knows exactly what it has lost. This is exactly the determinant difference of structure and melancholia is a psychosis. The melancholic individual is possessed by the so called melancholic stress which is no other than the moral pain expressed in a variety of emotions ranging from desolation to a delirium of self-depreciation [8] p. 118. The primitive and painful truth of the melancholic individual is that he is waste, garbage.

In mourning the attempts of recall of the libido that had been invested on the lost object take place on the location of the unconscious and the process follows a smooth course to the preconscious. On the contrary, in the case of melancholia, this normal work and procedure is not followed. The object becomes a battlefield of love and hate. Ambivalence is repressed, and the traumatic experiences related to the object might activate another repressed material. Anything touching these ambivalent conflicts remains far from conscience until the characteristic outcome of melancholia occurs. The outcome is this: the menaced libidinal cathexis eventually abandons the object, but only to withdraw in the Ego from where it had originally started. This way, love avoids dying out. After this regression of the libido, the process can become conscious in the form of a conflict between one part of the Ego and the judgmental character. Conscience never knows the essential part of the melancholic procedure, or the part that contributes to the closure of the psychic pain and grief...

Just like mourning forces the ego to deny the object, by declaring it dead and offering the Ego the motive to stay alive, in the precise same way every ambivalent conflict loosens the fixation of the libido on the subject, depreciating it, denigrating it, and in a way killing it.

Melancholia is thus governed by the characteristics of mourning, but also by the features of regression in the narcissistic selection of an object. If the love for the object resorts to the narcissistic identification, hate turns itself against the substitute object, it insults it, it humiliates it... it finally turns itself against the object itself [7]. The melancholic subject knows how it has been constructed, composed from the separation with the object, just like all subjects. Nevertheless, this knowledge is excessive to the point where the unwavering certainty it offers the Melancholic makes him reject the unconscious, and the unconscious knowledge that does not know itself. Therefore it cannot be composed as a desiring subject and as subject of the lack. It is only a refuse in certainty. As Jacques Adams says in melancholia it is a knowledge without limits, without this limit in jouissance, that can even go as far as meeting the point of its certainty in the suicidal passing into action [23] p. 49.

5. MOURNING

Lacan, in his Seminar L'angoisse, starting from Freud, and articulating the question of what mourning is, tells us that Freud focuses on the procedure – process – that the bereaving subject has followed in order to elaborate for the second time the loss caused by an unfortunate moment of destiny.

Lacan wonders what that means: Does the work of mourning not appear to us, in a light that is once identical and contrary, as the work which is done to maintain, to sustain all these links in detail. And Cod knows how much Freud insists, and quite rightly, on the scrupulous and detailed aspect of the remembering of mourning concerning everything that was experienced in terms of a link the beloved object. It is this link that must be restored with the fundamental object, the masked object, the object *a*, the veritable object of the relationship, for which subsequently a substitute may be provide which will not have, when all is said and done, any more importance than the one who first occupied the place [23]. (I used the unpublished English translation of Cormac Gallagher in lesson 3/7/63 of the Seminar).

So Lacan invents object *a* (object petit *a*: The object *a* is the imaginary partial object the one that can never be acquired, that is really the cause of desire, and this is why Lacan calls it object – cause of desire. Object petit *a* is every object that sets desire in motion, especially certain objects that define instincts) to define, like Freud, what we ignore, i.e. the untouchable presence of the other within ourselves, what we lose when the beloved other is lost in the external reality [7] p. 49. Because the one we love is the one who lies in reality, but also the one who is in me. My imaginary link with the other will be even stronger if I am for him what he is for me: the chosen other that he fantasizes about. I will hurt from the loss of the other who was for me what I was for him: the chosen other I was fantasizing about [7] p. 50. His duplicate that lies in me is that imaginary object defining my desire, leaving it unsatisfied on the borderline of bear-

able. The identification that the object *a* has to do with is related with the mourning. As an object of love, it brings the beloved one in the place of the one it loves, i.e. of the subject of lack. Object *a* gives it – if we may say so – the means of love. This way we return to the famous Lacanian quote: we love what we don't have [24] p. 282.

