PSICOLOGIA EM ESTUDO

ARTICLE 10.4025/psicolestud.v24i0.40350

# CLINICAL DIMENSIONS OF THE ACT IN OBESITY: COMPULSION TO EAT AND SYMPTOM IN THE PSYCHOANALYTIC PERSPECTIVE[1]

**Cristiane Marques Seixas**[2 3], Orcid: http://orcid.org/0000-**0003-2630-9746**

**ABSTRACT.** Starting from the differentiation of clinical dimensions of the act, conceptualizing with Freud the symptomatic act, the acting out, the faulty act and the passage to the act, and the discussion of the idea of symptom, the present work tries to understand what is involved in compulsion to eat present in so-called obese patients. This differentiation aims to instruct a new way of understanding compulsion to eat with in the psychoanalytic field by following the Freudian developments in the second topic. In view of the advent of the concept of death drive in 1920, the lato sensu compulsion can no longer be considered only as a compromise formation, because in the case of so-called obese patients, the compulsion carries a satisfaction that goes beyond the pleasure principle. The differentiation between Neurosis and Psychosis is discussed using the idea of Ordinary Psychosis, which allows us to point out a possibility of 'failure' in the effect of barring the jouissance that is evidenced in the insistence of these symptoms that takes a secondary gain to which the subjects remain bounded. Compulsion to eat is therefore a way of avoiding the anxiety that paradoxically produces suffering, or an act that merges with the ego and charges its price with anxiety. It is suggested to advance the understanding of the last Freudian anxiety theory to distinguish the different ways of clinical approach of the act in its different declinations.

**Keywords**: Compulsion; obesity; jouissance.

# DIMENSÕES CLÍNICAS DO ATO NA OBESIDADE: COMPULSÃO POR COMER E SINTOMA NA PERSPECTIVA PSICANALÍTICA

**RESUMO.** A partir da diferenciação de algumas dimensões clínicas do ato, conceituando com Freud o ato sintomático, o *acting out*, o ato falho e a passagem ao ato, e da problematização da ideia de sintoma, o presente trabalho procura entender o que se trata na compulsão por comer presente nos pacientes ditos obesos. Essa diferenciação visa instruir uma nova maneira de apreender a compulsão por comer dentro do campo psicanalítico acompanhando os desenvolvimentos freudianos na segunda tópica. Tendo em vista o advento do conceito de pulsão de morte em 1920, a compulsão *lato sensu* não pode mais ser considerada somente como formação de compromisso, pois no caso dos pacientes ditos obesos a compulsão comporta uma satisfação que ultrapassa o princípio do prazer. Discute-se a diferenciação entre neurose e psicose, lançando mão da ideia de Psicose Ordinária para apontar uma possibilidade de 'falha' no efeito de barra ao gozo que se evidencia na insistência

[1] Support and funding: Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes)
[2] Universidade do Estado do Rio de Janeiro (UERJ), Rio de Janeiro-RJ, Brazil.
[3] E-mail: cris.marques.seixas@gmail.com

desses sintomas que carregam consigo um ganho secundário ao qual os sujeitos permanecem atados. A compulsão por comer constitui, portanto, uma forma de evitar a angústia que paradoxalmente produz um sofrimento, ou ainda, um ato que se funde ao eu e cobra seu preço na moeda da angústia. Sugere-se avançar no entendimento da última teoria freudiana da angústia para distinguir as diferentes maneiras de abordagem clínica do ato em suas diferentes declinações.

**Palavras-chave:** Compulsão; obesidade; gozo.

## DIMENSIONES CLÍNICAS DEL ACTO EN LA OBESIDAD: COMPULSIÓN POR COMER Y SÍNTOMA EN LA PERSPECTIVA PSICOANALÍTICA

**RESUMEN.** A partir de la diferenciación de algunas dimensiones clínicas del acto, conceptuando con Freud el acto sintomático, el acting out, el acto fallido y el pasaje al acto, y de la problematización de la idea de síntoma, el presente trabajo busca entender lo que se trata en la compulsión por comer presente en los pacientes dichos obesos. Esta diferenciación pretende encamiñar la mirada hacia una nueva manera de aprehender la compulsión por comer dentro del campo psicoanalítico acompañando la segunda tópica freudiana. En vista del advenimiento del concepto de pulsión de muerte en 1920, la compulsión lato sensu ya no puede ser considerada solamente como formación de compromiso, pues en el caso de los pacientes dichos obesos, la compulsión comporta una satisfacción que va más allá de lo principio de placer. Se discute la diferenciación entre Neurosis y Psicosis, echando mano de la idea de Psicosis Ordinaria que posibilita apuntar una posibilidad de falla en el efecto e barra al goce que se evidencia en la insistencia de esos síntomas que cargan consigo una ganancia secundaria al cual los sujetos permanecen atados. La compulsión por comer constituye, por lo tanto, una forma de evitar la angustia que paradójicamente produce un sufrimiento, o aún, un acto que se funde al yo y cobra su precio en la moneda de la angustia. Se sugiere avanzar en el entendimiento de la última teoría freudiana de la angustia para distinguir las diferentes maneras de abordaje clínico del acto en sus diferentes declinaciones.

**Palabras clave**: Compulsión; obesidad; goce.

### Introduction

The frequent presence of obese people in psychoanalysis offices and in health institutions highlights the importance of thinking critically about the direction of these treatments and constructing a theoretical path that systematizes a broader reflection on clinical practice with different forms of feeding-related symptoms. This research also shows the lack of investment in psychoanalytic studies related to obesity, a complex problem that has been entering the public health scenario in a decisive manner and requiring discussions that are still incipient.

