Fatigue and the Mind-Body Relation: A Lacanian Exploration

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by

Amanda Diserholt

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Where does our modern world belong — to exhaustion or ascent?

— Friedrich Nietzsche

Declaration

I, Amanda Diserholt, hereby declare that this thesis is the result of my own independent work, and that the work has not been submitted for any other degree or professional qualification.

Abstract

This thesis explores the symptomatology of fatigue based on interviews conducted with seven people who are diagnosed with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis. The thesis starts by examining how a biomedical view of fatigue — the dominant perspective in contemporary Western society — is underpinned by aporetic divisions, such as mind/body and individual/society. In pursuit of a more rigorous approach to fatigue, which explores rather than disavows division, the interview transcripts are analysed through the lens of Lacanian theory. The analysis commences with an exploration of the onset of the participants' conditions, drawing on Lacan's notion of alienation. This brings to light a common experience of a confrontation with the capitalistic demand to 'keep going', as well as experience of facing contradictory demands. Lacan's notion of separation allows us to appreciate the emergence of fatigue as one way of unconsciously refusing these demands. This refusal consists of two intertwined but contradictory forces: the drive (which articulates to pain/tension and signals presence) and a defensive desire (which articulates to fatigue itself and signals disappearance). This allows us to understand a complex of phenomena related to the experience of fatigue, ranging from anorexia to mourning. The thesis then turns to the relation between the onset events and the participants' responses to them. Here Lacan's theory of the clinical structures is utilised in order to illuminate details around the function and structure of fatigue. This returns us to the conventional separation of the mind and body, showing how current medical and psychological approaches are unable to adequately account for the current findings. The thesis concludes by elucidating how the main points are situated within a larger sociocultural context, arguing for a view of the mind-body relation which moves beyond the aporia while refusing any reduction to either pole.

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Contents

Chapter 1: Challenging a Biomedical Approach to Fatigue

The biomedical perspective has become one of the most dominant lenses through which we view ourselves in contemporary society. Indeed, the term 'diagnosis' comes from the Greek word 'diagignoskein' and means 'to discern' and 'to know thoroughly' (Harper, 2011). The modern view of fatigue is no exception as it is largely moulded on the principles inherent in medicine. The medical model makes a diagnosis in relation to an established knowledge as a way of differentiating between health and illness, thereby recognising a generalisable syndrome (Verhaeghe, 2004: 4-5). But when a body of knowledge is not fully established, the diagnostic category and the condition to which it refers become questionable and mysterious — such is the case for fatigue, diagnosed as Chronic Fatigue Syndrome (CFS) and/or Myalgic Encephalomyelitis (ME).

The modern conceptualisation of fatigue/CFS/ME has engendered a vexing debate and a number of competing viewpoints regarding its nature, aetiology and treatment amongst patients, carers, practitioners, researchers and the public. Explanations range from the biological, such as viral infections or neurological dysfunctions in the immune system, to the psychological, such as depression and/or anxiety (Prins, van der Meer & Bleijenberg, 2006: 348). However, any uniform finding in research has been with a low number of participants or has been inconsistent in subsequent findings (Afari & Buchwald, 2003, *passime*; Prins et al: 348), rendering a conclusive explanation impossible. Despite a dearth of knowledge and evidence, two opposing views resembling a mind/body dichotomy have emerged as mirrored in the co-existence of the two names CFS and ME: Chronic Fatigue Syndrome denotes a psychological/psychiatric nature and aetiology, whereas Myalgic Encephalomyelitis is suggestive of a neurological manifestation and cause. Accordingly, the question haunting the area of fatigue is: is it biological or psychological? A headline in The Guardian (Cox, 2016) reads 'Is Chronic Fatigue Syndrome finally being taken seriously?' and explores the biological evidence with enthusiasm that new research shows great promise of finding a physiological cause. Another more recent article in The Guardian (Ludlam, 2018) has the subtitle 'As researchers close in on the genetic origins of ME/CFS, it's time to say to those suffering they are not forgotten'; thus indicating that what does not fit into the biomedical model — with its focus on physical evidence — is considered not serious and not 'real' or existing. Because how can we possibly take seriously a condition without a biological

underpinning? Most media depiction alongside research and lay and expert opinions on CFS/ME make it clear that the modern discourse around the condition is constitutive of a divide between the psychological and biological, with the body and the mind in exclusive opposition to one another. Associations with the mind delegitimises the condition, while evidence of a biomarker for the condition legitimises and authenticates it. Needless to say that this divide, which stems from a lack of a definition of it, has led to an uncertainty in health professionals' approach to diagnosis and treatment, and a questioning of the very existence of the illness (Bowen et al, 2005; Deale & Wesseley, 2001; Page & Wessely, 2003). Consequently, and not so strangely, patients are negatively impacted and dissatisfied with their clinical encounters (Deale & Wessley, 2001; Dickson, Knudsen & Flowers, 2007; Page & Wessely, 2003; Prins et al, 2006, The ME Association, 2010). There are therefore good reasons to thoroughly investigate the nature and potential influences of fatigue.

However, it is clear that past and current investigations have introduced more divisions and questions rather than answers to the area of fatigue. The majority of research stems from a positivistic, empirical scientific framework upon which the biomedical approach is built, thus meeting the demand for evidence-based results. The evidence-based focus omnipresent today, where the measurable and the tangible have priority, feeds the mind-body divide found within both science and biomedicine. The area of fatigue, probably more than any other, illustrates how such a mind-body divide leads to a deadlock in the acquisition of knowledge, and even leads to harming patients. There is thus a timely need to question the underlying assumptions of the biomedical approach and explore fatigue from an alternative perspective. This chapter, by outlining the ways in which the biomedical works — or in this case, does not work — will highlight the gaps needing to be addressed. The perception of the body in relation to the mind is of central importance to such a critique. By tracing this in-depth, the necessity to adopt another approach, one able to generate novel knowledge and advance the approach to fatigue, will become evident. More precisely, I argue that it is the adoption of a Lacanian psychoanalytic perspective in relation to first-person accounts of fatigue which has the capacity to do so as the theory goes beyond the mind-body deadlock and has a view of the mind-body relation which accounts for its complexity in its wider social, cultural and political context. Therefore, this project seeks to contribute insight into the area of fatigue, in terms of the individual and cultural influences on its formation, manifestation and development, through an appeal to Lacanian psychoanalysis.

The Rise of the Biomedical Model

Medicine as a social institution with its social rules, codes and knowledge moulds characteristics inherent in modern society (Turner, 2004: xiii), including the view of the mind-body relation, which has come to greatly influence our sense of identity. Historically, medicine was built on a mind-body divide where the two were considered radically different — following a structure and a belief which has impacted the perception of and approach to fatigue.

The pivotal breakthrough in Western medicine is considered to date back to the 19th century in France, when the dissection of dead corpses started taking place in order to discover the cause of bodily symptoms (Loose, 2014). It was consent from the Christian orthodoxy which allowed the initiation of dissecting bodies; a permission stemming from the viewpoint that the body was a mere transport vessel to a better world, while the mind was equivalent to the soul and belonged to God. Hence, the mind became excluded from physical investigations (Ibid.). Medical scientists then founded the biomedical model in the 1850's (Jennings, 1986:865) on scientific principles involving the development of a taxonomic system in order to understand, treat and prevent diseases. Classificatory medicine became concerned with localising a cause in the form of the smallest component at the level of bio-chemistry — in the absence of which a symptom was not considered to be part of an underlying 'disease' (Engel, 1977: 131). This gave rise to the distinction between 'disease' and 'illness': disease came to signify the presence of an observable, bio-chemical cause which was independent of patients' reports and actions, and illness had to do with subjective experiences; that which was communicated and complained about in the absence of any demonstrable cause (Jennings, 1986: 866).

The foundation of the biomedical line of reasoning stems from philosophical assumptions found within science at the start of its establishment. Verhaeghe (2004: 38) argues that Western science began with an interpretation of Plato: there was a search for invariant, observable objects, separated from the subject, which could be categorised in accordance to their ontological essence. However, the introduction of modern empirical rationalism (Turner, 2004: 95), and modern subjectivity on which a large part of positivistic science came to be built, started with René Descartes. With his famous utterance 'I think,

therefore I am', and his work 'Meditations on First Philosophy in which the Existence of God and the Immortality of the Soul are Demonstrated' (Descartes, 2002/1641), he developed the idea of the isolated individual by giving primacy to the self — one associated with the conscious mind and separated from the body and society. The Cartesian cogito is a self-sufficient (Parker et al, 1995: 13), fully self-conscious being reduced to internal states which are able to be controlled. Descartes postulated that cognising proves the existence of the self, and thus a desire for certainty accompanies the modern subject (Neill, 2014: 16-7). Cartesian rationalism was then conflated with Newtonian logic in order to discover mathematical calculations considered in control of the body (Turner, 2004: 96) — thoughts which prevail in contemporary science: the individual is at the centre with the measurable body belonging to the medical sciences and the mind belonging to the human sciences. However, the mind is becoming increasingly excluded even from the latter.

Biomedical Hegemony: The Body as Machine

While medicine has since its inception advanced the knowledge and treatment of diseases, the application of the biomedical framework to the area of mental health, as well as what is considered 'psychosomatic' as the two are considered related, has a different outlook. The failure of such an implementation was evident early on as, first of all, no consistent organic lesions were found, and is further evident today in a continued absence of biomarkers. Nevertheless, this does not hinder the appeal and use of a biomedical approach to mental health/psychosomatics due to the hegemonic status of it. Looking at how and why the biomedical approach has been adopted within psychiatry, an area with which fatigue is associated, will be useful in discerning the sociocultural and political atmosphere under which CFS/ME as a diagnosis emerged and has been developed.

The Statistical Diagnostic Manual of Mental Disorders (DSM) was created out of a need to provide more accurate descriptions than what was outlined in previous mental health manuals, since they did not match the suffering of the soldiers returning from World War II (Vanheule, 2014: 6). This was thought to be achieved through an a-theoretical compilation of disorders based on observation and empirical affirmation (Verhaeghe, 2004: 42). Prior to the DSM-III and from the beginning of psychiatry, diagnoses followed a prototypical approach in which clinical realities acted as templates. This approach is found in Pinel's work

in the early 1800's, inspired by Sydenham's proposition that diseases could be examined the way in which plants are by the botanist (Vanheule, 2014: 3). In a prototype-based approach, a set of characteristics in the form of narrative descriptions make up a clinical reality with the aim to provide a 'basic type' describing the typical patterns and prognosis (Ibid.: 3-4). With the creation of the DSM-III, however, there was a diagnostic shift from prototypes to a check-list based approach. In the latter, separate and disconnected symptoms add up to correspond to an underlying condition, thus suggesting that a greater quantity of symptoms resemble a more severe condition (Ibid.: 4). This rearrangement arose from the attempt to pull psychiatry out of its crisis which took place in the 1960's and 1970's due to criticism pertaining to its validity and reliability. Consequently, an endeavour to re-conceptualise psychiatric conditions along the lines of the biomedical framework was made through the DSM-III by a group at Washington University consisting of young psychiatrists who desired to find biological markers for the observable symptoms (Ibid.: 30-32). The conflation of biomedicine, science and taxonomy inherent in botany was turned into a legitimate way of diagnosing and discerning mental health and psychosomatic illnesses, as it satisfied a desire for standardisation which would supposedly increase validity and reliability. This occurred during a time when there was an aspiration to quantify human behaviour with the use of statistics, akin to what the World Health Organization (WHO) had done for medical illnesses by elaborating a taxonomic list which became the International Classification of Disease (ICD) (Ibid.: 6-8).

The quantification of the mind and human behaviour was made desirable and allegedly possible through the emergence and development of medical technology and laboratories, which aided the diagnostic processes within medicine from the 1850s and onwards. In turn, less emphasis was placed on patients' descriptions of symptoms (Berger, 1999: 5), since it was now thought that reliable instruments provided a more direct relationship with the body. This gave rise to one of the most dominant metaphors within Western medicine, 'the body as a machine' (Turner, 2003), constituting an ideological shift where the body is now considered a somatic entity capable of being measured mathematically (Turner, 2004: 97-9). More accurately however, the metaphor 'the body as machine' has been around for a long(er) time, evident through works such as 'Man a Machine' written by Julien Offroy de la Mettri in the 18th century. We can instead claim that contemporary society, as it operates under late capitalism and in which technology has advanced tremendously in all

areas, brings full force to this metaphor as the body is more than ever thought to correspond to a measurable machine. Our phones or gadgets are considered to be an extension of ourselves, acting as our memory and producing social lives which are available immediately and 24/7. This gives rise to the experience of constantly being present, and together with medical practices, gives birth to the idea that all parts of human life can be rendered visible (either online or through biomedical equipment). Relatedly, the body is considered capable of constant productivity and of extending itself to multiple activities simultaneously akin to that of a machine, as further shaped by the ideologies of late capitalism. The former is not only inclusive of the activity of work but of all kinds of activities such as enjoying, learning and consuming — something we should preferably engage in all at once. In other words, what is distinctive of contemporary society is that the ideas and aspirational goals of constant productivity and presence/visibility is not confined to the practices of capitalism and science where it guides the production of goods and medical procedures, but in its widespread reach it spills over to all areas of life and now also acts as a guide for human behaviour. Jonathan Crary (2013: 9), in his book *24/7 — Late Capitalism and the Ends of Sleep* claims that while many institutions in the developed world have operated on a 24/7 basis for a while, it is only recently that this idea of an 'uninterrupted operation' has impregnated the area of social and personal identity[1]. The presence of this cultural idea 'the body as machine' within the field of medicine and vice versa represents for Foucault a biomedicalisation resulting from scientific, economic and political forces, or what he refers to as 'biopolitics' (Kirshner, 2009: 96, 99).

This brief historical account outlined above illustrates that the biomedical approach is thought to represent a legitimate, objective measuring tool able to explain all conditions, and that this is strongly linked to the ideologies and practices of late capitalism. However, there is currently an increase in criticism of the biomedical model and consequently an increase in alternative health approaches (Turner, 2004: 89-91). Even the germ theory, on which the medical model is built, is limited when it comes to certain physical disorders and especially chronic illnesses (Ibid.: 118-9). The reality is that we experience our bodies as

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[1] For an account of how the ideologies and practices of late capitalism in which we find ourselves today are shaping this idea of the human capable of constant machine-like productivity, see Jonathan Crary (2013). In relation to fatigue specifically and for a historical account of this, see the extensive work of Rabinbach (1992). This section focuses on the biomedical view of 'the body as machine'. Related to the ideologies of capitalism is Mark Fisher's (2007) book 'Capitalist Realism — Is There no Alternative?'.

more than mere objects (shown in cases of mastectomy) (Ibid.: 80), and that the reflexive mind eludes mathematical calculations. These shortcomings of the biomedical approach have to do with limits inherent in its structural composition, and is especially evident in the approach to fatigue, which follows the presuppositions therein.

CFS/ME: The Biomedical Language of Fatigue

The inclusion of CFS/ME in the World Health Organization (WHO) in 1992 classifies the condition as a medical one (Prins et al, 2006: 347). The process inherent in medicine of gathering isolated symptoms to form a generalisable syndrome through observation and systematic ordering (Verhaeghe, 2004: 5, 79) is part of the check-list based approach. While this method is viewed as objective and rigorous, its implementation on fatigue suggests otherwise.

Historically, outbreaks of illnesses for which no aetiology was found and in which chronic fatigue was the main symptom have been reported since the 1930s (Briggs & Levine, 1994). But it was not until the early 1980s that interest in fatigued conditions increased (Prins et al, 2006: 346) and the terms CFS and ME were subsequently coined. The name ME first appeared at the Royal Free Hospital in London thirty years earlier as an epidemic broke out among staff, who presented with neurological symptoms and chronic fatigue (Prins et al, 2006: 346) that were suggestive of an inflammation of the brain and spinal cord. Hence the name Myalgic Encephalomyelitis, which literally means inflammation of the brain and the spinal cord. Chronic Fatigue Syndrome, on the other hand, was coined by the Centers for Disease Control and Prevention (CDC) of the United States, which advanced a case definition of fatigue with the goal of standardising its research population (Afari & Buchwald, 2003; Holmes et al, 1988). The origins of the names already reflect a division between medicine/practice and research, hinting at a mind-body divide. From then onwards, the following factors have been explored as possible causes to CFS/ME: immune dysfunctions, viral infections (such as Epstein-Barr), sleep disruptions, central nervous system dysfunctions, neuroendocrine responses, exercise ability, personality, genetics, and '(neuro)psychological processes' (Prins et al, 2006: 348).

Today the diagnosis of CFS/ME is typically arrived at by excluding illnesses, which makes CFS/ME a diagnosis based on a lack of disorders, or what is most commonly referred

to as unexplained fatigue (Banks & Prior, 2001; Hart & Grace, 2000; Ward, 2015), also categorised under the name Medically Unexplained Symptoms (MUS). It is generally agreed that the hallmark of CFS/ME is a profound and persistent fatigue distinguished from everyday tiredness and is typically accompanied by a number of bodily and cognitive/mental symptoms which impair everyday functioning (Afari & Buchwald, 2003; Bazelmans et al, 1999; Fukuda et al, 1994; Ward, 2015). While the National Institute for Health and Clinical Excellence (NICE, 2007) guidelines to CFS/ME acknowledge that there is a 'great variability in the symptoms different people experience' (p 4), there is a recognition that the same type of fatigue and muscle pain occurs in Fibromyalgia (Ward, 2015: 28). Fibromyalgia is distinguished from CFS/ME in terms of an emphasis on muscle pain as opposed to fatigue. For instance, the Royal Australasian College of Physicians (RACP, 2002) in their guidelines to CFS/ME highlight this overlap with fibromyalgia as well as Irritable-Bowel Syndrome (IBS), but state that the diagnosis should be based on the most 'dominant and disabling' symptoms (p. 23). Schur et al (2007), and Vandenbergen et al (2009) also acknowledge the overlap and subsequently question the separation of CFS/ME from the two latter conditions, both of which also lack organic evidence and are grouped under MUS and/or 'functional somatic syndrome' (Wessely, Nimnuan & Sharpe, 1999). This suggests that the categorisation of CFS/ME is not straightforward and that a diagnosis is based on a focus on bodily form. That is, the symptom of fatigue is considered in a neat fashion to reflect a disorder, CFS/ME, and is categorically distinct from the condition of Fibromyalgia, for which muscular pain is the representative symptom. The symptomatic form is taken as proof for the existence of a separate condition for which a symptom directly represents a disorder. Further, it reflects a modern tendency to reduce a condition to its smallest component.

In such a categorisation, interest lies in the *presence* of symptoms — a focus shaped by the implementation of arbitrary and abstract rules used to define a category (Parker et al, 1995: 62). For instance, in the diagnostic criteria for CFS/ME set out in the NICE (2007) guidelines, fatigue must be accompanied by one other symptom. In comparison to the criteria of the American Centers for Disease Control (CDC), four symptoms in addition to fatigue are required. The former criteria would exclude those with a very debilitating fatigue who did not portray any other symptoms (Ward, 2015: 27-8), and the latter, those who portray three very debilitating symptoms in addition to fatigue. In line with Vanheule's (2014: 61) criticism of the DSM's outlined mental health disorders, we can argue that an exclusive focus

on quantity ignores quality: the explorations of how symptoms are experienced, under what conditions, and the meanings created around them are excluded. The quantitative yardsticks are accordingly not based on any experience or knowledge — evidenced in the fact that the sets of criteria differ from country to country — but instead act as arbitrary cut-off points. Their generalisability bars the existence of unique, ever-changing personal situations, such as the experience of incapacitating fatigue on and off for say three months at a time which significantly disrupts one's life routines, which would fail to meet the criterion requiring fatigue to be present for at least four or six months. The existence of these sets of rules suggests that the classifying system is not based on theoretical knowledge (Verhaeghe, 2004: 44) deduced from the lived difficulties experienced by people, which are complex and varying in nature, but represents a pre-arranged, closed model into which people's isolated body parts are slotted. The complexity of experiences and the failure to integrate these into a category is evident in the current co-morbidity of CFS/ME with Fibromyalgia and IBS, in that patients often meet the criteria of all three categories (Schur et al, 2007; Wessely, et al, 1999). In this sense, the diagnostic categorisation erases individual, rich experience and variations (Foucault, 1973: 102) as it follows a fragmented, a-theoretical and quantitative procedure (Verhaeghe, 2004: 42).

Language and Diagnosis: Symptoms as Signs

While the constitution of the criteria for the CFS/ME diagnosis across governmental reports differs, the common ground is that they all follow a medical classification structure. Within such a system, symptoms are treated as signs (Foucault, 1973/1976: 90; Lose, 2014; Vanheule, 2014: 61; Verhaeghe, 2004: 5). A sign is something which 'can be linked to a fixed referent' (Vanheule, 2014: 61) and has a stable meaning, for example a red traffic light unambiguously means to stop (Verhaeghe, 2004: 5). When diagnosing CFS/ME, it is thought that symptoms correspond to a particular reality reflected in the name, and follow a cause-and-effect relation: a condition causes the appearance of symptoms (Vanheule, 2014: 61). Even if the presence of the same biological process was to be uncovered in most patients displaying symptoms of fatigue, the assumption that this process is the *cause* of fatigue cannot be maintained insofar as it could merely represent another symptom, not to mention that the same symptom (fatigue) can and does have different and multiple causes for various

people. That is, when does the cause of the cause of the cause come to an end? It is further believed that this cause-and-effect structure is of a natural kind, governed by laws inherent in nature akin to those governing plants and animals (Foucault, 1973: 7), and that these laws reside outside of the researcher or clinician who merely discovers the thing existing prior to its naming (Loose, 2002: 264; Vanheule; 2014: 84; Verhaeghe, 2004: 47). Within such a structure, the interaction and inextricability between different biological processes are often ignored, and so is the mind-body interaction.

The transformation of symptoms into signs is made possible with the use of language (Foucault, 1973: 114). A diagnostic name within the biomedical classification system is turned into a fixed material reality thought to control the mind and the body (Vanheule, 2014: 22) which functions as a 'scientific mirror-image of reality' (Verhaeghe, 2004: 47). Foucault (1973) observes the existence of this process through elaborating on what he terms the 'medical gaze', a gaze which observes the immediately visible, natural manifestations (symptoms) and in turn signals the essence of the disorder through space (localisation) and time (onset, duration). That which is invisible becomes visible (Ibid.: 90-92). The gaze is thought to be pure in the sense that imagination and theoretical reasoning are considered separate from it and from doctors' observations (Ibid.: 107) and descriptions, and that the essence of a disease is transparent in language — a line of thought which collapses observation, essence, symptoms and linguistic signs into a totality (Ibid.: 94-6). Foucault calls this the 'speaking eye' (Ibid.: 114). It leaves out any reflection on the relationship between a description, the nosological category (idealism/nominalism), and its clinical reality (materialism/realism), which induces the question: to what extent does a name match its concept? (Verhaeghe, 2004: 45-46). Symptoms as signs are believed to be unequivocal (Foucault, 1973: 94). However, this is no more than an epistemological myth (Ibid.: 117) as is seen in relation to fatigue since different sets of criteria constitute multiple and various clinical realities — not just one fixed reality.

In treating symptoms as signs, the biomedical approach endorses the belief that language is neutral and free from ambiguity and subjective involvement. Between a patient and a clinician there is an assumption that objectivity exists, firstly, in the descriptions elaborated by a patient assumedly self-conscious enough to accurately describe the body/a situation — resonating with the self-conscious, all-knowing Cartesian subject — and secondly, in the reception of these descriptions by the clinician. It overlooks the fact that

communication fails: our intentionality does not always align with the way a message is received (Verhaeghe, 2004: 33), and that clinicians are not mere objective observers following a straightforward code, but need to subjectively evaluate, not only patients' words but also the criteria used in relation to their descriptions. An example of the latter would be the requirement of fatigue, as outlined in the NICE (2007: 13) guidelines, to have 'resulted in a substantial reduction in activity level'. A diagnostician might not consider the discontinuation of a hobby to be substantial enough, however the patient might put more time and meaning into a hobby than work. The clinician would have to judge based on social-cultural norms, which he or she is forced to adopt in the absence of a theoretical framework, and which is intertwined with their personal experiences, opinions, prejudices and imaginations. Loose (2014) criticises diagnoses made in relation to the DSM-V on this basis and highlights how it constitutes a paradoxical situation: a patient's subjective element is excluded, being thus subsequently confronted with the subjectivity of the clinician in what he calls a 'return of the subjectivity via the clinician'. The reality is that language does not consist of (obvious) meanings independent of speakers and listeners (Neill, 2013: 336), but multiple meanings exist, and therefore someone needs to receive and interpret language. Neglecting the subjective and constructive nature of language results in the externalisation of symptoms and the viewpoint that a condition is separate to a person who is thought to be merely a carrier of symptoms and onto whom a disorder is autonomously imposed (Leader & Corfield, 2008; Parker et al, 1995; Verhaeghe, 2004: 44-5). CFS/ME, when following a biomedical approach, is treated as a transparent, observable and detachable object thought to accurately mirror a fixed, natural, material reality. This results in biomedical reductionism which effaces the person through an exclusive focus on symptoms part of a universal sign-system (Kirshner, 2009: 99-100). The biomedical account, in this sense, neglects subjective experiences and the idiosyncratic meanings weaved around those experiences (Vanheule, 2014: 66). Moreover, the allegedly 'natural' succession of a disease where a condition causes symptoms leaves out questions pertaining to subjective influences. However, if any certainty can be established around the debate of CFS/ME, it is that the reality perceivably residing behind the diagnosis is far from certain — as attested to by the fact that there are two main names for it reflecting distinct realities.

Dualism: Mind (CFS) Versus Body (ME)

That language is integral to the discussion of CFS/ME is evidenced in the current opposition between the names CFS and ME, out of which one is typically embraced depending on one's beliefs. CFS hints at psychiatric/psychological causes to the condition, and tends to be the name mostly embraced by health professionals and researchers and those who prefer an open-ended assumption of aetiology (Fukuda et al, 1994). Patients on the other hand are inclined to reject the name CFS and prefer to use the term ME, which alludes to a neurological/biological nature and cause. This mind-body dualism for fatigue was first mentioned in the WHO in 1992 when ME was classified as a post-viral fatigue syndrome in relation to neurology (David & Wesseley, 1993), while (benign) CFS was linked with the concept of neurasthenia and psychiatry. Briefly, neurasthenia was coined by the physician George Miller Beard in the 1860's, who postulated that fatigue consisted of an 'overpressure of the higher nerve centres' as a result of American modern civilisation (Rabinbach, 1992: 153). The condition came to be viewed by European physicians as extending beyond America, who thought there was a link between exhaustion and the intensity of modernity (Ibid.: 154).

The existence of disparate constellation of symptoms across various governmental guidelines, both within and between countries, demonstrates that the inclusion of symptoms depends on a consensus on the cause(s). For instance, the Canadian Consensus Document on CFS/ME (Carruthers & Van de Sande, 2005) states without supporting evidence that ME/CFS is a biological condition inclusive of neurological symptoms such as ataxia and photophobia (p. 2). The NICE (2007) guidelines in comparison have not included these but instead emphasise cognitive dysfunctions, such as 'difficulties thinking', and 'inability to concentrate', (p. 14). These divergent conceptualisations appear irreconcilable for some and result in an either/or view where the mind and the body are thought not to interact. In fact, the Scottish Public Health Network (Mackie, Dougall & Conacher, 2011) have proposed two diagnoses: a 'quick' one for diagnosing CFS and a more thorough investigation for ME (p. 12). Discourse analytic research (Banks & Prior, 2001; Horton-Salway, 2002; Horton-Salway, 2004; Tucker, 2004) more or less confirms the presence of such a mind-body division in the narratives between physicians and patients within a clinical setting.

Therefore, while the structure of CFS/ME follows that of a conventional, medical diagnostic system, there exist different ideas about what constitutes the reality of it, and more specifically, a gap between two main realities. The above illustrates how (a lack of) research evidence tends to be ignored when defining the nature of it. The Canadian document was created due to pressure stemming from a patient charity group, who recognised the need for clearer guidelines in relation to defining, diagnosing, and treating the condition, and who had much autonomy over the document (Smith & Wesseley, 2012). Furthermore, patient groups who voice their experiences online tend to endorse anti-psychiatric viewpoints and engage in personal attacks towards those professionals and researchers whose views reside on a more psychological side (Hawkes, 2011). Thus, the inclusion of neurobiological symptoms is on a whole driven by a desired outlook and pressure rather than research results or a knowledge of lived experiences.

The demand for a biological label resembles the situation for schizophrenia: the Schizophrenia Association for Great Britain (SAGB) is attempting to raise funds in order to uncover the biological basis of the condition (Parker et al, 1995: 10). Not to mention the attempt to conceptualise all mental conditions along these lines too. This reflects a sort of 'consumer demand' on a biopolitical level governed by a conviction that research will eventually find an organic cause. It exists in relation to the positivistic sciences which shape the idea of a uniform syndrome: one that has the same cause, manifestation and development (Verhaeghe, 2004: 84) and in which the psyche is not involved. Conviction rather than knowledge reigns — the medical model is seen as a trusting, powerful tool (Parker et al, 1995: 10). Furthermore, the demand exists in a society where neoliberalist ideology has grown, with which Foucault links biopolitics (Kirshner, 2009: 94), where individuals are thought (fully) responsible for their health (Turner, 2004: 84).

Therefore, the questions necessary to be raised in the face of these movements towards a biomedical hegemony are: how is personal desire intertwined with these wider social and cultural movements? What are the implications of a biological view? It is clear that the appeal to a biomedical model warrants and legitimises symptoms and experiences so that one resides on the conceptual side of an objective 'disease', rooted in discernible, bio-chemical processes. This would bypass a subjective view of the illness for which psychological experiences, thoughts or affects are considered to be the root, consequently leading to the opinion that it is somehow less 'real' and therefore made up. After all, 'Is it

real?' is a common question asked in relation to the topic of fatigue, which is strongly related to the question 'is it psychological or biological?' as was mentioned above. Not only that, but the psychology discourse touches upon individual accountability, with the consequence that the individual is considered fully responsible, and thus to blame, for their ailments[2]. This viewpoint appears to be the main reason for the existing campaigns against and the dismissal by many CFS/ME patients of the results stemming from the biggest research study conducted on fatigue, called the PACE trial.