In other words it is like saying eventually that we mourn our identification with object *a*, and what we mourn is the support of our castration, since object *a* – the befallen real object – is the cause of our desire, which rests on our lack. And fantasy operates as a regulator of desire – the real, imaginary and symbolic presence of the other in the unconscious. The real presence of the other is necessary for the fantasy to be constructed, because as the other, as an object of cathexis it is a source of excitement, of desire, and subsequently of fantasy. The real presence of the other allows his inscription in the unconscious. But the presence of the other is in three levels that correspond to the Lacanian dimension of the real, the symbolic and the imaginary. And as the real is the non-representable, it is, as Canellopoulos says, the energy that connects the two companions like a bridge [7]. The symbolic presence is the rhythm of that energy. The chosen one, as a psychical timer, has the symbolic function to force desire to follow the rhythm of our link... it impedes me from going mad by limiting my jouissance. And finally, the imaginary presence of the beloved other is the internal mirror reflecting my imagessomething possible when the beloved one is alive [7] p. 51.

We mourn because by losing the other we lose our cohesion and the texture of a fantasy necessary for our structure. The pain of loss is intensified as the ego tries to save the unity of the fantasy that is falling apart, and the process of mourning contributes to the hypertrophy of the image of the other, resulting in the reduction of pain.

6. CLINICAL EXAMPLES

Iasson (the names are change for the safeguarding of secrecy) comes having been diagnosed with depression since three years. At the age of fifteen he was diagnosed with *Crohn* disease. At the age of eighteen he left his birthplace and moved to a big city to study and has since then stayed there following the corresponding career after completing his studies. His life in this city could be described, as he aptly puts it, as frenzied, breaking free from all restrictions imposed in him by his family and his health condition. After four years he has a shattering recurrence of the disease resulting in three operations, the last of which presenting a great risk for his life. A year later he recovers but the doctors advise him to be very cautious as they say that his condition will probably lead to a new recurrence of the disease after three years. Iason falls in desolation, abandons his work and retracts gradually from his social relationships. He is diagnosed with depression as his treating doctor refers him to a psychiatrist. In a conjunction of circumstances he comes across a book about psychosomatic diseases. He decides to see a psychoanalyst, refusing to comply with the antidepressants treatment. During the first month of his analysis he speaks about the terror of the operation, about death lurking. Nothing is worth while, no desire seems attractive; he doesn't want anything. His desolation does not recede expressed through deep pain, tears, denial to think of any future per-

spective. He even considers abandoning the medical treatment of the disease but doesn't go through with this under my instigation. Nevertheless, I respect his decision not to follow the antidepressants treatment, as I had the duty to accompany him through our sessions on his mourning for the loss of his health and the illusion of invulnerability, which had not been done in puberty when he was diagnosed and was obstructed by his familial relationships and the position that they had put him on. After the space and time that was offered to him in order to speak about this rupture with the future experienced by all those who suffer from a serious chronic disease, from his lamentation about the diagnosis and the expression of his pain for the operations, Iasson started to return to the past and little by little talk about his history signifying his disease, connecting it with his sexuality and his relationship with his mother, and the absence of his father, and thus, assuming it. Certainly, it took a lot of time for Iasson to construct the position he holds now. His desolation has receded and he continued his work and his studies. It reappears when things get difficult for him in his encounter with the Other, and not anymore with his body. Five years has passed since the last operation and Iason has not experienced any recurrence of the disease since.

