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Misrecognizing the Clinic: Towards a Planetary Psychoanalysis
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Introduction

My study demonstrates how the Lacanian account of misrecognition can be a critical lens for the development of a planetary psychoanalysis, in which treatment is situated amidst the convergence of different temporalities that constitute modernity. First I will show how the imaginary, the desire to visually objectify an ideal 'self,' is a distinct export of Western bio-political modernity. Secondly I will turn to lessons from the diversity of medical practices in Malaysia, which I take to be indicative of medicine in Southeast Asia more broadly, to show how this export breaks down. This reveals two different ways in which misrecognition is spatially positioned. The former understands it as an unconscious phenomenon. Misrecognition is a problem to be unpacked in clinical enclosures. The latter, on the other hand, shows misrecognition as conscious and historical. Misrecognition occurs where the imaginary fails to sustain across modernisation's heterogenous spaces. What is misrecognised here is twofold. First the location of the psyche that is to say the subject's 'inner world' - as the border between the ego's interiority and exteriority is negotiated amidst different histories brought together by globalisation. This means that the psychoanalytic clinic, once planetary, must be discursively agonistic, constantly engaging with and engaged by contradictory experiences. By this psychoanalysis becomes a critique of the ego as a geo-historical, as opposed to simply domestic, formation.

My argument resonates with calls to pursue The Universalisability of Psychoanalysis, wherein psychoanalysis is deployed to critique globalisation. The aim here is to uncover 'the Real' of the Global - 'its rifts, gaps, exceptions and contradictions' - and in that unmask ideological celebrations of capitalism as a seamless process of expansion and hybridization (Kapoor xix). While I do not deny this premise I extend it through the claim that to universalize psychoanalysis is to similarly subject it to the very chasms and contradictions that are immanent to the globalisation process. To show this I turn to Susan Stanford Friedman's (2015) notion of the planetary, which understands modernisation as a fundamentally plural process. A key assumption in her approach is that the West, while an undeniable geo-historical force, is not the sole or even main author of modernity and thus should not be the measure against which all 'other' modernities are understood. Similarly the lesson for Lacanian psychoanalysis is that it too should not adopt a template approach where its fully formed theories are to be simply applied 'elsewhere.' The challenge is not merely of difference, of finding another place to explore, but contradictions produced from engaging with it.

Lacan's insistence that psychoanalysis is not a metalanguage is instructive in this regard, as Lacanian analysis is now just establishing its foothold beyond Euro-America, particularly in Southeast Asia where I am writing. But more than that, to take the planetary seriously is to take the active confluence of histories as an ongoing contest.

Therefore misrecognition, once cast in a planetary light, is no longer about the analyst-analysand dyad but an inquiry into the geo-historical limits of modern-Western subjectivity, the very subjectivity on which psychoanalysis is premised. Misrecognition so construed troubles psychoanalysis as subject and object: it exposes the limitations in psychoanalysis' model of 'man' and in doing so troubles its dynamic of treatment. It is now opened to otherness in a global historical scale rather than the uncanny of clinical enclosures. Psychoanalysis now becomes a discourse that shows how the ego constructed in the globalizing context is disrupted through the presence of historical temporalities. The location of the psyche too – its imagined immateriality or internality - is troubled as a result. Psychoanalysis becomes planetary as it can understand its objects of study is written over live geo-temporal antagonisms.

The Southeast Asian developmental context, is particularly insightful for revealing what I call an uneven imaginary wherein the interiority formed by the imaginary is traced out of historical contradiction. This is most obvious in how regional discourses on 'psychology,' 'healing' and 'health' are shaped amidst the convergence of modern scientific approaches and 'traditional' 'non-modern' ones. Of particular interest here is how the persistence of traditional approaches to 'healing' indicates a limit to the credibility of modern medicine and consequently its biopolitical machinations. The implication here is significant. The globalisation of the clinic and its roots in colonial history is impeded by other approaches and their distinct historical logics. This is a matter of misrecognition because it exhibits the failure for the subject of treatment to attain ego-closure as the psyche is also coded differently as a result. He is constantly 'de-centered' through a struggle for symbolic consistency. Moreover this struggle is geo-historical as it evokes historical temporalities other to that of the modern West. Misrecognition, once situated to a broader theatre of spatio-temporal struggle, situates the failure of ego-formation on a geo-historical plain.

This has the effect of misrecognising the established (Western) clinic, as 'treatment' is no longer reducible to clinical enclosures but is operating amidst a broader struggle of historical positioning,. The clinic now appears as just one mode of uncovering the ego's limitations amidst others. This, however, does not mean that Lacanian psychoanalysis no longer has a role to play. It simply has to attentively adapt to how global capital does not entail an export of the West to the Rest but rather the antagonistic coming together of different histories. This then brings us to a distinctly Lacanian response to the globalisation of psychoanalysis. Globalizing psychoanalysis does not simply entail adopting non-European myths into clinical transference, as Sudhir Kakar advocates in the case of India.[1] Rather it is a way of considering how the clinic is shaped

[1] Kakar's statement on this matter is worth citing in full for clarity: 'For the non-Western analyst, the analytic neutrality has to be interpreted and practised in the context of the broader communication patterns of his culture. In India, the cultural pattern requires that irrespective of the nature of the patient's psychopathology, the analyst be much more actively involved than may be considered desirable in the classical model. The demonstration of compassion and interest, warmth and responsiveness expected of the analyst by the Indian analysand is generally nearer to what he would expect from a personal guru than from a professional doctor—the model that pervades analyses in the West. An Indian analyst, if he wants to keep

amidst a broader ‘confluence of forms’ caused by the contradictory blending of the many times that constitute the global (Lacan, 2006, 100). Planetary psychoanalysis conceives of a strategic use of clinical space to sustain misrecognition in accordance to the distinct way the Western ego is globalized across different historical dynamics.