The PACE trial is the biggest randomised research study on fatigue carried out in the UK with 641 patients diagnosed with CFS/ME, spanning over five years and costing £5 million, as funded by the UK Medical Research Council. The study tested the effects of four interventions on symptoms, with the results showing that two treatments were able 'to moderately improve outcomes' (White et al, 2011: 823): Graded Exercise Therapy (GET) and Cognitive Behavioural Therapy (CBT). The former is aimed at gradually increasing physical activity levels, while CBT aims at changing patterns of thinking into more 'beneficial' ones. CBT and GET are currently outlined as the main recommendations in the guidelines for NHS treatment, alongside other therapies such as pacing, which consists of energy management in the form of terminating activity and resting (NICE, 2007). The results of the PACE trial caused much controversy as it suggests that engaging in exercise and 'positive thinking', with which CBT is associated, could lead to recovery — thus implying personal accountability: the possibility for change and cure (and thus cause) lies either in a person's thinking or in their willingness to exercise, or both. The authors of the PACE study were brought to trial due to the request for the release of the study's raw data, which they initially refused to share, but which they were subsequently ordered to release. The re-analysis of the data suggests that, first and foremost, the criteria for 'recovery' was redefined during the research and set to a low level (Friedberg, 2016), thus proposing that outcomes were not as favourable as once believed. This is thought by many to evidence that the PACE trial has been debunked (newspaper headlines refer to it as 'bad science') and one might find many patients supporting this refutal within the ME community. This discreditation stems from numerous people associating the PACE trial with psychology and personal

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[2] However, psychological factors could also turn into external elements from which the subject is divorced. This constitutes a structural similarity between the discourses of psychology and biomedicine, as is recognised by Verhaeghe (2004: 97): they both can pin an etiological agent on external circumstances, and thereby bar the subject who is merely a victim of these.

accountability and therefore not a real, serious, medical condition — as shown in the number of petitions signed by patients against the PACE trials, who demand therein more (and exclusive) biomedical research.

These real/unreal, and objective/subjective dichotomies related to accountability are ideologies conjured by the names CFS and ME, which most likely drive the psyche-soma opposition and elucidate that behind names, instead of finding a stable, empirical reality independent of language, lie multiple representations — representations which have a real impact on patients.

Research Questions

There is no denying the distress felt by people with fatigue is real. However, the ontological status of CFS/ME as a single entity separate from other unexplained fatigued conditions can be questioned on the basis of the discussion in this chapter. Condensing fatigue with an arbitrary number of other symptoms into a highly-structured, autonomous and generalisable syndrome with a single cause, creates a closed and rigid structure which is then imposed on a person who is thought separate from it. This leads to structural limitations in terms of it being unable to account for the complexity and diversity of experiences existing for fatigued people, and ignores reflexivity: how does the way in which we think about our bodies and sensations arising therein affect symptom formation and experiences (including biological symptoms)? The existence of these experiences is not self-evident but is constructed and organised idiosyncratically in and through the main medium of communication: language. Language is fundamentally social since meaning is created between people and always within the limits of a political and cultural background. What role does the body have in society today, as reflected in and constructed by language, which influences the increase in fatigued conditions? This sociocultural aspect of language alongside a person's choices, desires, and responsibilities are absent in the medicalisation of symptoms, where medical language is (attempted to be) stripped from ambiguity and contradictions, or in short, from subjectivity itself. The medical focus is on the isolated and decontextualised individual, as is reflected in the two main treatments given for CFS/ME: Cognitive Behavioural Therapy (CBT) and Graded Exercise Therapy (GET) (Prins et al, 2006: 350). From this perspective, the cause resides either in the mind or the body, creating an inside-outside dichotomy which obscures

the relationship between the two. More broadly, the cause is postulated to be situated within the individual as separated from the social. Certain qualitative research approaches address these gaps insofar as they engage in exploring the discourse surrounding fatigue, particularly interviews conducted and analysed through discourse analysis (such as Anderson, et al, 2012; Guise, McVittie, & McKinlay, 2010; Hart & Grace, 2000; Horton et al, 2010; Tucker, 2004). However, these studies focus exclusively on the experiences of the condition, particularly the doctor-patient relationship, tending to focus on the stigma around it; thereby leaving out an exploration of the influences of discourse, including broader socio-cultural ones, on symptom formation. These are considerable gaps in the way in which symptoms of fatigue are conceptualised, researched, and clinically approached, which highlights the need for an alternative approach. Therefore, based on the above, the main research questions are the following:

- What is the role of discourse in the formation, manifestation and development of symptoms common to fatigue/CFS/ME?
- How are the narratives of people with fatigue/CFS/ME structured and maintained through discourse?
- What impact does the language of and relationships with professionals have on the experience of fatigue/CFS/ME?
- How might this insight into the relationship between language and fatigue be used productively by professionals and others?

A Lacanian Approach to Fatigue

In order to address these aforementioned questions, this research projects calls for an approach in which the relationship between the subject and the social, and the mind and the body, held together by language, is at the centre. It also calls for one which takes into account the unconscious nature of the subject's relationship to both the body and language, one which acknowledges that when we speak we say more or less than intended, and which acknowledges that ambiguity — something I argued in this chapter that psychology and medicine unethically tries to eliminate in the quest for 'objectivity' — is related to the subject's desires and thoughts as intertwined with sociocultural ideas and ideals, which come

to affect the body. These elements are not consciously or directly available for either the subject him/herself or others, but form an implicit structure and logic discernible in language by paying close attention to it. An approach which elaborates in-depth on just such a relationship between the subject, the body and language is Jacques Lacan's theory of psychoanalysis — and for this reason, this project will adopt a Lacanian perspective in exploring the symptomatology of fatigue. The underlying premises of this perspectives offer not only productive, much-needed insight, but also the adoption of an ethical position *vis a vis* participants and other subjects who can relate to the research, something which will be discussed in-depth in the next chapter.

Lacan's theory goes beyond psychological and medical approaches which adhere to a strict inside-outside dichotomy whereby a person's internal states are postulated to exist as separated from sociocultural, historical and political aspects, which produces a hegemonic and decontextualised view of the subject as mentioned above. A Lacanian approach, by contrast, recognises that the inside is always on the outside and vice versa; or rather that the personal is always social and the social is always personal, and further recognises the impossibility of objectivity due to the structural incompleteness of language and consciousness and their reflexive and constructive nature (Frosh, 2007: 641). That is, events and memories are not reflected accurately in language but are constructed as they are put into writing or speech (Frosh, 2014: 23). Similarly, meanings, affects and thoughts cannot be fully articulated, and the very articulation of them changes their nature and the manner in which they are experienced in a retroactive understanding — thus meaning is neither pre-determined nor fixed. This is the case both for the subject/participant and researcher insofar as the medium of language is relied upon. The reason why I briefly outline the approach here before the sections on data collection and methodology is because, as might be clear, it extends far beyond the 'method' used in terms of merely applying a certain framework in order to understand the collected data — however while not being unrelated to it — and instead articulates to an epistemological position adopted beforehand (Willig, 2008: 7). Such a position, in this case a Lacanian one, entails the above-mentioned standpoint on language and the subject which informed the way in which I approached the topic of fatigue, formulated the aims and the criteria to take part in this study, and collected data, as it is not the case that one simply approaches data from an a-theoretical viewpoint.

There are a number of reasons why a specifically Lacanian approach is appropriate and fruitful in studying the topic of fatigue and the outlined research questions. The crucial premise underlying this perspective is that a subject is inseparable from the symbolic relations enabling communication and interactions (Parker, 2015b: 4) yet cannot be identical to, or reduced to, an effect of society — making it an ideal perspective from which to explore the subject-social interaction involved in fatigue, as well as the body-mind relation. In other words, the individual and the social, and equally the mind and the body, are inseparable and intertwined, while not collapsing into one. It avoids the pitfalls the majority of the current work on fatigue fall into: placing too much emphasis either on the individual, as biomedicine and psychology does, or on culture, as endorsed by those conceptualising fatigue as an effect of a high-paced society (for example through the work of the cultural theorist Byung-Chul Han's (2015) 'The Burnout Society'). However, this premise, alongside the constructive and unconscious nature of language, is also the underlying premise of other approaches, and most notably those falling under the category 'socio-critical' or 'psychosocial' approaches. These groups include theories such as psychoanalysis, feminist theory, Marxist theory, phenomenology and what is sometimes referred to as 'post-structuralism' (Frosh, 2003; Parker, 2015b: 64-65). Despite their similarities and overlaps, there are also certain differences, particularly when it comes to the conceptualisation of the subject. Lacan here arguably offers the most rigorous and in-depth account of the functioning of discourse in relation to subject and symptom formation[3]. Lacan's account of subjectivity is a rich one as it is formulated in relation to a sophisticated and rigorous account of discourse that is simply difficult to find elsewhere, *and* in relation to symptoms and the way in which the clinic can fruitfully work with these. Due to the latter, the theory also offers in-depth details around symptom formation and the relationship between the patient — or analysand in Lacanian terms — and clinician that is likewise difficult to find elsewhere. It thus allows, within a topic exploring a similar yet in no way identical clinical relationship between patient and medical practitioner, some ideas with which to think practically about the clinical implications within the medical field.

That Lacanian psychoanalysis has an in-depth account of discourse theory that is taken seriously in the clinic/practically, is evident in the use of the technique 'scansion' as

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[3] Discourse in this sense is not just inclusive of actual language in terms of words or rather signifiers, but also images and implicit and explicit rules which structure our psychic realities.

part of 'variable length sessions' which distinguishes Lacanian psychoanalysis from all other analytic as well as therapeutic practices. To briefly explain this, instead of ending a psychoanalytic session after the pre-determined, arbitrary but standard fifty minutes, the end of the session is determined mainly by the ambiguity of language (the unconscious) which accentuates it and effectively puts the analysand to work. The reason I mention this here is in order to shed light on just how seriously Lacanian psychoanalysis takes the unconscious as the place of non-meaning/ambiguity, which is not found in any other type of psychoanalysis. This commitment is reflected in the existing plethora of rich, theoretical formulations on which techniques in how to approach discourse are based, be it speech produced in a clinical setting or research setting[4]. Lacan's theory therefore goes the furthest in offering conceptual tools for disrupting meaning — making his writings and seminars difficult to read but simultaneously offering a radical and ethical position from which one is able to produce in-depth insight and multiple perspectives on a topic. This position, one constitutive of a rigorous combination between discourse and (unconscious) symptom formation, is arguably the result of taking seriously both structuralism — the work of Saussure and Levi Strauss for instance — and the work of Freud (and of course not to mention a number of other fields such as mathematics, logic, philosophy etc.). For a research project which explores the role of discourse in the formation, manifestation and development of fatigue and in the context of medical encounters, such a combination is ideal.

In using a Lacanian perspective, tracing the subject through articulated discourses reveals how symptoms are structured in and by discourse and vice versa. What occurs in our (biological) bodies has an impact on the type of symptom arising and its development, and subsequently will shape the discourses and experiences around a condition. Conversely, the ways in which we think of our bodies and the mind-body relation in discourse — influenced by life events in the context of sociocultural discourses— will impact symptom formation (in the body). In this way, a symptom from a Lacanian perspective is inextricable from discourse, or rather *is* a type of discourse, since it is integral to organising a psychic reality. A Lacanian perspective uniquely gives attention to the idiosyncrasies of a person as well as the social, cultural and political as the former can be found inseparably within the latter and vice versa. By adopting this lens in exploring first-person accounts of fatigue, the findings of this

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[4] However, while the approach is similar in terms of how speech is approached in these two settings, there are important distinctions between them which is discussed in the section on reflexivity in the next chapter.

research will be intimately intertwined with the lived experiences of those suffering from fatigue and the sociocultural discourses linked to them. Such a subjective exploration does not override the existence of any biological or more physical factors potentially involved in the conditions examined; meaning that it does not reduce a phenomenon to one or several subjective factors, something that will be discussed more in the next chapter in relation to ethics. Rather, as Leader & Corfield (2008) recognise, any condition can be approached from a so-called 'psychosomatic' standpoint. In fact, in their work 'Why do people get ill?', they uniquely use a Freudian-Lacanian perspective in examining the subjective side of medical conditions, convincingly illustrating how any symptom presented in the body, both organically evidenced and not, will be affected by subjective elements (such as responses to life events) and their interaction with the wider sociocultural discourse.

While Leader & Corfield's (2008) work is extensive and crucial, particularly in their attempt to bridge psychoanalysis and medicine, their work does not include fatigue. Nevertheless, the psychoanalytic theory of symptom formation delineated therein and used as ways of understanding medical somatic symptoms are also utilised within Lacanian psychoanalysis in conceptualising symptoms, including fatigue. Most discussed here are conversion symptoms (thought to belong to the overarching category of neurosis) where a bodily symptom in a disguised form stands in for a symbolic message addressed to someone and is posed as a question; and what are symptoms associated with psychosis, wherein symbolic material is directly inscribed in the body as an answer (lacking the communicative function inherent in a question). A third group, less discussed in Leader & Corfield's (2008: 126) work, concerns a structure in which symptoms bypass the mind altogether, thus containing no symbolic material. These symptoms arise when something (of the body and/or a situation) was not mentally processed, which likewise resemble symptoms of psychosis, although those belonging to a different group. The main theory drawn on in relation to this group is that of Freud's 'actual neurosis'.

Freud's theory of the actual neuroses has been picked up as a way of understanding fatigue, and more broadly modern somatic symptoms, by one of the most influential figures within the field of Lacanian psychoanalysis, Paul Verhaeghe[5]. In his work 'Being Normal and Other Disorders' (2004: 308), he tentatively and briefly suggests that chronic fatigue

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[5] Another influential work using Freud's actual neurosis, but in relation to modern addiction, is Rik Loose's (2002) 'The Subject of Addiction: Psychoanalysis and the Administration of Enjoyment'.

could be linked with Freud's concept of an anxiety equivalent, where it is thought that fatigue is an expression of anxiety. Verhaeghe's theory, and actual neurosis in general, conceptually comes close to the Lacanian psychoanalytic notion 'ordinary psychosis', which has become a dominant way within the field of framing modern symptoms, including chronic fatigue and pain. Here, too, symptoms are thought to lack symbolic structuring, while containing the colour of psychosis. However, the few works existing in English (Barreto & Besset, 2016; Stevens, 2009), to my knowledge, linking fatigue and pain with ordinary psychosis, are short papers based on one clinical case study respectively. Despite this, the authors come to make a generalisable claim that the majority of symptoms of pain and fatigue belong to the category of ordinary psychosis. Beyond the aforementioned theories, fatigue/burnout has briefly been discussed from a Lacanian perspective in some research studies, in relation to intersubjective factors (Vanheule, 2001; Vanheule, Lievrouw & Verhaeghe, 2003; Vanheule & Verhaeghe, 2004; Vanheule & Verhaeghe, 2005), and in two philosophical works (Schuster, 2006; Zupančič, 2019). It is the aim of this research to bridge the gap pertaining to the exploration of fatigue, by exploring it in depth and situating its structure, or rather what my analysis of their discourses suggests about its structure, in relation to these current theories on fatigue.

Overall, this research project constitutes a comprehensive study of fatigue and is the first with a dual focus as it investigates both the formation and manifestation of symptoms, and how discursive interactions (with friends, family, health professionals and within society at large) affect these symptoms and experiences. It is my hope that the results of this study have generated novel insight into conditions of fatigue which can help health practitioners and those in contact with fatigued subjects in their approach and treatment, consequently benefitting patients. More broadly, I hope this project acts as a catalyst for re-thinking fatigue, and the mind-body relation on which it is currently governed, and thereby brings a fruitful shift in perspective and approach to fatigue and related conditions.

Chapter 2: The Process and Ethics of the Data Collection and Analysis

The following chapter outlines the processes and ethical considerations surrounding the participant data collection and the methodology used in exploring the topic of fatigue (semi-structured interviews, Lacanian Discourse Analysis and the use of Lacanian psychoanalytic theory). It additionally includes a brief analysis of the participants' views of fatigue/their conditions in relation to how the mind-body relation is constructed in their discourses, as it relates to the biomedical discourse as outlined in the introduction chapter, as well as offering a way into discussing the ethical implications as well as reflexivity surrounding the type of knowledge a Lacanian approach produces.

Participants and Criteria

In order to address the research questions mentioned in the previous chapter, I have conducted in-depth, semi-structured interviews with nine people who experience fatigue, who all happened to be diagnosed with CFS/ME, and I conducted follow-up interviews with six of them. The aim was to interview around fifteen people, however nine people ended up volunteering, which I deemed sufficient. It was in fact too many for such an in-depth analysis, and as a result I had to exclude two participants' data in the final analysis, which is addressed further below. Six females and three males took part ranging from ages 23 to 65. Eight were white and one was "from an Asian family" (Gail[6], in her own words), and grew up abroad. No information about demographics beyond this, such as class or ethnicity, were collected during the interview, since it was my belief that if it was important enough to the topic of fatigue it would have been mentioned during the interview, which was as open as possible surrounding the participants' experiences. Nonetheless, their class belonging or information related to it, for instance, was not mentioned, and thus I am unable to provide this information.

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[6] Pseudonyms have been chosen for all of the participants throughout to protect anonymity. The participants were offered the possibility of choosing their own pseudonym, which three of them did. With the rest of them, we agreed upon a name I suggested to them prior to commencing the interviews.

The criteria for participating in this study was as broad as possible in order to attempt to catch a wide range of experiences. Individuals could volunteer to participate if they 'experience constant or intense fatigue which is different from everyday tiredness and which has affected your [their] life negatively', or consider themselves to have CFS/ME, or be diagnosed with it. The two first criteria follow a Freudian line of thinking in that it is the patient who decides, in a way, whether s/he has a 'pathology', as it is manifested through the presence of complaints, which is also part of the third criteria insofar as the person has turned to the medical establishment with complaints in order to be diagnosed.

The Data Collection Process

Prior to data collection, ethical approval was obtained from the School of Life, Sport & Social Sciences Research Integrity Committee at Edinburgh Napier University. The participants who took part in this study were recruited through the private Facebook group of an Edinburgh-based ME charity, with the exception of two of the participants: one was recruited through their newsletter and another through word-of-mouth arising from the Facebook advertisement. In addition to this, I also circulated a poster on my social media accounts. In the advertisement, I announced I was looking for volunteers for my research study in order to find out about the personal experiences of those with fatigue/ME/CFS (see Appendix 1). I made it clear in the Facebook group post that this research was not associated with or sponsored by the ME charity. In the social media post, I stated that my immediate friends/acquaintances would not be considered to take part, in order to hinder as much as possible imaginary assumptions and pre-learned knowledge from influencing the analysis. When people contacted me to indicate they were interested in participating, I emailed to them a recruitment sheet with more information (Appendix 2). The recruitment sheet outlines as much information about the study as possible, such as anonymity, their right to withdraw, the procedure in terms of what areas the interview would broadly be focused on, and the estimated time it would take. It was important that this information was included so as to prepare the participants' expectations, particularly of the topics I would ask since they would be of a highly personal and therefore potentially sensitive nature, which would help inform their decision to participate. Thereafter, upon them agreeing to take part in the study, we arranged a time and place for the interview. During the fall semester in October 2016, semi-

structured interviews were conducted with nine people. As the participants had the opportunity of choosing a convenient place, the interviews took place at various locations such as in cafés, their homes, one over Skype for the follow-up interview, and three interviews took place at the University campus. It was agreed beforehand with the ME charity that in order for me to be allowed to interview their members in their homes, I would need to have a recent background check, a Protecting Vulnerable Adults (PVG) Scheme which is managed and delivered by Disclosure Scotland. I happened to have had one due to my job as a support worker, the copy of which I sent to and got approved by the committee at the ME charity. There was also a procedure in place to protect myself in these situations where I met a participant off campus, which was agreed upon between myself, my Director of Studies and the Ethics Committee. In person and immediately prior to the interview commencing, the participants were given an information sheet (Appendix 3), followed by a consent form which they had to sign before the interview could start (see Appendix 4), and the chance to ask questions. I also went through the main and crucial points verbally (that their data will be anonymous, they have the right to withdraw or take a break at any time or skip questions without giving a reason) to ensure they knew this information reached them before commencing. An interview schedule had been prepared beforehand (see Appendix 5) with open-ended questions and as non-leading as possible.

The interview style I adopted towards the participants took the form of a 'traditional' one in terms of a 'non-directive' style (Willig, 2008: 24). There is of course no such thing as a purely non-directive approach since the way in which I framed the research questions already constitutes a direction, reflected in the topics I chose to be covered in the interview schedule. Nevertheless, such an approach is about eliciting as many details and as much information from the participants as possible, while my subjectivity (opinions, advice, information etc.) should stay as much out of it as possible. This is done by asking open-ended questions, prompts or using techniques such as mirroring in a way which allows the participant to elaborate on many details in many potentially different directions. I also, when I could, attempted to make the participants aware of any contradictions made or elision of a detail or event they had previously included in answering the same question — something I could do by referring to their first interview in their second interview. This was done in order to invite them to reflect on and analyse their own discourse, an interview style arguably in line with an open 'clinical' style whereby the interviewer asks about the participants' motives

and interpretations (see Young & Frosh, 2010). However, I did not at the time have the skills to do this very often or in a fruitful way; it was sometimes not beneficial since the participant did not always remember the moment to which I was referring, therefore leading to confusion which hindered instead of produced further elaborations.

After the interview, the participants were given a debrief form (Appendix 6), as well as an interest sheet to fill in for participating in a second interview, should they be interested (Appendix 7), and were offered a chance to ask questions. Again, I went through verbally the most important points on the debrief sheet (that they can still withdraw after the study and where they can turn to should they be distressed after the interview), to make sure they knew this information was on there. All of the participants were offered a follow-up interview (see Appendix 8 for the recruitment sheet sent out). I conducted a second interview about two months later, in December 2016, with the six people who agreed to it. For one of the participants, Gail, the sound quality was largely inaudible during our follow-up interview, and for this reason, I conducted a third interview with her in August 2017.

The purpose of the second interview was to obtain in-depth data, with an appropriate amount of time having transpired in order to allow for new material to emerge. The same procedure and sheets outlined for the first interview were used at the second interview, albeit with an updated information sheet (Appendix 9). Prior to this second interview, about one to two weeks, those who agreed to take part were sent their interview transcripts from the first interview for a chance to read it, should they wish to. Giving the participants a chance to reflect on their interview transcript acknowledges the reflexivity of consciousness and the constructive and reflexive nature (structural incompleteness) of language. I prepared follow-up questions beforehand based on their transcripts, choosing parts which I considered could benefit elaboration. I also repeated some questions I deemed important in order to be able to pay attention to repetitions, ellipsis, and new information. The interview schedule for the second interview was thus completely adjusted to the participant's unique transcript. I took notes after each interview where I recalled noteworthy moments from the interview that may have been difficult/impossible to have been captured by the tape recorder, such as emotionally charged moments, events or gestures (however the latter is not crucial to the analysis), but also my own feelings, thoughts and responses in order to better account for my reflexivity.

The participants' interviews were transcribed verbatim. I attempted to transcribe the interviews as soon as possible after the interview took place when their discourses were still fresh in my mind to aid transcription. In order to protect the participants' anonymity, their names were replaced with their pseudonyms in the transcripts and throughout this thesis, and any specific detail regarding location or names referred to in the interview that could reveal the identity of the interviewee has been left out or altered when included in the thesis, and also in the transcripts that were sent out to them via email, in the rare event of them ending up in someone else's hands. The transcripts are kept on a password protected computer to which only I have access, and will be destroyed ten years after the completion of my degree, as stated in the information sheet. When referring to the quotes from the interviews throughout the thesis, the first letter represents the interview from which it derives (A = first interview, B = second interview, and C = third interview). The lack of letter indicates there was only one interview. The 'L' and numbers following the letter refer to the line numbers as to contextualise a chronological order. *Italics* refer to an emphasis, and three dots indicate a pause of about three seconds.

My experience of the data collection where I had the first point of contact with those who are diagnosed with CFS/ME resonated strongly with the literature outlined in the previous chapter with regards to the mind-body divide and the vehement dismissal of a psychological viewpoint. What I thought was a relatively neutral advertisement in the ME association's private Facebook group sparked much controversy, heated debates, demands and questions from a large number of members. The most important question asked was from what perspective I was doing the research (biology or psychology) since this would determine their willingness to participate. This caused debates where people wrote lengthy and numerous posts (from which I abstained) which were centred around the big question: 'is it a mental or a physical condition?'. Without answering the question of which perspective I adopted (since the answer is a complex one not in line with a black-and-white view of the mind and the body and as avoid as much as possible to influence their participation), I reassured them that I was interested in finding out about their experiences of the condition and any interactions with medical health professionals, and that I was not looking to answer the question of cause or come out the other end recommending one treatment. I also mentioned the importance of keeping it as 'neutral'/'open' as possible when participating in the sense that I was unable to explain all aspects of the research beforehand, in order to

minimise influencing their answers. In conjunction with this, I explained that they could withdraw at any point, that the study had been approved by Edinburgh Napier University's Ethical Committee, and that they will be debriefed afterwards in terms of receiving information about the aims and rationale of the study and how their data would be treated. It may also be worth mentioning that the first person I interviewed returned to the Facebook post explaining that she had just participated in the interview, that it was a comfortable experience and that I had been respectful, and consequently encouraging others to take part. Despite of this, those expressing strong opinions against psychology did not end up taking part in this research, and one of the members from the group, who did take part, emailed me pointing out that the word "psychology" was included on my online research page, thereafter warning me of possible criticism/abuse from the ME community.

The reactions to my recruitment advertisement could be understood by taking into account the political context of research on fatigue/CFS/ME, particularly the controversial research study the PACE trial mentioned in the previous chapter, since it was referred to throughout the members' Facebook comments, in private conversations with me, and throughout their interviews — confirming it is crucial to the shaping of patients' perspectives on research. However, contrary to what has been suggested — that those endorsing a physical cause of fatigue are against the PACE trial as argued above and for instance in a Guardian article (Chainey, 2017) — what seemingly determined the participants' endorsement or rejection of the PACE study was a certain perception of the body in relation to the mind; one greatly overlapping with the biomedical view as outlined in the previous chapter. I will therefore in what follows briefly outline a summary of the participants' view of the mind-body relation, as analysed from the participants' interviews.

The Participants' Views on Fatigue

The participants' views of the mind-body relation come close to the underlying assumptions explored as part of the biomedical model in the previous chapter. The following section consists of a brief analysis of fatigue in relation to the construction of the mind-body relation, which draws upon biological and psychological discourses. First of all, noticeable in all of the participants' discourses is that there is a wish and conviction for having a biological condition despite a lack of physical evidence in most cases. The condition is considered to consist of a cluster of bodily symptoms going beyond fatigue, where a name, CFS/ME, stands

in for these — with ME being the dominantly preferred name. The name is thought able of unifying disparate bodily symptoms and of acting as an explanatory cause; one residing outside a subjective involvement. The mind is considered either excluded from symptom formation in an exclusive focus on the biological body, or subsumed under a biomedical discourse where what is normally considered subjective elements acquire an objective status. The latter view is what arguably determined the endorsement of the PACE trial for two of the participants, in relation to the activity of exercising. The inability to exercise —what is referred to as the body being 'deconditioned' — is put down to a biological cause. At other times, subjective/internal factors are turned into external ones, following the belief that stress or trauma is caused by one's environment such as one's family, from which one is separated. This also follows the reasoning inherent in the biomedical discourse. That is, the psychological discourse successfully joins with the biological on the condition that the mind, and its accompanied personal accountability, are excluded. Alternatively, when the subjective mind is acknowledged to influence the condition, it is often thought to only affect the experiences of the condition and not the actual formation of it. The mind is relegated to a secondary, less important and influential position. For some of the other participants and/or at other times, when subjective factors are considered to play a role in the formation of the condition, there is hesitation and carefulness of not putting too much emphasis on them. This is manifested when they describe a linear sequence in which biology could still be considered as the main cause of the condition: the view that the mind (such as stress) affects the susceptibility of acquiring a biological virus, which in turn causes the condition, not the psychological factor. Furthermore, there is for some a black-and-white thinking with fluctuations between endorsing a psychological and biological cause. Therefore, discernible in the interviews is a mind-body divide where the mind and the body are thought separate from one another; even when an interaction is postulated, they are unable to intertwine. It is further observed that if one acknowledges the involvement of subjectivity in the formation of the condition, then this has implications in relation to accountability: the individual could be blamed for being fatigued. To endorse a biomedical perspective on fatigue, the dominant one throughout the participants' interviews, means that the mind and anything related to it — the subject's desires, choices, intentions and responsibilities — are capable of being eradicated; externality and concretisation being its conditions. Some of these points will be touched upon and examined in-depth throughout the thesis through the help of Lacanian

psychoanalysis. At this stage, however, these issues raise the question as to what effect this type of research might have, which explores the subjective or so called 'psychological factors' involved in the condition, on a group of people who to a large extent disavow subjective factors. This will be discussed shortly, but it is first necessary to delineate the methodology used for exploring the interview transcripts.

Methodology and Data Analysis

For the final analysis of the transcripts, I excluded two of the participants' data and have engaged in analysing a total of seven of the participants' transcripts throughout this thesis. This was partly due to the nature of the approach taken, a Lacanian one, where a higher quantity would compromise the in-depth nature of the analysis. The second reason was that the data of the two interviewees excluded lacked the depth of the others' in relation to elaborations of life events: the attention of their interviews was devoted mainly to the encounters with health professionals and not many details were revealed beyond this, which makes an analysis of symptom formation difficult/impossible. This shortcoming could partly be due to my interview skills, particularly considering one of these was my first interview. Additionally, neither of them returned for a second interview, which affected the amount of data obtained. There is one person I included with whom I only conducted one interview; however, she elaborated extensively on many areas pertaining to her life and her experiences with CFS/ME in a lengthy interview. It is to be noted that such an exclusion of data was communicated to the participants to be a possibility in the recruitment and information sheets (Appendix 2 and Appendix 3), however while stating that their text will be carefully looked at — and indeed it was for the above analysis — as to avoid making them feel devalued.

The participants' transcripts have been analysed through a form of Lacanian Discourse Analysis (LDA), using techniques derived therefrom, and by drawing on Lacanian psychoanalytic theory. The reason I mention two moments here is because involved in the act of analysing are two different yet inextricable processes, both of which are related to the epistemological position taken as mentioned in the introductory chapter, which is a Lacanian one. The first moment relates to analysing the text in a way which discerns structures, links through associative networks, and linguistic elements; briefly what can be said to occur in the text, based on a stance on how language can be approached and interpreted (I outline this

in detail below). The second moment of analysing relates these former interpretations about the text to a theory on subjectivity and symptom formation, in order to further illuminate it and add details which will deepen our understanding of the discourse and thus of the topic; an interpretation of the interpretation. It is here that psychoanalytic notions such as fantasy, desire and the unconscious enter the picture, and in this stage one also goes beyond the text whenever possible to link with wider sociocultural, historical discourses and practices. The use of the theory also acts to aid the previous step — here noticing how intertwined they are — by opening up the text to perspectives and meanings that would have not otherwise been able to emerge, or would have been difficult. However, while theory is invaluable and crucial, it is important one does not operate chiefly from this standpoint as one would most likely fall into the trap of merely applying theory to a text and thereby confirming that piece of theory by magically finding what one was looking for. There is of course always theory involved, but I am distinguishing here between more specific theory about subjectivity (appertaining to fantasy, desire and the unconscious for example), and certain techniques; techniques which are nevertheless guided by a theory of language and subjectivity.

