THERAPEUTIC COMPANIONSHIP WITHIN THE CHASMSOF SOCIETY: THE POLITICS OF A VIABLE CLINICAL PROPOSAL

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This work has as its larger purpose to share some of the reflections that have emerged out of clinical experiences obtained by a multidisciplinary team in Mexico City where therapeutic companionship (TC) has played a key role. Its objective also lies in how, in my personal opinion, this latter form of intervention has demonstrated its effectiveness, as well as bringing forward itsfundamental workings, methods and broader possibilities for application in both clinical and social fields. In practice, TC not only plays out as a form of ambulatory intervention founded on clinical principles stemming from the dimension of acts (taken in the sense with which Lacan establishes his various registers), but also from spoken discourse, as has been shown in cases where TC is presented as an alternative to hospitalization and operates as an articulator of multidisciplinary treatments of diverse forms of psychosis. Here,the specific settings and operational concepts of this form of clinical approach are expounded on, as are notions such as companionship, psychic chasms, multidisciplinary strategies for crises, and treatment development; the aim is, therefore, to offer a clear description of the clinical relevance of TC, and for this to be achieved, it is necessary to provide clear illustration of the context in which this very specific type of multidisciplinary implement Takes its course. The proposals brought forward in this article are taken from my own clinical work and, as such, look to bring clinical testimony rather than any form of technical formulae into consideration.

The position that the therapeutic companion is required to assume, calls on such a professional to step out of the traditional trenches of clinical activities, be these institutionally based or more in tune with the analyst's private practice. The objectives of such an implement must stem from the interdisciplinary team, be put into practice through the companion and look to contain and gradually restore or re-invent social spaces in which the subject may live out his or her life. In the initial approach to each case there is typically an outbreak, an overflow of conditions, and this will often involve a surge of thoughts and ideas coming from the team, who will intentionally look to different ways of addressing the situation. This gives a

particularly important dimension to this form of treatment, since each intervention operates within the constraints of time and follows strategies that have been specially and previously designed on a case by case basis, and it is on these factors that their effectiveness depends.

When required to treat varying forms of psychosis in clinical practice, asprofessionals we must assume from the very beginning that we are faced with the epistemological premise that defines delirium as a purely primary process; that is to say, the very logic of such cases points to the impossibility of transmitting anything at all to others, and thus an abyss of knowledge is the ultimate outcome. Our own madness would consist in attempting to understand deliriums using the language that science provides, and it thereforebecomes important to pick our clinical battles with particular care. In my own experience, I have found that it is almost without exception more significant tobe there for my patient than to understand him or her, and it is here perhaps paradoxically – that an essential part of the technique I refer to lies in knowingthat we are not obliged to recognise the particular form of discourse being observed. We are therefore driven to find other forms of intervention, one of which is found within the dimension of acts; here, the way in which we are able to just accompany or be there for a patient makes all the difference.

The forms in which the latter plays out in this therapeutic proposal is through an articulator, where a certain otherness in relation to the patient's delirium or particular pathological condition enters the patient's space from the outside and imposes an alternative point of reference, different possibilities. Attheir core, these are evidently not cases that respond to conventional clinical criteria, and therefore our work begins when we are ready take on a situation that possesses unique characteristics; the versatility of action that such cases allow for is established on a one by one basis, operating within largelydifferent contexts that may involve a number of factors ranging from legal conflicts to infinite forms of singularity and their modes of expression. In recent years, it has been possible to implement TC in legal hearings, at schools, within different social spaces and also in the private practices of a growing number of psychoanalysts taking interest in this form of intervention.

In our own private clinical practice, we are able to observe how differentforms of delirium and the fantasies surrounding a 'declared' patient play out from the point of view of other family members, where typically such patients are tagged as insane and given that place by the family. It is important to stressthat, in almost all cases, the essential is not what appears to be most evident, especially when it is becomes a matter of pointing out the 'madman' or 'madwoman'.

It is also true that the entire situation never falls on a single family member – often taken as an easy way out for others – just as cases cannot be judged by rash presuppositions of the weight of genetic causesalone. It is, in fact, not unusual to find all immediate family members needing a cure that is expected to come from the place of the subject who is consideredto be insane, the one who has been selected for sacrifice. For this very reason, work done through the proposal I speak of is with every single family member; it is within this first mesh of signifiers that we are presented with thatthe phantasmagorical is interwoven, the first moment of intervention for TC asan active mode of otherness where someone from the outside makes their presence felt as it works through the space of the other: something or someone arriving from the outside and entering the kind of archaic solitude that is so particular to narcissism.

From the very way in which the TC implement is first brought into play, we are able to observe something, an unfolding of events that can be heard bya third party as it introduces itself and allows the subject to speak; thus, thereis a deliberate push for change in the politics inherent to/emerging from a given situation. That is why we must be capable of reading into forms, andthis we are urged to take almost literally in the sense rendered by the phrase 'What cannot be said, shows itself', and then go on to participate as an object or thing. It is precisely here that our intention resides: to reflect upon ways in which patients may count on our presence in any way they find possible so as to sustain the otherness, on their terms, in their own time and through theirown means, even if we commence as objects. Working within this context, however, TC engages itself with and through acts, operating in a realm where words are unable to do so. It is because of this that we can say that, at certain moments, TC is a clinical application of acts that often find themselves replacing words.