From the point of view of human and social sciences, obesity is a difficult phenomenon that cannot be defined with generalizations or simple explanations. According to Morin (2011), the solution of complex problems does not lie in its simplification or the discovery of a last truth in a single field of knowledge, but in the potentialization of the contradictions that concern it.

In this sense, the term obesity itself is problematic, so there is need to contextualize it here. It is not a matter of taking it under a biomedical reference, but of emphasizing the subjective aspects implied in this symptom as a way to reorganize the understanding of this body condition. In general, we can consider obesity as an organic characteristic, in which excess weight presents itself in a chronic way, promoting a permanent dissatisfaction with the body. However, in addition to this organicist reference, one must take into account, above all, the discursive complaint of these patients, from which we can highlight their inclusion in a broader spectrum of conducts related to impulsivity, where the dimension of the act is of great importance.

Maria Helena Fernandes (2004) rescues an important distinction between compulsion and impulsion from Brusset's analysis of the Ellen West case, when she states that in the case of bulimic accesses one could not speak of *stricto sensu* compulsion, since one cannot observe in these cases the typical defense mechanism of the obsessive person, but rather an evident feeling of emptiness. She also pointed out that there did not seem to be any use of substitution and displacement typical of the neuroses in the case, and that it would be more appropriate to use the term impulsion to characterize the eating behavior of bulimics.

Following these indications, we adopt with Jeammet (2003) a conception that is distant from the definitions of the manuals of diagnoses, emphasizing the perspective that every subject has on his/her act or body. Jeammet (2003, p. 106, emphasis added) explains that

> […] we should not retake the set of definitions of the bulimic syndrome, with its respective criteria that are more or less restrictive. Here we shall refer to 'any behavior felt by the subject as an obligation to eat', judged by him/her as excessive, evolving to crisis or accesses, developed without interruption once triggered and that can be repeated at a very variable frequency. It will be included cases that are both not accompanied by any measures of food restriction nor weight control by vomiting, for example, and that lead to excessive weight gain, in cases of normal weight or associated with anorexia.

This expansion in the way we understand and study bulimia interests us as it broadens the way of understanding behaviors related to the compulsion to eat, thus allowing us to focus more in moments of lack of control than in the very dimension of overweight, focused in biomedicine. This 'behavior felt by the subject as an obligation to eat' may be present in patients with obesity or overweight, but due to the chronicity of the problematic relationship with the diet and body, they tend to become obese in the long term. This behavior can even affect subjects who are not overweight or obese, setting up a specific relation to the body in which there is a change in body image, imposing an incomparable severity in the rigidity of diets, which often leads to severe cases of anorexia and bulimia.

Thus, the present study aims to delineate elements that can subsidize the psychoanalytic clinics in different clinical contexts, emphasizing not only the difficulties of the analysis, but especially the moments of treatment in which adherence to oral satisfaction is particularly difficult to circumvent, moments in which that the dimension of the act gains greater severity. Therefore, it is necessary to analyze the dimensions of the act in their different presentations, articulating them to the symptomatic formations and to a certain modality of *jouissance* to which so-called obese patients are adhered.

## Demand and psychoanalytic listening

The body issue is inscribed in the psychoanalytic field in a singular way. Since the 19th century, with the enigma placed by hysterical conversion, psychoanalysis is confronted with the real of the body in its articulations with culture, not escaping to the incidence of

language. Without any doubt, for psychoanalysis the body is not the biological or cultural one, but the instinctual body, from which the pure living and instinctual organism cannot be isolated. The drive was one of the fundamental concepts that allowed the founding of the psychoanalytic field as opposed to the medical field and which indelibly marks the specificity of the body-related symptomatic formations.

In cases where our studies are based, it is evident that the search for weight loss and the recovery of control over their compulsive acts occupy a privileged place and that, for this reason, these people present certain discursivity whose traits can be repeated. According to Birman (2012, p. 84), compulsion

> […] is a mode of action characterized by repetition, since the target of action is never reached. Hence its relentless repetition, without variations and modulations, which assumes an imperative character, that is, it imposes itself on the psyche without the ego can deliberate on the imposed impulse.

From this discursive repetition, we highlight, first, the passive position with which the so-called obese patients present themselves in relation not only to obesity, but to a series of aspects of life. This passivity is evident in excessive body references, in a body that the obese does not seem to appropriate, permanently seeking a separation or denial (Recalcati, 2002).

Another aspect that stands out from the listening of these patients is the aesthetic standards to which they are exposed daily and that are severe as to the gaze that comes from the other. This gaze is inevitably critic and accuser, demonstrating the clearly superegoic character of even the conscious thoughts. The requirement of perfection that we hear as a predominant trait in these cases is also related to this imposition, often leading to the discontinuity of attempts to lose weight after a small slip during a diet.

In a cultural context of unstoppable consumption, in which the subject is invariably submitted to demands of health, beauty and well-being, obesity also appears as a paradox. The lean body ideal is as an ever-unreachable requirement, reinforcing the superegoic imposition that throws, on the other hand, the subjects in the compulsion to eat as resource to cope with the frustration deriving from this permanent inadequacy.