My basis for a planetary clinic extends the long line of criticisms against psychoanalysis' Eurocentric limits. My particular argument, however, builds on the little-acknowledged detail that Lacan himself foresaw this problem. In 'Aggressiveness in Psychoanalysis' he positions the clinic as a space of anti-imperial intervention. Analysis encloses the imaginary 'one' in the analysand-analyst dynamic only for the very enclosure to eventually make way for misrecognition and consequently the subject's undoing. This early work mentions neither the symbolic nor the real. But Lacan was ahead of his time at least in historicising analysis to show how the subject it assumes is actually the European man that wrought global devastation. In many ways this anticipates post-colonial critiques of psychoanalysis, as Lacan faults the psychoanalytic establishment for assuming a model of man premised upon Western conquest. The work says little of what would replace it but its contemporaneity is striking especially in light of Lacan’s general indifference to world politics.

It also helps that ‘Aggressiveness in Psychoanalysis’ is the rare occasion where he uses the notion ‘planetary’ to describe the implications of the psychoanalytic process. Here I pay particular attention to a very specific claim he makes, namely that psychoanalysis' future cannot entail a straightforward globalisation of the Western clinic. Instead he anticipates antagonisms that will be the basis of newer configurations of social forms. Though he does not provide an alternative clinical approach he does point to how a truly global psychoanalysis requires an agonistic body of knowledge. In this sense Lacan can be said to be also provincializing the clinic: the clinic is a distinct product of Western colonial history. Indeed his critique of psychoanalysis is in many ways a critique of its geographical insularity. All this is to say that the clinic is not meant to be a timeless space. Lacan points to other horizons that are merging with that of the West. A planetary psychoanalysis similarly extends clinical work through a globally conceived temporality. This indeed is the basis of a distinctly Lacanian practice as a critique of empire.

At stake here is the question of finding the right mode of globalizing Lacan. The exportation of the psy-sciences (psychotherapy, psychiatry and psychology) has made the modern-Western model of the 'healthy' individual, and the clinical space in which he is 'treated,' globally normative. Indeed its global ubiquity as a model and space of treatment is rooted to the West's long history of disciplining colonial subjects, as various studies have documented. The globalisation of 'mental health awareness' is similarly a part of this development wherein the biopolitical model of the 'psyche' continues to cast the non-West into its ideal of 'man.' Meanwhile psychoanalysis, Lacanian psychoanalysis especially, positions itself as an alternative to normative psychology. But it has no response to how this alternative should be oriented globally.

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his patients, cannot ignore these cultural expectations and must carve out his analytic neutrality within the parameters set by them’ (Kakar and Boni, 2008, 11).

Here ‘Aggressiveness in Psychoanalysis’ is again insightful for how the clinic, however globalized, should not be conceived as a fixed and timeless space. Rather it is merely a strategic setting for the bigger goal of undoing the modern subjectivity of command and control.

In this sense my analysis presumes Christian Dunker’s (2011) assertion that we cannot think of psychoanalysis’ contemporary relevance without seeing it as a product of European biopolitics. My inquiry expands the scope of this assumption by showing how the hybridity of medical discourse in Southeast Asia offers insights on how modern-Western biopolitics is not globalized without also being challenged by heterogeneous spatio-temporalities. In this sense I build on Harry Yi Jui Wu and Wen-Ji wang’s (2016) claim that to understand the growth of the psy-sciences in the non-West is to consider ‘cross-cultural interactions of dissimilar knowledge systems and the complexities of colonialism and globalisation during the process’ (Wu and Wang, 2016, 110). The widespread, and at times even official, recognition of alternative medical models in Southeast Asia is an advance from the governmental insularity of Western biopolitical medicine. But what is also occurring as a result is greater normativity where, rather than confluence, difference is territorialized to extend the already-existing hegemony. Psychoanalysis then can similarly situate the clinical dynamic amidst this trajectory, sustaining hybridity in their antagonisms.

My argument situates Lacan's notion of the unconscious - as ‘the impropriety of trying to turn it into an inside’ - on a geo-political plain wherein Western capitalist modernity will be ‘misrecognised’ the more it encloses upon the non-West (Lacan, 2006b, 711). I begin by turning to 'Aggressiveness in Psychoanalysis' for Lacan’s account of imaginary boundedness and how this is troubled by misrecognition. I will then show how Lacan anticipates this to be a global question precisely because psychoanalysis is a distinct product of Western history, despite the global reach of its subject. I shall then turn to Southeast Asia for examples of how the globalisation of this subject, and the biopolitical structures that sustain it, encounters impasses , in the form of non-modern medicine and the subjectivities they assume. What is obvious here is a continuous reconfiguration of the duality between ego’s interior and exterior, and consequently mind and body. This comparison, to be sure, is not meant to say that Lacanian psychoanalysis should solve or harmonise these differences. Indeed they will be largely superficial. It would be enough for my purposes to show that the challenge of undoing the bounded ego of modernity is planetary. The goal is not to solve but to understand a certain dynamic of contradiction. The task then is to update the insights on misrecognition Lacan described for the West, for a world beyond it. Staying true to the truth of misrecognition, once cast in the light of global confluences, means that the form of psychoanalysis too may have to be rethought for a new world.

The clinic of conquest

In *Aggressiveness in Psychoanalysis*, Lacan describes the psychoanalytic clinic as a conduit wherein the spatio-temporality of subjective division can materialize. Spatially, the clinical session induces ‘in the subject a guided paranoia’ (Lacan, 2006, 89). Temporally this brings out the subject's ‘anxiety and its effects’ (Ibid). The analyst

meanwhile guides transference through offering ‘the subject the pure mirror of a smooth surface’ (Ibid). This 'mirror surface' is where the subject's relationship with the ‘motivating imago’ is eventually revealed as one of fundamental division (Ibid). By this point the clinical subject, who is struggling against the threat of his disintegration, has misrecognised his imagined identity through the transference, paving the way for the truth of his desire as a lacking, rather than whole, subject to emerge. Understanding why this moment of misrecognition is crucial for analysis, and why it is marked by aggressiveness, entails that we consider what psychoanalysis presumes the modern subject to be. For this we begin with a key term in this paragraph, namely, the imago.