This means I could have, hypothetically speaking, chosen techniques for the first moment which are less guided by a particular theory of language and subjectivity but still considered compatible (although this is debatable) with a Lacanian approach, for example a Thematic Analysis (TA). TA is a common qualitative method in which one discerns various themes in the text, and thus I could have applied techniques to the text and thereafter interpreted the results of that reading from the perspective of Lacanian theory. This, however, would not yield the same amount of details as would a Lacanian Discourse Analysis, which stays incredibly close to the text insofar as it focuses on the *structure* of the text, details of which could be eradicated if translating sections into 'themes' (however marking themes in the text could of course correspond to a useful starting place). Hence, using LDA in combination with Lacanian theory would mean getting the most out of the theory on discourse and symptoms, since the techniques part of it derive therefrom, thus producing more in-depth data and staying 'true' to the epistemological approach adopted.

More specifically, I adopted a Freudian-Lacanian perspective which acknowledges the over-determination of meaning, or rather the indeterminacy of language; that there are (social, political, cultural and historical) forces going beyond our intentions considering the fact that when we speak, we say more or less than intended. There are always exclusions

when speaking or using language: there is no 'saying it all at once' due to the structural incompleteness of language, and that the act of speaking constantly constructs and re-constructs our experiences. This surplus in speech, which can also be conceptualised as a gap as something is always left out (from language and consciousness), constitutes formations of the unconscious which are strongly intertwined with discourse on a wider, sociocultural level — following Lacan's famous axiom that 'the unconscious is structured like a language'. In other words, delineating the gaps in discourse allows multiple and associated meanings to emerge, revealing a logic potentially at work in a symptom. This place of multiple meanings is simultaneously the place of non-meaning, as meanings multiply to the extent of revealing their contradictory and non-sensical nature, thus marking the impossibility of reducing a phenomenon to one perspective or meaning. Or in other words, the unconscious from a Lacanian perspective constitutes *not* the place of hidden and permanent meaning, but the continuous deferral of meaning. Therefore, in order to take the unconscious and language seriously, the research techniques submitted to a text must consist of a deconstruction or disruption of meaning (Frosh & Baraitser, 2008: 355).

LDA is not an established or widely used approach which has a clearly defined body. However, tools in line with Lacanian theory and the above-mentioned viewpoint have been utilised in conducting discourse analysis and yielding valuable and notable work, most markedly by David Pavon Cuellar (2010) and Ian Parker (2010). An invaluable work identifying some of these in an accessible and lucid manner is that of Calum Neill's (2013), which offers guidance in how to approach a text in the sense of opening up multiple meanings/disrupting meaning in what is a Lacanian approach to discourse analysis. I drew on these recommendations, more precisely on those techniques facilitating a symbolic reading of the text; techniques used by psychoanalysts in approaching analysands in the clinic of Lacanian psychoanalysis. The main focus of such a methodology is on structure/the symbolic rather than content/the imaginary.

The symbolic and the imaginary, together with the real, are three intertwined realms which make up the symbolic order and make possible communication. The symbolic is the realm of actual language, not only encompassing physical words — signifiers — but comprising a way of organising experiences as a sense-making activity. The imaginary adds meaning to the symbolic in the sense that it forms an understanding and puts a limit to the circularity of signifiers, since a word can only be defined using other words in a circular

manner (Neill, 2013: 338-339), in an 'incessant sliding of the signified under the signifier' (Lacan, 2002/2006: 503). The signified is that which creates (imaginary) meaning and identification, by putting such a circularity to a halt — albeit temporarily — without which the symbolic would drift in an endless, meaningless shifting of possibilities pertaining to the definition of something. The imaginary thus consists of our idiosyncratic understandings which can never coincide with those of someone else's: in the process of (re)presenting a phenomenon, we partly construct it anew by bringing our own meaning to it based on our own past experiences, understandings, desires, fantasies etc.. The last realm, the real, is put simply that which escapes both symbolisation and identification (Neill, 2013: 339), that which cannot be integrated into a symbolic-imaginary comprehension; the place of impossibility and the failure of symbolisation.

In a Lacanian approach to discourse, attention is given not to the intended meanings, but to the identification of master signifiers — those either explicit or implicit terms which organise and give sense to a text — the order of words, which words are used and in what context, elisions, repetitions, punctuations (Ibid.: 340-341) and importantly, contradictions as these point to the place of non-meaning, of the failure and impossibility of language (Ibid.: 335). As Neill (Ibid.) points out, this approach is not about excluding the imaginary in the sense of eradicating our own imaginings — as this would be out right impossible — but about decentralising the image 'to add further images, to force the notion that this is not *it*' (p. 341). It is thus, broadly, about allowing multiple meanings to emerge and coexist, which occurs through a focus on structure, or what we could say is a focus on the interplay between structure and content, between the symbolic and the imaginary, which then marks out the edges of the place of the real. Using an example from the thesis to elucidate this process, when the participants of this study utter that a certain activity leads to "pain or fatigue", by using the two words in conjunction to each other indicates a structural association between pain and fatigue: that being fatigued is painful and vice versa, constituting a painful fatigue; but by using the word 'or' — here focusing on content — marks a distinction between them, an attempt to keep the two apart and perhaps an opposition between them. One could then further discern the functions of taking each perspective, which could for instance relate to taking or exonerating responsibility, by tracing the associations to both pain and fatigue and paying attention to what words and concepts or signifiers are used in conjunction to them and in what contexts. More specifically, associations are demonstrated between words/concepts

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and contexts when, as was partly demonstrated above, one word/concept is followed by another, even if the speaker had intended them to be part of separate sentences in a change of topic, and when the same word is used in different contexts. This process is known from a Lacanian perspective as 'following the letter'. The analysis is thus not about choosing one perspective over the other but exploring as many as possible and merely highlighting, as opposed to reconciling, views and contradictions which cannot be reconciled.

While I used the techniques stated above, they do not form part of an objective 'method' from which I am separated, one capable of being replicated and passively applied to the text — as there is no such thing. Analysing is a creative process. That is to say, someone else could apply LDA to the same text and our analyses would look radically different. This is useful, and the reason for which texts should be discussed with others, something encouraged as part of a Lacanian approach in terms of having 'cartel' groups but could also occur through presenting at conferences and seminars, as to 'submit' discourses to as many perspectives as possible. My subjectivity is inevitably involved, something which will be discussed below, as my use of the techniques emphasised certain ones more than others, which was furthermore not a largely conscious process. This makes a sequential 'step-by-step' guide impossible, and indeed is something suspicious and undesirable from a Lacanian or critical perspective as it alludes to an objective and fixed set of steps (Parker, 2015a: 4).

Nevertheless, attempting to trace my steps as much as possible, the first thing I did was to read the interview transcripts as a-theoretically as possible so as to pay attention to the structure of the text with the use of the techniques outlined above, meaning I tried to suspend my knowledge of Lacanian theory and what I might bring in at a later stage to make sense of the discourse. The latter was relatively easy considering my understanding of Lacanian theory at that early stage was underdeveloped in comparison to my grasp of it at the end of the PhD. I made notes in the margin of possible and multiple meanings and connections, and marked the text into different areas as much as is possible (such as symptom description, life events, medical encounters, analogies, etc.). I thereafter copy and pasted certain quotes in different documents, where I gathered all the excerpts from the participants but ordered them into the different broad areas, and where I could more easily discern and 'compare' their discourses in relation to a topic. This was a messy and long process where I constantly revised the documents in terms of adding and removing quotes and adding an analysis of them, and shortening documents into other documents in what seemed to be an

ad infinitum process (turning the documents into notes of the notes of the notes etc.). However, it enabled me to pay attention to structural patterns both within and across interviews and provided me with a basis on which to choose to hone in on and learn more about certain relevant theoretical concepts. It also allowed me to make connections with some wider sociocultural discourses and practices, however time did not allow me to engage in this activity as much as I had planned and would have liked to.

This type of work meant that some of my analysis did not make 'the final cut'. For example, in preparation for chapter eight, which looks in-depth at individual differences in terms of the link between events surrounding the bodily response of fatigue and pain, I made an analysis of all of the seven participants' discourses surrounding this, but ended up including only the analysis of two as I opted for an in-depth analysis. However, it was necessary to first make a brief analysis, a close consideration, of all of the discourses before choosing the ones with enough details which would make an important elucidation.

There was a constant, dynamic interaction, a back-and-forth movement, between interpreting the interview transcripts and the theory, with the two processes enabling each other; the theory facilitated different understandings of the texts but the interviews also facilitated interpretations of Lacanian theory as they made certain concepts 'come alive'. This occurred more so towards the end. I constantly had to return to the interviews, particularly to explore the context of the excerpts I was interpreting. Accordingly, when I started paying more attention to the order of words and concepts of the discourses — quite simply to associations part of the process of 'following the letter' — the analysis took off and multiple meanings emerged; it almost felt like the analysis wrote itself. This required a certain level of skills as it constitutes a unique, complex way of reading a text in which it is necessary to suspend our automatic and commonsensical way of understanding it; indeed, to suspend as much as possible our imaginary understanding in order make space for other ones (for example to suspend the 'or' in "pain or fatigue" and not understand them as exclusive entities). I therefore came to re-read the full interview transcripts at a later stage in this manner, which significantly produced new notes and interpretations. For instance, this was the point at which I linked fatigue with sleep and disappearance, and pain with bodily tension and aliveness; two moments further related to the words and concept of 'doing nothing', which enabled me to compare both the similarities and differences between them, and how they were linked to other signifiers in a network of associations. These links subsequently

led me to bring in Lacan's theory of the drive and desire as conceptualised in the context of alienation and separation, and related concepts such as unconscious refusal and (fundamental) fantasy, two various but related ways of conceptualising 'doing nothing'. This use of the theory both elucidated and added more details around the structure and functions of the discourses.

Using psychoanalytic concepts such as 'unconscious desire' in order to understand discourses produced by subjects does, however, poses questions pertaining to knowledge and ethics: what kind of knowledge are we claiming to produce here, and what consequences does this production of knowledge have on the subject about whom we are speaking? This brings us to consider ethical issues in relation to psychoanalytic research of this kind.

Ethical Considerations

Considering the participants' and many CFS/ME patients' dismissal of psychological/subjective factors, to conduct research exploring the subjective factors involved in symptom formation might come across as controversial and unfavourable to those referred to, and thus, unethical. However, to not acknowledge subjective factors involved (in any condition) would arguably mean to commit an even bigger ethical 'crime' as it would dismiss the functioning of human nature; that life events and the way in which we think about these and our bodies will come to affect (of course to varying degrees) the symptoms arising and occurring in our bodies and the experience of them. As such, it would do injustice to the discourses elaborated by the participants of this study as they come to show a convincing trend that subjective factors exert a large influence on the conditions, as evident for example in their conditions worsening after having encountered medical practitioners' dismissive attitudes. Nonetheless, using specifically psychoanalytic concepts in relation to research participants, ones used to facilitate in a clinical setting an understanding of what is often (mis)understood as a person's 'most essential, deepest and darkest secrets motivating his/her behaviour', is a controversial topic within the field of qualitative research (see Frosh & Baraitser, 2008). It poses questions surrounding the type of knowledge produced and its effects on not only the participants but those who can relate to the research results. What is included and excluded in taking a Lacanian approach to the topic of fatigue, what conclusions can be drawn, and what might the effect of these be on others?

Considering research results today can come to significantly impact others as they are widely digested by citizens, used as ways of understanding oneself and guiding one's behaviour, researchers bear a certain responsibility in how it is conducted and what conclusions are drawn from it[7].

Adopting a Lacanian approach in research constitutes simultaneously adopting an ethical stance *vis a vis* the data and the research findings stemming therefrom, if taking seriously a Lacanian conception of ethics. An ethical stance from a Lacanian perspective excludes a judgment concerning the essence or definition of a subject in terms of his/her 'true' nature which would pin her/him down to a certain reductive aspect, to one meaning, and would, based on this, elevate some elements to the status of universal 'ideals' or 'goods' through dividing behaviours into 'right' and 'wrong'. This would place the researcher in a superior position to the participant, as the one who knows the participant better than him/herself, who can access his/her mind by extracting 'objective' knowledge with only the correct 'objective' tools, and inversely whose own subjectivity is not involved in the process. Many mainstream psychological approaches, including discursive ones, operate from this standpoint, particularly those stemming from a behaviourist viewpoint, which claim to uncover internal states of the speaker such as emotions, meanings, cognitive mechanisms, or intentions (Parker, 2015a: 16) in what is a reduction of a phenomenon to an individual problem. Not only is this unhelpful — since it obscures the complexity of human nature in terms of the subject's idiosyncratic meanings and experiences as shaped by social, political and cultural structural forces — but unethical (Parker, 2015b: 76). It is unethical insofar as it creates a particular type of impossible/false, reductive knowledge, which is imposed on people by authority figures and through the guise of objective scientific knowledge/truth, which is then believed by people, and consequently affecting them in harmful ways, as this research will demonstrate. More specifically, the supposed knowledge that a person's suffering is the cause of his/her internal state is turned into a universal norm, or 'truth', upholding divisions such as normal/abnormal and sending the message that a failure to embody certain pre-established ideals must mean one is abnormal, and further, fully to blame for this abnormality (Parker et al, 1995; Parker, 2007). These norms become accepted as they are disseminated and consumed, which is the case more than ever today considering the

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[7] However, there is a problem here with how both lay people's and researchers' interpret scientific research results and studies, for it is not uncommon that results are interpreted in more universal and less flexible ways (not recognising the impossibility of objectivity) than the claims made by the authors of those studies.

psychological discourse has become one of the main ways in which we view ourselves in contemporary society as it seeps into all areas of life (Neill, 2016: 11). Consequently, the reduction of human nature to these assumptive stories (Ibid.: 108) leads to ever increasing alienation from ourselves as we are fed, and indeed today overstuffed, with stories which are not our own (De Vos, 2012: 9), and leads to more suffering and unequal power relations in that structural social, political and economic issues contributing to this suffering are left unexplored, unquestioned and thus maintained. One group of people benefits (the normal 'successful' ones), and the other (the abnormal/pathological or the 'weak' ones) is further blamed and oppressed. The psychological discourse in this manner creates certain subjects more than it describes them (Neill, 2016: 108). Individual blame inherent therein is perfectly compatible with economic exploitation as part of contemporary capitalist society (Parker, 2005b: 105). From this perspective, patients' dismissal of psychology can be considered reasonable. However, there is likewise a reductive aspect inherent in the biomedical perspective insofar as suffering (be it either physical and/or mental) is reduced to an individual, but this time *biological* problem/cause, albeit with the possibility of exonerating individual responsibility through a diagnosis.

The unethical issue, therefore, pertains to the reductive nature and to making a strict inside-outside opposition, a way of closing down the subject to one meaning and separating it from determining influences, which is an act of violence, an act of illegitimate restriction. A further act of illegitimate restriction is to postulate this meaning as universal and permanent; implying that one's 'weakness' or abnormality is irreversible. Psychoanalysis can fall into this trap and indeed does so through the so-called 'culture of psychologisation' (Parker, 2015b: 79). That is, psychoanalytic notions are pervasive in contemporary popular culture and act as ways of understanding human nature, most notably through concepts such as 'repression' and 'the unconscious' (more commonly referred to as the 'subconscious'). It is believed that a person's behaviour and decisions are guided by an unconscious intention, a meaning or feeling that was previously hidden away, repressed, but which can be uncovered as the actual, 'true' and 'authentic' intention of the person; one which is further considered a permanent motive throughout a persons' life. This is not what Lacanian psychoanalysis is, even if some researchers/clinicians/scholars come to wrongfully use it in this manner. The ethical in Lacanian psychoanalysis is a mode of openness: the multiplicity and polyvocality of meanings brought out by a disruption of meaning and a focus on the nonsensical aspects

of discourse (Saville Young & Frosh, 2010: 518). Adopting a Lacanian approach therefore entails taking seriously the unconscious as the place of an absence of meaning, or rather the perpetual deferral of meaning (Frosh & Baraitser, 2008: 355) and not a hidden away intentionality or agency of an individual subject. Respect is paid to subjectivity, and equally language, as something irreducible and indeterminate, or in other words to its idiosyncratic, contradictory, fleeting, and thus structurally incomplete nature. A Lacanian analysis is accordingly not 'down and deep' but 'out and wide' (Ibid.: 357). As there is no fixed essence of the subject, one cannot make a judgement as to 'the' definition or cause of a phenomenon such as fatigue, or particular states or characteristics which would be desirable for a collective society or group to obtain. In the light of this study, this means I have not answered the question of the cause of fatigue or reduced the condition to subjective factors explored, but recognise it emerging in a multiple aetiology where biology may play one role alongside subjective elements inclusive of both individual and socio-cultural phenomena. I have neither recommended one (reductive) solution to fatigue. Instead of uncovering one or the 'true' meaning behind discourse — as may be misunderstood to be inherent in a psychoanalytic method — I have, through a focus on the structure of the discourse, opened up manifold meanings able to co-exist. These constitute my interpretations of the text and I acknowledge there are others to be made; the same applies to my interpretations of Freudian and Lacanian theory.

In accordance with this, there is no expert able to objectively evaluate a phenomenon, since all subjects, participants and researchers alike are submitted to these limits of discourse in terms of its structural incompleteness. This is a resource rather than a hinderance (Parker, 2005b: 117), as it allows to open up perspectives around a topic. Thus, avoided in this type of research is the validation of the interpretations made, either by the researcher, others in the field or by the participant themselves, as occurs in some approaches where the researcher and the participant come to 'agree' on some views. This is nothing other than staying on an imaginary level and ignoring the structural limits of discourse, that it goes beyond individuals' intentions (Parker, 2007: 175), thereby shutting it down to certain views. It does mean, on the other hand, that patients'/the participants reactions to these research findings could go in any direction and is somewhat out of my control. Negative reactions where the participants may feel invalidated is of course a huge concern of mine for this study considering the controversies surrounding the PACE trial, which has created a distrust in

patients of psychological research as it is perceived to be doing a huge injustice to their realities. I have therefore attempted to take certain steps mitigating this.

First of all, I have attempted to be as transparent as possible in my analysis in terms of how I reached the interpretations, outlining as many steps as possible in my thinking and outlining as much of the interview excerpts and their context as possible. It is up to the reader to be convinced by them or not. I have, beyond this and as made clear above, not reduced fatigue to one interpretation or aspect or collapsed the participants' experiences into one. For instance, the next chapter exploring alienating encounters highlights a common experience for all of the participants, an encounter with the demand to 'keep going', but also showcases how the participants encounter and emphasise different aspects of this demand which have to do with different alienating elements (lack of control, accumulating demands, lack of acknowledgment of subjective differences etc.). I have in other words not united the interpretations into one, or reconciled contradictory views where I have taken one side over the other, neither within nor across discourses/interviews. I am, moreover, not making any fixed or static claims about the participants as individuals. I recognise that their situations since the time of the interview have most likely changed, and thus some interpretations may not be applicable to their current discourses/situations for this reason. In a similar vein, it is important to recognise the uniqueness of a situation in the fact that the discourse was produced at a specific time of the participants' lives and in a specific context which influenced it; between them and me as both a person and a researcher of an educational institution. This means that their discourse cannot be generalisable in terms of either extending it to their current situations or to everyone else who is suffering from fatigue/diagnosed with CFS/ME. Neither does this mean, however, that their speech says nothing about the current sociocultural context in which we find ourselves. Due to the fact that the subject is inseparable from sociocultural discourses, speech will highlight broader viewpoints as subjects come to draw on various discourses in formulating his/her experiences, some of which are easy to find elsewhere in common medical discourse, for example, or in popular culture. Indeed, one of the aims of this research is to underline dominant discourses as they repeat themselves both within interviews and across, in order to obtain the possibility of changing them, particularly as they oppress and harm subjects. In this way, by taking seriously Lacanian theory and rigorously, as much as possible, using the techniques part of it, the interpretations derive from a close consideration of the language

used, thus gaining an account more in tune with people's lived experiences and, inversely, mitigating the abovementioned unethical position where one makes illegitimate assumptions largely from the perspective of one's imagination. A Lacanian approach avoids these pitfalls (Neill, 2013).

Nevertheless, despite the abovementioned ethical standpoint, it can still be considered problematic to conduct in-depth analysis on highly personal and sensitive issues, as the analysis is formulated through someone else's words and perspective. This brings us to the issue of the use of clinical concepts and techniques in research, which again raises the question as to what we are doing when applying concepts to a text, and particularly those linked to a diagnostic category such as 'neurosis'. In this way, as Parker (2005a: 175) recognises, the researcher or the one analysing the text gets 'full reign' over interpretation, whereas in practice it is the analysand who mainly engages in the act of interpretation albeit with interventions and support from the analyst. This makes it all the more important to follow the ethics as outlined here in terms of keeping the text open to multiple meanings, making these interpretations as transparent as possible, and abandoning any reduction or rigidity (final words) around results. However, while this research uses some techniques and concepts which are similar to the clinic, there are also important distinctions. In the clinic, the analyst is constantly encountering a dynamic discourse constituting of a treatment, whereas my analysis, which nevertheless stemmed from a dynamic setting, is afterwards more or less un-changeable. It simply means that we need to be extra careful about drawing conclusions in research (indeed, which is also crucial in the clinic considering the fleeting nature of subjectivity). Symptom formation particularly constitutes a complex topic even in a clinical setting where considerably more meetings with the participants than time allowed in this research are necessary. I can here only repeat that I am not analysing the symptom of an individual, but a symptom of a discourse elaborated at a unique time and place. Moreover, and based on this, transparency is paramount not only in regard to my interpretations, but in terms of sharing this research with those who contributed to it, considering the thesis will be available for anyone to read. To this end, the participants of this study will be given the opportunity to read how their discourses have been treated, as a final type of debriefing stage. Once the thesis is completed, the participants will be notified and will be sent a copy of the thesis, and this will also constitute an opportunity to raise any questions or concerns they may have.

Continuous conversations about the topic and findings of this study with others and particularly patients and medical practitioners is essential, in terms of continuing to understand the area and revising/adding perspectives on it, and realising productive and respectful ways of formulating sensitive issues. Additionally, these conversations are crucial in terms of not merely highlighting dominant and/or harmful discourses — as that would reinforce them — but of allowing interpretations of a topic to change the coordinates of that topic. By focusing on the indeterminacy of language in relation to fatigue and importantly the intricate mind-body relation, it creates the possibility of changing those views on this relation and changing practices to more beneficial ones where the complex relation between the two is acknowledged, and ones which do not lock certain people (in this case those cases unable to be confirmed with biomedical evidence) in certain oppressive or restrictive positions. Productive conversations between CFS/ME patients, carers/practitioners and myself have already taken place at public seminars I delivered on my research in Edinburgh, where engaging and fruitful discussions opened up surrounding fatigue and psychoanalysis in relation to the practices of biomedicine and other contemporary ones. I am planning to continue, if funding opportunities allows, to engage in public seminars about this research and topic in order to shape knowledge with others.

Nonetheless, as the interpretations made in this thesis could come to affect others, and in order to follow an ethical approach as part of Lacanian psychoanalysis where meanings are multiplied as opposed to closed down, it is all the more important to consider the influence of myself as a researcher on this research.

Reflexivity

I no doubt coloured this research with my own views, experiences, desires and fantasies, from the very choice of the topic to the analysis of the interview transcripts. Indeed, such a subjective involvement was necessary as it fuelled a thorough investigation of fatigue, without which this research would not have been possible. But beyond me as a person, I belong to an educational institution existing in a specific culture where research has certain meanings and expectations for people volunteering to take part. That is, even though it is tempting to generalise the characteristics of the participants' relationships with me as a researcher to say their relationships with their GP's, medical practitioners or therapists (what

could be termed a transference structure), one again needs to recognise the specificity of the research situation. There will be different stakes, expectations and consequences involved which influences the discourses produced in this situation. For instance, the participants' discourses may be similar when speaking to a doctor as when speaking with me insofar as they 'borrow' from the same sociocultural discourses when attempting to explain their condition and attempting to communicate, for instance, that their condition is serious. In this way, I might embody 'the Other' (a governing authority), someone capable of bringing recognition to their condition on par with a medical practitioner. On the other hand, the situation greatly differs from a medical setting in terms of expectations and outcome, insofar as the participants were not prescribed a medicine or recommended or undergoing a treatment (therapeutic/psychoanalytic practice), even though there were expectations that participating in the research would facilitate this process insofar as the results would be fed back to medical health practitioners. Indeed, one of the participants was curious regarding my opinion on some management strategies in which he participated. This shows how intertwined but also different the situations are.

Something that hugely influenced the interviews in this research were the controversies surrounding my recruitment advertisement via the Facebook post outlined above, since it framed my research in a certain light. For instance, it may have been clear from the way in which I framed the criteria for participating that the research was open and flexible when it came to the diagnosis, insofar as I included people who experienced profound fatigue but who were not diagnosed, or who considered themselves diagnosed. This may have come across as unserious in some people's eyes if it was thought I was comparing discourses among people they considered were not part of 'their' ME group. This was not necessarily the case though, as some of the participants believed that ME/CFS could be further broken down into different groups and that those differences might come across in a study such as this. It arguably did, however, set up people's agenda for participating and the direction of what they wanted to talk about, since they did have much influence there. My emphasis on fatigue in the advertisement and in the criteria arguably gave rise to the participants' downplaying fatigue as a symptom and instead accentuating the cluster of symptoms involved; indeed some people asked in the Facebook post if there was a reason I had focused on one symptom (fatigue) out of many. As a result, I remember I made a note to myself to try to follow the participants' speech and the way in which they describe their bodies and

situations as opposed to being fixated on fatigue. This type of discourse of course also goes beyond me and the wording of the advertisement in the sense that the general view of fatigue, that it is not 'real' as discussed previously, determines people to speak from certain positions.

The controversies surrounding the Facebook post also, arguably, highlighted to potential participants that taking part was a risky business in terms of not knowing how their discourses/interviews would be treated. This risk was minimised insofar as they are anonymous and were told they would be debriefed afterwards, and in this way the interviews could have presented a unique and open space that some might not have encountered previously. In line with this, most of the participants were more open-minded in terms of the aetiology of fatigue (although as demonstrated above, there was much ambivalence here between physical and mental influences), than is oftentimes voiced within the ME community. It is probably true that those who were more open-minded were more willing to participate and thus ended up taking part in this study. Not only that, but some of the participants expressed a lack of confidence in voicing opinions therein if they go against the shared, dominant views. This showcases the importance of this type of research as some of the data produced might not have been able to emerge elsewhere[8]. The structure of the research does on the other hand make it (more) possible for certain discourse structures to emerge. Inviting people to volunteer to speak about their experiences presupposes a desire to speak, be heard and recognised, for their experiences to be symbolically registered and marked. It is therefore important to conduct research on a topic in different settings and in various ways.

In terms of the reflexivity related to the analysis of the interview transcripts, I inevitably coloured this insofar as I came to focus on parts of the interviews and theory in which my own subjectivity was more invested; the reason for which it is crucial to obtain other perspectives on the same topic through discussions, and not to mention the importance of disrupting meaning by bringing in multiple perspectives through a focus on the structure of a text, the process of following the letter. This was a learning process, meaning that I came to influence the research more at certain moments and places, particularly when my skills of discerning discourse structures alongside my understanding of the theory were under-developed. Because while the interview transcripts are more or less static — however the

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[8] Such as life events surrounding the onset of the fatigue, since this is not discussed in-depth elsewhere, to my knowledge. Other discourses, on the contrary, are omnipresent within the ME community and easily found online, for instance that the condition is described as a broken machine/battery run out.

production of which during the transcribing process I had also influenced in the sense of interpreting when to punctuate and exactly what to transcribe — my position was constantly shifting in relation to the texts. I came to interpret them differently at different stages. I admit I came into this research with a narrow view of the mind-body relation, believing there was a strong possibility of the research ending up being 'just another' one on depression. This turned out to be far from the case, and fortunately my views changed and became less rigid. There was particularly one significant moment which radically changed my position in relation to the texts, which I mentioned briefly above as being the point at which I begun focusing on the associative networks present in the text[9]. Before this, I was seduced by Freud's theory of 'actual neurosis', which I more or less imposed on the text. Briefly, this theory states that the cause of the symptom — symptom here being used in a Lacanian sense in terms of the underlying structure of a 'condition' — is somatic and not psychical, and thus the symptom corresponds directly to a physical sensation and more precisely anxiety (or an anxiety equivalent such as fatigue) as a result of an accumulation of tension which has been unable to be mentally processed. If a symptom takes on this structure, one would be unable to find any symbolisations in the speech surrounding the condition, or in other words an associative network where the symptom would be linked to discourses surrounding life events and other subjective factors. This is in stark contrast to that of a psychoneurotic symptom and the more commonly known conversion symptom, which has been formed due to a psychical conflict and constitutes a formation of the unconscious, a symbolic message addressed to the Other, where the body has taken the place of certain signifiers, answers or questions, as an attempt to symbolise that which was not symbolised. In this case, we would find a plethora of connections between signifiers and various meanings surrounding descriptions of their symptoms and various events or thoughts. While the theory of actual neurosis is not completely irrelevant to the structure of the discourses of those interviewed of this study, as I will argue in the course of this thesis, leaving it there does not do justice to what I eventually deemed more appropriate, which better resembled the form of a psychoneurotic symptom; or rather the combination of the two structures. Namely, there were

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[9] Paying attention to the structural associations of the text, understanding the theory and also realising my influence on the research, particularly at times I had to a large extent coloured it (or rather imposed my own meaning on it such as this moment), was admittedly aided by my own personal analysis with a Lacanian analyst. This is not to say that in order to productively conduct LDA one must be in his/her own Lacanian analysis, but I merely point this out to be transparent. I wonder how differently the research would have looked had this not been the case.

plentiful of symbolisations surrounding fatigue and the losses it entailed, which nevertheless arose from moments of impossibility/inability, or gravitated around these moments. This led me to consider the texts in the context of the differences and similarities to actual neurosis, and more importantly in comparison to the theory on conversion symptoms, which assisted with elucidating the structure of the discourses, and also helped me stay clear from the idea of 'the' cause of fatigue. That is, instead of an inability to symbolise one's body and situation (actual neurosis), what I found were many attempts at symbolising these (psychoneurosis/conversion symptom), even though these symbolisations and meanings repeatedly and eventually fail (there is no such thing as *complete* symbolisation but some stability can be found in certain symbolisations). In other words, what I wanted to find is not what I found. I wanted to find a lack of meaning, and what I surprisingly found were a multiplicity of meanings and the impossibility of escaping these, and furthermore the impossibility of ascribing to a condition a single cause and finding the 'truth' — realisations which were personally difficult. I found subjects attempting to, in various ways and sometimes similarly and sometimes differently, to symbolise the situations they found themselves in; constituting a type of logic embedded in an associative network which allowed me to put together the following interpretations. It was thanks to taking seriously a suspicious/critical point of view that made me repeatedly return to the texts and consider their structures closely, together with a constant scrutiny of my own motivation for taking the research in particular directions, as facilitated for instance by productive supervision meetings which allowed me to speak of and make sense of these issues. I further believe the concern I had about doing injustice to the participants' discourses given the context of CFS/ME ultimately made me a better researcher and made me extra critical to my own interpretations. Such a process reminds me of the quote from Picasso Lacan brings up in his seminars, 'I do not seek, I find'. In what follows, I invite the reader to suspend as much as possible what they think they may be seeking in reading a research study on fatigue, to constantly remain suspicious of the interpretations made and to add their own — hopefully ones that do justice to the discourses and realities presented in this study.