It is precisely in search of adequacy that many patients come to psychoanalysis. The health professional is delegated to the task of healing, and the obese person remains with complains about the sacrifice he/she submits in vain to lose weight or about the suffering that genetics imposes. This subjective justification with which the obese demands a new treatment poses problems for the analytical device, since directing a question to the analyst is an initial condition for the establishment of the transfer, field in which an analysis happens.

Diana Rabinovich, in *A clínica da pulsão: as impulsões* (2004) analyzes the wide field of disturbances that present specific difficulties in the establishment of the transference, denominated by the author as demand disturbances. Among these, she chooses a case of obesity as an example to be analyzed. In the case presented, the author questions the possibility of analysis of certain cases, since it creates in the analyst a sense of impotence that, as the author warns, should not be confused with the logical impossibility of analysis. These cases require patience and a permanent questioning because despite the visible obesity, the patient does not refer to it and presents with a nonspecific complaint that raises a question to the analyst: What to do with this person who seeks consultation but does not know well the reason or for what, who does not demand anything?

Clinical experience shows its diversity here, because just as we receive patients who have a discourse that is excessively marked by body references, who surrender themselves to the health professional as a body to be treated, we also receive patients who do not refer

to themselves nor to their bodies and do not show any evidence of subjectivation. According to Recalcati (2002, p. 55), this excess of body entails the difficulty of “[…]rendering the action of discourse effective in analytical treatment”.

As already mentioned, so that an analysis is possible, there must be a demand addressed to the analyst, a demand that articulates the malaise with a symptom and not only a demand for weight loss or even a diffuse demand. It is in the constitution of an assumption of knowing elsewhere that the possibility of analytic work is given. However, the imaginary imprisonment to which the drive economy of so-called obese patients is attached requires weight loss at all costs, making it difficult to expand this initial moment that would promote a relief of this urgency in favor of the construction of a questioning about their suffering.

In this sense, it is necessary to think carefully about what the patient demands when seeking a treatment to lose weight or when he does not convey in his discourse anything to arise a questioning about his suffering. This is crucial to think about the possibility of psychoanalytic treatment with these patients, since it is not a matter of making obese person loose weight and adapting him to the desired Body Mass Index (BMI), but of sustaining the demand “[…] so that the signifiers in which their frustration is retained may appear again”. (Lacan, 1998, p. 624)

It is around this fixation of the signifier derived from frustration that the dialectics of the treatment of these patients should gravitate, either in which it allows the entry into analysis, or in which it favors its continuity, being able to reach its end.

It is in this sense that in Seminar VIII, Lacan (1992) circumscribes the issue of demand in relation to love by stating that all demand is ultimately demand for love. He indicates that, in the subject who speaks, everything that would be a natural tendency must pass through the gorges of the demand, situated in a further beyond as a demand for love and in a beneath as an object of desire, a partial object. Considering this proposition, a treatment should be provided to respond to the demand for weight loss as if it was, as if it was possible in a response to account for the division of the subject, promoting the overflow of demand in new demands, or worse, ready solutions that proliferate with each new summer. According to Quinet (2009, p. 16, author’s emphasis):

> The demand for analysis correlates with the elaboration of the symptom as an 'analytic symptom'. What is at issue in these preliminary interviews is not whether the subject is analyzable, whether he has a strong or weak ego to withstand the hardships of the analytic process. The possibility of analysis is a function of the symptom and not of the subject. The possibility of analyzing the symptom is not an attribute or qualifier of it, as something that would be its own: it must be sought for the analysis to begin, transforming the symptom of which the subject complains in an analytic symptom.

With the establishment of transfer as a guiding horizon for the beginning of treatment, the management of the discursive content - whether it is full of bodily complaints or diffuse discourse that is not put as a question - in favor of the constitution of an analytical symptom is what allows collecting the necessary elements for a continuous treatment. Preliminary interviews thus have an essential role in the treatment, since ciphering the symptom, articulating it to the supposition of knowing to the analyst, is a *sine qua non* condition of the analytic work. This is one of the biggest challenges faced by analysts who intend to treat so-called obese patients.

## Obstacles in the diagnosis and direction of treatment

If in the medical field the diagnosis is established by means of quantitative parameters from a population mean, in the psychoanalytic field this must be thought from the particularity of each case, which does not allow generalizations. The discussion on establishing a structural diagnosis appears very early in the Freudian work. In 1913, in one of his *Trabajos sobre técnica psicoanalítica*, his concern about the differential diagnosis between neurosis and psychosis becomes clear, emphasizing that making a mistake is much severe for a psychoanalyst than for a psychiatrist.

In this text, as in many others, Freud is emphatic in the thesis that psychoanalysis should not be undertaken in cases of psychosis. However, something incongruous arises when we think of the diagnosis for psychoanalysis, namely, that it must be elaborated right away, when little is known of the patient's history and his illness, so that this inference can, to some extent, provide an indication as to the type of treatment to be undertaken. This elaboration involves a margin of error, indicating that something escapes the notion of clinical structure. We often come across Freudian texts approaching the continuity between pathological cases and normal cases, an aspect from which Freud constructs his concepts and clinical perspectives, such as in the text *Introducción del narcisismo* (Freud, 2006c, p. 79, our translation)[4], where he states that

> […] just as the transference neuroses enabled us to trace the libidinal instinctual impulses, so *dementia praecox* and paranoia will give us an insight into the psychology of the ego. One more, we will have to infer the apparent simplicity of normality from the distortions and exaggerations of the pathological aspect.