Anna comes for analysis already following a treatment with antidepressants and anxiolytics; her diagnosis is double since her psychiatrist diagnoses a disorder on two axis, an affective disorder and an anxiety disorder. At the time, she is in a love relationship with a married man much older than her, holding a position of power in the community where she lives, and her mother is diagnosed with cancer. Her relationship is troubled and a separation is probably ahead. Her deep pain is unraveled in the sessions when she decides – after five weeks during which she cried in every session – to talk about the fear of abandonment that emerges in view of her mother's diagnosis and her impending separation. As she says, her big wound is the desire of the other, which haunts her. No one desires her, starting from her mother who, as Anna says, had always wanted to leave and abandon the family and now she is achieving it by means of the cancer. The treatment, as she says, is not helping her and is unable to give her any relief from the pain and fear that she feels. Indeed, Anna, in spite of taking her medicines, never ceases to complain about the unfair way of her mother and her partner. She constantly repeats the word *I am hurt*. A long time will pass before she conceives the frame in which she lives and exposes herself to pain, and that this frame is directly linked with her parents' marriage and her relationship with them. Her punitive mood against her own self will be expressed in the session, after a lot of effort, by conceiving the repressed representations and the incestuous anxieties that push her to make herself available to abusive situations alternating with depressive phases of absolute inertia.

Since Konstantinos suffers from suicidal ideation and commits acts of self-harm, he is referred to a psychiatrist who diagnoses depression and prescribes a treatment of antidepressants. Nevertheless, he decides to also follow a therapy through speech. He is unable to complete his studies, he cannot find himself in any love relationship, and he keeps on quarreling with his parents who give him money for all his activities.

Konstantinos says: I am a sexual and alone. Sex is an obligation and it is coercive. The pleasure it gives lasts only a

few seconds. A body without a penis would be a relief. It is the root of all evil. Every time I have sex is like I'm a spectator in a porn movie. Besides, this is how I learned. I never discussed with my parents, with my father; I learned it all from the Internet. I suffer from abdominal troubles and the crises are manifested before or after sex, therefore they are prohibitive of sex and expose me. Nonetheless I have sex since everybody must do it, but these crises are something like an objection.

Do I like a girl? Nothing ever functioned on a desire level, my parents kept pushing me to go to a brothel and become a man, same as my friends of the same age, same as the Internet; it is all an obligation, an obligation of pleasure. I came here because this can't go on. I'm not recognized anywhere, there is nothing I can do but self-injure my hands with vertical cuts and go to the toilet. Why vertical, and why in a row? So that I can put things in order, arrange them...

After some time Konstantinos says: I will have a tattoo, one that will resemble the cuts. Why? So I won't forget myself, so I remember, recognize me. On the vertical lines I'll add a diagonal; this will be something of my own.

Konstantinos is a young man, a contemporary subject of the capitalistic discourse, indifferent to the objects of pleasure around, who despises life by denouncing even desire. Despite the fact that his ideation and at times his depreciation of himself would make us believe that he is a melancholic subject, the unraveling of his speech within the session little by little gives prominence to his obsessive-compulsive structure that seems at first to be covered by the new symptoms and the melancholic elements he possesses.

In the clinical examples we see three modalities of pain. If we had only remained on the diagnosis of depression, we would have prevented the said subjects from weaving their story and unravel the subjective causality of their pain or the reasons that encapsulated them in the depressive state.

TO CONCLUDE OR TO POSE QUESTIONS

I would like to emphasize the clinical importance of two points. The first one: The so called depression must be inserted into the signifying chain of the subject in order to be signified by the subject and reveal its cause and the connection with the contemporary social link. And to continue: The pharmaceutical treatment and the psychiatric diagnosis without conducting a substantial investigation of the pain of existence that accompanies every melancholic state is there to cover the hole that this state reveals.

We would argue that an abuse is been committed from the side of medicine and pharmacology when desolation, sadness and moral pain are medicalized, when the mourning and the pain for a separation or for the moral control of an act are medicalized and the subject is not given the margin to even say a word about them. The idea of a subjective causality is obliterated; the categorizing criteria of psychiatric clinic under the term depression extend even further to include the concept of melancholia, of normal mourning, of the moral pain of every thinking being. Could this endanger our clinic? Or even worse, endanger those addressing themselves to us? ... Could it be that our scientific and clinical gear should be also enriched through other fields of approach of the human psychic apparatus and mentality that are not content with biology?