There are many ways of confronting outbreaks; in other words, such situations may be approached from a number of angles, and it there that TC is required to create a response that originates elsewhere, and the companion is there for this very reason: his or her presence brings with it a political proposal, a summons to put matters into words. From here, we must assume that the way in which the TC listens gives shape to a directive, a vector that opens the way, where the tone of voice employed together with our gaze and/ or body language speaks within the context of the passion being addressed. The mere presence of the Real begins to take on sense in the universe of objects. Listening is translated into a way of being and acting, where the act oflistening doesn't mean we understand, for this runs through the labyrinths of our own impossibility, starting off with the question that we may pose to ourselves of what we

are to do with that which is not made for us to understand. Perhaps what is described here makes its transit through the channels of intuition, thus enabling us to give account of how we are being heard, of how we may proceed to make a joint proposal. It is in this sense that TC is a measure of clinical practice operating outside the usual trenches, a form of clinical intervention that lends its attention to an inner form of struggle, a place where we cannot be expected to understand. The only thing we can know is that our presence has become indispensable, however awkward and uncomfortable this may prove.

Put in this way, there seems to be a price to be paid for being able to listen, and that price is an inherent pain, for it pains one to hear the multiple forms and surges of pain coming from others; such experiences are not at all easy to carry, given that our intuition is also a fertile breeding ground for our own phantasms and we are driven to face our own demons. These do not simply disappear when we set out to work with others, but if we are prepared to find a space where we can also be heard, as might occur when we turn to ananalyst of our own, we may then be better equipped to make use of our phantasms to carry out the art that is clinical practice; and this may take the form of listening with our bodies, of being able to hold ourselves together when we face the knowledge void that lies before us.

Any clinical proposal designed for the patient can only be derived from something that emerges as a result of both parts thinking it possible, evenwhen this means that one has to leave the room and go out into the street; it is details such as these that can turn out to be transforming, and no one can actually imagine the terror that a simple act as the one described can cause in apatient, just as it is hard for us to grasp the sense of achievement that this may instill in him or her. The construction of a therapeutic proposal such as the onepresented here has a definite effect on society, for there is restitution of the bond, and this is achieved through pacts as well acts. And so the elusive question finally shows itself: From what place or position are we to offer our companionship? And to this we might venture a response with another question: What place or position of the 'other' is in need? Our own fantasies also frequently appear when we create imaginary spaces towards which we may want to direct something we would like to propose to the other; there, we seem to appear as a function of some otherness, a possibility of an 'us' where the roads are paved on something other than the sensation of that archaic solitude, a becoming of restitution in the social bond, which also involves moving from the logic of objects (primary unconscious process) to that of subjects (secondary unconscious process).

The ability to provide accompaniment requires being willing to place oneself at the disposal of the orders given at all times by the Master, be it during each spell or delirium or at any other given moment, by way of a transference established with the other that is basically embodied in bothanalyst and companion. It is thus that the latter two begin to witness thelogical operations of the Master, first by occupying the place of an object, thenas a third party, later as a witness and, finally, if one is fortunate enough, as anally. Modes of intervention are built on styles, that is, from our own transference of each outbreak or delirium. An analogy of this may be found if we turn to the writings of Lewis Carroll, as he displays the whims of the Other to which Alice[1] is bound in that most enticing of worlds: 'Wonderland'. There,we can observe how the place of the object is conditioned by the logic of a dream; hence, we are reminded of the same condition being produced by deliriums, for Alice is trapped by and remains subjected to the words of the Other: a form of logic of the univocal. It is from there that this logic establishes the condition for all things: objects, and this condition is incorporated into the reigning order with its own set of orders; like the dream into which Alice seems to fall, it is a hallucinating realization from which she will not awaken. Working within these realms, the effectiveness of TC lies in its ability to find mobility in the position of the 'other' strictly for the patient; the companion is someone who does not let the patient down, and thus has a fundamental role in the structure of language.

The clinical scope of TC looks to include cases that tend to be left out ofthe traditional practice of psychoanalysis or clinical institutions; it is wrongly assumed that psychoanalysis cannot act as a guide to something that liesoutside the 'divan' and the analyst's practice, and that is why we are set on finding multidisciplinary implements that are able take on such illnesses and contribute to the development of the type of outpatient clinical practice that is capable of intervening in the act and is also ready to expand the territory working in several contexts simultaneously: historical, family and social. The challenge is therefore to develop a clinical approach that is viable within all ofthose circumstances. It is not uncommon that patients are separated from their social status as citizens, as state institutions are unable to help them with treatment. An example of this are people who suffer from addiction, are delirious and unable to find institutions that work with dual disorders. It is a practical necessity to have intervention teams that can turn this type of implement into a more reliable option that is at the same time able to cover different territory. As an example of the effectiveness that does not limit itself to intervention by the analyst but that also provides companionship, we can add

[1] Deleuze, G. (1990). *Lógica del sentido*. Barcelona: Paidos Publishing.

psychiatric care and its use of medication – anxiety pills are a common example – to the TC, who is a listener, a lasting presence of someone who willat times intervene by the sole act of listening. It is equally important to point out that such methods are not naïve proposals, for they are specifically designed in a way that allows for the presence of the 'other' to speak for itself in an act of solidarity so as not to oblige the patients to confront their afflictions on their own. The aim is to make the presence and form of intervention of the 'other' as an agent that is able to break through a profound and archaic form of experiencing solitude, where the main challenge is to spurthe ongoing sense of a hopeful presence, as is, for example, the trust that may be a cultivated in a person suffering from a paranoid delirium.