The imago, in a general sense, refers to an image one identifies with. Technically speaking, however, the imago is an image that guides identification through and with another person. This could be a father, a person of authority, or a celebrity. The imago, to be sure, is not simply a matter of validation by someone else. The imago structures inter-subjectivity insofar as the ego is only properly formed through an anticipated wholeness through another person. It is in this sense of unconsciously enacting an imagined reciprocity between subject and object that the imago is likened as a mirror: it grants the subject a stable reference point from which he or she can form an identity. The process then is essentially narcissistic: A 'mirror' is present for as long as the subject has the image of another person on which his identity can be fixed.

This reciprocity, however, is imaginary because it is underlined by a fundamental contradiction. The image then does not reveal so much as it fixes the subject into a gestalt, a whole form, with which he is able to objectify himself as an ostensibly unique individual in the world he calls his own. But that the subject requires an image for this to begin with speaks to a fundamental dependency on a symbolic order, broader structure of meaning-making. In the immediate sense this dependency marks a division between an 'I,' the conscious subject, and a 'me' personified in another image (be it of myself or another person) from which I can expect wholeness. But in a deeper sense this also articulates a division between the I and the Other, the locus of discourse from which the subject seeks reciprocity. This sets him up for a worldview of boundedness wherein his dependency on an object would be symbolised as a duality between inside and outside, self and other, man and woman and conversely mind and body.

Far from unifying the subject then the imago is ‘an image that alienates him from himself’ (Lacan, 2006, 92). These divisions, sustained further by the fact that the subject can never overcome them, is what moves desire. Subjectivity in this sense is always beholden to an Other in a dynamic of dependency and failure but never one-ness.

That the imaginary is formed to conceal subjective division indicates that identification is always underlined by misrecognition. The subject in anticipating wholeness through the image of another is also denying the fact that subjectivity necessarily lacks. This quality of denial is why Lacan describes misrecognition as ‘being structural at the level of not wanting to know’ (Lacan, 2014, 333). Every instance in which wholeness is expected out of the duality is a logical admission that such an expectation can only be fictitious. This takes us to the equally dualistic aspect of the clinical interaction. The analyst begins as a 'mirror,' insofar as the analysand speaks

through the interpersonal dynamic sustained in the clinical arrangement. But the analysand's identity will soon be revealed as inconsistent and untenable. Just as the dependence upon an imago is also a futile clamouring for an idealized wholeness, so too does the analyst assume a mirror function in transference to make way for the analysand's eventual misrecognition: ‘Of course, due to a more unfathomable heartfelt exigency, the patient expects us to share in his pain. But we take our cue from his hostile reaction’ (Lacan, 2006, 87).

But the fact that misrecognition is a precondition for identification also makes it a potent source of truth as getting to the truth of the subject requires addressing the truth of misrecognition. Thus for Zizek to abolish the misrecognition is at the same time to abolish the bounded duality, that is to say, ‘to dissolve, the 'substance' which was supposed to hide behind the form-illusion of misrecognition’ (Žižek, 1989, 73). To bring misrecognition to the fore, in other words, is to expose the lack that the ego had been trying to avoid. It is in this sense too that misrecognition is productive: ‘only the 'working-through' of the misrecognition allows us to accede to the true nature of the other and at the same time overcome our own deficiency’ (Žižek, 1989, 67). Working through is a key description here especially as the analysand becomes more defensive the more analysis brings him closer to misrecognition. This is where Lacan positions aggressiveness as a key opening especially where the analysand's narcissism disintegrates.

The clinic as enclosure

It is important to note that by aggressiveness Lacan does not mean aggression. While the defensive analysand becomes more aggressive when denying misrecognition, aggressiveness marks the deeper ambivalence at the heart of subjective constitution. The fact that the imago is fundamentally fictitious means that the subject is failing to sustain its imaginary wholeness. Aggressiveness emerges out this failure where the desired unity with the image only stresses the actuality of subjective division and vice versa. Neither here nor there, the subject grasps for any sense of control it might have over its imaginary. For Lacan this is indicative of human relations more broadly. Antagonism towards others is the obvious manifestation but Lacan is clear that aggressiveness can be discerned even in ostensibly 'gentler' gestures such as kindness, and love. They are all aggressive inasmuch as they are attempts to manage the imaginary through another. Thus the aggressiveness in intensified misrecognition is useful because it brings the subject's division to the fore. The clinic therefore enables this ebb and flow of desire and failure to surface and be contained for analysis. Indeed Lacan says a lot about how treatment amounts to ‘isolating’ aggressiveness by which the structure of the ego is apprehended.

The discussion takes a rather interesting turn when we ask why aggressivity needs to be contained at all. It is at this point that Lacan situates analysis, for want of a better phrase, as a form of international action. Aggressiveness, as subjective constitution, is the hallmark of the West. It accounts for how ‘strength’ has characterized so much of modern morality. He singles out Darwin’s theory of evolution as an example how aggressiveness informs an entire cultural worldview as its ethos of survival corresponds to the Victorian capitalism (‘and the social devastation that it initiated on a

planetary scale that structures it ‘ (Lacan, 2006, 98). Indeed he is clear that Psychoanalysis is very much a part of this intellectual tradition. [2] This explanation quickly becomes current when Lacan describes world war as Western history's inevitable trajectory. Just as the West is globally expanding, so too is the psychoanalytic imaginary of man and its aggressiveness.

Lacan does not spell it out but the implication is clear. The clinic 'isolates' the subject then not simply for analysis but to intervene against an impending global conflict. Basically to isolate the subject for misrecognition is in effect to halt world war. The global picture Lacan paints then has a crucial implication that seems to have gone largely unnoticed: the clinic more is more than simply a private matter. Clinical analysis is geo-historical critique, ‘a technical enterprise on the scale of the entire species’ (Lacan, 2006, 99).