In the same way, we use this perspective to think that severe cases of obesity open the possibility of glimpsing what is unfolding in the functioning of the compulsion to eat of patients who daily attend the offices of psychoanalysts, doctors and nutritionists in search of ready-made solutions for their suffering.

In addition to this structural differentiation between neurosis and psychosis, severe cases of obesity, in which there is a recurrence of episodes of compulsion to eat, as well as cases of bulimia (which present compulsion followed by compensatory methods that do not have a significant change in weight) suggest a certain inoperability of phallic logic, a logic that is so evident in the classic neurotic symptom. During the course of the treatment, most of the patients are structured in a classic neurotic dynamics, hysterical or obsessive, marked, however, by the severity of the dimension of the act that suggests to us a frailty of the effect of barring the *jouissance* that must be inscribed by castration. The term *jouissance* is taken here in the Lacanian sense, in which, taking Freud back, we can consider it as the counterpart of the pleasure principle, since it places the impossibility of its fullness and homeostasis, one that goes beyond this principle. *Jouissance* points to the compulsion to repetition, since, from the economic point of view, the excess configures the *jouissance* to which the subject remains attached (Miller, 2000).

For psychoanalysis, obesity does not constitute a clinical category, a clinical structure or even a clinical type, but rather the effects on the body of the obstacles of a subject. For this reason, it is important to distinguish theoretically the different subjective responses to loss and *jouissance*. That is, if castration is what allows the subject to symbolically articulate

[4] "Así como las neuroses de transferência nos posibilitaron rastrear lasmocionespulsionales libidinosas, la dementiapraecox y la paranoia nos permitirá ninteligir La psicologia del yo. De nuevo tendremos a colegirla simplicidade aparente de lo normal desde las desfiguraciones y exageraciones de lo patológico".

loss as lack, and if it is possible that this articulation does not occur, then we can glimpse the broad field of responses that a subject can construct in an attempt to circumvent the emptiness. In this vast domain, the obese body and the compulsion to eat may function as both suppleance in psychosis and constitute itself as a symptom in the neurotic structure, that is why in psychosis there is a symbolic deficit through the foreclosure of the signifier Name-of-the-Father. In the neurosis there is a symbolic lack due to the own castration that inscribes the real deprivation by the Name-of-the-Father.

This idea accompanies Recalcati's proposal when he distinguishes a generalized substitution that would respond to what Lacan addressed in Seminar XX (Lacan, 2010) in terms of the impossibility for the human being to perform out sexual intercourse, and give place to love as suppleance, and a suppleance that would be the substitution of the foreclosed Significant Name-of-the-Father (Recalcati, 2002). This issue is pursued by Calazans and Bastos (2010), when they identify the possibility of the occurrence of discrete passages to the act. From the notion of suppleance, they wonder whether it would be possible to think that the repetitive acts of anorexia and bulimia, which implies duration and not only rupture, would be discrete ways of presenting the passage to the act. Considering that the passage to the act indicates that the fictional structure of neurosis is not sustained by a short circuit between subject and object, could the act be a way to appease *jouissance*?

In the compulsion to eat, the severity of the dimension of the act without a regulation throws us into a minefield, where the concern for the effects for each subject of the analytical listening is worth. If in the Freudian device the interpretation operates in the form of a cut that is articulated with the logic of castration, and if somehow it seems that something of castration has not been subjectivated, the analyst's words can function as persecutory words, strengthening the superegoic commandment of adequacy to the aesthetic ideal. They may even determine the psychotic trigger that confirms, *a posteriori*, the stabilizing function in psychosis.

The compulsion to eat somehow condenses the dimensions of the superegoic commandments and anguish in an obvious vicious circle: one eats out wildly, recriminates oneself excessively and, as a result, the anguish remains, which appears in all its tonalities. The so-called obese body thus comes to dress and name this anguish as tied to *jouissance*, whose relativization or franking is dependent on the barring mechanism that castration promotes. For Gerez-Ambertín (2003, p. 234), it is necessary to "[…] find a referential that allows to distinguish the imperative aspect of *jouissance* of the superego in the neurosis from that of psychosis, because although the former appears sometimes as a voice, there are other forms of presentation that, even if silent, are no less atrocious […]", suggesting to organize these clinical parameters from the desire of the subject before the desire of the Other or the *jouissance* of the Other.

It is about, therefore, thinking about the particularity of a modality of *jouissance* and the response to it, to which so-called obese patients are adhered, either at the beginning of the treatment, by the demand made to the analyst, or in its continuity, by the short-circuit described in the free associations. From this point, it would be possible to differentiate the cases in which a possibility of reestablishing castration and the phallus can be differentiated as an archimedical point and clinical compass of the analytic treatment, from those in which an ordinary psychosis must be assumed.

Ordinary psychosis is a term coined by Jacques-Alain Miller at the *Convenção de Antibes,* held in Paris in 1998, to circumvent the rigidity of a binary clinics (neurosis-psychosis) and to think the specificities of clinical cases that surprised analysts in less lush ways of presentation of psychosis, where the elementary phenomena characteristic of

classical psychoses were not clearly observed. Miller (2010) states that the analyst must identify in the clinics the cases of neurosis by its precise and recognizable structure. However, when the analyst is led for years to doubt about the subject's neurosis, then, in this case, one should bet that is faced with an ordinary psychosis. Therefore, one should not forget the warning that these cases should be treated as psychosis.