Chapter 3: The Alienating Demand to 'Keep Going'

What culture is, in the first place, is a stream of implicit and explicit commands to "Wake up!", keep on living, working, producing, consuming, copulating, loving, and enjoying…

— Aaron Schuster

The analysis of the participants' interviews as conducted for this study will start by exploring the discourses surrounding the onset of their conditions. Examining the onset of a condition is imperative for understanding any phenomenon as it is indicative of factors influencing its emergence and development, suggesting to what a condition is potentially a response. What elements are encountered at the initiation of fatigue which possibly act as some precipitating factors? Overall, at the onset of the participants' condition, recognisable there is a mind-body divide akin to that which was outlined in the introductory chapter: demands are encountered which ignore the subject's choices, identity, desire, needs and most importantly his/her lack and losses of these as a result of various life events. The participants' experiences of the demands can be elucidated through Lacan's notion of alienation, as the theory explains the process of symptom and subject formation — the two being highly intertwined from a Lacanian perspective — via the alienating encounter with demands. More precisely, integral to the process of symptom formation is the encounter with, and the subsequent response to, demands, since the subject/symptom emerges as an effect of language (demands articulate by others) on the (biological) body. Alienation will henceforth aptly offer details with which to analyse the interviews in what follows, alongside the notion of anxiety as it relates to it.

The Demand to 'Keep Going'

The demands found at the onset of the participants' conditions are tied to various life events, with the content of these differing between the participants. Nevertheless, there is an overarching attribute brought forth under the imperative to 'keep going!' — the most dominant one found for all of the participants at the onset of their conditions. The commandment to 'keep going' is shaped by the ideologies of late capitalism, and particularly by the idea of 'the body as machine': it asks for perpetual and constant activity and presence, for the body to operate like a machine. In so doing, the imperative asks the subject to ignore

the need to sleep and rest, or in the very least, relegates them to an unnecessary and inconvenient position. We can link sleeping and resting with an absence insofar as they constitute passive activities where the (conscious) subject withdraws from societal obligations in terms of pre-determined activities[10]. An absence, in turn, is what constitutes subjectivity insofar as the subject is inextricable to lack as a point of indeterminability. The subject is thus excluded if meeting the demand for constant productivity and presence. This occurs through the demand's suffocating characteristic which reduces the subject to an object of productivity, as depicted in the interviews; a reduction to a pre-determined, concrete place where the subject is left out. It is therefore necessary to outline an account of subjectivity from a Lacanian perspective in order to proceed with this argument. But I will first delineate how the demand for non-stop activity manifests within some of the participants' accounts at the initiation of their conditions, starting with a close focus on Tom's and Amy's discourses.

Tom was 48 years old at the time of the first interview. He explains that his condition emerged alongside two events: working "extra" hours at his work where he was doing twelve-hour shifts (A/L19-22) at a multidisciplinary emergency unit, and when his neighbours started making continuous noise by "having parties all the time" (A/L28-30). Even though he does not explicitly mention sleep around this event, we could infer that his sleep was disrupted due to the neighbours' noise. Potentially as a result, the demand to work, and/or the demands *at* work, become heavier. This could be interpreted through the statement he makes with regard to becoming more "sensitive" to the noise: "And this was a continual thing but I kept on doing my work, I kept on working" (A/L36-37), after which he became tired. The "I kept on working" could be read as a demand to 'keep working' and to 'keep going': that he had no choice but to keep working, and this aspect was arguably emphasised during the introduction of the neighbours' noise. A stronger suggestion that working possesses the quality of a demand is that the word "continual" used to describe the noise, is also mentioned in relation to his work, in connection to overwhelming demands. Tom lists the tasks involved at work: "get case lists going for patients, sitting, bringing them in, monitoring", and "up, down, walking up corridor, getting stuff back", "on my legs twelve hours a day" (A/L386-389) — tasks which could be interpreted as demands for the body to physically work. Not only that, but there is a sense in which he is reduced to these physical

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[10] While sleeping and resting are interchangeable in this manner, I will mainly use the term 'sleep' since it more aptly relates to the response of the subject in terms of a drive and desire for sleeping (fatigue), and with Lacan's notion of the drive being an effect of a demand on the biological body, with sleep being a biological need.

activities since he says straight after this: "I was continual", denoting an existence, "I was", in never-ending activities. The continuous aspect implies there is a lack of room for other activities, most notably those with a low level of activity such as resting and/or sleeping. Accordingly, in relation to his neighbours' partying noise, he said "there was no fucking escape" (B/L422). The element of inescapability reinforces the reductive experience. Amy similarly invokes the notion of being reduced to work through the factor of inescapability.

Amy was 42 years old at the time of the first interview, and her condition started after having been "forced", as she put it, to have the H1N1 vaccination for the swine flu at work as a nurse, in order to protect chemotherapy patients. She says: "we got…*made*, I suppose um, *encouraged* maybe forced may be another word, to go and get the vaccine - to have the vaccine" (B/L104-106). While she hesitates to call it "forced", she emphasises this aspect in the first interview: "I was a bit bitter but I was made to have it at work, it was an enforced thing" (A/L24-25). This could be interpreted as constituting an event going beyond the immediate vaccination where Amy is instead confronted with a general demand to work, or to 'keep going', which could further be experienced as an intrusion. For Amy, the demand does not appear to be limited to work, for when I asked her what was going on generally in her life when she got ill — something I repeatedly asked the participants in order to uncover details about the potential influences at the onset — she replies: "Apart from being a - a working mum…" (B/L302). This can be read as, beyond obviously referring to that she both works *and* is a mother, that being a mother *is* work, which is attested to when she says that while she always had a "high level of stress - stress, high level of responsibility" (B/L363) at work, she found that "planning meals for a family was more overwhelming" (B/L364). It points to a blurring of the distinction between work and private life — life itself becoming a chore and is experienced as homogeneous. Accordingly, when Amy talks about the onset of her condition she conveys: "and I would *dread* every week I would dread *work*, my home-life because I would come home from work not able to cognitively thinking about planning a meal for children" (A/L50-52). The two, work and home life, are related, both involving a high level of responsibility and a similar task seeing as being a nurse and a mother involve taking care of others (we return here to the other side of "working mum" where working is being a type of mother). The latter is reinforced insofar as Amy just prior to this explains how she switched to a "less physically demanding" role, where she was "using my thoughts", which can be linked to the statement "cognitively thinking about planning a meal for

children". That this leads to a homogeneous reality could be seen in the following excerpt where she speaks about being on and off work in what she calls a "cycle":

> Think, when you're in this work cycle of you know ill, you get better you go back to work then you become ill again. When you're in that complete wheel you're always worried about the next stage. Like you would sit "ugh" if you were on a day off you'd be like "God I've got work next week". Or Monday um how am I gonna cope with that, how will I feel on Monday night? (B/L199-203).

Even though she is talking about being ill and the fluctuations between working and not working, a cycle is linked to work insofar as she terms it a "*work* cycle", and the demand to work is immanent in the expression "God I've got to work next week" — something she *had* to do. She refers to this as a "complete wheel", with the "wheel" part suggesting a movement into which she gets caught, perhaps helplessly so. That she calls it "complete" denotes something inescapable and enclosed, and more specifically what she is unable to escape is thinking about having to work (outside of it). The demand is ubiquitous. The enclosed quality is corroborated in the following sentence: "But when you're in that cycle you don't - you don't see that window, you don't see that way out" (B/L211-212)[11]. This suggests a cycle of never-ending homogenous motion, which is strengthened in her interviews when speaking about a "dark period" where she had an "ear infection": "But to get up every - every morning with the same way and every day being the same" (B/L295-298). There is here an imperative to 'wake up', inextricable to that of 'keep going'. Amy's indications of experiencing a homogenous reality is in line with what is theorised today regarding contemporary society, as influenced by late capitalism. With the belief in a non-stop operation of human activity, the binary day/night, and on/off, does not exist and instead, life becomes homogenous (Crary, 2013: 13). It also goes with Byung-Chul's (2015: 5) argument that in modern society, instead of finding a negativity, there is a 'surplus positivity', or more clearly, 'too much of the same'.

Relatedly, it is not (only) a high level of activity which is troublesome for Amy, but seemingly when the activities melt together into one. Amy mentions that she became unwell after she finished her degree in nursing (B/L334-335), the timing of which is the "opposite

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[11] Indeed, since she is still talking about fluctuations, fatigue could be a way for Amy to install difference through a cycle, which will be discussed in the subsequent chapters.

of what you'd expect", since during it she had to work, study and take care of children — involving a high level of activity. However, studying entails working towards a goal, where there is a difference between now (attempting to obtain a degree) and then (having obtained a degree), and could furthermore be linked to a more personal achievement, something one does for oneself. This suggests an experience that might also be the case for some of the other participants: during the onset of their conditions, a goal (as an object of desire) was achieved, and without the creation of another goal afterwards there is stagnation and homogeneity with no perceived way out of one's current situation. There thus seems to be a difficulty in working full-time after the object of desire was obtained, as Amy herself says during the onset: "I was a band 6 nurse, I was in a really good career, and felt important and achieved everything I wanted to achieve" (B/L641-642). Another indication of such a difficulty is that she explains feeling tired after she gave birth to her son: "So I was trying to be full-time - work full-time, um and have a baby at home and it just - the whole things just, crashed around me" (B/L322/323). That she says she was "trying to *be* full-time", suggests an existence reduced solely to the aspect of working, both as a nurse and a mother, the solution to which was to work less: "I reduced my hours and then I was *great*" (B/L326-327).

Therefore, in both Tom's and Amy's discourses — present too in the other's discourses which will be evident as the chapter unfolds — we discern the demand to 'keep going', a demand which asks for constant presence and productivity. If met, it reduces the whole of one's being to concrete, specific activities, with no room for other activities and subjective factors, as illustrated by the inescapability of their situations. What is excluded is, commonsensically, one's own desire due to a focus on others' demands, which will be considered more below. The disappearance of the subject behind a demand is in line with, and can further be understood through, Lacan's concept of alienation. Alienation outlines the emergence of the subject and inversely, how the subject is excluded by meeting a demand when the demand refers to a pre-determined, concrete place — constituting a highly alienating state. This then necessitates a discussion on what the subject is, and conversely, what it is not.

Subjectivity from a Lacanian Perspective

The subject from a Lacanian perspective is reducible neither to the body with its biological rhythms, nor to culture (Schuster, 2016: 44) as mediated through discourse part of the social order. Rather, the subject can be understood as emerging through the difference between biology and culture; a difference which ultimately makes possible a link between the two. This can be explained in-depth through the interaction between need and demand, since the subject is produced through an effect of language (demands articulated by others) on biological needs (Neill, 2014: 52); the pathway by which socialisation occurs.

The process of socialisation transpires through the communication of biological needs addressed to someone else. An infant is at first largely governed by biological needs and communicates these through actions such as crying. In order for the child to have its needs satisfied, communication in language is necessary. But once a need becomes articulated within the structure of language, it is turned into a demand which takes on a symbolic and intersubjective function as it addresses someone else, usually the parents (Van Haute, 2002: 104, 107). Needs then become bound up with social rules through the interactions taking place between the infant and the parent(s): the parent demands how, when, what to eat, drink, and how and when to defecate, urinate, sleep and so on, the content of which is shaped by social decorum. In turn, the child responds to these demands with his/her own demands; the demands from both directions becoming intertwined (Pluth, 2007: 65).

Demands are part of what Lacan calls the big Other, which is inclusive not only of language such as words and images as sense-making activities, but also implicit and explicit social rules governing our cultural world, thereby giving it meaning and making co-existence possible (Salecl, 2000: 3; Žižek, 2006a: 26). The Other structures our psychic realities and enables communication through a reference to shared meanings, and through the three intertwined realms: the symbolic (which consists of a logic of signifiers producing sense), the imaginary (which adds meaning and makes possible imaginary identifications), and the real (that unsymbolisable which escapes the two former orders). The intervention of this social order on the biological body, through a demand, diversifies needs in that we come to have different eating habits for instance, highlighting the fact that biological processes alone cannot account for the varied ways in which people eat (Van Haute, 2002: 106). These biological processes then become highly intertwined with that of pleasure, also determined by social interactions and exchanges taking place around what Freud called erogenous zones

(oral, anal, and genital). The articulation of a need in language transforms the need into a demand, something that aims beyond the (object of) need such as food, since the demand takes on a symbolic function: it possesses the quality of always being about something else and something more. More specifically, this 'something more' is the search and demand for love as Lacan states (2002/2006: 580). The search for (unconditional) love is probably obvious in human interactions but particularly evident in children who are not just wanting the food or the candy in a shop, but wanting to see how far their parents will go in meeting their relentless requests. It is thought that unconditionally meeting the child's demands is a sign of love. In accordance with this, it is well documented through research in attachment theory that certain animals are not sufficiently satisfied by basic survival items such as food and water, but need something beyond biological satisfaction in the form of a sense of comfort, safety and thus love. As Lacan writes: 'In this way, demand annuls the particularity of everything that can be granted, by transmuting it into a proof of love' (Lacan, 2002/2006: 580). With this, he points out that demanding love involves asking for something impossible to be 'granted', because how is love given to the subject who demands it? The simple answer is that it is not possible to give — one of the potential meanings of Lacan's famous axiom 'love is giving what one does not have'. There is no final answer or guarantee for the demand for love (Van Haute, 2002: 109), which simultaneously means unconditional love does not exist as it is not possible to satisfy all of a person's demands; hence why we see repeated attempts from people expressing their love to their partners — the need to constantly repeat 'I love you' for instance. We ultimately do not know what love entails. 'Why do you love me?' one asks one's partner (either explicitly or implicitly), only to be met by disappointing answers. This means that answers to love always fail; the demand for love is insatiable. The demand for love is strongly tied up with questions of existence, as being in the position of someone lovable would give meaning to one's existence; a position which is associated with certain qualities the subject perceives to be upraised by the Other. To be loved means, for instance, to work hard, or to be engaged with certain professions and so on. However, the child cannot, likewise, receive an answer for his/her existence that would guarantee a place in the world. At moments when this is realised by the subject, s/he is confronted with the mOther's enigmatic desire and radical lack in the sense that the subject does not know what she desires, and consequently, what the subject's existence and purpose is in relation to her

desire. This has to do with the structural incompleteness of language, language being the route through which an articulated need travels.

Structural lack/incompleteness stems from the fact that there is always a mismatch between the physical need, the language used for articulating it as a demand, and the way in which the parent interprets the demand; and furthermore, how the child interprets the parents' interpretation. Meaning is either too much or too little (Van Haute, 2002: 109) and demands are contradictory (Fink, 1999: 122). Consequently, we naturally coincide neither with our biological bodies nor with images or words used to represent and think about ourselves. The fact that we say we *have* a body as opposed to that we *are* a body attests to this. Our bodies are unable to be adequately represented symbolically, which we can all most likely attest to during attempts to describe in words a bodily sensation, such as a headache or tiredness. Words are insufficient as they do not match up with our bodily experiences and one cannot say it all at once (Frosh, 2007: 641). Similarly, an image cannot capture a real, living and breathing human being, despite the expression 'an image says a thousand words'. A mirror image or a picture only offers a limited view as it cannot capture all angles simultaneously, nor the insides of the flesh. Thus, a representation (of identity) is always partial. Not only that, but representing an experience changes the very nature of that experience since it comes to frame it (Frosh, 2007: 641), as was argued with biological needs, and such a framing will give new meaning to it and alter the previous meaning. We are thus always alienated and separated from ourselves since the introduction of the symbolic adds a layer through which our experiences get filtered, whether we want it or not. As a consequence, all we can do is retroactively postulate a sensation, or a biological need, as having been there beforehand (Neill, 2014: 55), since entering the symbolic, a mode of alienation, entails losing access to the primordial real as that which resides outside signification, but which nevertheless exerts an influence on significations and experiences (Moncayo, 2012:193), such as biological factors. In other words, we cannot step outside the symbolic and gain direct access to our (biological) bodies, but can only come to understand our bodies through the standpoint of the symbolic. What this all means is that we cannot receive an answer for love/our existence, due to the fact that 'there is no universe of discourse' (Lacan, 2011: 69). The word universe, etymologically speaking, means to turn something into one/into a whole. The statement refers to the fact that the subject cannot be one with the Other; cannot be fully integrated into society, or with its own body which comes to have a life of its own. Non-reciprocity is part

of what Lacan (Seminar XIV: 215) calls the 'fundamental logic argument', foundational to subjectivity and alienation[12]. Something always escapes.

However, the subject is not the 'true' or 'real' being which cannot be captured in images and words, but arises as a surplus from the failure of integrating nature and culture, or in other words, the body and the mind, where the mind represents the imaginary-symbolic order and the body represents the primordial real. The real as the surplus which escapes the integration to a system of representation is conceptualised by Lacan's theory through the notion of *object a*, that which 'gives body to the impasse' (Schuster, 2016: 44). More exact, structural lack inherent in language becomes expressed in the body as a lack of satisfaction: a need which is taken up at the level of a demand turns a biological activity, such as eating, into an unquenchable appetite as we come to eat either too much or too little, as Freud observes (Shepherdson, 1997: 138). A tension related to biology turns into a tension of non-satisfaction pertaining to the drive and desire, thus driving us to repeat activities, just as we repeat love expressions. In contrast to this, a need is a physiological lack which can be (temporarily) satisfied, and is satisfied with a specific and concrete object, for instance food satisfies the need of hunger (Van Haute, 2002: 104). If a need has the factor of specificity to it, i.e. can only be satisfied by a specific object (food, sleep, etc.), in a demand this element is lost due to the un-specificity involved in lack (as surplus). Not only that, but a surplus is present as the driving force of the subject, which is the very substance of the subject and more specifically in the form of drive and desire. The drive and desire are both the effects of the intervention of language on the body, having escaped as something 'additional, supplementary or adjacent' (Neill, 2014: 55), with Lacan stating that desire 'rebels against the satisfaction of need' (Lacan, 2002/2006: 580). A symptom consists of the drive and desire, which come to act as attempts to articulate answers of existence through the fundamental fantasy. However, this occurs on an unconscious level, and indeed the surplus is strongly related to the unconscious since the latter is the place of non-meaning, from which meaning nevertheless emerges. An in-depth account of the interlinked yet different concepts of the drive, desire and fantasy will be outlined in the next chapters; the most important factor

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[12] The process of alienation can only come about retroactively through the other logical process of separation, which introduces lack into the social order. Alienation and separation are thus highly intertwined (the lack of separation results in a lack of alienation as seen in certain cases of psychosis where a sense of identity is missing). In the seminar from where this paragraph is taken, the two notions seem to be more exchangeable. As Fink (1997: 61) observes, in seminar XIV and XV, separation becomes subsumed under the term 'alienation'.

to note here is that the subject is not equivalent to a surplus, but that it *emerges* through a surplus.

The subject is more specifically divided between two poles. When structural lack is embodied, or imprinted in the body as a non-satisfaction, the subject comes to confuse lack with loss, thereby experiencing a loss in his/her body. This loss in turn inaugurates a fleeting, insatiable desire, perpetually seeking an object that is 'not it' (Neill, 2014: 40) — particularly searching for its completion through love as a way of remedying it. Lack then comes to act as the basis for identifying with an image, an image better and more complete than the experience of one's current shortcomings, which is how the mirror image *qua* the ego and consciousness is established (see Lacan (2002/2006) 'The Mirror Stage as Formative of the *I* Function' essay). However, the subject is neither the imagined completion (consciousness), nor the incompletion as the driving force (unconscious) towards completion, but the very split between the two, between the unconscious and consciousness (Neill, 2014: 22-23) — which nevertheless comprises a form of incompleteness. The subject is only capable of emerging through lack and absence (of a symbolic-imaginary place), as the embodiment of the surplus stemming from the failure of integrating nature and culture, or the body and the symbolic order.

In this sense, identity, as a representation of the subject in the Other, always entails an alienated form due to its partiality: the subject inevitably disappears behind a representation, a process Lacan (Seminar XI: 208-210) refers to as *aphinisis* based on Ernest Jones' term. But a more alienating form, arguably, is not recognising the factor which escapes and postulate the subject as complete, as fully coinciding with an idea and/or an image. This constitutes a reduction to a need insofar as satisfaction removes lack and the point of indeterminability which is the subject. The subject is that which perpetually questions a place (Pluth, 2007: 61), meaning that when a demand entails an articulated need, an object is present which is able to extinguish desire and thus the subject (Van Haute, 2002: 110).

In light of this account of alienation and the formation of the subject, we can better understand Tom's and Amy's discourses delineated above. The demand to 'keep going' represents a strengthened form of alienation insofar as, if met, the subject is wholly reduced to a physical, concrete and known object akin to a reduction to a need. This is highlighted in Tom's case as someone always on his feet, working with physical tasks, and through the position of a 'working mum' in Amy's case, something she is arguably reduced to after

having finished a goal (studying). The reductive aspect of it can be recognised through references to inescapability present for both, further linked to a homogenous reality. These experiences constitute confrontations with being reduced to a machine-like entity, an object of productivity in the sense of solely serving others (patients at work and/or children), through a constant (conscious) presence. This leaves little or no space for an absence in terms of a break or resting, or even something else such as one's own goals. Meeting the demand to 'keep going' suffocates desire and the subject.

The Indifference of the Demand to 'Keep Going'

While we discern in the interviews the participants being addressed as a machine-like object of productivity — being suffocated by someone else's demands — we also detect, conversely, experiences of not being addressed, which around the onset of the condition seem more prevalent for some of the participants rather than for others. However, these two aspects are strongly intertwined and result in the same scenario: the subject is excluded in a lack of a place, still through the demand to 'keep going'. This will be illustrated in what follows, and how a combination of the two can be found for one person, particularly within Mark's and Beth's discourses which take centre stage in the following analysis.

Mark was 44 years old at the time of the interview, and as he describes the events surrounding the onset of his condition, some similarities emerge between them. During the time he felt unwell, and after having been to the General Practitioner (GP), he presented his work with the GP's fit note, which recommended one day off work a week. His work's Human Resource department subsequently refused "to honour" (A/L29-32) the GP's recommendation. Mark uses the word refuse ("refusing") to describe this, and what is refused more specifically is his subjectivity in the sense of there being a lack of regard of his particular circumstance: that he was unwell and needed rest. The latter activity did not receive a place/registration, and for this reason, it strongly relates to the capitalistic commandment to 'keep going'. Mark thereafter explains: "I just tried to work full-time um with the inevitable result that I collapsed completely and I had to remain off work for some time" (A/L36-37). This event thus appears to exert a significant influence on his condition. The scenario is repeated when presenting his work with the GP's second fit note, recommending him to work even less (two hours a day): "my work declined to honour my fit note and that

is what caused my second collapse" (A/L233-234). Work thus refuses to meet his demand for time off and instead demands full presence though full-time work. There is another event which potentially relates to this, insofar as Mark is met with a refusal, although in a medical setting.

Mark goes to his GP and demands to be referred to a specialist clinic, Maudsley, since he wants comprehensive help: "CBT, graded exercise therapy and liaise with employers" (A/L142-144). He then receives an appointment at Maudsley, only to have it cancelled two weeks after. He goes there "literally in floods of tears" with his wife asking them: "Why, why have I been declined?" and "why…why can't I get to see you?" [tearing up] (A/L157-160). This was the most emotionally charged moment of his interviews, which could be elucidated through the words chosen here. The fact that he says "Why have *I* been declined" rather than the appointment, points to the cancelling of the subject itself by not being taken seriously and not receiving what he thinks would benefit him. There is beyond this a lack of understanding as to why his demand was refused, corroborated when he says prior to this that the appointment was cancelled with "no reasons given. No nothing" (A/L152). It suggests that he is reduced to an object of nothing — not worthy to be seen, let alone being given a reason for why he cannot be seen. The Other's refusal, here embodied by medical professionals, comes across as random and vicious. This moment could be compared to that of encountering the mOther's enigmatic desire whereby the child attempts to symbolise her presences and absences in order to figure out what s/he means for her. As long as the absence of the Other cannot be explained, or before the child creates an answer in and through the fundamental fantasy, the Other appears as an autonomous, omnipotent and unpredictable agency who randomly decides whether or not it will meet the child's demands (Van Haute, 2002: 117). One faces in such a moment the indifference of the Other; the Other more specifically being indifferent to the subject's own needs and desires, which could relate to Mark's situation when meeting his GP's refusal. The Other's refusal in this way is akin to a cold indifference, where, as, as Schuster (2016: 140) puts it: 'There is a side of the Other that is not concerned with me and does not in the least accommodate my existence' (Ibid.: 142). An indifference stemming from a refusal is present for Mark both in a medical setting and at work, which he experiences simultaneously. He explains the following in a similar scenario when he returns to his GP demanding to receive help beyond CBT:

They said 'No. You're getting the CBT'. And du-and during that time my condition worsened so much that I was regularly crying in meetings with my boss, saying 'I just can't do it, I just can't do it'. And him saying 'Yeah well it's not my problem' (A/L177-179).

The refusal of his demand is clear by them saying "No. You're getting the CBT", in turn demanding a specific treatment. Their refusal is analogous to the demand to 'keep going' in terms of a reduction to a need with regards to the aspect of universality and pre-determinacy: everyone is getting the same treatment, regardless of idiosyncratic needs/personal preferences. This situation is not unique to Mark's situation but omnipresent in contemporary society, governed by the logic of science where the average number applies to all. The indifference of the Other presents itself when his boss is perceived to proclaim "Yeah well it's not my problem". In other words, he is not concerned with Mark's inability to work or his need to rest. We notice here the passivity and disorientation connected with encountering the indifference of the Other (Shuster, 2016: 142), since their refusal is enigmatic as well as unable to be influenced by Mark. Subsequently, the impact of these experiences on his condition is evident as it "worsened so much" to the point of being unable to carry on working.

A disregard for the subject is likewise discernible in Beth's account. Beth was 23 years old at the time of the interview, and the emergence of her fatigue came about as she was in her final year of her undergraduate studies at university, which she describes as an intense and stressful time. Additionally, during this time, her parents split up, resulting in her not having a place to live: "So they just didn't think about it and they both like made new plans for their lives that didn't include me having anywhere to live" (B166-171). It is not just the aspect of not having a home after finishing university, but that her place was not even considered by her parents, pointing to an indifference of the Other in an exclusion of a place therein. Something analogous takes place for Lucy and Gail, whose conditions both developed after having undergone operations.

Gail, 57 years old when I interviewed her, considers that three events precipitated her condition: two major operations and her sister's death. In relation to the operations, she postulates there was a reaction to the anaesthetics: "…it was like I never came out of the

anaesthetics" (A/L310-311). The first operation occurred in 2000 and was an elective hysterectomy as a result of Endometriosis (A/L265; L283), and the second operation took place in 2008 where they re-made her oesophagus due to issues related to GERD and IBS (A/L69-70), after which she was "bed bound for a year and a half" (A/L305-306). She conveys in relation to this latter operation a lack of acknowledgment pertaining to her needs:

> Cus the cuts and stuff were so deep and the amounts of cuts they made and things. And they wouldn't give me anything for pain after the operation. *Nothing*. *Nothing*. I've been through *hell*. And I said I need something for the pain and they just wouldn't give me not even a Paracetamol. And I've just been cut like in eight places. That trauma just about wiped me under the table (A/L311-315).

The repetition of the word "cut" is reminiscent of having lost something of her body — here an actual physical castration — which gives rise to a discomfort in the body, pain, of which she then wanted to get rid/diminish. The discomfort constitutes a lack of satisfaction in the form of a need/wish, and is expressed through a demand, "I *need* something for the pain", which the health care professionals refused to meet: "they just wouldn't give me not even a Paracetamol". This moment of privation, in a similar fashion to the other participants, can translate into a confrontation with the Other's radical lack *qua* indifference: the Other is not concerned with your needs or wishes, subsequently leaving you alone with your "trauma". A similar experience of privation occurs in a third hospitalisation in 2012 where a stone from her gallbladder was taken out, and when the health practitioners refused to give her "any food or water for six days" (A/L328). Thus, the experiences appear to entail an exclusion of the subject and potentially a reduction to being "nothing". This situation can be elucidated through the concept of anxiety as conceptualised by Freud and Lacan.

Freud (1959), when (re)conceptualising the concept of anxiety in his 'Inhibitions, Symptoms and Anxiety' paper, somewhat dismisses the view that anxiety results from a separation and the subsequent loss of an object, such as the mother as the love object. Instead, he emphasises the fact that the mother immediately satisfies all the child's needs — hence the danger lies in a non-satisfaction: 'a growing tension due to need against which it is helpless', associated to 'the experience of being born' (Ibid.: 137). This resonates with Gail's experiences where her needs were unmet, and she further invokes an element of helplessness

in relation to this: "I just had to lie there and cry out and say I can't do a thing for myself (C/L429-430). A Lacanian reading of how Freud conceptualises anxiety entails taking 'being born' not literally but as part of the process of alienation. Alienation, entering into the social order, always entails the experience of loss related to the structural lack of language, which comes to be felt in the body as a lack of satisfaction. Nevertheless, anxiety about loss or non-satisfaction here would not be in line with anxiety proper from a Lacanian perspective. Rather, such an experience refers to what Lacan singles out as (imaginary) castration anxiety, in the sense of encountering a loss which should not be there, in which case it is accompanied by the belief that loss can be resolved (Lacan, Seminar XI: 175-176). For Gail, we can postulate that the loss experienced after her operation through references to cuts is considered unnecessary since it is thought that it can be remedied by the Other; though the Other chose not to and instead ignored the loss of the subject[13]. Something similar is noticeable in Lucy's discourse who also experiences loss after an operation.

Lucy, 44 years old, had an operation in March 2012 (L/446), a "colposcopy to remove pre-cancerous cells" (L761), which she deems being one of three causes of her condition. The other two were thought to be glandular fever, which she had a suspicion of having, and an infection as a result of the operation. There was, similar to Gail, a potential reaction to the anaesthetics given at the operation, which she explains as follows:

> And then the day I went for the operation, I had a sore throat, a really sore throat again. And I though they were gonna say "no" when I went in, 'cus it was a general anaesthetic. And I thought they were gonna turn me away and they didn't. So I thought oh well, must be alright then to get an operation with a sore throat, 'cus I know in the past if that was one of the things - if you had a sore throat they would not give a general anaesthetic. So they took me, and…the day after I just - I was ill, I was so ill (L/779-785).