For a fuller picture of aggressiveness imperial quality we must consider how it views space. For Lacan the intensification of desire-failure overcomes the subject with a sense of corporal dislocation. This is why misrecognition takes a distinctly anxious form. The failure of the imaginary is felt, first and foremost, as an impingement upon 'the body.' Just as identification with the imago concealed the subject's fundamental division, so too did it misconstrue its essential organicity, the totality of which can never be symbolized. Physical co-ordination was mistaken for corporal control as 'the body' too is reified as a whole object, conceived 'to belong' to the subject in his imagined uniqueness. Imaginary wholeness disintegrates to also undo the analysand's sense of 'the body' which he had depended on the imago to visualize. The 'body in the mirror,' that is to say, the reciprocity anticipated in the other object-image, can no longer sustain as the subject aggressively desires the integrity of his imaginary form to no avail.

But this is not a point about 'the body' so much as it is a point about spatial conquest. The ability to see 'the imago' as whole requires an assumption that space is homogenous, that is to say, continuous with the ideal image. In other words, the image-other cannot be idealized, and the body cannot be imagined whole, if they are not made seamless with familiar surroundings. Indeed, Lacan draws from animal psychology to show that space emerges from the social nature of species membership. Space is the vector produced in the intersubjective mirroring required for his identity. However, aggressiveness indicates a distinct human divergence from this natural pattern as our relationship to the mirror, and thus the space therein, is one of misrecognition. Aggressiveness in this sense is the double failure to master the ideal image and the space that situates it. The distinct spatiality that is essential for the imaginary to sustain therefore accounts for aggressiveness' quality of conquest: The ego's yearning for wholeness requires an imaginary other that is congruent with a similarly consistent space. Aggressiveness moves the subject to extend space for its narcissism and thereby submit

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[2] Two examples: World War One was the setting for Freud’s Beyond the Pleasure Principle (1920). In addition to the soldiers Freud observed the father of the Fort-Da child was also absent due to the war. The same applies for attachment theory where the observations were made at a hospital run amidst the Second World War.

the world into its own image. The sexual oppression this produces should also be evident in how the need to conquer an object to obtain an idealized mastery is also what structures misogyny.

In any case, clinical analysis contains the analysand to also contain this trajectory of imaginary conquest, leaving the subject with nowhere to go as it is brought to face the division that led it to desire space in the first place. But this containment is merely a moment in a longer strategy to reveal the eventual failure of enclosure. In steering the analysand to the contradiction immanent to subjectivity, the analyst also deploys the clinic, as an enclosure, in a contradictory way. The analysand comes to a 'safe space' wherein it can speak freely. The four walls sustains the ideal gestalt. But instead of a mirror the analyst confronts his own misrecognition through the analyst, and in that, the failure to embody the wholeness it desires. This resonates with what Lacan says later about the unconscious as the failure to enclose that is realized only *after* closure was thought to have happened: 'it is the closing of the unconscious which provides the key to its space – namely the impropriety of trying to turn it into an inside' (Lacan, 2006b, 711). The subject is eventually unable to conceal his division but only upon first believing he had.

Lacanian Historicity

Lacan does not articulate an account of how clinical practice is a form of historical intervention. Teresa Brennan (2002), conceding that Lacan does not sufficiently explore the historical specificity of his approach, notes that there are nonetheless indications that Lacan has the subject of the West specifically in mind. He refers, for example, to the 'the dialectic common to the passions of the soul and the city' (Lacan, 2006a, 99). This situates his practice in an urban capitalist context but also recognizes the containments it produces: 'thinking and experiencing oneself as an energetically contained system is more likely in a culture in which fixed points proliferate' (Brennan, 2002, 168). Lacan allows us to see 'a dialectic working between space in the environment and in the psyche … This is because the objectification of the other depends on establishing a spatial boundary by which the other and the self are fixed' (Brennan, 2002, 8). But there is little else beyond this. The most we get is 'a lever (not an elaborated theory of history, not at all) but a lever for thinking through the trajectory of modernity' (Brennan, 2002, 7). The reason, for this, as we shall see, is that Lacan recognizes other histories. In this sense the absence of a Lacanian theory of history should be understood not, as Brennan does, as an aversion to grand narratives. Rather it is an opening for thinking of psychoanalysis globally.

But the absence of such a that it is worth considering how the hegemony of 'fixed points,' of thinking in terms of containment and boundedness, explains the historicity of the clinical experience more particularly. It resonates, for one, with the biopolitical contraction of subjects into individual units. Christian Dunker describes how the modern medical clinic, out of which psychoanalysis emerged, has its roots in a complicated blend of cultural and socio-economic factors and early modern practices of scientific inquiry and classification. But the eighteenth century marked a crucial turning point as medicine became systematised to subjugate bodies under the scrutiny of modern

nation-states struggling to manage their booming populations. Normalization was of political importance, as a discourse of 'good health' became measure of model personhood.

The clinic is the space where techniques deemed bio-politically useful were retained while jettisoning the diverse host of techniques that were not. ‘The modern clinic arose when the system *reduced* this diversity to a single sovereign policy, bio-politics’ (Dunker, 2011, 246 italics added). The merger of the university and the hospital, as spaces of medical inquiry and treatment respectively, were decisive for this reduction. The symbolic closure is evident in the streamlining of medicine into a unitary discourse: ‘With the passage from the clinic of the ancient world to the classical clinic that took place during the eighteenth century, the agonistic and rhetorical relationship between types of knowledge ceased to exist’ (Dunker, 2011, 249)

The enclosure of identification in the imago is evident, in any case, in how we tend to speak of 'the body.' The definite article makes 'it' a specifiable entity and this resonates with how modernity has cast it as a discrete object where an autonomous person is the owner of his or her equally autonomous body. This outlook perceives the body as a ‘bounded, entity, immobile in space and time, and as an impermeable container, a hard membrane that separates inside from outside, an internalized and externalized body’ (Stephens and Stephens, 2016, 258). This is a departure from how the body was regarded in more sensorial terms in the Middle Ages. It was, as a result, ‘more leaky and permeable’ and thus experienced less as an enclosed object then (Blackman, 2008, p. 51). The body as bounded in fact became the basis for Claudia Benthien (2004) historicisation of skin. It was only in the modern age that skin too became objectified and regarded as a frontier between depth and surface. The idea that the skin is a boundary, in fact, pervades everyday imageries and manners of speaking (i.e. skin deep, thick skinned, to save one's skin etc). But more than that this marked a turning point for identity politics, as race and gender became about materializing specific types of surfaces, that is to say being recognised as a particular objects.