## Act, compulsion and symptom

The dimension of the act is manifested in the clinics in various ways, whether through the faulty act, the symptomatic act, the acting out, or the passage to the act. These are considered ways of responding to malaise, together with inhibition, symptom, and anxiety (Calazans & Bastos, 2010). The symptomatic act and the faulty act can be considered formations of the unconscious, and can be, therefore, interpreted in the analytical device as the symptoms are. Acting out, in turn, would be a form of act that would appear in the place of remembrance and indicates that something of what appears in the course of an analysis is not symbolically articulated through remembrance, but makes its presence in the acts under transfer, being yet susceptible to the approach under transfer. In addition to these variations of the act, Freud (2006g) points out, through the analysis of the young homosexual woman, a third mode of presentation of the act (which will be named by Lacan as a passage to the act) when an attempt of suicide occurs that breaks with the encryption of the symptom and walks against the analytical process.

The differentiation introduced by Lacan as regards the dimension of the act dates back both to his investigation of criminal acts, also called crimes of the superego - such as the Aimée case and the crime of the Papin sisters -, as well as to the reading of certain analysis carried out by some post-Freudian scholars, in which he emphasizes the dimension of the act to compose a critique of the way these analysts conducted their analysis. An example that is treated by Lacan at various times of his teaching is the case of the patient of Ernest Kris, known as a man with fresh brains. This is the case of a patient who believes he is a plagiarist. Considering this, Kris is willing to read his writings and verifies that there is no plagiarism, which makes him rashly interpret that the patient defensively sketches an attraction for the ideas of others, followed by a long silence. Then, the patient says that, some time ago, when leaving the session, he strolls down a street where there are several restaurants and eats his favorite dish: fresh brains. For Kris this is a great interpretation, but for Lacan it is a technical mistake because Kris would have made the drive emerge by means of an acting out instead of bringing out the truth of the symptom. In this case, Lacan indicates how the conduct of treatment can often favor the production of an acting out as a way of summoning analytical listening and a repositioning of the analyst in the device.

With the help of the conceptualization of the object a, Lacan (2005) can make explicit the differentiation between passage to act and acting out. Unlike the acting out, in which there is an addressing from one act to the Other, the passage to the act would be something that breaks with the transferential/phantasmatic scene, insofar as the subject does not present itself. This differentiation allows us to question the compulsion to eat from the point of view of the analytical device, considering that often the ‘compulsion to eat’ is configured as an address that summons the analyst to his function, but at other times it has the characteristics of a passage to the act, where there is an effacement of the subject going against the analysis. Perhaps we can also think of the compulsion to eat as a symptom, that is, as a compromise solution that negotiates the impulsive impositions and the repressing

forces of self, to the mode of compulsion in obsessional neurosis. We will analyze these differences in details.

First of all, compulsion is treated by Freud from the typical clinical picture of obsessional neurosis, whose symptoms include obsessive ideas, the struggle against these thoughts, as well as the compulsion to perform rituals and undesirable acts. What marks the specificity of compulsion in obsessional neurosis is its coercive character, an internal force (*zwang*) that coerces the subject to action. The main example in the Freudian work is the analysis of the case of the 'Rat man', where the compulsions had the function of protection against the anguish coming from the fantasies originated from the report that the patient had heard of a type of oriental torture provoked by the penetration of rats in the rectum of an individual (Freud, 2006b). In this sense, the compulsion (*zwang*) present in the obsessive neurosis (*zwangneurose*) is an action resulting from a psychic conflict and is inscribed in the phantasmatic frame of the subject.

Another way of thinking about compulsion in psychoanalysis would be to take it as an automatic repetition, differentiating it from the symptom, since it could not be translated through the statement of a fantasy. In this sense, it is articulated with the Freudian concept of compulsion to repetition (*wiederholungzwang*) presented in *Más Allá del principio de placer* (Freud, 2006f), which consists of a mobilization of the psychic investments in order to bind the excess free excitation which invades the psychic apparatus without being prepared for it. This compulsive dimension that presents itself as radically strange and not symbolic would be a fundamental characteristic of the death drive, and its most familiar clinical expressions are traumatic dreams, the *Fort-da*, fateful destiny and repetition in transference. These examples addressed by Freud are the clinical testimonies of a work of the psychic apparatus in relation to the death drive, that is, a possible symbolization for the drive excess that is present through a compulsion to repeat.

Following this Freudian differentiation, Barros (2002) proposes a third way of understanding compulsion. For the author, it is not about knowing whether it is possible to broaden the margin of what can be symbolized, but to "[…] enlarge the very notion of symptom, which would no longer be a symbolic representative of the subject, but a form of drive *jouissance* without discursive mediation" (Barros, 2002, p 104). The symptom, understood as repetition and no longer as a compromise formation, would frame contemporary clinical challenges such as bulimia, an important aspect that we may find in the Freudian conception of symptom itself.

## Symptom: gain of weight, gain of jouissance

Cosentino (1996), when analyzing the different conceptions of symptom in the Freudian work, reiterates Freud's insistence, from the *Manuscrito K* até *Moisés y la religión monoteísta*, on the thesis that the symptom has the character of a compromise formation between repressed and repressing representations, replacing a pathogenic rememberance. With the gradual abandonment of the perspective of genital sexuality and the consolidation of the drive point of view, the symptom tends to be taken more as the result of the conflict that is established in the psyche between an unconscious tendency that seeks satisfaction and a conscious tendency that represses, being considered as a substitute no longer for remembrance, but for sexual satisfaction itself. By analyzing the source of the compulsions to which obsessive symptoms obey and the model of anguish neurosis, Freud identifies an amount of energy from the sexual life that causes a disturbance within the psyche, thus

giving more emphasis to the economic aspect at play in the symptoms to the detriment of the dynamic aspect.