What is described here pertaining to the operation appears first to be something of the opposite to the other participants, since the medical professionals did *not* say "no"; she was not refused ("And I thought they were gonna turn me away and they didn't"). However, this

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[13] However, Lacan's proper concept of anxiety is also very relevant here and throughout this chapter (as a lack of a lack), which I will explain later on and argue how the two anxieties are interrelated in the sense that the former leads to castration anxiety.

could also be read as a refusal of her subjectivity since they did not account for her sore throat, something which was wrong with her and according to Lucy deserved a thought of precaution in relation to the anaesthetics. The expression "So they took me" could indicate a disappearance behind the Other's decisions/demand to operate, which lead to an actual physical loss which might have amplified a symbolic loss. Sore throats seem to be integral to Lucy's identity as she explains they have been present constantly since she was a child, alongside the hay fever associated with it (L/92-95). Based on this, an important part of her identity was perhaps not considered by the Other. We could postulate that there is an implicit demand here to 'get on with it' for both Lucy and Gail around the operations, since they were given the impression that being put to sleep by anaesthetics is no big deal: there is no need to consider what a specific person might need either before (Lucy) or after (Gail) the operations which could facilitate the recovery. Recovery/resting time is neglected — in line with the lack of space for inactivity found in late capitalism and through the injunction to 'keep going'. However, the indifference of the Other is clearer for Lucy following another loss, after which she appeals to the medical Other as a body of knowledge.

The third event Lucy postulates as a cause to her condition is an infection acquired from the operation (L288-289). In September after the operation, she was "bleeding constantly" (L794), and went to the toilet to wipe herself, whereby a "cotton wool" came out of her: "And it had, bits of…tissue on it, as in *me* attached to it. It was, it was like [quietly] vile" (L/803-804). This moment can be considered to constitute a loss of herself ("as in *me* attached to it"), for which she makes an appeal to the Other. It is here Lucy describes a clearer refusal as she recounts her interaction with the GP: "I said 'You *don't* need to see me?' 'No." (L805). The indifference of the GP is palpable here, and further so when she says after this "…[he] didn't need to see me. Didn't *want* to see me" (L/817-818). The GP was unable to account for a loss pertaining to her body, or was unable to symbolise her body. Not only that, but the Other was perhaps unwilling to do so as there was no urgency ("didn't *need* to see me") nor wish ("didn't *want* to see me") to consider the potential dangers for Lucy. Radical lack comes to the forefront, which for Lacan is inevitable considering the body can never be taken up into a symbolic framework and full recognition (unconditional love) is impossible. We further discern, analogous to the other accounts, how the medical encounter constitutes a reinforcement of the onset event, where the subject is refused and loss is not recognised, as it is experienced through various bodily discomforts strongly tied to a loss of productivity/an

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inability for the body to 'keep going'. This is in line with what Verhaeghe (2004: 310-311) observes regarding the medical treatment of modern somatisation, that the medical setting repeats an earlier situation where the Other has failed to provide answers. Arguably however, this moment arises from having received an answer from the Other, most commonly in the form of 'there's nothing wrong with you'; an answer which excludes the subject from the Other.

'There's Nothing Wrong with You'

All of the participants, when going to the GP for help with their conditions, encounter the medical Other's either explicit or implicit message that 'there's nothing wrong with you', after which their conditions worsen. Amy for instance relays the following:

> …you go away and you think 'right ok. They've said there's nothing wrong with me. I'll keep going'. But then, I was vomiting after I was eating my tea at night. And I'm like [breathes out], there's something else not…something not right (B/L476-483).

We discern how the statement "there's nothing wrong with me" simultaneously invokes the demand to 'keep going', since Amy says "I'll keep going". Indeed, in the face of a lack of any positive medical results, there is no excuse to stop — hence the scientific discourse reinforces the commandment found in late capitalism. In this case, the statement 'there's nothing wrong with you' (alongside the demand) constitutes a lack of a lack insofar as it comprises a complete answer which stops further speculations. That is, uncertainty and indeterminability (lack) which fuel questions and investigations in an attempt to explain the body and the incomprehensible situation and bodily discomforts a subject finds him/herself in (an experience of lack/loss), are foreclosed in a lack of a lack. There is no space for considering any other explanations or possibilities other than 'nothing is wrong with you', which excludes subjectivity and desire as such. It involves a symbolisation which stops further symbolisations. This statement can also be traced implicitly in the accounts just examined, because if nothing is considered wrong with a person, there is no need to take into account his/her lack (of satisfaction) or other bodily sensations which has led to a loss of

productivity. The subject, in the eyes of the (medical) Other, is not considered lacking, or having lost anything. Contrarily, if lack or loss is acknowledged by the health professionals, it is thereafter attempted to be removed through treating it, which can be observed when Mark is offered CBT. There is an emphasis on a lack of a lack whereby the subject is supplied with 'the' valid answer regarding one's well-being which science purports to hold: that CBT will be able to remove one's lack, or that nothing is wrong. Such a moment of shutting down indeterminacy relates to Lacan's notion of anxiety proper, since he conceptualises it as a lack of a lack, as the 'void being closed' (Lacan, 2014: 53 as cited in Hook, 2015). Lacan also terms anxiety a 'universal satisfaction' (Lacan, 2002/2006: 689), referring to satisfying a need which would remove the gap[14]. If the void as lack/*object a* closes, then the subject disappears.

However, the expression 'there's nothing wrong with you' does not remove lack/loss for the subject but seemingly does the opposite: it comes forth with a vengeance. For Amy, we notice incomprehensibility in the statement "there's something else not…something not right" linked to throwing up, in terms of not knowing the cause(s) of her vomiting (bodily tension). Fundamental lack comes to the fore in the fact that it becomes palpable that her current body does not coincide with the statement "there's nothing wrong with me", and more broadly with a person capable of constant activity and conversely incapable of lacking. However, through vomiting, Amy is arguably attempting to install an absence in the face of a lack of a lack, to create a gap in the place of fullness, which will be the focus of the next chapter in relation to this particular passage. Now, the important factor to note is that the participants' experience of loss is reinforced instead of it being represented/acknowledged and considered potentially treatable, as promised by a specific treatment linked to a biomedical diagnosis. This can be explained by elucidating the function of a symbol/representation.

A representation distances the subject from the real, offers respite, through the Other's recognition (McGowan, 2004: 22). It does so through putting into movement the signifying chain and thereby the production of lack, for example, in the form of speculations of what fatigue/the condition could be linked to: biological factors, psychological factors, life events,

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[14] The link with anxiety here, and in what follows in this section, does not necessarily mean that the participants are *experiencing* anxiety, but I am merely linking the structure of their discourses with the relevant concepts. This is not to say that anxiety is *not* felt: there is a case to be made that the bodily tensions/symptoms appearing afterwards are linked with anxiety. However, fatigue as a response will be the focus of the subsequent chapters and not dealt with here.

and so on. Lack in this way becomes represented through possibilities pertaining to its causes, influences and nature, or rather exists through them, is mediated by them; a process which gives rise to the possibility of externalising loss onto a symbolisation. Without these representations — considering also that representations bring with them possibilities of removing lack through an answer — lack becomes less mediated through an external source (language). Subsequently, lack becomes more of a presence for the subject through a confrontation with it, which could be suggested to be the result of encountering the demand to 'keep going'. Žižek (1996: 107-108) recognises such a situation using the Greek sophism: 'if you do not have horns, you lost them; if nothing can be done, then the loss is irreparable'. The encounter with a lack of a lack, a lack of space for subjectivity linked to Lacan's notion of proper anxiety, thus seems to *lead to* castration anxiety where the subject encounters loss[15]. This would tally with the psychoanalytic theory of repression insofar as the more something is repressed/ignored/denied, the more it will come back to haunt the subject in what is called the return of the repressed. After all, the fact that the Other does not consider the subject having a loss, or to be lacking, does not change the situation for the subject who experiences a loss of the body, be that either in pain or other bodily sensations which is inextricably tied to a loss of energy and productivity. Rather, the result is that the subject is alone with his/her loss, having been reduced to an object of 'nothing' in the eyes of the Other.

The Otherness of the Demand to 'Keep Going'

The confrontation with the demand to 'keep going' appears, furthermore, for the participants, to include an experience of otherness insofar as the demand is experienced as a foreign and intrusive element 'coming in' from the outside, subsequently questioning the boundary between self and other. This can be discerned in all of the participants' interviews, but I will firstly explore Tom's discourse in-depth.

The experience of an imposition for Tom could be traced in his discourse surrounding his neighbours' noise, an event postulated as significant by him since it precipitated his "crash and burn" (B/L471). He mentions at the onset that he became "sensitive" to the neighbours' "noise". Elsewhere, he explains he has become sensitive to noise in general, which could

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[15] The other type of anxiety, anxiety proper, will be scrutinised more closely further down in relation to other examples, where instead of being a confrontation with the void, objects appear therein.

indicate an association to the event with his neighbours'. He describes in the following a moment in the "canteen" where there are "so many different conversations going on":

> I'm just so sensitive and canny concentrate in one conversation 'cus I'm - it's like I'm listening to other's things. […] I wasn't - never as sensitive to the - other people's conversations. And the stress of that - so it just kinda *drains* the - the life, eh drains the - it's like somebody sticking a big syringe in your brain and s-sucking all the serotonin out (A/L292-299).

There is an aspect of otherness here when Tom conveys he is "listening to *other's* things", repeated when he says "*other* people's conversations": it is not his own "things" but that of others he is sensitive to. This occurrence is linked to "somebody sticking a big syringe in your brain and s-sucking all the serotonin out" — giving the indication that the noise penetrates the inside-outside barrier as someone reaches in and steals/removes serotonin *qua* energy, which is further associated to life ("*drains* the – the life"). We could tentatively argue that "listening to other's things" is further related to, beyond the neighbours' noise, demands at work, insofar as his work involves a high level of noise in the form of *other* people "shouting commands". Another indication of a link between the two is that the canteen experience involves "so many different conversations going on" (A/L243), whereas at his work Tom becomes "confused with too many - of two people that talking to me once" (B/L339). In relation to work, he relays the following:

> But if I went back there and it's like, poof…eh, cardiac arrest, material, open the chest, bypass, ooooh a whole (sic) - everybody - that's another thing - everybody getting *high* frustrates me now, people getting all excited and shouting and poof. That gets me. Before that was normal. People shouting commands, you know swearing 'Where the fuck's this? I need that, I need this, I need this, I need that'. Boom. (A/L614-624).

The demands in this quote are stated in the form of necessary tasks to be performed, "material, open the chest, bypass", in the event of a patient having a "cardiac arrest". There are a number of factors appearing overwhelming about the demands. Firstly, they are

concerned with *other* people's needs: "[people] swearing 'Where the fuck's this? I need that, I need this, I need this, I need that'". It conveys a sense of being swept away by someone else's needs as experienced through never-ending demands; being reduced to the Other's need through concrete activities such as "material, open the chest, bypass". Secondly, they materialise from "everybody", meaning that they stem not from a specific, localisable place, but they become piled up by many people shouting simultaneously. Thirdly, these demands are attached to a high level of tension: people are "shouting", "swearing", "getting high", "getting excited". It seems to present a mix of what is normally associated with unpleasure, an aggressive quality through "swearing" and "shouting", but also pleasure through "getting high" and "excited". The demands therefore potentially blur the boundary between pleasure and unpleasure, which is the implication of experiencing what Lacan terms *jouissance*. Not only does it appear to question the boundary between pleasure and unpleasure but between self and other — also the implication of experiencing *jouissance* — as there may be a sense in which his own "adrenaline", or tension, is reflected in others' excitement. Indeed, Tom describes his work involving "all that adrenaline" (A/L550). His discourse moreover showcases how the body and the signifier share a similar structure insofar as the movement of demands reflects a movement of bodily tension. It is particularly in relation to the patients having cardiac arrest that there could be a blurring of limits, since Tom describes the following scenario:

> Well when you got a patient coming through the door, stabbed or - coming up
> through the [imperceptible] labs, cardiac arrest. And they go 'a thump badoom
> badoom badoom' (sic), doing CPR and we're all waiting to take these people in
> and you know it's drama crisis, isn't it? It's tshtshtsh (sic) fight and flight. ME's
> fight and flight. So you put two of them together, it's gonna burn me out (A/L558-
> 562).

That Tom is "waiting to take these people *in*", could potentially refer to a breaking of a boundary, where the beating of the patients' hearts corresponds to his own "adrenaline" and the "fight" stage of ME. To "put two of them together" also implies a merging, perhaps of him and the patients, if reading the discourse structurally. This experience for Tom could then entail a presence of an otherness which is too close; he explains his work is "too much"

(A/L545), perhaps being "too much" involved in other's demands/needs. What belongs to the patients' bodies in terms of a rapidly beating heart also to a certain extent belongs to himself: a very embodiment of the failure of integrating himself into a symbolic structure which would allow to distinguish himself from others — the subject being the surplus of such a failed intersection as outlined above.

A blurring of the identity barrier can further be related to a sense of a lack of control for Tom, insofar as he describes his work as unpredictable, particularly in relation to the cardiac arrests of the patients as described above. However, a sense of not being in control is more noticeable in Tom's discourse where he explains how he felt "uncomfortable" phoning the police for help (for the neighbours' noise): "'Cus I would usually deal with that situation myself" (B/L429-431). Something similar may be the case for Amy when referring to the "closed wheel" in relation to work/fatigue: it represents a movement in which she is not fully included since it is "closed", perhaps closed to her influence, which might have been reinforced trough the "enforced" vaccination as an experience of an imposition of otherness. Indeed, when Amy talks about her work around the onset, she alludes to an aspect of helplessness: "there was young people and they were dying and there was nothing you could do" (B/L337-338). This foreign aspect of an out-of-control movement, something further consumed by one's entire being in a continuous motion (the closed wheel being too close?), can be elucidated through Lacan's notion of alienation.

Symbolic alienation, first and foremost, entails what was outlined above in terms of structural lack: that we cannot be One with our bodies or cultural representations. On the other hand, we are only able to have a socially meaningful existence and identity, and communicate and operate under shared, social rules, by incorporating certain words and images, which constitutes Lacan's concept of imaginary alienation. The way in which an existence in the Other is alienating is due to its paradoxical nature. In order to be represented and possess a sense of self, one depends on something *other* than oneself, such as a reflective surface in the form of a mirror or another person's gaze, or language itself — in other words, something external and foreign. Because the subject did not invent language, it is not his/her own, and it is further something in which s/he inevitably and uncontrollably becomes caught up as it precedes and exceeds the subject. Other people largely determine the subject's identity whether s/he wants it or not by carving out a symbolic place, such as naming the child before its birth (Pluth, 2007: 55), and that name then comes to largely determine one's

sense of identity. The paradox is that this externality becomes internalised, and is experienced as the most intimate part of oneself. This is illustrated through Lacan's neologism 'extimité'/extimacy which constitutes a combination of the word exterior and intimacy: the basis of who you are is something you are not, something determined by social forces (and of course, in combination with biological ones). The price of having an identity is that the mirror image which establishes it through an inside-outside barrier, is but an illusion: the inside is always on the outside and vice versa. As a result and due to the mediation of discourse, imaginary alienation involves a separation *of* oneself *from* oneself (Boothby, 1991: 45), meaning that life does not naturally originate from within, but is something one becomes caught up in (Schuster, 2016: 44). The subject is produced by language. Entering the symbolic order then — a process which is repeated throughout life due to the fact that identity always fails — may be more akin to a game of rope jumping between a group of people, where one tries to gracefully enter the moving ropes without getting hit by them, but ending up hit by them in any case.

The otherness involved in the process of alienation is not only inevitable, but crucial for identity formation, since the subject cannot define itself with itself; a highly circular and unsustainable process. That is, the subject and the Other cannot be one, but due to their dependency on one another — the subject cannot exist without the Other and the Other cannot be meaningful without subjects endorsing its existence — they also cannot be counted as two separate entities. For this reason, they are highly intertwined and linked, impossible to separate — a status applicable to the structure of the subject since it is, according to Lacan, 'neither one nor the other' (Lacan, Seminar XI: 211). This structure can be compared to that of the mind-body relation insofar as the mind can be linked to the symbolic Other, and the body to the subject unable to be taken up therein. The mind and the body are neither one entity nor two separate entities, meaning that both dualistic and monistic perspectives are incorrect/partial ones (Moncayo, 2012: 33). In this way, Lacan's account of alienation differs both from the common view of the term alienation, as a separation from oneself which can be amended by a reunion with the lost object — as if an authentic, complete subject exists — and from a Marxian perspective of alienation, where alienation is viewed as a result of a social structure where the subject is separated from the produced object as a commodity, which has an independent status from the subject. Instead, for Lacan, alienation is fundamental and unavoidable (Pluth, 2007: 88-89). We can say that the participants are not

suddenly alienated at the start of their conditions, but merely become confronted with the alienating nature of their lives; and one which is moreover a highly strengthened version due to encountering a demand in which the subject is reduced to a need, something we find in all of the participants' discourses.

Beth's discourse showcases such a realisation of alienation where the inside has become the outside. When she was in her last year of undergraduate studies, she explains the overwhelming experience it entails as it involves "demands on your time and your effort and stuff um, that I didn't really feel like I'd chosen" (B/L410), and:

> … things like having time to relax or having time with your friends or having time to exercise or cook or um eat nutritional food, and stuff like that, gets put to the wayside. And at the time I was like oh that's just what you do like, I need to get - I need to get, good grades, I need to pass, otherwise what's the point of being here. Um but I think that looking back it was actually quite unhealthy to sacrifice your - your whole life in order to get your degree. Um. [5 second pause]. So being ill has forced me to act on my own needs first rather than anything else (B/L48-56).

There is a confrontation with an existence (she says before this her studies were an "intense experience" in relation to "get[ting] into an existence") at the core of her being, since it was her "whole life" she sacrificed, one which has now become foreign as she realises it is not something she chose. She was allegedly before this unquestionably following the demand of the Other (to go to university), but now comes to realise the aspect of otherness involved in this, and further mentions how "unhealthy" this was. She recognises she was wholly reduced to someone else's demand (as a need), which constitutes a realisation of her alienation. Because alienation is about loss, an elimination as Lacan describes it, and one such loss is the inability for a stand-alone existence (Lacan, Seminar XI: 205), due to what was just outlined in terms of identity formation always necessarily involving something other than oneself. We witness a recognition of a dependency in the interviews, but further an intensified version of it insofar as one's whole being is reduced to an object of productivity determined fully by someone else's demand. The process of entering into the symbolic and the inevitable loss this entails is illustrated by Lacan by what he calls the *vel* of alienation through the

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analogy of the highway man. 'Vel' is the Latin word for 'or', alluding to a choice between two scenarios, which the highwayman is confronted with when receiving the threatening choice of "your money or your life". Money here represents the subject, who disappears in both situations. If one chooses money, one will lose both; if one chooses life, one will have a life without money, or, a 'life deprived of freedom' (Lacan, Seminar XI: 212), which is not much of a life. Thus, some kind of "sacrifice" mentioned by Beth is necessary and unavoidable — although certainly not one's *whole* life — even though she alludes to in a way to having overcome this by "act[ing] on my own need first". We will indeed see as this thesis progresses how fatigue could be a way of saying no to the otherness of alienation.

The aspect of the inside becoming the outside discernible in Beth's account, the *extimacy* of the subject, is also aptly depicted in Gail's discourse and more explicitly so than in the other accounts, when she proclaims:

> That anaesthetics dulled me for a whole, four weeks I think. Everything became exterior to my internal self. It was like I was out there watching *me*. It - it was very scary (A/L311-313).

We observe how the inside is almost literally experienced on the outside, consequently blurring the distinction between inside-outside — something experienced as "scary". The experience of 'the Other of the Other does not exist' is important here, which could be alluded to in Gail's discourse; that no one else is watching but her, that you cannot see things from other people's perspectives. In her second interview, when I asked her what it was like to be put to sleep by anaesthetics, she again alludes to something similar as an "outer body experience". But she first of all replies: "It's like…waking up". Waking up and the related outer body experience is further associated to a moment of numbing, something also observed above through the word "dulled". Evoked here is arguably a sense of having lost oneself, yet not completely: "You're here but you're not here", "You've lost consciousness of, the present. But you are still conscious". This comprises the very structure of alienation as an appearance of a disappearance (an inclusion of an exclusion). We could thus reformulate her experience as constituting a waking up to her alienation — akin to the other participants — as she becomes conscious of her own disappearance (behind the Other's signifiers).

These aspects of reduction, inescapability, and foreignness have so far been explored in relation to the demand to 'keep going', which demands something specific and concrete of the subject (going to university, working x amount of hours, receiving CBT etc.), constituting a reduction to a need through a removal of lack (subjectivity and desire). However, there is additionally for the participants an encounter with demands which are less understood.

Contradictory Demands: 'Keep going' Versus 'Slow Down'

Within the interviews, we find alongside and contrary to the imperative to 'keep going' — which asks for perpetual presence through motion/activity — the imperative to 'slow down': to take a break and to unwind. The imperative to 'slow down' is reflected culturally in the increase of popular movements such as yoga and meditation, and more generally in the importance of the idea of 'taking time for yourself'. The two commandments appear to follow a mind/body divide whereby the body is asked to constantly perform through the 'keep going' motto, to 'do without thinking', and the mind is seemingly linked with a moment of stopping and making time for reflection, processing and understanding. In the light of this, the two demands together entail a contradiction experienced by the participants, with some saying it made their conditions worse; hence its significance in the formation of fatigue. I will outline in what follows how this moment comprises a confrontation with the Other's lack, pertaining to a lack of answers regarding one's existence and what to do with one's body.

The two contradictory commandments are present more or less in everyone's discourses, however more explicitly so in Brody's discourse. Therein, the demand to 'slow down' is sometimes depicted as stemming from the medical setting and is contrasted to the imperative to 'keep going' as stemming from the general attitude of society/loved ones — a dichotomy likewise observed in some of the other participants' interviews. Brody, who was 36 years old at the time of our first interview, states that "there was no diagnosis to say 'you need to slow down'. It was like 'we don't know so, sorry'" (B/L73-74). A diagnosis is thus strongly associated to the demand to slow down, with the demanding aspect of it being showcased through the words 'need to'. However, for Brody, the contradiction is also found within the medical field, one between the psychologist and physiologist:

…. and I really struggled with pushing through, feeling the symptoms coming on, which is contrary to what the physio - the psychologist was saying. That if you feel the symptoms, stop. Have a rest. And the physio was saying… push yourself a little bit. Uh so it was contradictory and really [small laughter] unpleasant to bring on symptoms… (B/L38-42).

Both demands are placed alongside each other here via the demand to "push yourself a little bit" which stems from the physiologist, versus the demand to "stop. Have a rest", stemming from the psychologist. It presents an impossible situation as the two demands cannot be met simultaneously. Moreover, the demand to slow down for Brody is strongly tied to taking the time to understand (why one cannot keep going), insofar as he mentions that his sessions with the psychologist were "very useful" and "kinda made me understand how to - or how I needed to pace myself" (B/L29-30) — pacing constituting one of the main recommended treatments/strategies for ME/CFS where one attempts to become aware of one's limits and adjust one's level of activity accordingly, sometimes with the goal to increase it. Contrarily, the demand to 'keep going' ignores reflections of such a kind. When Brody says in the above excerpt it was "unpleasant to bring on symptoms" he is probably referring to following the demand to push through where "the symptoms [are] coming on". However, we could also interpret the unpleasantness to refer to the contradiction itself since they come one after another, which is indeed strengthened in another place when talking about the "attitude" from the GP and his partner, to "get up and get on with it": "…that's contrary to everything else. All the other ME advice I've got. And I would say that that made me either worse or deeper into ME" (B/L183-186). Through the contradiction, the subject stumbles upon the Other's lack in terms of there being no answer pertaining to what to do with the body, and on a bigger level, no answer to one's identity. Nevertheless, beyond having a difficulty of being met with the two demands simultaneously, it is likewise the demand to slow down with which Brody struggles: "… when you are working when you've got a great bit of work, it's really hard to down tools 45 minutes into it. Which - because that's what the rules say" (B/275-277). The difficulty of meeting the demand to "down tools" could be due to experiencing it as yet another demand, which shines through when conveying: "because that's what the rules say". Indeed, the ambivalence regarding this commandment is discernible when he states earlier, in conjunction with describing how he wanted someone to tell him to slow down: "If I've

been told, simply told 'you're knackered. Slow down' I would have done - [clears throat] probably would have done. No I would've done" (B/L75-78). Such an ambivalence could point to the divided unconscious/conscious subject in that he wants to meet the demand, but (unconsciously) this is difficult/undesirable, particularly if it entails a reduction to a need whereby subjectivity (in terms of subjective differences as respected by the factor of unknowability) disappears; for example, to take a break every 45 minutes, which is a specific requirement. In the light of this, when scrutinising the demand to 'slow down', we notice it also contains a reduction to a need in terms of pre-determinacy and concreteness (a reduction to numbers) akin to the demand to 'keep going'.

This is most clearly illustrated by Beth when speaking of her experiences at the ME clinic when she had to "count every single thing you do" (B/L111, 116-120). What can be inferred from Beth's discourse here is that the activity of resting is highly regulated: it is pre-determined since it is restricted to "certain types of rests" ("lying in silence" without having to "listen[ing] to the radio or watch[ing] TV or anything") and has a time frame (has to be done every day). It can be interpreted that it is both the activity of lying in silence Beth finds "depressing", but also the fact that she "*must* go and lie down in silence" — that it is commanded — since she claims what is boring is "knowing that you *have* to do that every day" (B/L119). We thus notice how what is supposed to be an absence and passivity, resting in the form of taking a break from life or conscious activities, becomes registered in numbers and specific activities and turns into a conscious activity, thus becoming a presence which removes absence and subjectivity, turning uncertainty into certainty. The subject is removed due to the aspect of reduction present therein as governed by the logic of universality and pre-determinacy: it is considered, in advance, that only a certain type of resting is beneficial for everyone — assuming to know what is 'good' for someone (and everyone), which dismisses subjective differences. In line with the aspect of reduction, during Personal Independence Payment interviews where it is determined whether or not someone suffering from fatigue/an illness is entitled to support money from the government, the inability to engage in specified, concrete activities is often taken to stand in for one's whole condition. For example, the interviewers — as based on the experience of some of the participants — decide that being able to walk a certain distance signifies that one is not ill and entitled to money. It thus dismisses subjective differences and the complexity of human nature. That the demand to 'slow down' dismisses subjectivity in terms of idiosyncrasy is also showcased

by Amy when speaking of the general advice stemming from ME support groups, which is "don't do any exercise". Amy clarifies that for her, other activities such as "planning a meal, shopping" are things which make her condition worse (A/L135-140). This aligns the demand to 'slow down' with that of to 'keep going', and we can therefore conceptualise the former as a commandment to 'keep slowing down'.

Accordingly, the imperative to 'slow down' becomes yet another imperative for constant productivity/presence insofar as it is requested *in order* to increase productivity levels. This is suggested by Amy when stating the aim of Graded Exercise Therapy: "So I had to learn to stop doing things, before I could learn to do them again" (B/L78-79). Brody analogously relays that one should attempt to "get rid of all the variables of the stressors", "And then try[ing] to add in things very slowly" (A/L383-386). The ultimate goal is to 'get back to work' and return to engaging in activities — the general societal attitude underpinning most short-term and cost-effective treatments. Not only that, but in contemporary society, sleeping/resting has been turned into a commodity as a means of increasing productivity levels. Thus, on the level of content, the demand to 'keep going' and to 'slow down' are incompatible: to exercise and to sit down (or rather, to not exercise) are opposite activities unable to be met concurrently. The 'keep going' side demands to indulge in life and activities and thereby asks to ignore/get rid of the need to sleep which is considered an inconvenience, while the 'slow down' side values sleep and resting, considering them worthwhile activities to engage in. However, on the level of structure, this contradiction dissolves insofar as they both demand presence and productivity, albeit through different activities.

Apart from both imperatives containing a reduction to a need and demanding productivity *qua* movement, what they further have in common is that they demand control: either get rid of the need to rest/sleep, or contain it within perfect limits — as if the body can, like a machine, turn on and off on demand. This type of thinking is omnipresent in today's society, where a synthesis of the two imperatives is well portrayed through the popular saying 'keep calm and carry on'. The context of the emergence of this expression is telling of the general attitude of how one should engage in life. It was created as a poster by the British government in preparation for the Second World War in 1939, with the purpose of sending a motivational message to its British citizens. It strongly conveys the view of the human being in modern society: even if your life is at risk and could be potentially ended by a bomb

dropped at any moment, life must continue in the name of productivity. And in order for productivity to continue, a sense of calmness is necessary, which could be the ultimate aim fuelling the increase of yoga and meditation today. This echoes another robotic state: 'don't be (too) affected by life — or death — just do it'.

The Accumulation of Demands

Arguably, the above-mentioned experiences of contradictory yet not contradictory imperatives come to have some consequences for the subject. First of all, there is a strengthening of the realisation that life is inescapable; that demands are never-ending and it is life itself *qua* movement and productivity which is commanded. This leads to demands accumulating and becoming overwhelming. Secondly, given the fact that the contradiction is there and in combination with the demand for life, the content of the demand for life is highly unknown: it is not known what type of life is commanded. As a consequence, incomprehensible demands accumulate. Not only that, but there is a growing sense that, particularly as brought forth by the imperative for control, life eludes control. This leads to experiencing the demands as impossible.

Tom's discourse showcases these above-mentioned elements when he speaks about his work at the onset of his condition, where the overwhelming aspect of demands comes to the fore. What appears overwhelming is first of all a lack of understanding the demands, or "instruction" as he says, as part of performing a bypass (in the event of a patient having a cardiac arrest). In his discourse, there is a shift from having met demands ("I could take instruction from surgeon, anaesthetist, ODP, whatever, and I could do everything that they're wanting") to being unable to do so ("now I can't do that"). The reason he attributes to this inability to meet demands is confusion due to "two people talking to me at once", which marks the place of incomprehensibility, of either not having understood/heard demands due to their simultaneity — they all come at "once" — or referring to a confusion as to which demand to engage in first (and how)[16]. Because even if each demand is more or less understood and not contradictory, the simultaneity of demands creates confusion in one way or another, since it requires a balancing act on behalf of the subject in terms of having to understand what to prioritise. Accordingly, when Tom speaks in his first interview about

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[16] We saw this above when Tom denotes that demands come from "everybody": a non-localised location.

"running" around at his job, he mentions this inability to process what to prioritise: "Or you can't eh cognitively take instruction like I used to take instruction from like five people at once. And process what's the most important thing I need to do here" (A/L519-520). Nevertheless, it marks the place of an impossibility since one cannot either listen to or follow two or five people's instructions "at once". It becomes, for Tom, "too much" (B/L300), which is mentioned in conjunction with the overwhelming demands, all of which is seemingly related to anxiety: "Fuck. Everybody is just *rushing*. Wherever it is it's just *rushing*. Creating stress. Anxiety" (B/282-283). This moment accordingly relates to Lacan's notion of anxiety proper in terms of an overbearing presence, for Tom in the form of demands, which is helpful to bring in here.