The nature of identification as a kind of constriction is evident in his description of the imago as kaleidoscope: The mirror image, however unitary, is kaleidoscopic in that it is a composite of different 'others' that is discursively compressed into a static duality of self and image. Lacan's theory of identification, and thereby misrecognition, therefore offers an account of how the complexity of modern inter-subjectivity became narrowed into a dyad. The broader political stakes here can be grasped through considering how this static self-other duality resonates with modern accounts of sovereign individuality whereby autonomy is sustained through a rigid distinction between a bounded self and an equally bounded other. ‘Difference’ too is similarly defined from the vantage point of mastery over an object rather than otherness. Indeed the sense of insulation that conditions the imaginary is why Lacan says that the modern ego ‘has no room for others’ (Lacan, 2002, 31). The imagery of an enclosure this

phrase evokes is telling.[3] As Jacques Alain Miller puts it: 'The 'One' is also the cult of identity from self to self, the difficulty in bearing the Other' (Miller, 2011)

Teresa Brennan reminds us that 'we can only be self-contained in relation to an environment with which we are potentially connected. The boundary the subject erects is a boundary against freely mobile energy and excitations in general' (Brennan, 2002, 116). The bounded imaginary, in other words, emerges upon a violent segmentation where otherness is ejected or forced into familiarity. Lacan accepts this general picture but rather than 'boundedness' he prefers the term 'saturation' instead. By this whether a subject is bounded or not depends on the extent to which the symbolic order is similarly fortified:

> 'the increasing absence of all those saturations of the superego and ego ideal that concur in all kinds of organic forms in traditional societies, forms that extend from the rituals of everyday intimacy to the periodical festivals in which the community manifests itself. We no longer know them except in their most obviously degraded aspects' (Lacan, 2006a, 99).

Lacan does not elaborate on the 'saturations of the superego and ego ideal' that he takes to be definitive of the non-West or 'traditional societies.' But he does use it as a contrast to what has happened in the West. Here two things are important. First, and more obviously, this confirms that Lacan does not think that the spatiality assumed in the modern ego is universal. Secondly, the comparison also implies a process of privatization. Put simply in traditional societies the ego-ideal (the identity one assumes and turns to for a place in the symbolic order) and the super-ego (the one who prohibits and demarcates the boundaries of that very order) are dispersed. Modern man, on the other hand, experiences them privately and bound together as a unit. The general distinction is that the symbolic order in the Western-capitalist context is ossified whereas the symbolic order in the non-West is malleable. The ossification of the modern nuclear household from broader pre-modern networks of kinship, is the basis of why Lacan would frame 'the father' as the Western symbolic order's quilting point. The key insight to note for our discussion, however, is that Lacan is differentiating the West from non-West by the extent to which identification with the symbolic order similarly amounts to a containment of the subjectivity. This indeed accounts for why the imago is encountered as a 'unit.'

What is noteworthy for our discussion, however, is that Lacan does not foresee an inevitable Westernization. Instead he describes the globalisation of psychoanalysis as 'the mutual adaptation of adversaries.' Therefore it is not a matter of putting the West against the non-West. Rather globalisation, or the exportation of the Western model of subjective aggressiveness, will entail a 'competition of forms.' In other words, regardless of the outcome difference will prevail:

[3] Anievas and Nisancioglu (2015) traces the geopolitical emergence of the sovereign self to the conquistador encounter with Indians wherein self and other had to be more crystallised in ideologically hardened ways. The difference in personhood would soon acquire territorial distinction as the Spanish conquest went on.

> 'The adaptation of adversaries, opposed in their social systems, certainly seems to be progressing towards a confluence of forms, but one may well wonder whether it is motivated by an agreement as to their necessity, or by that identification Dante in the Inferno, depicts in the image of a deadly kiss' (Lacan, 2006a, 100).

'Aggressiveness and Psychoanalysis' is an early work that predates Lacan's more mature account of spatiality based on the imaginary, the symbolic and the real. His references to 'traditional' societies, in addition to being rather cursory, are brief and crude. While he neither uses the west nor non-West, preferring 'us' and 'them' instead, he is still guilty of constructing his theory in light of a non-Western other, a problem that is definitive of the psychoanalytic tradition as a whole as Ranjanna Khanna has pointed out. But at the same time it should be noted that Aggressiveness in Psychoanalysis prefigures critiques of psychoanalysis 'as a masculinist and colonialist discipline that promoted an idea of Western subjectivity in opposition to a colonized, feminine and primitive other' (Khanna, 2003, ix). It is also unique in that it offers an account of how this subjectivity amounts to a narcissism sustained by an impossible fantasy of spatial closure that leads to global conquest. But more than that Lacan describes this distinct spatial attitude only to conclude that it is limited. Psychoanalysis in the Western mould will only globalize to encounter antagonisms.

The failure of closure established in the clinic is taking place in the more global failure of the West to similarly enclose itself upon the rest of the world. This takes him beyond the psychoanalytic tradition in a crucial sense. Unlike Freud, where the non-West is regarded as a developmental stage, Lacan sees the non-West as that which cannot be excluded. In this sense the conflict he anticipates is not unlike what Franz Fanon said, indeed in far more bellicose terms, in concluding *Wretched of the Earth* (1963). But beyond this we must note why Lacan points to difference in the first place. To say that the ego produced out of European history will be resisted is not the same as saying that European peoples will be resisted. He highlights difference to question if the modern ego as it has developed has a future that he, and the analysts of his generation, will recognise. Thus if we are to take this as a statement about the globalisation of psychoanalysis, then Lacan is pointing out the need to be attentive to global antagonisms. In other words psychoanalysis can only be universal if it can account for variations that persists within, and in spite of, a dominant mode of identification. But with little else said about what it might look like we have to look at what globalisation has produced and it is for this that we shall turn to Southeast Asia.