This point needs emphasis, since this sexual excitation that causes disturbance and promotes the formation of the symptom as a satisfaction that replaces it does not extinguish the pulsional source, remaining a rest. The symptom itself may acquire a compulsive aspect because, in the quality of satisfaction, it guarantees an achievement to which the subject remains bound. We can see this understanding in the speeches that the clinics presents to us

> I cannot look at myself, I am angry at this body, it is a barrier that I cannot get close to anybody, especially my husband. I cannot make love to him, I cannot get close. I am ashamed to go out on the street, I only change clothes with the light off, I do not even look in the mirror. But I also cannot stop eating, it is my only pleasure (Lugão, 2008, p. 63).

In analyzing the formation of symptoms at the 19th Conference, Freud states that in the case of transference neuroses, patients suffer from frustration when the satisfaction of their sexual desires is rendered unfeasible by reality. Satisfaction appears as the "[…] substitutive satisfaction of what has been lost in life" (Freud, 2006d, p. 274, our translation)[5]. He then states that there would be a number of objections to this idea of satisfaction of the desire present in the symptoms, especially by the observation that the symptoms seem to have the opposite purpose, that is, to exclude or cancel the sexual satisfaction, as we can see in the featured speech above. In response to this observation, Freud adds that the symptoms

> […] are products of compromise, are born from the interference of two opposing aspirations and replace both the repressed and the repressor who cooperated in their origin. Replacement may tilt to one side or the other, and it is rare for one of these influences to fail altogether. In hysteria, one reaches the coincidence of the two purposes, most of the time, in the same symptom. In obsessional neurosis, the two parts often separate and the symptom then becomes two times, it consists of two successive actions that cancel each other out (Freud, 2006d, p. 275, our translation)[6].

For Cosentino, at the 23rd Conference, Freud clearly distinguishes between symptoms and illness, stating that the elimination of symptoms is not the cure of the disease, since the ability to generate new symptoms remains. The compulsive aspect of the symptom already delimited by Freud in relation to the resistance in the analysis indicated the need to reformulate his understanding of the process of analysis. At first, Freud was betting on the need to make the unconscious aware, stating at various moments in the work the importance of communicating to the patient the unconscious contents, making them aware for a resurgence of symptoms. This conception, however, became problematic, since the clinics pointed repeatedly to something that was not inscribed in the psychic apparatus, escaping the possibility of awareness.

We can thus follow the extension of the concept of symptom as substitutive satisfaction, which now includes the paradoxes of the drive: something strange and unrecognizable begins to wave in the symptomatic formations that are not subject to healing, but lead to permanent displacements. With the turn of the theory of drives in 1920, the drive

[5] "[...] una satisfacción sustitutiva de lo que se echó de menos en la vida".

[6] "[...] son productos de compromiso; nacen de la interferencia de dos aspiraciones opuestas y subrogan tanto a lo reprimido cuanto a lo represor que han cooperado en su génesis. La subrogación puede entonces inclinarse más hacia un lado o hacia el otro; es raro que una de esas influencias falte por completo. En la histeria se alcanza, las más de las veces, la coincidencia de los propósitos en el mismo síntoma. En la neurosis obsesiva, las dos partes a menudo se separan; el síntoma se hace entonces en dos tempos, consta de dos acciones sucesivas que se cancelan entre sí".

dualism centered on the opposition between the drives of life (of self-preservation) and sexual drives (libido) is abandoned, and the drives of life begin to encompass the drives of self-preservation and sexual drives, as opposed to the death drive. This turning makes it possible to think of elements that go beyond the pleasure principle, such as "[…] this paradoxical mission of the symptom, adequate to put as an expression the insistence of the drive" (Cosentino, 1996, p. 21).

The detachment of the suppression of symptoms in relation to the cure of the disease indicates secondary function of the symptoms, for if at the beginning the symptom is a poorly received guest, in the psychic economy it gains, on the other hand, a secondary external function that Freud notes in a note added to the Dora case in 1923:

> The reason for getting sick is in every case the purpose of gaining [...] but in every neurosis one must recognize a primary gain. Being sick saves, above all, a psychic operation; it is presented as an economically more convenient solution in the case of a psychic conflict (refuge in the disease), although most of the time this exit is unequivocallyinadequate. This part of the primary gain of the disease can be called internal, psychological; it is constant. In addition, external factors [...] provide reasons for becoming ill and thus constitute the external part of the primary gain of the disease (Freud, 2006a, p. 39, our translation)[7].

If the primary gain of the disease corresponds to an economic gain within the psychic apparatus, the secondary gain constitutes the palpable external advantage, whose real value must be charged to the self, more or less (Freud, 2006e). The gain of the disease is also treated by Freud in *El yo y El ello* (2006h) in order to clarify the intimate affinity of the superego with this, considering the cases under analysis in which patients react in an inverse way to the advances of the analysis and, instead of improving, they get worse. The so-called negative therapeutic reaction evidences a need to be ill, and even in the face of the classical management of resistances, it proves to be an even stronger obstacle (Freud, 2006h). This position was sustained by Freud (2006j) until the end of his work, even remaining as an issue addressed in *Análisis terminable e interminable*, on the limits of the interpretation and destination of the transfer at the end of analysis.