We set our course in the abyss, unique to every case, with no manual or reference whatsoever to guide us through the specific situation that lies before us and where we are always forced to begin with a given situation more than apatient. First, we listen, then we begin to understand, *Nachtraglich*, and that only at times. Certain moments of the TC experience, especially during the containment of a crisis, do indeed prove to be abysmal, but it all rests within the TC's formation and ability to listen. In essence it is not only about words, for we generally find that more is said in what is otherwise observed, as if silence were confessing through the acts. There are many territories encountered by clinical TC whose language cannot be understood. During a clinical sequence and especially in our condition as subjects who tend to others, it takes time to cross the darkness of reason, of science. The abysmal and the silences speak through their own forms.

At first, we can only hope to add ourselves to these forms, a clinical vantage-point taken by the TC to read into acts and also to produce them. If we observe those forms, we are able to discover what cannot be said but is there; and thus we should listen always, with our reasoning, with reasons and with our body, listening to ourselves as we do so. What we decide to do in these situations, when faced with this ignorance in relation to the objects ofour clinical practice, involves a playing out of our own relationship with the impossible. That is why it is more important to be there than to be able to understand. We may establish certain coordinates basing our thoughts on the premise that the only thing that is essential is that which makes us different; inthis sense, TC is a science of the particular. And so initially we are taken through the way in which each delirium is configured, a medium where forms express themselves; taking each moment and action in its own time allows us to listen without prejudice and has a

double finality: to listen for ourselves andsomehow find a means to let the patient listen to him/herself. At given moments in each case we begin by speaking through acts, gradually movingon to use words to help restore the principle of social bonding.

A clinical space can be produced in many ways, and that is where the subjectivity of the TC comes in. This does not only depend on the theoretical framework to which each case formally refers to, for as we can see in Latin America, there are a number of ways in which this type of work can be carriedout and indeed several theoretical premises for the implementation of TC. It is very important to have an idea of the scope of our active participation in the unfolding of each case, and this is above all true for specific moments of a crisis. As TCs, the way in which we position ourselves when confronting a tragedy experienced by others is largely conditioned by our own history, and that is where our transference with the case intervenes with its own directiveof signifiers. The question formulated above on how we are to proceed alwaysopens roads to the specificity of each case in any of its moments. When we find ourselves listening to a form of delirium, whatever it is that it evokes inus and how our gaze may respond from where it is sustained, forms part of what constitutes a manner of being present which then returns as a response tosuch delirious activity. The implications that TC has for each case are of utmost significance and, owing to this, the most important space in the formation of a clinical specialist is his/her own analysis, therapy or manner of treating his/her own vulnerability.

Here, we would do well to remember that we are made of the same essential elements and that we are also, in principle, vulnerable. Therefore, the personal work we do is of primal importance, for it is within our own forms ofthe abysmal where we can find ways of inhabiting more tragic states; it is in this territory where our creative listening gives its first signs. The ability to hold a close relationship with our own phantasms does much to sustain this type of clinical intervention. We ourselves are the worst case in any given situation, and for this reason our biggest and most impending challenge is to see to our own condition, for that is what more often than not prevents us fromlistening.

The act of accompanying is imbued with dignity. It is one of very few vectors that provide clarity and places its confidence in the subject who, in turn, is faced with the chasms of language, whose forms the subject will taketo their choosing, in his or her own way, for the realm is strictly *sui-generis*. Thus, listening becomes a way of not leaving a subject crumbling on his or herown; the end is to always be present with and for such a person, even in his or her own

absence, which is the most profound solitude that one can experience.The process which we go through when we are touched by the suffering of another person opens up a window to whatever it is our delirious patient is experiencing, but he/she is no longer alone in this, and thus it becomes indispensable to 'put our bodies on the line', as one will hardly choose toplace oneself where one understands nothing. TC is carried out without necessarily having to understand the other, for the subject being accompanied finds him/herself in a place where they cannot think, and therefore they must obey.

The act of accompaniment emerging from any position on the intervening team also constitutes a form of *jouissance*, where we keep acertain blind faith in the subject, which allows us to venture into his/her becoming, just as the poet might bring words to life from the abysses of language. It is in this way that style is created, like the musician who sharesthe labyrinths of his art through the invention of a way of listening, a form which also carries with it the need to find discretion in its voice so as to beable to deal with the demons around it; at times, one's only weapon is to let thedemons speak... until finally they listen to themselves.