Confluence of forms

What Lacan calls a 'confluence of forms' is a useful start into Malaysian psychology's current predicament. In terms of our discussion we can say that the clinic is historically situated amidst challenges from non-modern approaches. For example, a 2010 survey about mental health awareness among university students show that the majority of Malay women still turn to traditional medicine to cure depression as opposed to what the authors call 'evidence-based mental healthcare' (Khan, Sulaiman, and Muhammad A., 2010, 34). The problem, however, is not just the presence of such 'alternatives.' Rather the two cannot be brought together. A 2013 study finds that 'The strong influence of

culture in the Malay society results in the general concept that mental illness is an outcome of abandoning or neglecting traditional values' (Sheau, Mohamad, and Er, 2013, 3). This extends a similar view by the Malaysian Psychiatry Association (2005) which holds that Malaysians tend to prefer traditional devotions and beliefs to treat psychological issues. Marhani Midin and Abdul Aziz are summarise it to say that: 'Mental health services in Malaysia often face competition from traditional healers especially among patients with psychosis' (Phang, Marhani, and Salina, 2010, 1). Indeed the prevalent conclusion is that the psy-sciences are struggling. The following paragraph is indicative of the way the challenge is framed:

> In Malaysia, as in many developing countries, the stigma associated with identification as a psychiatric patient may contribute to commonly observed preference for help from the 'more acceptable' traditional healers, even if it means that the patient that the patient is subjected to ineffective and dangerous treatments. Seeking help from a mental health professional is often a last resort. (Reddy et al., 2005, 505)

Claiming that the problem is applicable to 'many developing countries' is obviously problematic. But this passage is also indicative for two things. The first is that it positions 'traditional approaches' as modern psychiatry's historical other while psychology and psychiatry is placed favourably on the side of 'development' and 'science.' Like many other psychiatric studies on Malaysia, little explanation or detail is given as to why traditional approaches are actually more dangerous and ineffective. This however is not our concern. It would suffice at this point for us to note how commonplace it is for the average Malaysian to experience both modern and traditional approaches. A confluence then is taking place: subjects experiencing problems with the 'psyche' do not immediately nor solely seek recourse from the dominant psy-sciences for help. The clinic – the default globalizing space for psy-scientific scrutiny - has not become the default subjective setting. In Malaysia it is one option for treatment in contest with many others.

It is worth noting that this problem is situated amidst broader tensions in Malaysian modernisation. Recent mainstream political discourse is seeing liberal Malaysians and more pious Malay-Muslims accuse one another of being the hegemony with each claiming that the 'system' unfairly privileges the other. There is also an on-going debate on whether science and math should be taught in English. Dr. Mahathir Mohamed, former Prime Minister and advocate of the policy justifies it on the basis that English is the universal language of science and that Malaysians will be more economically competitive if they are equipped to learn science directly in its language (Harian, 2020). This, needless to say sparked disagreements on whether Bahasa, the country's official language and the native language of the majority, has the 'capacity' to innovate with global trends. The fact that this has to be nationally debated, needless to say, is a gateway for deeper insecurities, as it intensifies already prevalent doubts on whether Malays can truly 'catch up' with the globalized master discourse of capitalist science and innovation. Malaysia was an early exemplar of post-Independence development as it ranked alongside Singapore, Thailand and Taiwan among the

successful tiger economies in the 1990s. They no longer have this esteem given that other countries in the region, such as Vietnam, have overtaken them economically.

This situation then can be summarised as follows: national development is dependent on the circuit of capital that is dominated by Western imperial powers. But it is also struggling with its own dynamic as globalisation cannot contend with local history and the antagonisms therein. The discourse of 'health' too insofar as it trails the broader development of Western science and its colonial complicity is not simply about healing people.[4] It is about subject formation. To be a healthy individual is to be in step with modernity in that one is to evaluate one's self in accordance to the standards of capital and the sciences it approves.[5] Good health leads to optimal functionality and desirability for the job market structured by global capitalism and the state. To participate in globalisation is to be productive and innovative. But subjects do not emerge in a vacuum but are made out of historical dynamics that exist prior to modernisation. This casts 'health' in a broader light wherein traditional and non-Western modes of treatment remain live options. The case of Malaysia shows deep attachments to Islamic history. But its maritime Southeast Asian rootedness shows influences in Hinduism and animism that predate the impact of Western modernity. Thus the turn to non-modern medical approaches, or the blending of modern with non-modern approaches, (and the average Malaysian tends to have tried them all) marks a deviation from the scientific-capitalist national masterplan, however indirectly. ‘With the spread of globalized biomedical discourse there is also a process of localized adaptation resistance and recreation’ (Narny, Andoni, Herwandi, and Pohlman, 2019, 498).

For a broader view of the situation it will help to consider how this speaks to a regional trend. Despite thoroughgoing modernisation in various aspects of modern life, Southeast Asia stands out for the persistence of what may be broadly called 'non-modern' medicine, that is to say, medicine with a body of knowledge and traditional practices that are significantly autonomous from modern medicine as institutionalised by colonial-capitalism and eventually the post-colonial developmental state. Various studies have shown how modern medicine was practiced through colonial measures to manage colonised populations. But equally compelling are the historical evidences that point to the limit of such measures, wherein non-colonial and non-modern approaches persist. As Sunil Amrith and Tim Harper note that ‘there was a cosmopolitan market in traditional medicines from the earliest times, and a significant long-distance circulation of specialist

[4]Deva Parameshvara (2005) notes that The British established its first hospital in Malaya for its rubber-estate plantation workers and tin miners. It was called in fact the Estate Health Service.

[5] The planetary nature of the psy-sciences is notable when the 1980s saw Malaysia become the regional epicenter of heroin abuse. It provided the new market for consumers after the departure of American soldiers from Vietnam. The Malaysian government thereby launched massive nationwide anti-dadah (anti-narcotics) campaigns as the epidemic claimed majority-Malay victims. Narcotics were also articulated as a threat to the country’s developmental ambitions. Psychiatrists were required to treat users as well as serve in the country’s over 30 rehabilitation centers worldwide as reported by Parameshvara (2005).

healers' (Amrith and Harper, 2014, 3). Thus while modernisation significantly affected traditional medicine as an immediate medical option its popularity never waned: 'Overall the picture has been of the persistent adaptability of traditional therapeutic systems into the modern period' (Amrith and Harper, 2014, 3). Indeed numbers from Malaysia, where I will be drawing my examples from, is staggering enough: '80% of the population consult traditional healers even if seeking simultaneous treatment from the Western medical system' (Merrian and Mazanah, 2013, 3593). Azizah Rahmad (2013) notes that modernity only accelerated the availability of so called traditional practices as they can now promote their services through newspaper ads and Facebook pages.