The relation of the symptom to the ego is again addressed by Freud (2006i) in *Inhibición, sintoma y angustia*, demonstrating that as the symptom replaces both the repressed and the repressive tendencies, it gains an independence from the ego by establishing a tedious and endless sequence of operations, in which the struggle of the ego against the drive is prolonged in a struggle against the symptom. There is an attempt to absorb the symptom on the part of the ego, whose classic example would be the hysterical symptom of punishment, since

> […] the symptom exists and cannot be eliminated, and it is necessary to accept the situation and get the most out of it. An adaptation to the fragment of the inner world that is foreign to the ego and represented by the symptom, adaptation as that which the ego does with the real external world, comes to pass [...] so the symptom is gradually charged with representing important interests, 'demands a value' for its affirmation, 'merges more and more with the ego' and becomes more and more indispensable to it. The value of this secondary adaptation to the symptom could be exaggerated by

[7] "El motivo para enfermar es en todos los casos el propósito de obtener ganancia. [...] pero entoda contracción de unaneurosis debe reconocerse una ganancia primaria. El enfermarse ahorra, ante todo, una operación psíquica; se presenta como la solución económicamente más cómoda en caso de conflicto psíquico (refugio en la enfermedad), por más que la mayoría de las veces se revele después inequívocamente el carácter inadecuado de esa salida. Esta parte de la ganancia primaria de la enfermedad puede llamarse *interna*, psicológica; es, por así decir, constante. Además, factores exteriores […] proporcionan motivos para enfermar y así constituyen la parte externa de la ganancia primaria de la enfermedad".

> claiming that the ego sought it exclusively to enjoy its advantages (Freud, 2006i, p. 95, our translation, emphasis added)[8].

It is from the Lacanian perspective that we can advance a little further in the understanding of this strange combination of gains and losses of disease which Freud carefully investigates and which is posed as an issue through the compulsion to eat of so-called obese patients. Here the weight gain resulting from compulsion gives shape and form to the paradox of the symptom: while it brings about a gain of pleasure provided by eroticized oral activity and the saving of psychic energy, on the other hand, it brings suffering linked to excess, excess weight, criticism and acts. A real weight in consciousness.

## Final considerations

Taking the proposal of Barros (2002) to think of the amplified symptom as a form of *jouissance,* we can deduce from the Freudian trajectory outlined by Cosentino (1996) that the compulsion to eat is a way of avoiding the anguish that paradoxically produces suffering, or even an act that merges with the ego and charges its price in the currency of distress. It would be necessary to advance in the understanding of the anguish to distinguish the different ways of clinical approach of the act in its different declinations, because whether it is passage to the act, acting out or symptom, the diminution of *jouissance* is promoted from the analytical device, because as Lacan tells us

> The symptom by nature is jouissance, do not forget it, concealed *jouissance,* undoubtedly *untergebliebene Befriedgung*, does not need you as acting out, it is enough in itself. It is from the order of what I have taught you to distinguish from desire as being *jouissance*, that is, that which goes towards the Thing, after having passed the barrier of the pleasure principle, and that is why such *jouissance* can be translated as *Unlust* - for those who have not yet understood, this German term means *unpleasure* (Lacan, 1992, p. 140, author's emphasis).

It is, rather, to broaden the possible responses to the superegoic commandment that binds the subject to an oral *jouissance* that transcends him and renders castration inoperative. Therefore, it is necessary to verify the hypothesis that the incidence of the superegoic demands would be directly related to the maintenance of the symptom and to the increase of the anguish due to a failure in the symbolic operation that regulates the relations between superego, *jouissance* and desire to restore to the symptom its possibility of favoring the handling of anguish. The symptom follows in its role of substitute and return of the repressed, whose

> […] demand for satisfaction is renewed repeatedly, constraining the ego to give in each case the sign of displeasure and to put itself in a defensive position. The secondary defensive fight against the symptom is varied in its forms, fought in different scenarios, and uses several methods (Freud, 2006i, p. 96, our translation)[9].

---

[8] "[…] el síntoma ya está ahí y no puede ser eliminado, ahora se impone avenirse a esta situación y sacarle a máxima ventaja posible. Sobreviene una adaptación al fragmento del mundo interior que es ajeno al yo y está representado (repräsentieren) por el síntoma, adaptación como la que el yo suele llevar a cabo normalmente respecto al mundo exterior objetivo (real) […] así el síntoma es encargado poco a poco de subrogar importantes intereses, cobra un valor para la afirmación de sí, se fusiona cada vez más con el yo, se vuelve cada vez más indispensable para este. […] podría exagerarse el valor de esa adaptación secundaria al síntoma mediante el enunciado de que el yo se lo ha procurado únicamente para gozar de sus ventajas".

[9] "[...] exigencia de satisfacción renueva una y otra vez, constriñendo al yo a dar en cada caso la señal de displacer y a ponerse a la defensiva. La lucha defensiva secundaria contra el síntoma es variada e sus formas, se despliega en diferentes escenarios y se vale de múltiples medios".