Or is it perhaps that we medicalize or psychologize every aspect and taint of pain because we can no longer stand to hear it? Every desolation is shameful, unjustified and therefore pathological [25] p. 62, if one relies on the diagnostic and statistical manual of mental disorders of the American Psychiatric Association who gives a two-month tolerance to mourning [26]. Beyond this period the grieving individual becomes a patient. Mourning is an evolutionary process through which the Subject over-invests on the deceased as a defense against the loss of the beloved object, an act that induces extreme pain on the subject and then the progressive de-investment from the lost individual. Who can define over how long a period a subject will mourn its loss or how the one who is mourning will speak about this pain in order to be able to proceed to the de-investment from the lost object? Who defines this complexity? [27]. Freud says that it does not cross our minds to confide the cure of mourning to a doctor, even if it is far from the normal behavior. We estimate that it will be overcome after a certain period of time and that it would be inopportune, even harmful, to disturb it [8].

And what happens to the one who is organically ill? Is it perhaps that his pain that his life will never be the same is also a virus disease that must be healed with the use of an antibiotic? Or how can we listen to the melancholic subject and offer relief to its merciless delirium when we simply categorize it? Or perhaps are we going to silence a young man who submerges his life into despair since none of the gadgets offered to him are able to awaken him?

From the other side what can suppose for the rapid increase of dysfunctions or mental disorders? Is the difficulty of subject a dysfunction or a disease? Or the history of a human being and its symptom are a syndrome? Probably we must think carefully what happen in 2003 when R. Moynihan placed under contestation the diagnostic criteria -which had been shaped recently- of a new disease, the female sexual dysfunction, with percentage 43%, percentage confirmed by the science. I refer to the valid journal, British Medical Journal [28]. Or, we must remember and examine how the program Teen screen extended the warning indicators of six mental disorders, and depression, in students. Also we must consider the relation between those who promoted the program with the pharmaceutical laboratories. Furthermore in 1990 in United State, existed roughly one million diagnoses of Attention Deficit and Hyperactivity disorder (ADHD) and today their number it is over five millions [29] and in 2002 the 53% of drugs were prescribed in disorders of behavior or affective disorders in children [30] p. 63.

Psychiatry and pharmacology have a long history and they can certainly teach psychoanalysis a lot. At times they even stand out as its main helpers where the subject slithers towards its annihilation. But from her own side, psychoanalysis can share its knowledge by decoding the words of pain of the subject, pushing it to depreciate the jouissance that ravages it and take the side of the life instinct. But how can a subject choose the life instinct if it is not heard? Man can suffer from his thought, as from his body, just as speech is the form of cancer attacking him due to language parasitism. Suddenly, it is not a privilege to be a speaking being; on the contrary it is rather a bigger risk to become deficient compared to other animal species [12].

Therefore, we need to take into consideration the circumstances of subjectivation of these individuals, the circumstances of subjectivation of the suffering subject that concern its representation, its physicality, its place in the symbolic. The embodied existence is always in interdependence with the Other, Lacan teaches us. The state of the subject in its relation between the imaginary and the real establishes the world, all the more so the transformations of the social institutions that have obvious impacts on the process of subjectivation, and by synecdoche to the subject itself and to its place in the symbolic; consequently to its symptoms, its body, but also to its emotions, affects and thoughts [31].

Psychoanalysis is responsible for those who come to meet the unknown knowledge (savoir). The analyst bears a responsibility for the articulation of the signifiers in the symbolic universe of the subject. He bears a responsibility for the subject's savoir of its relation with the symbolic order; for this relation itself. All the more so for all those who suffer by flirting with death or with deathly inertia inhibition.

It is up to the clinician to be able to discern phenomena of inhibition or perfect ossification that could apparently disorient and confuse the differential diagnosis between a melancholic and an obsessive-compulsive subject, between a subject in the work of mourning and a contemporary subject which is lost in the consuming objects. And this could certainly have a fatal outcome. Otherwise, perhaps, as Lacan taught us: Let him rather resign from this, he who cannot catch up with the subjectivity of his time on the horizon. Because how could he establish the being of the axis of so many lives, he that would know nothing about the dialectics that binds him with these lives in a symbolic movement? [32].

CONFLICT OF INTEREST

The author confirms that this article content has no conflict of interest.

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PATIENT'S CONSENT

No. Patient's indentifying data are disguised.

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