The commonsensical view of anxiety relates it to loss or absence — castration anxiety could be said to belong here, which was explored above in relation to privation. But for anxiety proper, that which could also be termed uncanny anxiety (L. Jonckheere, personal communication, 2018, August 28), Lacan instead emphasises an overwhelming presence where an object appears in the place of the void, constituting a lack of a lack[17] (Salecl, 2004: 31). In Seminar X about anxiety, Lacan elucidates what is anxiety-provoking about this situation through the fable of a man being confronted with a 'gigantic' praying mantis. The man is wearing a mask but is unaware of what type of mask he is wearing — the importance of which in confrontation with the praying mantis is of a life and death matter, considering a female praying mantis bites off the head of a male mantis and devours him after mating: 'I couldn't see my own image in the enigmatic mirror of the insect's ocular globe' (Ibid.: 6). This is nothing other than being confronted with the Other's enigmatic and traumatic desire, as Lacan makes it clear. Someone who wants something, but one does not know what: 'the anguishing *I don't know what object I am'* (Ibid.: 325). In other words, one is addressed as an object by the Other, but knows not what *kind* of object. It comprises the moment of not having a mirror image, a lack of inside-outside boundaries, and an experience of being engulfed by an enigmatic presence. Lacan in this way comes to conceptualise anxiety as a

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[17] Lucy's discourse aptly illustrates both types of anxieties: castration anxiety is traceable in that which was delineated earlier in terms of a physical loss surrounding the operation, more specifically the "cotton wool" which came out of her, while uncanny anxiety took place as a panic attack (which she terms "bizarre"), when she felt a sore throat coming on — something that was lost after the operation. Thus, it returning would constitute a lack of a lack where an object (in this case a sore throat) is present as opposed to missing. Also, she believes her condition, ME, is still there due to the loss of sore throats, as if it might be necessary to hold onto a loss. This is discussed more in chapter six.

presence of an absence. Further, Lacan repeats in Seminar X that anxiety is 'not without object', implying that it circulates around an undefinable object. We could all certainly relate to these aspects during a nightmare: there is a presence which should not be there, accompanied by an enigma.

Something akin to this situation is traceable in Tom's discourse and in many of the other participants', but in general it does seem more prevalent for some rather than others at the onset of their conditions, where they are submerged by a large presence through the accumulation of demands. They are addressed as an object (of productivity) through demands, while being unable to make sense of them. Tom saying "I'm like poof" in relation to the overwhelming demands could allude to him disappearing — seeing as it is the noise one makes when indicating a disappearance — and thus could point to a lack of processing/symbolising his own position, with "poof" further amounting to a nonsensical, undefinable sound. The demands constitute an impossible presence bigger than himself, into which he becomes lost, which is further conveyed in the following excerpt: "I was a hundred miles an hour the way I was - well a hundred miles an hour: brbrb (sic), patient, anaesthetics, theatre, tssh (sic), out, up boom" (B/L273-275). What he "was" was an impossibility as one cannot go "a hundred miles an hour", an extension of himself into several demands simultaneously ("patient, anaesthetics, theatre, tssh (sic), out, up boom"). Such a movement of an impossibility is analogous to Mark's discourse as he speaks about his job at the onset of his condition. His manager told him "you need to have - you need to devote twenty percent of your time for every person you manage", which, given the fact that he managed eleven people, meant "operating at 220 percent of your capacity" (B/L334-338). Not only should one operate with energy one does not have, but this demand is perceived to be ubiquitous since he straight thereafter says: "That's *before* you start doing your job" (his emphasis). The movement perceived to be demanded is much bigger than himself, or in other words, constitutes an overwhelming impossibility akin to the presence of the praying mantis[18]. That this entails a suffocating presence — in line with a lack of a lack — is discernible when Mark says: "And…it's - it's - it's an overwhelming almost suffocating feeling. It's f - so

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[18] Different factors are emphasised at the onset of their conditions: for Mark it seems to be a lack of limits involved in working, for Tom the inescapability and incomprehensibility of demands, and for Brody, unpredictability as will be seen shortly (all related to control). Apart from inescapability, we do not really see this in the others' discourses, but more an emphasis on the Other's lack of acknowledgment (desire) or lack of having met one's needs/demands; however, the two are also present simultaneously. These differences between subjects are discussed in chapter six in relation to Lacan's clinical structures.

frustrating" (A/L302). While this is relayed in relation to his condition, it could also be applied to the situation of work, since he right after mentions his life before he got ill where he was managing a team: "working nine hours a day" and then "socialising" (A/L304-305) — reflecting the act of demands piling up. Therefore, in line with what was outlined earlier in relation to anxiety, it is not that the 'void closes up' (the void *qua object a* as the failure of symbolisation), that it disappears completely, but that it closes up around the subject whereby s/he loses distance to it, it becoming a presence instead of an absence. This is illustrated in the fact that one does not understand the demands addressed to oneself and how to live one's life; an experience of lack which comes to the fore around the onset of the participants' conditions. The element of unknowability pertaining to the demands could further be discerned in the fact that they are unpredictable, and hence uncontrollable — an aspect brought forth particularly by Brody.

Brody's condition started with, according to himself, working long hours (he works within radio) where there "wasn't much down-time really" (B/L145), and the breaking up of a relationship, specifically receiving an email from his partner when in India on holiday: "the content of the email just put me into shock and I was 'poof'" (B/L108-109). The content of the email is unknown since Brody was unwilling to share it (it was not "appropriate" he said). Nonetheless, what can be suggested from his discourse is that the content of it is incomprehensible and came unexpectedly, since it entails an element of "shock", as seen when he says "it was just out of the blue and description of horrible thing" (B113-114). This would constitute an encounter with enigmatic desire, something coming to the fore when he speaks about the demands of life:

> … my body tenses up which takes energy or if you're in the car and it's a bit erratic the driving you know you sorta tense up, your body naturally tense up to protect yourself, which takes a *huge* amount of energy. And I'd be exhausted. So again, get rid of *all* the variables of the stressors of work and relationships and whatever, and eating well, that's - establish that baseline seems very important. And then trying to add in things very slowly, but that's not just how life really works. Um you know there'll be work emails or whatever coming in or, other thing I needed to go to Linlithgow for, so I don't feel like I got that ability to - to react (A/L381-388).

Being in a car with "erratic" movement could potentially be read as a metaphor, standing in for "all the variables of the stressors of work and relationships and whatever", or in other words, demands as a movement one gets swept away by. Not only are they connected by their proximity in his discourse — indicating an association — but through the words "erratic" and "variables", denoting an irregularity and an unpredictable motion. Indeed, this paragraph comes as he explains that he is trying to "see if that *can* be predictable" [the condition] (his emphasis) (A/L377-378). However, what is encountered is the unpredictable nature of demands: that despite trying to "establish that baseline" and "then trying to add in things very slowly" — a form of control through slowing down — there is a realisation that "that's not just how life really works". He comes up against the impossibility of life in the sense of not understanding how it works and what kind of life is demanded of him, but also, he comes up against the inescapability of demands. This can be seen when he says: "there'll be work emails or whatever coming in" after having conveyed an attempt to control them. Indeed, the moving of demands *qua* signifiers, "work and relationships and whatever, and eating well", signals a lack of understanding with regard to how to handle them, and maybe how to handle them in relation to one another. How does one balance a relationship, work and being healthy? It showcases the metonymy of the signifier without the point of stability, the imaginary *point de capiton* or the signified, and consequently the accumulated demands tip into an overwhelming confrontation with enigmatic desire. This forms an anxiety-provoking moment in the face of an unbearable presence: there is a lack of space for an absence, a lack of a lack, in the sense that there is always something [email] "coming in". It seems to echo the increase of tension occurring for Brody in the body, a heaviness of the body, possibly mimicking the unbearable heaviness of demands.

In this way, Brody conveys something akin to the other participants: that it is not one specific activity which is demanded, but wok, relationships, eating healthy, and socialising are all part of the demand for productivity merging under the imperative to 'keep going'. In other words, life itself becomes one huge chore, something recognised by Schuster (2016: 32, 124) in relation to the emergence of lethargy. In acknowledging the alienating nature of culture, that it is something emerging from the outside and not naturally stemming from within, Schuster (2016: 124) eloquently identifies culture with the demand to live: 'a stream of implicit and explicit commands to "Wake up!," keep on living, working, producing,

consuming, copulating, loving, and enjoying'. Add to this the enigmatic factor of not knowing how to live one's life, life itself becomes painful and unbearable, as seen by Brody in the above excerpt when conveying "that's not just how *life* really works". This can be compared to what Lacan describes as the pain of existence, or the unbearable heaviness of being[19], which Lacan describes as a 'pure feeling of existence' (when speaking about a patient of his): 'It was the sense of existing, as it were, in an indefinite way', which he links to pain: 'Existence was apprehended and felt by her to be something that, by its very nature, is extinguished only to re-emerge forever further on, and this was accompanied in her by intolerable pain' (Lacan, Seminar VI: 90). It is thus lack, an exclusion, which comes to the fore (re-emerges) in an intolerable way, in its presence, as a presence of an absence.

That life itself becomes the problem is attested to more clearly in Amy's and Lucy's discourses, when I ask them what made their conditions worse. Lucy responds: "Everything made it worse. Living made it worse. Just getting up made it worse" (L/132). And Amy states:

> It's like you put a - as soon as I get out of bed in the morning and put a foot on
> the floor the shooting pain's go up through my legs. And so you - you just go 'oh
> here we go'. And so you just keep going because you *have* to (A/L248-250).

It seems like waking up to life is the problem and not a definable, concrete activity (at least here). Further, the issue lies with the *commandment* to 'wake up'/'to live' as inherent in the imperative to 'keep going', since Amy says "And so you just keep going because you *have* to".

Arguably, however, both these types of demands as explored in this chapter — demands which include a need and demands which include enigmatic desire — are unbearable; each on their own but also in their combination. On the one hand, demands which reduce the subject to a specific, concrete place (a reduction to a need) has *too much* meaning, whereas incomprehensible demands (enigmatic desire) have *too little* meaning Both, therefore, lead to an encounter with radical lack and one's alienation. All in all, we can say

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[19] Or as Milan Kundera's title suggests, this moment could likewise and conversely refer to the 'unbearable *lightness* of being' if we compare existence to an inability to be fixed and stable; a fleeting moment unable to be repeated; our own insignificance and lack of understanding. But in the face of accumulated demands, I believe a heaviness primarily better represents existence.

that the subject wakes up to his/her alienation, consequently experiencing life as a heavy, unbearable burden.

Chapter 4: The Unconscious Refusal of the Demand to 'Keep Going'

> *What is a rebel? A man who says no: but whose refusal does not imply a renunciation.*
>
> — Albert Camus

While the previous chapter delineated demands encountered around/before the onset of the participants' conditions, this chapter examines the response to these in the form of symptom formations. How a symptom is formed and in what context can shed light on the potential function(s) of a symptom. In the interviews, the encounter with the demand to 'keep going' is accompanied by bodily manifestations which causes the participants to engage less, or not at, all in (certain) activities. The emergence of bodily ailments suggests that that the response to the demand to be reduced to a machine-like object is enacted through the body as a way of saying 'no'. At this stage — still focusing on the incipient phase of the condition — the participants do not present so much with the form of fatigue *qua* a diminishment of tension, but with a wide variety of tensions. We will see in what follows how this initial moment of the refusal could entail making space for one's own desire in a moment of defence, and marking the presence/aliveness of one's body. This chapter unfolds through a Freudian and Lacanian exploration of symptom and identity formation; identity and symptom being inextricable from such a perspective. This entails a focus on related concepts such as anorexia as a refusal of the Other's demand, and the (death) drive, which explains the various bodily forms acquired at this stage. These notions come under Lacan's more overarching concept of separation, which aptly elucidates the structure of the discourses, insofar as separation constitutes a defence against alienation through the creation of a space, a distance, into which the subject can emerge and take up a singular position.

Symptom Formation: The Body as the Place of Protest

When exploring the participants' descriptions of various bodily manifestations emerging at the start of their conditions, what is noticeable is that they appear in conjunction with the demand to 'keep going', that they take on numerous forms, and that they lead to fatigue and less engagement in activities. I will firstly scrutinise Brody's discourse in relation to this.

Brody accords pain a prominent role at the onset of his condition, and his discourse suggests that the formation of pain appears as an unconscious protest against the demand to 'keep going'. This can be inferred from the following excerpt where he explains how he received no help from either the GP or anyone around him (including his now ex-partner):

> …that partner and a couple of other people was like 'you just have to grin and bear it, get on with it'. So I did, so whenever we were socialising or working I'd have *incredible* pain like… up and - you know eight out of ten if - yeah - like ridiculous pain. But there was no other answer, I couldn't lie in bed all day 'cus I needed to work. It wasn't socially acceptable and [deep breath], I have to live my life. So I'd have *ridiculous* pain down my legs and arms and um, base of my neck, um. And you just had to get on with *it*, and I lived a - in spite of that lived a relatively normal life I suppose (A/L331-336).

The imperative for perpetual movement, appearing under the overarching demand to 'keep going', is clear when he says "you have to grin and bear it, get on with it", not just in relation to work but socialising, and that "I have to live my life". That the body unconsciously refuses this demand can be observed through the emergence of pain, insofar as pain leads to fatigue and causes him to engage less in work and socialising (not altogether stopping them; if anything, Brody seems to engage less in socialising than working). But we have to be careful here and not suggest that pain has the hidden meaning of 'saying no' — as if the unconscious is the place of the true and actual intention of a person (someone who refuses) — but that it stems from an impossibility, a failure of symbolisation.

Prior to the outlined excerpt, Brody describes the events and experiences surrounding the onset of his condition: he was going through a break up, received shocking news, experienced a "huge amount of emotional stress" (A/L323), and subsequently did not get any help from those around him or the GP due to the idea to 'get on with it'. Being met with the demand to 'keep going' presents an unsymbolised situation for Brody in the sense that his current state, inclusive of shock and stress as he mentions, is incompatible with the idea of someone who keeps going, is fine, energetic and positive — terms all implied in the statement 'grin and bear it'. As if one can switch off like a machine. Something was not processed or symbolised, attested to when he conveys "there was no other answer". That there was no

other answer implies, on the other hand, that the answer was pain, albeit as a last resort, a 'forced' solution. This is indeed how all symptoms start, as a failure of having symbolised one's situation, which leads to the emergence of a surplus which the subject then tries to express and meaningfully integrate into his/her sense of identity— something that Freud explains in his account of symptom formation.

According to Freud, a psychoneurotic symptom[20] arises due to a psychical conflict: an idea accompanied by an excitation/affect (an 'unsatisfied libidinal force') comes into conflict with the ego as it is incompatible with its moral strivings, the way in which it wants to be seen. In order to defend against this contradiction, the ego attempts to diminish the idea and affect by separating the two: the idea becomes repressed or detached from a(n) (conscious) associative network, while the affect or 'sum of excitation' (Freud, SE XVI: 359) gets 'put to another use' — it needing to be used in some way — by transforming it into something tolerable for the ego (Freud, SE III: 49). The detached/repressed idea thereafter forms connections with other repressed ideas and becomes part of a different network which makes up the unconscious, while the libido/affect transfers its energy to the unconscious where it undergoes condensation and/or displacement and becomes a substitute satisfaction by having inhibited satisfaction in reality (Freud, SE XVI: 359). This part is the same as for dreams: the preconscious censor finds an alternative way of satisfying the libido, while simultaneously finding a means of expressing the symptom/dream in an acceptable way for the ego (Ibid.: 359-360). However, the difference between a dream and a symptom, according to Freud, is that the sleeping person is more tolerant towards ideas in dreams due to being asleep, whereas in relation to a symptom, the consciousness/ego shouts out 'sharply 'No! on the contrary!' to the unconscious wishful impulse' (Ibid.: 360). This means there are two oppositional forces in the form of an anti-cathexis involved in the formation of a symptom:

> Thus the symptom emerges as a many-times-distorted derivative of the unconscious libidinal wish-fulfilment, an ingeniously chosen piece of ambiguity with two meanings in complete mutual contradiction (Ibid.: 360).

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[20] A psychoneurotic symptom is thought to belong to the clinical structure of neurosis from a Freudian-Lacanian perspective. I discuss the three clinical structures (neurosis, psychosis, perversion) in relation to the structures of the interviews in chapter seven. However, it is to be noted now that I operate from the standpoint that the structures are capable of being fluid (simultaneously existing) for one person. I merely link the theory most able to elucidate the structure of the interviewee's discourses (which happens to belong mainly to the theory of the neuroses).

In the context of Brody's interview, the act of fighting against an impulse is traceable when stating it was not "socially acceptable" to "lie in bed all day" and not work (something present in everyone's interviews) — the impulse being just that — probably stemming from a wish on behalf of the ego not to be considered lazy in the eyes of society. There is a pull in two opposite directions, which could be depicted through attempting to meet the demand ("So I did"), while refusing (through "pain"). This is attested to when he says: "'you just have to grin and bear it, get on with it'. So I did, so whenever we were socialising or working I'd have *incredible* pain". The word "so" in the statement followed by the expression of the emergence of pain links the ideas of the sentences together and implies a consequence of what came before, a refusal of the idea to 'keep going'. We could say that the incompatibility between the idea 'everything is fine' and his current state, leads to an unconscious protest against the sociocultural idea to 'keep going'.

However, pain could simultaneously act not only as a refusal, but as a resistance against the impulse to *not* keep going; saying 'no' to the symptom, which would constitute a refusal of the refusal. This would turn pain into a means of meeting the demand to 'keep going'. Because a similar structure repeats itself when he mentions, and in relation to the demand to live life/keep going: "I have to live my life. So I'd have *ridiculous* pain down my legs and arms and um, base of my neck, um". This suggests, together with the sentence "in spite of that I lived a relatively normal life I suppose" — if temporarily suspending the content of the meaning "in spite of" — that pain is not only a stand-in for a refusal to live life, but a *solution* to living his life, with the emphasis being on *his* life. It follows Freud's idea that a symptom offers a solution through a 'flight into illness' (Freud, SE XVI: 382). Pain would perhaps offer a more acceptable form than fatigue as a form of (partly) withdrawing from society, potentially following a belief that it better represents the biological body. We have here what Freud expresses as 'an ingeniously chosen piece of ambiguity with two meanings in complete mutual contradiction'. The mutual contradiction is that pain is a means through which one simultaneously refuses to live one's life and is able to live one's life. It is the depiction of two forces coming together concurrently, amounting to a condensation in the body through what Freud terms a conversion symptom[21]. The body then

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[21] This is by Freud linked to the clinical category of hysteria, whereas in obsessional neurosis/phobia as a distinct category (while also, like hysteria, belonging to the overarching structure of psychoneurosis), an idea stands in for the original incompatible idea/impulse as opposed to the body, constituting a displacement (Freud,

stands in for these contradictory ideas (to keep going and to not keep going). Or put differently, there is an inability to have reconciled these two ideas: an impossibility which acquires expression in the body. This follows both a Freudian and Lacanian perspective on the unconscious, which is helpful to clarify.

As stated above, it would be easy to (mis)read the unconscious, which is commonly done, as the site at which the 'deeper' message hides, the 'true' and 'authentic' version of a person which is tucked under one or a few surface layers. This follows the belief that once we remove those layers, the real message can be revealed as a desire for stopping and a refusal, as the true intention of the person. Or in an almost opposite way, the unconscious is commonly referred to as the 'subconscious', thereby implying that the subconscious is a kind of substratum to consciousness and thus secondary and less significant. This word indeed reflects the general unacceptability of the unconscious in today's society since there is a tendency to override lack with knowledge. The omnipresent endorsement of the ancient Greek aphorism to 'Know thyself!' means we believe to be in control of and self-aware of all our actions (and if we do admit an unconscious element, we only admit it in relation to small decisions such as subliminal messages influencing our choice of drink with a meal). However, both these conceptions outlined above are wrong from a Freudian and a Lacanian perspective. The former view of the unconscious as a 'hidden site' is more heavily attributed to a (mis)reading of Freud, since Freud depicts the unconscious as 'another scene' where thinking is always elsewhere in relation to consciousness. The unconscious is not an independent entity but an 'inconsistency of consciousness, its internal skew and division' (Schuster, 2016: 33). This is in line with Lacan's notion of their relation, which is not so much a case of chronology or, as mentioned, separate entities, as in there is first a subject (a perpetually working/moving person) which is *then* refused in the unconscious. But the subject is the division between consciousness and unconsciousness, the very split itself. Lacan elaborates on this in seminar XI where he outlines that the unconscious is where the subject is subjected to an 'irreducible, traumatic, non-meaning' (Lacan, Seminar XI: 251).

Returning to Brody's discourse, what the symptom of pain more specifically allows is to live one's *own* life, as Brody proclaims "I have to life *my* life", as opposed to living

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SE XIV: 155-156). Within the Lacanian field, a conversion symptom is likewise commonly associated with hysteria; however, for now a discussion on the clinical structures is left aside until chapter seven, and I take the stance, following Bruce Fink (1999: 115), that a conversion symptom is capable of belonging to any clinical structure.

someone else's, or being too close to other people's desires/needs inherent in meeting the demand to 'keep going'. This aspect is observed in all of the participants' interviews as they allude at the onset to the experience of otherness in following someone else's commandment and the subsequent relief through the illness of having 'more time for myself'. It suggests that one of the functions of the symptom formation is to separate from the proximity of the Other and others with their suffocating demands, in order to create one's own identity, through the use of the body. This can be inferred when exploring the refusal in a slightly different context, and can be better understood by bringing in Lacan's notion of anorexia as a refusal of the Other's demand.

Anorexia: 'Doing Nothing' as a Refusal of the Demand to 'Keep Going'

The unconscious refusal of the demand to 'keep going' enacted through the body can further be detected in the interviews after having been in contact with medical practitioners. We notice here an incredibly common situation to all of the participants which was expounded in the previous chapter: they go to the GP, who tell them, either explicitly or implicitly, that 'there's nothing wrong with you'. This statement reinforces the demand to 'keep going' because in the face of a lack of a biomedical marker, there is no excuse to stop. It is after this encounter that the participants mention their conditions worsen and bodily tensions appear (leading to fatigue), which points to the significance of it, indicating that the body is used as a refusal of the demand to 'keep going'. Amy for instance conveys the following after having seen the GP about her symptoms:

> And so - you do, you go away and you think 'right ok. They've said there's nothing wrong with me. I'll keep going'. But then, I was vomiting after I was eating my tea at night. And I'm like [breathes out], there's something else not…something not right (B/L476-483).

I explained in the previous chapter how this excerpt and the sentence "there's nothing wrong with me" constitutes a lack of a lack as it comprises a full answer preventing further speculations and possibilities regarding the subject's condition. This is reminiscent of too much presence — particularly if considered in conjunction with the demands to 'keep going'

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— which Lacan explains is the conditions under which anorexia emerges. Anorexia arises, he writes, when the Other stuffs the subject 'with the smothering baby food it does have' instead of 'what it does not have' (Lacan, 2002/2006: 524). In comparison, instead of allowing a space for lack which would fuel investigations, the Other, by pronouncing 'there's nothing wrong with you', stuffs the subject with an imaginary-symbolic meaning, one which kills off lack as the point of uncertainty (and other possible significations). This leads to a fullness in which the subject does not participate since the subject is the place of non-meaning and lack. We can say that the emergence of a bodily tension here (vomiting) is a way of introducing absence — or lack in proper Lacanian terms — in the face of fullness. This is arguably enacted by refusing the demand to 'keep going' and embodying the notion of 'nothing'. Amy, through vomiting, expels the meaning the Other imposed on her, refuses it, in order to make space for a void and otherness insofar as she says "there's something else not…". That is, she does not say *what* is wrong but merely that *something* is wrong, which constitutes a point of indeterminability. The body marks its impossibility to be taken up into a symbolic-imaginary position, unconsciously pronouncing that something is wrong, thereby carving out a void.

However, it should again be noted here that this does not translate to the 'true' or 'authentic' desire of the subject, but there is a simultaneous pulling of two forces. The statement "I'll keep going" in conjunction with bodily tensions seen for all of the participants reveal the conscious/unconscious split of the subject which is that of the mind-body divide. Consciousness is exposed in that to one's knowledge, one is merely following the demand to 'keep going', but the flipside reveals a refusal inscribed in the body as that which does *not* keep going. Lacan's intricate relation between consciousness and the unconscious as depicted through the Möbius strip can be helpful in deepening our understanding. The Möbius strip does not consist of two separate sides, but a single surface with a separation from a void (Greenshields, 2017: 56). In other words, consciousness and the unconscious have the same relation as the mind-body: neither one entity as they cannot be united, nor two entities since that would imply too much of a separation. Rather, they are in opposition to each other while being highly intertwined, containing the impossibility of saying what belongs to what. Because while the unconscious body can be seen as that which protests against the demand of "I'll keep going" (as that which does *not* keep going), we also find that something *does* keep going, which is precisely the physical body in the form of various tensions. This blurs

the distinction between the two as it is something which reveals and hides at the same time. Nevertheless, let us look closer at the refusal as that which does not keep going through Lacan's concept of anorexia. Lacan writes about anorexia:

> It is the child who is most lovingly fed who refuses food and employs his refusal as if it were a desire (anorexia nervosa)… Ultimately, by refusing to satisfy the mother's demand, isn't the child requiring the mother to have a desire outside of him, because that is the pathway toward desire that he lacks? (Lacan, 2002/2006: 524).

Lacan is not referring to anorexia as literally not eating, but he is approaching it from the viewpoint of the symbolic, as entailing a symbolic refusal to be suffocated by someone else's desire (through a demand); the start of separation. Subject formation for Lacan includes, in addition to alienation, separation as a logical moment. Separation is part of the process of socialisation whereby one comes to occupy a place in society, and more specifically, enables one to become alienated in fundamentally different ways (Fink, 1999: 162). This includes the ability to take up a singular place and not become completely lost in other people's meanings — because if alienation was the full story, we would be wholly determined by others in a machine-like manner. Separation, *se parer* in French, equivocally refers both to dressing oneself, to be 'put into the world', and to defending oneself, as Lacan (Seminar XI: 214) points out. More exact, separation is a defence against alienation, against the Other as a governing body of authority and/or language, in a moment of giving birth to oneself through taking up a position in relation to it.

In relation to anorexia, Lacan invokes the mother who lovingly feeds the child, which means she bombards the child with demands, demands formed through her own ideas about the child's needs, as Lacan mentions (2002/2006 524). In this way, should satisfaction through following a demand be obtained — leading to being reduced to an object of the mOther's desire — the subject('s desire) disappears (Lacan, Seminar VIII: 201). A bodily manifestation in conjunction with having mentioned the demand suggests a refusal to incorporate the Other's ideas inherent to the demand(s) in an attempt to create a path for

one's own desire as separate from the mOther's[22]. The refusal here is thus not a desire in and of itself, which Lacan makes clear when stating 'that [lack] is the *pathway toward* desire that he lacks', but it carves out *object a* as the void in order to allow desire to emerge, which would make it equivalent to the object *cause* of desire, or rather allowing this to materialise. In this respect, Lacan clearly specifies that anorexia is not about a negation of an activity, not eating, but about 'eating nothing', where the subject savours an absence 'vis-á-vis what he has facing him, namely the mother on whom he depends' (Lacan, SIV: 211). To 'eat nothing' is to make room for a nothingness *qua* lack in order to introduce distance between oneself and the Other/other. Lacan thereafter claims about this 'eating nothing': 'If you do not understand that, you can understand nothing not only of anorexia, but also of other symptoms, and you will make the greatest errors' (Ibid.). We can therefore go beyond conceptualising anorexia as tied to the literal activity of not eating or certain surface conditions and view it as part and parcel of symptom formation, because the condition for the subject to emerge is the bringing forth of a void necessary for desire[23]. We can say that a refusal is the minimal sign of subjectivity insofar as it constitutes a refusal to be part of the symbolic order, following Hoens' (2018: 176) take on the Lacanian subject: 'yet the notation that presents the subject most adequately, is a plain and simple 'no' (to the symbolic order)'.

In line with 'eating nothing', I argue that the fatigued subject is refusing the Other's demand by 'doing nothing'— something pronounced by all of the participants — as an attempt to introduce distance from the Other and create a void therein through which one can emerge. Indeed, this 'eating nothing' is evident in Amy's account if following the structural order of her discourse: the mentioning of eating her tea precedes the pronouncement "something else not" pertaining to uncertainty (lack). Thus, putting the two together would amount to eating lack. We find this in other accounts, for example in Gail's when she describes the inactivity tied to fatigue, that there was: "No eating. Nothing" (C/L274). Accordingly, if the Other asks for the subject's constant energy under the imperative to 'keep going', a way of creating a desire outside the Other's would be to *not* give it, to withhold

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[22] Modern society is very good at telling us what we are and should be and do: 'you are what you eat!', 'Be Happy!', 'Keep going!', 'Enjoy!' — and in an era where technology aids to strengthen the experience that the Other is always present, particularly via never-ending demands through our phones/gadgets.

[23] Perhaps here Lacan is referring to neurotic symptoms since strictly speaking there are no 'symptoms' in psychosis insofar as repression is non-operative therein, and desire is absent. However, all subjects regardless of structure deal with the proximity of the Other in one way or another, and the three clinical categories could be viewed as three various defences (refusals) of the Other.

energy. Not only does one simply engage in not-doing, but one 'does nothing': engages in the activity of 'doing nothing' in order to carve out, through the body, a void. In this way, considering there is an increase of tension in relation to the demand to 'keep going' (vomiting and pain as explored so far), we can postulate that the subject, through 'doing nothing', hoards energy instead of producing it for the Other. And perhaps by hoarding it, it accumulates and turns into a tension. Or put differently, energy is produced by the subject but not expelled, transforming it into an overwhelming tension, and one which is furthermore unsymbolised as it signals a void.

A loss of energy here does not take the form of what we normally associate with fatigue, an 'impoverished tension', the way in which Freud (SE III: 114, 144) describes it, particularly as he conceptualises it under the rubric of 'neurasthenia' part of the actual neurosis. On the other hand, the similarities of the participants' accounts to what Freud theorises under the term 'anxiety neurosis' — the other sub-category of the actual neuroses — is striking. Anxiety neurosis is thought by Freud to constitute an 'accumulation of excitation' which has not been mentally processed, in line with an unsymbolised tension. It is thus worthwhile to briefly explore Freud's theory on the actual neurosis since it will add to the discussion of the function(s) and form of fatigue, including its possible link with the biological body.