Thus 'traditional treatment,' while helpful as a term to indicate practices beyond modern science is somewhat misleading. A close look what falls under the category reveals a wide gamut of non-governmental and informal options. There's Islamic medicine, where healing is strictly drawn from Quranic verses and Islamic concepts. It may also refer to more folk-oriented healing involving *Bomohs* and *Dukuns,* local terms that have been translated as 'shaman' and at time 'faith healers.' They broadly refer to healers who serve as a medium between the patient and otherworldly spirits and creatures. These are considered 'folk' practices because they are not canonised. In other words, their approaches do not refer to any established texts or written code of conduct. Rather they are techniques that are learned only through oral transmission from an elder who is deemed proficient in the tradition. Many healers apply some combination of both Islamic and traditional methods. Those who are less inclined to abide by Islamic principles also practice *sihir* or *ilmu hitam* ('the dark arts'). Their repertoire exceeds healing to include hexes and curses. It is not unusual for all of them, however, to advertise their services either online or on local publications. In addition to these there are also musical oriented forms of healing that draw from pre-Islamic influences. *Main Peteri* induces trances in the patient, through chants and mantras dedicated to spirits, as to release the patient's 'dark' energy. *Kuda Kepang,* whereby participants are encouraged to mimic horse-like movements, is at times spoken of a form of healing. But that they are often left spellbound walking aimlessly while chewing glass has led to accusations that it is more recreational than therapeutic.

Planetary treatment

The complicated diversity also explains the lack of consensus on the proper nomenclature. 'spiritual healing' (Khadijah Hasanah, Suriati, Shalisah, and Muhamed Hatta, 2016), 'cultural health beliefs' (Kamil M., 2006), 'traditional healing ' (Merriam and Mazanah, 2013) 'culture bound syndromes' (Haque, 2008) and have all been used to describe the phenomena. But recognising the power dynamics modernisation ushers shows that culture is experienced as a broader political contest. In this regard the notion of 'planetary treatment,' drawing from Susan Sanford Friedman's notion of the planetary, may help describe not necessarily non-modern practices in particular but the way they are discursively situated in the Malaysian context. The most significant resonance is in the confluence of diverse histories that reveals a 'geohistorical condition that is multiple, contradictory, interconnected, polycentric, and recurrent for millennia and across the

globe' (Friedman, 2015, 4). The diversity is most palpable in how the profound and popular appeal of non-modern treatments has led to calls for a fusion with modern medicine. For example, the divergence of approaches can be regarded as a problem of translation rather than epistemology. They are just different idioms that nonetheless recognise the same phenomenon. By this 'Continuous discourses and collaboration with faith healers and religious scholars would smoothen the integration process' (Asrenee, 2017, 4). Indeed there have been initiatives exploring the possibilities of deeper collaborations between traditional and modern medicine as reported by Sharan Merriam and Mazanah Mohamad (2012) (although this is conditional upon how much the given traditional method can be made amendable to a modern scientific approach) .

But more than that it is planetary for how it eventually reveals the narrow particularity, rather than the universality, of the Western approach. Thus the planetary is not simply about stressing cultural diversity. Rather it reveals a modernity that transcends the West, or indeed the notion that any one culture is the sole 'centre' of history. In this case the modern medical-institutional a discursive apparatus, and its colonial roots, is neither sovereign nor alone. It is to be sure powerful and expanding. But it has not overcome history insofar as it does not have the final say on what it means to 'heal,' and in that the last word on what modern personhood, as ideal and discourse, should be. Thus where the psy-sciences is typically perceived to be bio-politically hegemonic, the same cannot be said of the Malaysian case where other modes of medicine thrive.

Planetary Misrecognition

What is also misrecognised as a result is modern-Western notion of mind and body. This is most obvious in the inability for medical science to dictate the terms of health and well-being. But it is misrecognised most in the pain of confronting modernity's insufficiency. Thus what is unique about the planetary experience of Malay medicine is that it always embodies the limits of modern Western epistemology. The fact that modern medicine is not the default health option for a significant portion of the populace makes this obvious enough. But the point is even more accentuated when modern medicine is taken to have failed. This indeed constitutes a sizeable aspect of patient testimony. Consider a common scenario: A given patient approaches a modern medical institution, typically a government hospital or a private clinic, in search of a remedy. The healing does not happen. The afflicted person then turns to other modes of treatment or combines alternative treatments with modern medicine. There is a process of trial and error in exploring these 'other' options but by that point it would become clear is that official medicine is a distinct cultural product rather than a universally guaranteed science. The following statement summarises the circumstance:

> The ineffectiveness of modern medicine often compels many cancer patients turn to traditional healing. Often, this comes in the form of a patient's previous experience with treatment such as when: prescription medicine did not bring relief there was no improvement after treatment, the patient had a previous bad experience in a hospital, or the patient suffered negative side effects from a treatment where leads them to try complementary treatment (Nurshamilia, Maznah, and Krauss, 2016, 1511).

These 'other' measures of healing, to be sure, are also not always guaranteed to work. But they are exempted insofar as they rarely, if ever, promise perfect health. Indeed they do not promise such a thing because they do not formalize their failures into a master discourse. Thus they are not only experimental in that their techniques are not imbued with promise, they are also non-institutionalized. Recall that the cure for all pain, in any case, is a distinct ambition of Western medicine. Where official discourse tracks and archives the locals' refusal or reluctance of the modern approach into a body of knowledge that goes towards strengthening a discourse, the knowledge gathered in informal medicine is neither organized nor rationalized to control the subject and make him work better.[11] The turn away from modern medicine, its failure embodied in a pain it cannot treat, indicates the inability for official medical discourse to enclose the subject.