Considering the symptom, not only related to its substitution function, but especially in the perspective of this exigency of satisfaction that is renewed repeatedly, we can articulate the symptom to an economy of *jouissance* that is established in the compulsion to eat, whose regulation depends on the operation of the symbolic aspect. From this, it is worth checking the possibility of thinking, according to Freud, on the extension of the notion of symptom as that which at the same time replaces the repressed one and articulates the real one of the anguish. This is undoubtedly a metapsychological question, but it is necessary to think about possible forms of intervention among so-called obese patients in the contemporary clinics.

## References


Barros, R. R. (2002). Compulsões, desejo e gozo. *Latusa, 7*, 95-106.

Birman, J. (2012). *O sujeito na contemporaneidade*. Rio de Janeiro, RJ: Civilização Brasileira.

Calazans, R., & Bastos, A. (2010). Passagem ao ato e acting-out: duas respostas subjetivas. *Fractal: Revista de Psicologia*, *22*(2), 245-256.

Cosentino, J. C. (1996). A concepção do sintoma em diferentes momentos da obra freudiana. *Revista da Escola Letra Freudiana, 15*(17), 3-31.

Fernandes, M. H. (2004). *Transtornos alimentares*. São Paulo, SP: Casa do Psicólogo.

Freud, S. (2006a). Fragmento de análisis de un caso de histeria. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 7, p. 7-107). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1905.

Freud, S. (2006b). A propósito de un caso de neurosis obsesiva. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 10, p. 123-194). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1909.

Freud, S. (2006c). Introdución del narcisismo. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 14, p. 71-104). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1914.

Freud, S. (2006d). 19ª Conferência. Resistencia e represión. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 16, p. 262-276). Buenos Aires: Amorrortu. Trabalho original publicado em 1917.

Freud, S. (2006e). 24ª Conferência. El estado neurótico común. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 16, p. 344-356). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1917.

Freud, S. (2006f). Más Allá del principio de placer. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 18, p. 7-62). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1920.

Freud, S. (2006g). Sobre la psicogénesis de un caso de homosexualidad femenina. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 18, p. 141-164). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1920.

Freud, S. (2006h). El yo y el ello. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 19, p. 13-66).Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1923.

Freud, S. (2006i). Inhibición, síntoma y angustia. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 20, p. 83-164). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1926.

Freud, S. (2006j). Análisis terminable e interminable. In S. Freud, *Obras completas* (2a ed., J. L. Etcheverry, trad., Vol. 23, p. 219-254). Buenos Aires, AR: Amorrortu. Trabalho original publicado em 1937.

Gerez-Ambertín, M. (2003). *As vozes do supereu na clínica psicanalítica e no mal-estar na civilização* (S. Chebli, trad.). São Paulo, SP: Cultura Editores Associados.

Jeammet, P. (2003). Desregulações narcísicas e objetais na bulimia. In B. Brusset, C. Couveur & A. Fine. *A bulimia* (M. Seincman, trad.). São Paulo, SP: Escuta.

Lacan, J. (1998). *Escritos* (V. Ribeiro, trad.). Rio de Janeiro, RJ: Jorge Zahar.

Lacan, J. (1992).*O seminário, livro 8: a transferência* (D. Duque-Estrada, trad.). Rio de Janeiro, RJ: Jorge Zahar.

Lacan, J. (2005). *O seminário, livro 10: a angústia* (V. Ribeiro, trad.). Rio de Janeiro, RJ: Jorge Zahar.

Lacan, J. (2010). *Encore (1972-1973)* (A. L. T. Ribeiro, trad.). Rio de Janeiro, RJ: Escola Letra Freudiana. Edição não comercial.

Lugão, S. M. (2008). *Aspectos narcísicos da clínica da obesidade* (Dissertação de Mestrado), Programa de Pós-graduação em Teoria Psicanalítica. Instituto de Psicologia. Universidade Federal do Rio de Janeiro, Rio de Janeiro.

Miller, J-A. (2010). Efeito de retorno à psicose ordinária. *Opção Lacaniana Online, 1*(3), 1-29.

Miller, J-A. (2000). Os seis paradigmas do gozo. *Opção Lacaniana*, *26/27*, 87-105.

Morin, E. (2011). *Introdução ao pensamento complexo* (4a ed., E. Lisboa, trad.). Porto Alegre, RS: Editora Sulina.

Quinet, A. (2009). *As 4+1 condições da análise* (12a ed.). Rio de Janeiro, RJ: Jorge Zahar.

Recalcati, M. (2002). O “demasiado cheio” do corpo: por uma clínica psicanalítica da obesidade. *Latusa, 7*, 51-74.

Rabinovich, D. (2004). *A clínica da pulsão: as impulsões* (A. L. de O. Lopes, trad.). Rio de Janeiro, RJ: Companhia de Freud.

*Received: Nov. 05, 2017*
*Approved: Dec. 13, 2018*

---

*Cristiane Marques Seixas:* holds a bachelor's degree in Psychology from the Universidade Federal Fluminense (1997), a Master's degree in Collective Health from the Institute of Social Medicine of the Universidade do Estado do Rio de Janeiro (2009) and a PhD in Psychoanalytical Theory from the Universidade Federal do Rio de Janeiro (2013). She is currently Associate Professor at the Instituto de Nutrição da UERJ and researcher at NECTAR - Núcleo de Estudos sobre Cultura e Alimentação. Psychoanalyst member of the Escola Letra Freudiana. She has experience in the area of Psychoanalysis and Collective Health, working mainly in the following themes: obesity, anorexia, bulimia, psychoanalysis, biopolitics and contemporaneity.