Freud's Actual Neurosis and the Mind-Body Relation

Freud first developed the theory of the actual neuroses early on in his work in the 1890's, being preoccupied with it specifically in 1893 and 1894. Some of the symptoms which Freud links with anxiety neurosis come close to the descriptions of the participants of this study, such as an oversensitivity to noise, digestion problems in the form of vomiting or diarrhoea, paraesthesias (sensations of tingling in your body) (Freud, SE III: 92-98), and pain (Ibid.: 114). Oversensitivity was seen for Tom in the previous chapter, and is something that many of the participants mention; pain was relevant for Brody — and we will see further on how this is relevant for everyone — vomiting was observed for Amy above, and is further, in conjunction with diarrhoea, the first symptoms Mark mention (after tiredness) emerged at the onset (A/L10-12). And lastly, one of the first and predominant symptoms Amy mentions, in line with Freud's list, is tingling (B/L25-26). These symptoms are all linked to each other according to Freud — more so than symptoms part of neurasthenia (Ibid.: 114-115). What

the symptoms more precisely appear to have in common is that they constitute a tension which is too much (such as oversensitivity), and an attempt by the subject to expel the tensions (digestion problems through vomiting and diarrhoea). This is in line with Freud's main thesis about what occurs in anxiety neurosis, that there is an 'accumulation of excitation' (Ibid.: 114) taking place in the body which fails to be symbolised, and for this reason, it transforms into anxiety. Anxiety here can take on various forms, but what would be relevant for this stage of fatigue — since anxiety in its pure form is not so much mentioned — is what Freud terms 'anxiety equivalents'. An anxiety equivalent is where another bodily sensation has taken the place of anxiety (Freud, SE III: 91-94). The same process according to Freud takes place in hysteria through a conversion symptom, which belongs to the overarching category of the psychoneuroses. In hysteria, however, there is an accumulation of tension stemming from a 'psychical insufficiency' (Ibid.: 115), a failure of symbolisation. Instead of being worked over mentally, the tension is directed to the body where it transforms into a tension. This is what I argued above could be traced in Brody's and Amy's discourse in the sense that that their situations are not symbolised, resulting in a surplus of tension. However, Freud distinguishes between hysteria and anxiety neurosis on the basis of one important factor: that a conversion symptom has been provoked by a psychical conflict, whereas the origin of an actual neurotic symptom is 'purely somatic' (Freud, SE III: 115). The symptoms part of actual neurosis are thought to have no link to symbolic material since they are not, in contradistinction to psychoneurotic symptoms, a substitute for an idea deemed unbearable to bring to consciousness, and for this reason they present no solution. In other words, the symptoms are not formations of the unconscious since there is no repression of symbolic material involved here. Freud more precisely thought the tension was a result of an excitation worked up during sex but which was insufficiently dispelled, through for example coitus interruptus. Thus, what was explored surrounding Brody's (and Amy's) discourse does not match a symptom part of actual neurosis, since I argued that the structure of a conversion symptom could be outlined in the former, where the idea of a refusal is repressed. Another reason for this is that the participants are met with an idea, as opposed to engaging in a purely somatic activity, which points to a conflict pertaining to symbolism. This also differs from one of the leading clinicians and theorists within the field of Lacanian psychoanalysis, Paul Verhaeghe's (2004) argument in relation to chronic fatigue — and other accounts in which Freud's theory of actual neurosis is utilised as a way of viewing modern symptoms as direct

encounters with the real, for example De Rick (2002) and Loose's (2002) theory of modern addiction.

Verhaeghe (2004: 308) postulates that chronic fatigue 'in all probability' belongs to the group of anxiety equivalents, as well as is part of what he coins 'actualpathology'. His concept of actualpathology subsumes Freud's outlined view and combines it with Lacanian theory as well as attachment theory, mainly that developed by Peter Fonagy. He, akin to Freud, places symptoms here which have no symbolism, and in more Lacanian terms, where an 'original' bodily tension as he calls it has not been processed through the imaginary-symbolic order, and thus is not a defence against the real. In this way, a symptom part of actualpathology constitutes an unmediated, direct encounter with the real and has no links to mental factors. However, a complete lack of symbolic material does not have to be the case, insofar as he claims that in actualpathology — probably particularly when linked to neurosis which he deems a possibility — there is either little or no symbolism involved — that the symptom has not at all undergone processing through the symbolic-imaginary axis (Ibid.: 289) — or there is a 'minimal inscription of the somatic in the Symbolico-Imaginary order' (Ibid.: 309). Verhaeghe could be said to view a refusal as containing minimal symbolism, insofar as he links anorexia proper with the position of actualpathology, which is 'semi-independent' of the sociocultural discourse. The subject here refuses to identify with the Other's images, and the focus is on the act of separating in order to gain one's own position. This would differ from anorexia as part of psychopathology — linked with hysteria within psychoneurosis — where the subject is dependent on the gaze of the Other and desires to identify with the Other's images (Ibid.: 231-232). So far in the thesis, there could be an indication of both of these, since the bodily symptom, I argued, could be recognised to contain a refusal of the sociocultural idea to 'keep going', but also an attempt to meet it, it then suggesting there is a desire to do so. However, more comparisons are needed with other aspects of fatigue in order to situate them in relation to the theory of actualpathology, which I will make as I continue to analyse the participants' discourses throughout this thesis. Nevertheless, while Verhaeghe (2004: 308) distinguishes between actualpathology and psychopathology and claims it is crucial to tell the two apart — thus postulating they can and do occur apart from each other — Freud arguably views them as more linked than separated.

The link between actual neurosis and psychoneurosis is attested to in the structure and development of Freud's work: that he came to develop his theory of actual neurosis early

on where he dedicated a few essays to it, whereas later on in his work when mentioning it, it no longer received individual papers and was not mentioned independently from psychoneurosis. Additionally, while Freud stated that 'neurasthenia and anxiety neuroses are easily found in pure forms as well, especially in young people' (SE II: 259), he did not go further into this or provide any examples[24]. Some of his published case studies he had investigated mainly from the viewpoint of hysteria, such as Anna O, Emmy von N, Miss Lucy R and Elisabeth von R, whose pathologies he suspected had a basis in the actual neuroses. Although some of these, such as Anna O, had never been considered from the perspective of actual neurosis (Ibid.). The actual neuroses is thus considered the foundation of the psychoneuroses such as hysteria (most commonly) and obsessional neurosis — the two subcategories of psychoneurosis. For instance, in hysteria, where symptoms are substitutes for fantasies or memories, Freud argues that the pain linked to these 'was also at one time a real one and it was then a direct sexual-toxic symptom, the somatic expression of a libidinal excitation' (Freud XVI: 391), and that hysteria borrows from symptoms of anxiety neurosis (Freud, III: 115). The focus in his later work is thus on their interaction. He claims: 'For a symptom of an 'actual' neurosis is often the nucleus and first stage of a psychoneurotic symptom' (Freud, SE XVI: 390):

> … [the actual neuroses] provide the psychoneuroses with the necessary 'somatic compliance'; they provide the excitatory material, which is then psychically selected and given a 'psychical coating', so that, speaking generally, the nucleus of the psychoneurotic symptom - the grain of sand at the centre of the pearl - is formed of a somatic sexual manifestation (Freud, SE XII: 248).

The mind-body interaction depicted here means that what occurs in the body will influence the selection of symbolic material for a psychoneurotic symptom, and to the former belongs biological processes since Freud oftentimes links actual neurosis, although more so neurasthenia than anxiety neurosis, to organic occurrences, saying it is 'not amenable to psychotherapy' (Freud, SE III: 97; Freud, SE XX: 26). This may be relevant for the

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[24] He writes in SE XX about the actual neuroses that they 'seem to me still to hold good' (p. 26). He nevertheless adds: 'I should have been very glad if I had been able, later on, to make a psycho-analytic examination of some more cases of simple juvenile neurasthenia, but unluckily the occasion did not arise' (p. 26).

participants of this study, seeing as they mention that their conditions potentially started with viruses, and the fact that Amy went through a vaccination, and Lucy and Gail had operations, which would have had physical effects. And in general, fatigue is usually associated with organic occurrences such as Lyme disease, glandular fever (which Lucy suspects she had), flus and viruses.

When writing about the interaction between biology and psychoneurotic symptoms, Freud states that a more or less physical symptom can be imbued with symbolism, where 'unconscious phantasies [which] have only been lying in wait to seize hold of some means of expression' (Freud, SE XVI: 391), while, nevertheless, acknowledging an influence in the other direction. That is, after an operation or another bodily event, bodily sensations felt in conjunction with it can prove to lend themselves well to unconscious material (such as a refusal). For instance, the fatigue involved in being put to sleep by anaesthetics could have had an impact on Gail's and Lucy's symptom formations. This can occur some time after the event, where a symptom of the body was registered and later turns out to fit appropriately with a current thought (Leader & Corfield, 2008: 132), or immediately afterwards where a biological bodily sensation (biological here in the sense that it was brought on by anaesthetics and the operation) does not disappear. In light of this, causes are retrospective: it is not an event which in and of itself causes symptoms, but a subsequent episode throws light at the perception of an earlier one and gives it (new) meaning. Several factors need come together concurrently, amounting to an aetiological equation according to Freud, or more broadly, to the over determination of a condition. Furthermore, as Leader & Corfield (2008: 321) recognise, a condition will move through different stages with different emphases and influences, and 'the factors that predispose one to an illness will not necessarily be the same as those that sustain it or, indeed, those that initiated it'. The fact that there is a similar pattern for all of the participants in terms of a rise of bodily tensions after having encountered the imperative to 'keep going', suggests fatigue cannot be reduced to a biological occurrence, or even a purely somatic condition which Freud suggests is involved in anxiety neurosis, but that it goes beyond it. The fact that the words and beliefs of others have such an impact on the condition — alongside an apparent absence of positive biomedical results for many and/or that treatment does not help even when something is found (most commonly inflammation, a lack of vitamin D or iron deficiency) — proposes there is a large subjective element

involved. A biological condition, or precipitating factors involving biology, could have turned into something else and something more.

However, while Freud does seem to postulate a pain which was once 'real' before the formation of a symptom, to engage in a discussion of what was there before — a bodily sensation or a thought — amounts to an impossible discussion akin to 'what came first: the chicken or the egg?' Did it all begin with a thought, or with a physical sensation? From a Lacanian perspective, an answer regarding the existence of something *prior* to symptom formation is impossible. This because the mind and the body cannot be entirely separated due to the fact that alienation is inevitable. Once operating from within the symbolic, one cannot step outside of it and postulate something prior to it because such postulation occurs from within the confines of the symbolic. Nevertheless, that which is outside of signification — equivalent to Lacan's concept of the primordial real — influences signification and vice versa, as Freud recognises. The mind and the body therefore exist in an intricate, and almost impossible relationship. Freud could be said to recognise the impossibility of this too, insofar as he states that 'not infrequently it had to be left an open question which of the two elements [a bodily sensation or thought] had been the primary one' (Freud, SE II: 180).

The interaction between the mind and the body is sometimes acknowledged within the medical establishment insofar as many health professionals will acknowledge the involvement of subjective factors (talked about mainly in the form of 'stress' and 'depression' etc.), for example in the lowering of the immune system, and consequently in the acquiring of an illness. Conversely, if someone breaks a leg, it would probably be impossible — particularly for subjects who operate within a shared, symbolic order — to not imbue it with meanings. There is therefore no telling how something started, particularly if it is no longer relevant for the condition and it is maintained, as was hypothesised, by other factors. I am not concerned in this research with answering the question of the cause of fatigue, but more precisely — in line with a Lacanian perspective — to suggest how fatigue for the participants is structured, and what that might suggest about some of the subjective influences on the symptom formation. This will, inevitably, not capture all of the influences involved in the formation of fatigue, not only due to the fact that there are other forms of fatigue which have not been included in this research, but also because discourse is not stable, and I can only examine the current discourse as it was elaborated at a specific time in a specific place and context. A symptom is not a stable entity but is something which, akin to

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identity and separation, repeatedly fails and consequently forms — hence why various factors can influence it at different stages.

Thus far, the structure of actual neurosis appears both similar and dissimilar to the structure of the participants' discourses, the latter in the sense that the symptom here cannot be reduced to a purely somatic factor. I will nevertheless continue to make comparisons to it as we go along, particularly to the theories within the field of Lacanian psychoanalysis using it as a basis for theorising modern symptoms. In terms of subjectivity, what fatigue has been linked with so far is the function of separation through a refusal, and an attempt to gain a position independent of the Other, which I will continue to explore in what follows and more specifically in relation to the function of bodily tension.

A Lack of Energy: The Body Speaking the Unspeakable

Returning to the Lacanian concept of anorexia which was brought in above, fatigue can be viewed not as a pure refusal in the form of a negation of an activity, not doing, but as 'doing nothing' whereby a tension is produced. The tension appears to signal a void, and further, to then be 'used' in order to mark the presence of one's body, to be included within the symbolic order. Arguably, Amy, through vomiting, attempts to signal a difference and an otherness as a way of including herself in the social order. This would be in agreement with Lacan stating about anorexia that 'Nothing – that is precisely something which exists on the symbolic plane' (Lacan, SIV: 211). The refusal would in this way amount to an inclusion of an exclusion, or the presence of an absence, an embodiment of nothingness.

Using the body for this function is also noticeable in Brody's discourse when explaining the onset of his "symptoms" in relation to the physiotherapist's demand to "push through":

Um so I've been referred to a physio to build up some strength because I've lost it all. And she wants me to do five minutes a day where my - of exercise where my heart rate is higher than 110 bpm. And I did that for two days, measuring my pulse and 110 or around that area is where the symptoms start coming in and the - the - the nerves go and it's, my body's saying 'drrr (sic) something's wrong' (A/L279-286).

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Present in the above discourse is the demand from the physiotherapist to 'keep going' despite symptoms coming on, in order to build up the strength which he lost. In accordance with what was argued, he is attempting to meet the demand ("And I did that for two days"), which is followed by the emergence of bodily tension — a tension which could be interpreted as a refusal of the demand. Not only is the bodily tension a negation of the Other's commandment, it is here clear that the body is used to convey the message of saying 'no' through a tension: "the nerves go and it's, my body's saying 'drr something's wrong". Akin to Amy's "something not right", what the body signals and devours is not a specific sensation, such as pain or fatigue capable of being captured in words, but merely something unspeakable and undetermined. It is a void or nothingness as that which is missing from any pinning down in comprehension; and by the very fact of it missing and that this is signalled (Brody saying his "body's saying"), it is included. This inclusion of an exclusion is inherent to anorexia and is aptly captured by film producer Samuel Goldwyn's pronouncement to 'include me out!' (Leader, 1997: 67). It can further be compared to the process of the naming of the void, which is precisely what is involved in identity formation as part of alienation and made possible by separation.

Imaginary alienation entails, if established, an identification with ideas and images making possible a sense of identity and co-existence with others within a shared, meaningful social order. As was mentioned in the previous chapter, this identification through incorporation is built on a paradox because in order to define oneself, one comes to depend on something *other* than oneself, either in the form of an external reflective surface such as a mirror image, or language, which also represents an externality, and one into which one is born since one does not choose or invent one's language. This system of externality is thus partial in representing the subject and something always escapes: *object a*. The exclusion stemming from the act of representation can be exemplified with René Magritte's painting, 'La Trahison des Images', known as 'This is not a Pipe'. It is not a real-life pipe insofar as it constitutes a representation of a pipe which cannot correspond to the real-life thing. It cannot be viewed from all angles and capture all its qualities. In the act of representing/naming, all the distinguishing elements of the event are obliterated. Lacan follows Hegel's line of reasoning here by paraphrasing his idea that 'the symbol first manifests itself as the killing of the thing' (Lacan, 2002/2006: 262). This is nothing other than the failure of integrating

biology and culture. The failure gives rise to a surplus, an exclusion, one which does not amount to a pure exclusion but instead is included as a crucial element within the symbolic order. More specifically, this impossibility *qua* failure of symbolisation becomes inscribed in the body where it operates as a mark of difference. The surplus is then a void as a form of a gap emerging logically before subject-other differentiation (Moncayo, 2012: 53, 194). For self-identity, defining oneself with oneself, is impossible. There needs to be an otherness or difference in order to invoke meaning, or else one would disappear in one whole mass with no means of differentiating between oneself and the other, as found in certain forms of psychosis. This mark of difference comes about by transforming nothing into something, which is fundamental to the process of alienation by which the subject emerges, through the 'naming of the void' (Fink, 1990: 87). Lacan illustrates this idea through the making of pottery: a gap is formed through the creation of its sides, thereby turning emptiness/nothingness into something. To explain it yet differently, we can compare it to the emergence of desire, which amounts to a moment of pure desirousness, a desire to desire part of 'include me out!'. The desire to desire involves counting the form (structure) into the content as put by Žižek (2000: 113). This is explained eloquently by Leader (Seminar XI: 49-50) with an anecdote about a man suspected of stealing at work. Every day they search his wheelbarrow for stolen goods, but they cannot find anything — until they eventually realise it is the wheelbarrow itself the man steals. It moves attention away from the inside of the container to the empty container itself, from a set of objects on the inside to the set itself (the set of the empty set), which Leader (1997: 50) compares to the act of speech. Within speech, it is not a particular object which is sought, but the act and meaning of speaking itself which has priority (Ibid.: 51), insofar as the act of speaking produces differences and gaps on which desire feeds. The only way in is out. We discern this in the interview excerpts mentioned so far where different bodily sensations take the place of a nothingness. The idea of 'there's nothing wrong with you' inherent in the demand to 'keep going' is a type of nothingness (I suppose one could also call it a fullness, which I did above) which the subject attempts to make a gap in, one included in the social order. We can take this moment to amount to an endeavour to invoke a void in relation to the symbolic, or in more Lacanian terms, bring forth the real in relation to the symbolic; a void *in relation* to structure as opposed to *within* structure (Chiesa, 2006). The naming of the void is then something which 'sutures' — a Lacanian concept coined by Jacques-Allain Miller (1977-1978) — the relation of the

subject to the Other, and constitutes the precondition of taking up a position within the social order.

That is, one has entered the symbolic order when one is capable of using metaphors, for which a void is necessary. Accordingly, Lacan refers to the metaphorical function of language as a 'synchronic structure' and explains that it is when the child can say 'the dog goes meow, the cat goes woof-woof' that the transformation of the sign into the 'function of the signifier' has taken place. This involves 'disconnecting the thing from its cry' (Lacan, 2002/2006: 682): recognising that a word does not correspond directly to a concrete, external referent; that any word can take its place. This allows us, for example, to speak of anorexia as disconnected from the activity of literally not eating (something not everyone in the field picks up on). Put differently, disintegration is necessary for integration (of identity); *object a* has a creative function. This process is inherent in the practice of psychoanalysis wherein one's identity is first and foremost disintegrated in order to build up a new one (or rather to accept that identity and integration is impossible). In this way, the refusal of the symbolic, logically speaking, starts already at the alienating encounters when the subject encounters the indifferent 'nothing' of the Other, and realises that one is excluded therein. The subject realises that the statement 'there's nothing wrong with you' does not correspond with his/her situation. It follows Lacanian theory in that, as Pluth (2007: 73) recognises: 'what is called the subject in Lacan's theory begins when the Other no longer addresses you'. Along these lines, Lacan explains that an anorexic refusal, contrary to common sense, is 'the first sign of this bond' (Lacan, Seminar X: 328). The refusal does not constitute a separation from the mOther but the 'inhalation, into oneself, of a fundamentally Other environment' (Ibid.: 327), with the Other environment implying something *other* than oneself as a point of nothingness and difference. The refusal, counterintuitively, through which one installs and realises the gap between the subject and the Other, allows a link to be made between the two since one can therefrom use metaphors in an act of identification[25]. It is thus the inhalation of the statement 'there's nothing wrong with you' by the subjects which illustrates both the difference from and link with the Other.

Thereafter — still logically speaking — the subject('s body) taking the place of lack could be tied to the activity of the anal drive, which can be understood in its relation to

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[25] The gap between the subject and the Other as it occurs through the act of separation will be discussed in more details in chapter seven in relation to the clinical structures.

anorexia *qua* the oral drive. Lacan explains that anorexia occurs at the level of the oral (drive), where 'that from which the subject was weaned is no longer anything for him' in the act of 'eating nothing' (Lacan, Seminar XI: 103-104), which I just explained. However, the body taking the place of lack could be related to the anal drive insofar as Lacan links this with 'the locus of metaphor — one object for another, give the faeces in place of the phallus', which is further where 'man is inscribed' (Ibid.: 104). One then gives lack ('nothing') as something. We can supplement this with what Lacan claims in seminar X (p. 328), that following an anorexic refusal involving a making of a bond, the anal object 'is going to come and fulfil this function in a more clear-cut fashion when the Other itself elaborates its own function in the form of a demand'. The function more specifically relates to 'give what he is – in so far as what he is cannot enter the world except as a remainder', meaning again that *object a* as lack (a nothingness) is given. The relation between the oral and the anal drive could potentially be understood through the concept of retroactivity which puts into question any theory of genesis and sequential development: it is only from the standpoint of the body having already taken the place of lack in a metaphorical act that the void retroactively appears to have been there beforehand.

In line with the anal object and in the context of fatigue, one gives a lack of energy to the Other through 'doing nothing' as a response to the demand to 'keep going'. Albeit this giving nothing is enacted through bodily tension, possibly linked to a moment of producing and hoarding energy, which carves out a void. The subject gives nothing as something, introducing an object (a bodily tension) between the subject and the Other through which the subject both appears and disappears, or appears by disappearing (here literally withdrawing from activities)[26]. The anal object *qua* faeces is appropriate here since 'shit' has connotations both to 'nothing' — through expressions such as 'it's shit' and 'you ain't shit' — and to something valuable — through for instance saying 'it doesn't mean shit' and 'get your shit together'. The reason for this could be structural and traced back to the infant-parent interactions.

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[26] It is akin to what Lacan mentions in relation to 'active separations' in Seminar X, referring to a case by Margaret Little where a patient stole whenever her mother came close: 'I'm showing you an object I've stolen, by hook or by crook, because somewhere else there is another object, mine, the a, which deserves to be considered, to be allowed to emerge for a moment' (p. 145). She was trying to put an object between herself and her mother when her mother did not recognise her lack, as a way of 'acting out' and showing her lack by disappearing behind an object. The object here could be said to be an unsymbolised bodily tension.

The anal object is related to the actions of giving and receiving because the excrement represents a sort of gift: the parents demand the child to go potty, to produce something for them, which the child, upon success, gets commended for. It sends the message to the child that something of its body is wanted by the parents and that it can be given to them as a gift which would bring pleasure and joy. But the excrement is a highly ambiguous object because what is thereafter demanded is to flush it away, to get rid of it. This changes the message into: we want something of your body (loss) that we then reduce to nothing. We can contrast this to current capitalistic production in that the human is demanded to constantly produce through work and enjoyment, but mass production takes over and the objects, and the humans producing them, are more and more viewed as exchangeable, replaceable and ultimately temporary and insignificant. This moment of being excluded from something of value can be related to the participants' alienating encounters where they are reduced to nothing. Embodying the anal object thus could be said to counteract this, by producing energy/tension which is then withheld from the Other, reduced to nothing, albeit something which nevertheless is valuable. It represents something of a paradoxical situation since in order to signal a lack of energy and delineate a gap, a deficient of some sort, tension *qua* energy is needed. The production of an unsymbolised tension can thus aptly be compared to the process of naming the void as an inclusion of an exclusion.

The naming of the void in this manner can be found at a more general level for the participants, who explain that their symptoms and conditions elude descriptions. However, it is most clear in the act of diagnosing fatigue, in which case a name as opposed to the body signals a void (although these are highly intertwined). The diagnosis is arrived at based on exclusions of illnesses insofar as nothing is found in terms of biomedical markers, and thus assigned to the condition is the name CFS/ME. This name represents an enigma, evident in categorising it as Medically Unexplained Symptoms (MUS). But more precisely, the name comes to represent a nothingness without an established set of knowledge backing it up and, perhaps more importantly, without validation and recognition from the Other pertaining to its existence. Indeed, the participants repeat through complaints the fact that the diagnosis "means nothing". On the other hand, it is something which gets assigned a name and is 'counted' as a diagnosis, as something. It then amounts to a registration of an absence. Instead of viewing this complaint as a pure 'negativity' (as a complaint), the existence of a nothingness also implies there are potentially endless possibilities and explanations which

could take its place — as long as the nothingness represents a void as opposed to a foreclosure of it (a lack of a lack); or rather they try to counteract the foreclosure of the void by bringing it forth. A void means it is not pinned down to anything in particular — with many of the participants and patients in general holding out hope for explanations pertaining exclusively to the biological body. While a name is thought to be powerful enough to signal differences, at a more fundamental level, it is the body which allows the void to be brought forth. Pain seems particularly apt for this function, and further acts as a way of differentiating between the self and other, as found within the context of the interviews.

(Pain) Signalling the Boundaries of the Body

The increase of tensions seems better able to signal an aliveness than fatigue, where particularly pain acquires a prominent role. What this refusal entails, beyond that which has been discussed, is an endeavour to delineate the boundary of one's own body. This comprises a focus on the inclusion part in an attempt to erect a barrier between self and other.

Using the unsymbolised body as a way of signalling the presence of one's own body was seen in Amy's and Brody's discourses above, but it is more perhaps clearly recognised in Mark's discourse, particularly when speaking about his mother not taking his condition seriously:

> But she *still*, she *still* - and she's *seen* me collapse through exhaustion. She's…she's done it repeatedly, she - I've been in the car saying 'I'm too tired to talk, don't talk to me I'm too tired to talk', and then they continue to talk to you. And then the-the-the shaking comes back due to stress in that situation, when my body is starting to really enter survival-mode. And she's *seen* me collapse and start to twitch uncontrollably because of the energy I spent *listening* to her talk to me and she still has this world where…I - I might be able to just go for a drive for half an hour then wander around the museum on foot for an hour and then drive back for half an hour. Like a normal person (A/L388-397).

The demand found within his discourse is that of being "a normal person", someone "able to just go for a drive for half an hour then wander around the museum on foot for an hour and

then drive back for half an hour". In other words, there is a demand for constant movement, stemming not just from his mother but the big Other insofar as he states "then *they* continue to talk to you", it being embodied by several others. The demand is linked with the Other refusing his subjectivity, since there is a lack of acknowledgment that Mark is unable (or unwilling) to 'go on'. Or rather, the Other refuses *his* demand ("I'm too tired to talk, don't talk to me"), thereby disregarding his wishes; in line with Lacan's conceptualisation of anorexia where the mOther (literally here Mark's mother) has 'its own ideas about his [the subject's] needs' (Lacan, 2002/2006: 524), marked by Mark's words that "she still has this world where… [he is able to drive and walk]". This results in his body "shaking", described by Mark elsewhere as a "Parkinsonian tremor" (A/L38), which can be interpreted as a refusal of the demand to 'keep going' since they are mentioned simultaneously; a refusal of the Other's refusal. One of the reasons for this refusal is suggestingly not to disappear altogether in the Other's desire, but to preserve one's own, indicated by him saying that "the shaking comes back due to stress in that situation, when my body is starting to really enter *survival-mode*". Survival-mode is related to the shakes, further linked to something visible: "she has *seen* me collapse and start to twitch uncontrollably". The emphasis here is not on the retreat from the activities mentioned through the condition (a disappearance), but rather about a part of his body surviving in the social order, through a registration of something uncontrollable. The rise in tension points to a lack standing outside of a symbolic understanding, if I can interpret the world 'uncontrollable' in this way. The body here takes the place of lack, as an element included in the symbolic order, something capable of differentiating between self and other, between him and what is considered a "normal person", and thus between him and his mOther's desire. The body is that which allows the link to the symbolic to be made, since the symbolic order is built on differences between signifiers — words are defined with other words in a circular movement — and thus, the subject's body can support this nature by constituting a difference from the symbolic (Hoens, 2018: 176). Throughout the interviews, it is indeed not the form of fatigue which acquires this role of signalling a presence and establishing a link, but pain appears to better demarcate the body.

When mentioning at some point his "physical pain", Mark explains it "exhibits mostly in my legs" (A/L345-348). That he uses the word "exhibits" could point to an (unconscious) attempt to signal the presence of his body, as something showing itself as "burning" — another word Mark uses to describe pain — a flame which hardly goes unnoticed. Indeed,

many of the participants describe their pain as a burning sensation. In addition, Gail seems to associate pain with her wheelchair and crutches, since these are frequently mentioned together, where her pain is explained as the reason for using them. She further talks about how this increases the visibility of being ill, necessary particularly for interviews regarding her Personal Independence Payment. This moment could thus comprise an attempt to give lack (of energy) to the Other; to open up people's eyes to the fact that something is wrong with them, that it eludes their understanding and assumptions, and, ultimately, that one is different from others. Brody, along these lines, mentions fatigue and pain and gives an indication that pain is a way of differentiating oneself from others: "'Cus I feel, *tired*. I feel tired the same way anyone else feels tired *but* with like constant pain in my legs, just now" (B/228-230). That "anyone else feels tired" implies a feeling capable of being experienced by everyone, perhaps following the omnipresent sociocultural expression we hear today that 'everyone's tired'; hence the inadequacy of fatigue of singling out a unique position. The emphasis on the word 'but' would point to a situation of an exception, which is that of "constant pain", capable of perhaps distinguishing between everyday tiredness and a serious, severe form of fatigue. We see how the body as a mark of difference supports the conceptual difference within the symbolic as one between 'fatigue' and 'everyday tiredness', and the differentiation between self and other. Bodily pain functions to signal the aliveness of the body, which is not surprising since 'pain sharpens and defines bodily boundaries' seen in practices such as cutting (Leader, 2017: 106):

> The cut here is an autonomous act, and the cutter the sole agent. As well as permitting an idea of agency, it can introduce a rhythm, a sense of before and after, crucial if the person feels caught in a relentless and never-ending experience of numbness or anxiety (Ibid.: 107).

Introducing a rhythm in the form of a difference indeed seems to be one of the effects of the condition as the participants explain that their lives can be divided according to a 'before' and 'after' ME/CFS. Mark explains it as a division into two "very clear sections" (A/L596-598). However, like I stated previously, what supports this division is the body, more specifically the process of hoarding energy — an accumulation of excitation — which transforms energy into a tension signalling a void. These tensions, in turn, seem to cause

sleepiness, as they ultimately lead to sleeping/resting/stopping, and thus resemble the drive to sleep.

The Drive to Sleep as an Unconscious Refusal

While there is a large variety of bodily tensions present in the interviews of the participants, tensions which signal a refusal and the presence of the body through a void, a subsequent moment — still a refusal — sees more uniformity, as all of the participants describe an urge or necessity to go to bed and sleep (or rest), or largely to 'do nothing', usually in relation to the demand to 'keep going'. There is a wish or a push on behalf of the body to stop and disappear, but most importantly to sleep. For Mark, pain constitutes a signal to stop, a point where he knows he "shouldn't be trying to do anything else" (A/L348), which seems to be the case for the other participants too. We can therefore note that these tensions *cause* fatigue, or rather constitutes a movement towards fatigue, and thus I argue that they can come be conceptualised as a drive to sleep — the drive being, according to Lacan, a constant tension arising in relation to the demand of the Other. Unpacking the notion of the drive can therefore shed light on fatigue as a refusal of the Other's demand to 'keep going'. While the moment of stopping will be considered in the next chapter, I here (still) focus on a tension as a movement, however one towards a non-movement.

In the interviews, discernible for all of the participants is a necessity or an urge to "close my eyes and get to bed" (Gail, A/L621), and a "need to get back to bed" (Tom, B/L366) — usually expressed in relation to demands. This is strongly related to 'doing nothing' as they are usually mentioned together, illustrated in the following by Lucy in the context of the never-ending demands of life:

> …the body's physically unable to do anything. The mind wants to, but what can you do if your body's acting like it - just wants to sleep all the time. It's *horrible* (L/224-226).