The following paragraph is another indication to this effect:

> Robiah: When I was doing chemo, I felt like collapsing, very bad. I went to Y (a well known Islamic healing place). I felt much better the next time I did chemo. I used (drank) the (healing) water he gave me. I always drank three or four times (a day). (Maznah, Merriam, and Nurshamilia, 2012, 5)

In Lacanian terms, we can say that the pain therein, misrecognises the assumption that treatment requires that the imaginary be bounded. It marks the inability to personify the Western notion of the individual that is to be subjected by the defining gaze of the modern Western medical apparatus. This shows an ebb and flow in which interpellation into Western ideology forms only to eventually fail. The modern medical institution is briefly acknowledged only for it to be cast in the light of failures or severe limitations. The subject does not fall under its enclosure as his or her speech is extended to other treatments. Indeed the biggest measure of misrecognition is how the Western notion of the singular and enclosed body too is deformed as a result. Thus misrecognition – the investment and eventual loss of reliance towards modern approaches – disrupts the modernity of the body as it is extended in other discourses. Where the medical gaze, we should recall, aims to contain the subject in the guise of his or her individuality, the planetary circumstance sees it antagonised across different discourses, which we should recall are imbued with their own history.

The fact that the body is unable to be subjected to the bio-medical gaze means that the psyche is also dislocated as a result. This takes a particular configuration wherein psychic pain can be addressed through bodily treatment. The following account reflects a familiar dynamic:

> There was no significant improvement despite treatment by various traditional healers and medical practitioners for two weeks. Most of the *bomohs* consulted attributed her symptoms to the evil spirits and believed that the spirits acted on the behest of a powerful *bomoh* who was engaged by the second wife. The method of treatment employed by the traditional healers included various types of incantation (jampi), the giving of holy water (air tawar), taking a special bath (bath with a

> mixture of flower or lemon) and prescribing herbs. A few general practitioners prescribed anxiolytics and vitamins to her (Razali, 1999, 471).

This example evokes a common 'issue' in polygamous marriages in which wives are usually known to be envious of one another. But this speaks to how many Malays turn to alternative healing for ‘psychic’ issues, from quotidian relationship difficulties to work stress. In this case a wife suffers paraperesis for two weeks that would be later attributed to evil spirits ordered by a jealous second wife (note that their rivalry resulted to a dynamic between competing *bomohs*). This, however, is not to be regarded as a matter of the psyche or ‘emotions’, that is to say, a problem implicating the merely non-material aspect of her personality. She is also subjected to physical treatment wherein the body is put through both traditional (natural and herbal remedies) and non-traditional (modern medication). The obvious implication is that the material and immaterial here are not understood as separated domains but are deeply intertwined. But viewed historically this is situated amidst a broader historical tussle to draw the boundaries to construct the modern biopolitical subject. It is in this tussle then that misrecognition – the failure to sustain symbolic boundaries across imaginary worlds – is planetary.

One final example serves to extend this misrecognition within a more personal domestic domain. The following is a case study of an Indonesian family dealing with their mother's schizophrenia. Amak Dahniar always related more to ‘spiritual and religious explanations over medicalised discourses’ (Narny et al., 2019, 493). The cultural difference stems from the differing notion of reality. In Amak's community ‘hearing, seeing and talking with the dead and other beings, while not commonplace, are accepted and are normal interactions with those beings (Ibid).. But her eventual diagnosis with schizophrenia by the hospital, who treated her initially for vomiting blood, developed a rift between her and her children. They accepted the diagnosis because it offered a much-needed explanation to a longstanding problem. ‘The new way diagnosis of paranoid schizophrenia and the new vocabulary to describe their mother's visions and dreams offer …. a 'better, modern' way to understand their mother's illness’ (Narny et al., 2019, 497) But while Amak's children found it helpful it ‘almost displaces Amak's way of talking about her illness’ (Narny et al., 2019, 496). The medical diagnosis actually does little to Amak's relationship with her condition for ‘traditional remedies’ allow her to build ‘an understanding of how voices and visions operate within their community's tangible and intangible worlds’ (Narny et al., 2019, 514). The generation gap in the household extends the broader historical-institutional tensions that surround it.

Conclusion

It will help to return to mainstream psychoanalysis by way of Jamieson Webster: ‘We inhabit a body that is not an object of knowledge unless it wants to become an object of science, in which case it ceases to be ours’ (Webster, 2018, 1). This brief phrase is as rich as it is efficient. It summarises the problem of masterisation psychoanalysis identifies in the modern subject. Medicine is personal but it is also a regime of government that removes the subject from its truth. This truth furthermore is an

experience of the body concealed by discourse. Analysis returns the subject to its bodily uniqueness through imagine the concealment only to eventually undo it: the individual faces the other in a private space only for this dynamic to eventually be misrecognised. The Malay body, indeed the body of treatment in Southeast Asia, is not yet the exclusive object of science. But neither is it, on that note, a body that can properly belong. Where Western capitalism produced the enclosed biopolitical subject, Southeast Asian development produced this very but not without also encountering its Others.

The imperative to refuse the master – in the biopolitical confluence of science and capitalism – is ever more urgent as modernisation intensifies. But taking the planetary seriously means that Lacanian psychoanalysis, should it wish to retain its critical signifiance in Southeast Asia, must think beyond its commitment to Western history. In this sense it must rethink, if not altogether reject, the claim that 'the Western symbolic order has become the de facto symbolic order' of the contemporary world (Kapoor, 2018, p. xxviii). If the constriction of clinical space assumes a subject that is similarly enclosed, then analysing the historical subject of Southeast Asian modernisation must go beyond the clinic. This therefore is the basis of a global conversation for Lacanian analysis. Jamieson Webster says that Lacanian analysis was 'invented to deal with the strangeness of the human condition, not to fix it, but to expose that strangeness to itself' (Webster, 2020, p. 30). Situated upon a planetary plane this cannot be achieved without also misrecognizing psychoanalysis, to similarly allow the confluence of forms to reveal the strangeness of psychoanalysis unto itself.

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