Noticeable here is a mind-body divide, where the "mind wants to" (do something) while the body "just wants to sleep all the time" (do nothing), showcasing the unconscious refusal of the body in the face of the ego fighting against the impulse to 'do nothing'. It is the divide

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itself which Lucy could be referring to as being "horrible", referring to a force experienced out of one's conscious control as well as, most likely, going against the ideal image of a hard working person. Nevertheless, the crucial aspect here is that she does not say she *does* sleep all the time — something some of the participants mention: that being fatigued is not necessarily about sleeping more; however this could certainly be the case for some — but that she *wants* to sleep. There is a bodily force driving the subject towards sleep or resting (stopping, disappearing), which is in line with the other participants' urge and necessity to sleep, and one which is present "all the time" as Lucy states. We can then conceptualise this force as a constant bodily tension, which brings us close to the notion of the drive as theorised by Freud and Lacan.

Freud defines the drive as a 'constant tension' situated on the 'frontier between the mental and the somatic' (Freud, SE XIV, 121-122). With the introduction of the death drive, however, things become more complicated. The death drives, or Thanatos with which he equates it, is thought of in opposition to another group of drives, the life drives, Eros, which are thought to possess two distinct functions:

> The aim of [Eros] is to establish ever greater unities and to preserve them thus -
> in short, to bind together; the aim of [the destructive instinct] is, on the contrary,
> to undo connections and so to destroy things (Freud, SE, 23:148).

The death drive as a destroyer of things is usually thought of, particularly following a simple reading of Freud, as a diminishment or removal of tension. This is detected in Freud insofar as the death drive is thought to aim towards death, or the inorganic, inclusive of a return to an earlier state. Contrarily, the life drive is constantly producing tensions (Freud, SE XVIII: 63). However, this binary view gets put into question, particularly when Freud links the death drive closely with the pleasure principle, whose function it is to 'reduce, to keep constant or to remove internal tension' (Freud, SE XVIII: 56). The presence of three various functions concurrently suggests an ambiguity pertaining to the functions of the pleasure principle, as also noted by Boothby (1991: 86). Indeed, Freud (SE XVIII: 62) states himself that he could not decide which one of these three functions is inherent therein. That the pleasure principle is thought by Freud to overlap with the death drive, and in turn with the life drive, complicates the concept of tension in relation to the death drive. The inextricability between the life and

death drive will be dealt with later on in this thesis; the most important aspect to note here is that the drives on a whole are linked to a continuous tension, insofar as Freud is merely speaking about the *aim* of the death drive (as removing tension), and not the result as such. In accordance with this, Freud (SE XIV: 122) puts emphasis on the fact that the drive is always 'a piece of activity', even if its aim is passive. Indeed, a common misconception of the Freudian death drive is that it constitutes a wish to die, where even the execution of dying/suicide is prescribed to it. I discuss in chapter six of this thesis how Freud's view is more nuanced than this, but for now I will focus on a Lacanian perspective wherein the death drive is less ambiguously an attempt to keep a tension alive.

The drive for Lacan is a bodily force which emerges as an effect of the social on the organic body. The social intervenes on the biological body primarily through demands articulated by those around the subject, and thus in more Lacanian terms, the drive stems from an intervention of a demand on an organic need (Neill, 2014: 52). That Lacan prioritises a demand when it comes to the theory of the drives is seen in his formula of the drive, where the split subject is situated in relation to a demand ($\$ \& D$). This can be explained through the interrelation but difference between need, demand and drive.

As was outlined in the previous chapter, when a biological need such as hunger is expressed via language, it changes the very nature of the need and turns it into a symbolic demand. A demand becomes imbued with a social, subjective function, acquiring a certain colour influenced by the child-parent relationship. This means that biological activities obtain the symbolic function of always being about something else (pleasure), and something more (unconditional love). Lacan expounds on the drive in relation to a demand in the following manner:

> The drive is what becomes of demand when the subject vanishes from it. It goes without saying that demand also disappears, except that the cut remains, for the latter remains present in what distinguishes the drive from the organic function it inhabits: namely, its grammatical artifice, so manifest in the reversals of its articulation with respect to both source and object (Freud is a veritable wellspring on this point) (Lacan, 2002/2006: 692).

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It is evident from Lacan's paragraph that the drive 'inhabits' an organic function yet is distinguished from it by its 'grammatical artifice'. The way in which the drive is linked to organic life is that the drive follows a demand in which a need of the body resides: it follows the activity to eat, defecate and sleep for example. But the difference between the drive and an organic function stems from the presence of 'the cut' as Lacan mentions, which refers to the signifier of lack having arisen as an effect of entering the social order. Due to the fact that the body cannot be fully integrated into language — that nature and culture cannot coincide — a surplus *qua* impossibility arises as that which escapes the conjunction of the two. The drive as the surplus of the failure of integrating the two (Schuster, 2016: 101) then gets inscribed in the body, or more precisely, a part of the body takes on the place of lack (Van Haute, 2002: 174-175). These places are called erogenous zones, privileged sites where pleasure is produced and where exchanges with the caretaker take place such as feeding and potty training, giving rise the oral and anal drive (Van Haute, 2002: 142). That is, biological functions such as receiving nourishment, since they become intermixed with the exchanges and demands of the Other, become imbued with pleasure, turning these into activities extending beyond biology. The difference between a biological need and a drive is the following: while hunger as a biological need is capable of being extinguished/satisfied with the physical object of food and food alone, the advent of the oral drive turns hunger into an unquenchable appetite where satisfaction never arrives; one comes to eat either too much or too little as Freud recognises (Shepherdson, 1997: 138). In other words, the drive constitutes a bodily excess signalling a lack of satisfaction. Not only that, but the drive ensures this very excess where a lack of satisfaction is the aim. Lacan in this way takes up the notion of a constant tension by defining the drive as 'la pulsion en fait le tour' (Lacan Seminar XI: 168), which in French signifies 'to walk, to drive, etc., round something'. With the word 'tour' he plays on a double meaning where in addition to a circular movement, it refers to a deceit (Ibid.: translator's notes). The drive 'turns' around the object, as Lacan explains, through a 'trick', and it is such a detour which amounts to the 'satisfaction of the drive' (Ibid.): to never reach the goal and instead gain satisfaction through the very repetition of activities, even if that satisfaction is accidental (see Zupančič, 2017: 102). Nevertheless, attempts at satisfaction are enacted through substitute objects in relation to the source, such as thumb-sucking, alcohol, smoking for the oral drive (Shepherdson, 1997: 138). The drive keeps returning to the source (hunger in the case of the oral drive), and its object (food supposedly

capable of extinguishing the source), moving from the source to the object and vice versa. Lacan thus helpfully distinguishes between the goal and the aim. The goal of the drive is to get rid of appetite and non-satisfaction, while the aim is to miss the goal in order to circulate around *object a* as a void, to instead repeat the activity of eating, enabling the 'constant tension' immanent to the body. The drive supports the biological function, as without an appetite, one will not eat. On the other hand, we are also far too aware today of the destructive tendency of the drive acquiring an independent status of biology, where people engage repetitively in the oral drive such as smoking, drinking and eating, despite the risk it poses to their lives, and no doubt do people derive pleasure from these activities and their repetition.

We can link this constant-ness of a tension arising due to the introduction of the symbolic order, as Lacan does, to a gap (Ibid.: 171), to the structural incompleteness of language since he states that the object of the drive is the lost object appearing in the gap of language (Lacan, Seminar XI: 185). Something of the body has failed to be satisfied and understood. Put differently, a lack of satisfaction is coterminous with a lack of symbolisation, since as long as something is not understood, it is repeated; and as long as pleasure was not derived from an activity, it is repeated. The body and language then share a similar structure. 'It goes without saying', as Lacan mentions in the excerpt above, aptly characterises this moment of the drive where both the subject and the demand disappear behind an unsymbolised constant tension. In this manner, for Lacan (1977: 199) every drive is a death drive, as it — in line with Freud postulating the death drive as a destroyer of connections — contains an anti-synthetic function (Chiesa, 2007: 143). The drive as a bodily surplus gives rise to the experience of loss since it carves out a void, non-satisfaction, in the body. The object of the drive is thus loss itself as a means of maintaining a gap, from which desire springs up.

In relation to fatigue, due to the intercession of the sociocultural demand to 'keep going' (to be awake and alive) on the body, and the subject's response to this in the form of a refusal, the organic need to sleep — which is temporarily satisfied after a night's sleep — transforms into an unquenchable drive to sleep in the sense of wanting to "sleep all the time" as Lucy puts it. It becomes an urgent, necessary force manifesting as a loss of energy, and a subsequent need to remedy it — the drive being both the goal to remedy it and the aim to make sure that such a remedy is unattainable. This drive to sleep, arguably manifested through various bodily tensions insofar as they lead to fatigue/sleep, is capable of undoing

identification/points of identity, evidenced when the participants explain how they lost a part of themselves through the emergence of the condition, which has come to sabotage their lives and desires. The desire sabotaged here is that of wanting to be a hard-working person, attested to when the participants attempt to meet the demand to 'keep going'. The drive unravels this identity tied to 'the body as machine', through sacrificing a part of oneself and repeating a loss, which simultaneously amounts to an 'act of creation' linked to entering the social order, as recognised by McGowan (2013: 13) in relation to the death drive. The loss of energy is this 'saying no' to being reduced to a bodily machine in order to make space for one's own desire; an anti-synthetic, unconscious attempt to separate from the proximity of the demanding Other. However, as have been argued, this loss is not a pure loss but amounts to a tension *pointing to* and carving out this loss — or really at this stage we are speaking of a void and not really a loss, since the unsymbolised tension in the interviews constitutes a presence of an absence — the way in which we can understand the hoarding of energy and accumulation of tension. Fatigue here follows the view on anorexia as a rejection of otherness. Legrand (2011) explains that the anorexic rejects a dependency on food as an object other than oneself, 'the realm of anonymous organic processes and of corpses' (p. 506), in order to preserve one's subjectivity. Subjectivity is that which cannot be incorporated to an object considering the subject (tied to the realm of indefinability) and the object (the realm of the definable) are irreconcilable. The objective realm of anonymity and dead corpses can be compared to that of the symbolic-imaginary order: a pinning down therein entails the the 'murder of the Thing' as explained above, insofar as representations are always partial and reductive, and even more reductive when that partiality is not acknowledged. Considering the latter, the statement 'there's nothing wrong with you' presents a strengthened version of alienation. Fatigue in this way could be viewed as a refusal of the Other's otherness, a saying no to alienation and being reduced to an object therein; however by paradoxically embodying the otherness of one's own body.

The drive can therefore be equated to pure desire, a desire to desire, since the aim is to keep on living/desiring and to persist as a tension, to never reach the object of desire or to coincide with an object. Because lack/loss is the basis for desire, the presence of which inaugurates a search for an object which will quench a tension and remove loss (arguably sleep which is the focus of the subsequent chapter). It is thus arguably the search itself which is sought after, where — in contrarily to what is normally thought of the Freudian death drive

in relation to the idea of Nirvana — the drive is concerned with keeping itself alive, presenting an excess of life (Žižek, 2006b: 62). It becomes a form of inertia since the drive is fixated on a gap and in this way presents a movement of a non-movement as it repeats certain activities. The drive being an excess of life would make it appropriate in signalling the aliveness of the body.

The drives are accordingly the bodily manifestation of the 'single force' of pure desire. More precisely, the representation of desire takes form through a variety of part objects of the drive (Evans, 2006: 38). Part objects are both something corporeal and hypothetical in that *object a* as the void is present therein, and they are related to the erogenous zones (Vanheule, 2014: 132). This would explain the variety of tensions present in the interviews at this 'initial' stage of refusal if reading the interviews chronologically, such as pain, vomiting, and shaking; all of which cause fatigue just as the drive is the object *cause* of desire. In contrast to this, the 'wish to sleep' as a desire capable of extinction is expressed in the same/similar manner. Putting the two together would amount to the movement of a non-movement as seen in the interviews.

While Lacan did not put forth a 'drive to sleep', since his drives (the oral, anal, invocatory, scopic) are organised around bodily rims, sleeping is nevertheless an organic need, and we need not take the drives too literally. The uptake of the body's anatomy into the social order provides a link yet differentiation between the body and language, the latter since language fails to refer to a direct, physical correspondence with its inevitable ambiguity (or excess of meanings) and its capability of using metaphors. The symbolic takes advantage of a 'margin or border' where there is an opening and closing, such as the lips/mouth, genitals, anus and ears through what Lacan terms 'the cut'. (Lacan, 2002/2006: 692). Lacan adds the gaze and the voice to Freud's list of drives in light of this. The potential reason for language having its effect in those rims is that a continued opening and a closing mark the incompleteness of the body, thus the signifier can come to inscribe itself there as lack (Van Haute, 2002: 144-145). Such an opening and closing of the body reflects an opening and closing of the unconscious in relation to consciousness. The drives contain a certain structure: Lacan relates the oral and anal drives to the Other's demand and the invocatory and scopic drives to the Other's desire (Lacan, Seminar XI: 104). This I argue means we can interpret the drives to be flexible pertaining to their physical content, even though they were formed based on the anatomy of the corresponding bodily part, as seen from Lacan stating in relation

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to the drive: 'This does not in the least mean that, in our symptomatology, other zones do not come into play' (Ibid.: 172). The organic need to sleep could be taken up into any of the existing drive structures put forth by Lacan[27]. Accordingly, in this chapter I have linked pain relating to the drive as a constant tension with the oral and anal object, the former being part of the 'eating nothing' as recognising the void and the latter where the body takes the place of the void. Additionally, in the next chapter I briefly link the desire to sleep, strongly related to the drive to sleep, with the scopic drive, which seems to follow Lacan's structural differentiation that the anal and oral are related to demands, while the scopic drive is tied to desire. It would also suggest that the oral and anal drives are more linked to biological functions and more tangent, insofar as the drive is situated in relation to a demand. Lastly, sleeping can be considered a zone since it constitutes an opening and a closing in a rim-like structure: as one opens one's mouth to eat and fill a gap, one sleeps and closes one's eyes for the same reason. Sleep is aptly associated with a breach due to its unconscious nature — it represents somewhat of a black hole into which we disappear every night. For some people, this moment of letting go control and of not existing in the conscious moment presents such a difficulty that insomnia creeps in. This brings us back to Lacan's quote above about the subject disappearing in the demand and the drive. We have to engage in biological needs whether we want to or not, and particularly due to the fact that they have become interwoven with social influences beyond our control. Being a speaking subject entails forces going beyond one's conscious intentions, and indeed we see this in Lucy's discourse where she is describing a surplus on behalf of her body, an unquenchable wanting-to-sleep force, belonging to herself yet unable to be controlled by her — which is what the "horrible" element could refer to.

Accordingly, the drive to sleep, immanent in the refusal to be reduced to an object of productivity, is unconscious and constitutes a force going beyond the subject. It amounts to a moment of alienation and in agreement with Lacan's notion of extimacy where the core of oneself — wanting to constantly sleep presumably being the prioritised activity in one's life — resides on the outside. The drive possesses this structure of an external internality, hence why Lacan (Seminar XI: 181) claims that the manifestation of the drive is a 'headless subject, for everything is articulated in it in terms of tension, and has no relation to the subject other

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[27] Of course, the theory of the drives can be questioned; are there really only four (structural) drives? Further, sleep, in contrast to the other drives, does not have a physical external object which stimulates the zones as obviously as the other drives, such as food and faeces.

than one of topological community'. Tension is the flip-side of the Möbius strip which is the subject: tension is both that which never manages to be taken up into subjectivity/a symbolic structure in the first place, but also an effect of the structure — acquiring a paradoxical, impossible status akin to that of *object a*. Put differently, the subject is that which is always lacking, missing; a tension is likewise missing from the symbolic order, however simultaneously ex-ists as a physical presence, one from which the subject is separated yet forms an integral, inextricable part with. This split constitutes the subject/object split (with the object being the drive here) manifested as a mind-body split, where the two are inextricable yet irreconcilable. As Žižek (1996: 161) puts it, the 'drive is that which is "in the subject more than herself"' as an 'impersonal willing' which disregards his/her well-being. It appears for the subject as a force stemming out of nowhere, *ex nihilo*. Taking responsibility for the force constitutes a self-contradiction as noted by Nietzsche (2014: 23) in his discussion of the drives, who claims that to be fully responsible for one's actions, to postulate a cause and effect, is an illusion 'amount[ing] to pulling yourself up by the hair out of the swamp of nothingness into existence'. The subject as an agency having been there before an act, as the one intentionally committing it — an argument in line with the postulation of a biological cause which was discussed in this chapter — can only ever be an assumption in an impossible moment. The drive is nevertheless something which must be assumed by the subject since it has the paradoxical status of being both on the inside and the outside — Lacan (Seminar XI: 184) refers to the object of the drive as a 'headless subjectivication'. The subject is therefore the object of the drive, the same as it yet different from it, following Lacan's logic of 'the same but different'. We return here to the formation of a symptom as a 'forced solution' as presented in the context of Brody's discourse at the start of this chapter: the symptom (of fatigue) is both a solution and a problem. Or rather, a problem is used as a solution. Nevertheless, we will see in the next chapter how another moment of 'doing nothing' is more tied to the function of a solution and defence through escapism.

Chapter 5: Fatigue as the Desire to Sleep

I love sleep. My life has the tendency to fall apart when I'm awake, you know?

— Ernest Hemingway

The formation of fatigue as elaborated by the participants of this study is arguably not just about making room for one's own desire by signalling the aliveness of the body through a lack of energy — best done through bodily tensions such as pain, on which the previous chapter focused. In contradistinction to this, a 'second', subsequent moment outlines fatigue as a disappearance and an escape from the life of demands, and, ultimately, from the limits of society and the body. This moment seems to take the form and function normally attributed to fatigue, as a diminishment and an absence of tension, related to "doing nothing" (stopping, disappearing, sleeping). To diminish tension would constitute a way of counteracting the anxiety-provoking accumulation and movement of demands, accompanied by a rise in tension. This will be explored in what follows through Lacan's theory of desire, particularly 'the desire to sleep' as a defensive desire related to the fundamental fantasy, and further linked to his and Freud's notion of inhibition.

The Loss of Energy through Consumption

Noticeable in the interviews alongside the demand to 'keep going' is a rise of bodily tensions, which was investigated in the previous chapter. This was related to a hoarding of energy as a refusal of the demand to 'keep going', where energy was turned into a tension signalling a deficit of energy. However, following this, particularly once the condition has 'settled in' so to speak, we discern how the subject aims not towards an aliveness but quite the opposite: to extinguish all tensions in the quest to 'do nothing', as another way of refusing demands/the demand to 'keep going'. Fatigue here takes on the role of a protection against tension, a protection associated with stopping, disappearing, sleeping and being fatigued. Arguably, this could constitute another aspect of 'eating nothing', where energy is consumed to the point of losing it — loss and lack being highly inextricable from one another but ultimately different.

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The presence of a rise of tension/energy followed by a loss is demonstrated in Brody's discourse when explaining the unpredictability of his condition, which was analysed in the previous chapter in relation to an accumulation of demands:

…my body tenses up which takes energy or if you're in the car and it's a bit erratic the driving you know you sorta tense up, your body naturally tense up to protect yourself, which takes a *huge* amount of energy. And I'd be exhausted. So again, get rid of *all* the variables of the stressors of work and relationships and whatever, and eating well, that's - establish that baseline seems very important (A/L381-389).

The expression to "tense up to protect yourself" makes a link between a rise of tension and an act of protection. Thereafter he says this "takes a huge amount of energy", meaning energy is used up, ultimately leading to exhaustion ("And I'd be exhausted"). Exhaustion is therefore linked to a loss of tension. The moment of increasing tension here could be compared to the activity of consumption in order to quench a non-satisfaction *qua* something uncomfortable in the body. The consumption of energy is enacted in order to eradicate unpredictable demands ("get rid of *all* the variables" which are linked to "stressors of work and relationship and whatever and eating well"). There is a loss of energy whereby nothing is left. More correctly, it is the activity of 'doing' which uses up energy, and this is something observed in all of the participants' discourse, particularly at the onset of their conditions where they utter "I kept going", or that they were pushing themselves. Tom, for instance, indicates not just a continuous movement, but an increase of it when he says he was "pushing" himself more at the onset of his condition:

I would say since November, December, I felt a - a *change*. I felt a kind of - I was pushing myself more and more - becoming *chronically* fatigued like somebody pulls your battery power out. That what it was like at the start and that was after having a shower. I'd be like ah no I need to get back to bed (B/L362-366).

It is the activity of "pushing" himself "more and more" which leads to the urge to sleep/rest for Tom ("I need to go back to bed"), not necessarily sleeping. A similar 'pushing' is present to a large degree in Gail's discourse throughout her interviews, who says she is unable to stop pushing herself and start pacing, as instructed by the medical establishment through the imperative to 'slow down'. This process whereby an increase of energy is followed by a decrease can be compared to an activity towards passivity, and thus we can compare it to Freud's notion of neurasthenia.

Neurasthenia is a concept subsumed under the term 'actual neurosis', which was explored in the previous chapter (but with a focus on the other subcategory, anxiety neurosis). Instead of an accumulation of excitation taking place in anxiety neurosis, neurasthenia consists of an 'impoverished tension' (Freud, SE III: 144), which is where Freud places fatigue. He conveys that a neurasthenic, as a result of excessive masturbation, is constantly removing 'even the smallest quantity of somatic excitation' (Ibid.: 111). Perhaps similarly, fatigue here could be a way of 'masturbating' in the sense of engaging in the activity of 'doing', overexertion, in order to eventually deflate, to discharge and lose tension — in line with the Freudian notion of the drive being a piece of activity which seeks discharge (Boothby, 1991: 86). Important to this process is that a tension rises, as an increase is supposedly necessary for a decrease. This may be more relevant at the incipient phase of the participants' conditions as it is mentioned more frequently there. However, many do describe throughout their interviews problems with pacing, with them mentioning a "boom and bust" cycle and many fluctuations inherent in their conditions. The masturbatory act is especially appropriate since, as was argued, fatigue could be a way of keeping energy to oneself as an attempt to create desire away from the Other. Accordingly, this moment could constitute another aspect of hoarding energy in relation to 'doing nothing': using it up oneself and keeping it at a distance as a means of *truly* preserving it.

The loss of energy could be an attempt to ensure a separation from the Other, because energy is both something the Other is asking for and takes away from the subject. The latter is attested to in the interviews when the participants mention that their lives have been stolen, with energy more precisely having been taken. Tom explains fatigue as someone having stolen his serotonin, which is in general linked with energy: "it's like somebody sticking a big syringe in your brain and s-sucking all the serotonin out" (A/L249). The act of stealing is especially evident in Mark's discourse who recounts analogies of people stealing someone

else's food (sometimes unbeknownst to themselves, sometimes intentionally), where Mark identifies with the position of the victim. The loss of energy occurs at moments when people talk to him, observed in the last chapter in relation to his mother, and is further present elsewhere in his interviews: "Even if I'm not responding, even if you're just talking to me, you're consuming energy…of mine" (A/L488-492). He names the energy *his* ("energy…of mine"). However, in the act of someone else stealing, it no longer belongs to him. Therefore, keeping energy to oneself instead (*qua* tension) could comprise an attempt to preserve one's *own* (desire), in a way stealing energy (back) from the Other. But if the Other is asking for it through the imperative to 'keep going', the best way of ensuring energy does not reach the Other, that energy cannot be stolen — constituting at the same time a subtraction from/a protest of the idea of 'the body as machine' — is to use it up and get rid of it completely, as a means of truly preserving it; a separation of oneself from oneself (and the Other). The function of the anal object could be compared to this scenario, which was linked in the previous chapter with the act of embodying lack/the void. 'Nothing' is given a valuable message, seeing as the word 'shit' has connotations with both a devalued nothingness and something valuable. Here, instead, we could emphasise the aspect of nothingness and separation, where the subject in a sense literally gives nothing to the Other, or gives one's loss. Giving nothing could comprise a type of withholding, however one which is enacted through first and foremost separating from a part of one's body and losing it, which is the structure of the act of defecating: a part is flushed away — used up by the subject — and thereby reduced to nothing. The function of fatigue here would additionally be, alongside a separation, a protection against the energy and anxiety produced via the movement of incomprehensible demands, which was perceivable in Brody's discourse ("your body naturally tense up to protect yourself"). This resonates with that put forward about automatic and signal anxiety in Freud's paper 'Inhibitions, Symptoms and Anxiety'.

Therein, Freud argues that a signal anxiety arises as an 'intentional reproduction of anxiety' in order to prevent automatic anxiety to emerge, which has the aspect of economy (Freud, SE XX: 138). Automatic anxiety is an 'involuntary fresh appearance of anxiety' equivalent to a real danger insofar as there is an accumulation of tension which needs to be discharged (Ibid.: 137) — strongly echoing the picture of anxiety neurosis part of actual neurosis which Freud himself links to automatic anxiety. That is, automatic anxiety part of actual neurosis equals a 'surplus of unutilized libido'; in other words, an unsymbolised

tension which the ego endeavours to defend against and does so by binding the anxiety through the formation of a symptom (Ibid.: 141). Therefore, signal anxiety as an intentionally produced tension is a protection against automatic anxiety in the same way that a psychoneurotic symptom is a defence against an intolerable pain rising unexpectedly. Based on this, we could link automatic anxiety with the participants' descriptions of the alienating encounters since these include an invasive, unsymbolised and unforeseeable force of pain capable of accumulating in the form of demands and physical sensations. Then, the rise of tension in relation to the demands as explored in the previous chapter and here can relate to signal anxiety as a form of protection. However, these moments cannot truly be separated, which is in line with what I argued in the previous chapter with regard to the inseparability between psychoneurosis and actual neurosis. Nevertheless, what is seemingly more protective in Brody's discourse is the successive loss of this tension — to bind it through a symptom as Freud states. We can perceive this in the interviews for all of the participants through the act of numbing the body (and the body of language) into nothingness as it relates to the formation of the fundamental fantasy.

Numbing the Body (of Language) into Nothingness

In the interviews, 'doing nothing' is linked with stopping, disappearing and/or sleeping. What these 'activities' have in common is that they entail a numbing of the body (of language) into nothingness. It is here that fatigue comes to the fore as the function we normally attribute to it, as a diminishment or loss of tension, a shutting off, which is expressed via various inhibitions pertaining to mental and physical movements.

First of all, what fatigue seems to shut off (or attempt to) through 'doing nothing' is the ever-constant movement of demands, as expressed by Lucy:

You're under pressure to earn money, you're under pressure with your studying or your working if you've got kids. I was a single parent at the time. Life canny[28] just *stop*. But that's what this disease wants you to do. It wants you to *stop*. It wants you to do *nothing* (/L143-146).

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[28] 'Canny' is Scottish slang for 'can't'.

The commandment for productivity presents itself as the "pressure to earn money", "studying" and also being "a single parent". That these entail a constant movement is seen when Lucy says "Life canny just stop"; an acknowledgment that it is impossible to stop, particularly seeing as one cannot bypass the demand to "earn money". Thereafter is expressed a wish "to stop" and "to do nothing". This can be read as a(n) (unconscious) desire to shut off life itself, a desire for the impossible — desire after all being about that which lies beyond an obstacle. The unconscious nature of the desire is attested to in the fact that the refusal/the act of 'doing nothing' is not recognised to belong to Lucy but is an action attributed to the "disease" as something seemingly independent to her.

Beyond shutting off demands, or in conjunction to it, what 'doing nothing' appears to involve is an inhibition of the mind. The participants and many patients in general refer to what is called 'brain fog': a well-known symptom for fatigue in which mental aspects are diminished. Brody for instance conveys the following:

> There will be times when I'm having a conversation and somebody will be talking for a decent long time and I'll - yea - lose the track – I would just stop listening [small laugh]. Like really not being able to concentrate on what the point of it is. Um. A dulling of the senses I guess [quietly] (B/L353-356).

Brody is experiencing a "dulling of the senses", not being "able to concentrate on what the point of it is", which suggests, in conjunction with the fact that he "would just stop listening", that the interpretative aspect of language is turned off. That is, meaning is shut off, or conversations are rendered meaningless in that he is unable or unwilling to figure out "what the point of it is". Fatigue numbs cognitive thinking, something present in everyone's accounts as they describe being unable to think, find and remember words, form responses, and there is a difficulty in understanding or processing what others are saying to them. Furthermore, not only are mental activities inhibited but so is desire, as relayed by Gail:

> My brain stops taking in anything, it's not interested even if I'm in college I just basically cut out. Completely. Um I've got to - got to get to bed. I've got to close my eyes and get to bed (A/L606-621).

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Gail articulates an urgency to sleep, not in the sense of *falling* asleep but a *push towards* it, which can therefore be related to a drive to sleep. This is associated to a "cut[ting] out" of one's surroundings, including an "interest" in college, possibly reflecting desire. Indeed, the inhibitions presented by the participants extend far beyond thinking and appear to be linked to a core part of themselves, evident in that they associate the loss of their bodies and their minds to themselves (having 'lost themselves' through having acquired the condition). For instance, for Mark, the mental difficulties are analogous to having removed the "whole layer of one's personality" in a lobotomy, which relates to "higher mental functions [which] just aren't there" (B/L257-259). It is as if one is reduced to a mere, barely existing body.

Nevertheless, it appears that it is not just the body of language the subject attempts to numb into nothingness, but also the body in its material, fleshy and ultimately excessive state. Lucy conveys something like this: "There's *nothing* there so any kind of emotional stress and you're, you're, you're floored" (L359-363). Expressing that she gets "floored" from emotional stress in relation to "nothing" suggests that the emotional stress gets numbed into nothingness. Likewise, Gail alludes to disappearing into nothingness by saying "And I'm not really here. I'm - I'm like, just floating above the surface. 'Cus I can't really feel" (B/L331-332). She refers to a state of numbness into which she and her feelings disappear. The participants in other words describe zombie-like states, becoming dead and numb objects whose affects, desires and, ultimately, responsibilities are shut off. At large, their bodies are disconnected from a meaningful Other. Lucy proclaims: "…your body, feels completely disconnected. And you feel, you feel like you're permanently drunk" (L39-40), where being drunk relates to a nonsensical state where there are no laws or rules. All in all, it is thus not a specific emotion or meaning which is shut off, but emotions and meanings *as such*, or in other words, the symbolic Other and the body as such. Instead of viewing this numbing into nothingness as a purely 'negative' experience which 'happens to you' and contains the element of horror to the person experiencing them in the sense that it reflects an encounter with the incomprehensible real — which it no doubt does — we can recognise the protective aspect of it as well. This is in line with the idea that a symptom formation is a defence against anxiety from both a Freudian and Lacanian perspective.

Freud had previously come to view anxiety as a product of repression, but when revising the concept of anxiety in his paper 'Inhibitions, Symptoms and Anxiety' (Freud, SE XX) he came to the opposite conclusion: that anxiety was a cause of repression (however

while not dismissing the view of anxiety as an effect). Lacan likewise views a symptom as a defence against the Other's desire, against the enigma of existence and identity to which there is no answer, through an act of separation. Separation (*se parer*) in French after all signifies to 'defend oneself'. We have seen how the encounter with incomprehensible demands involves encountering enigmatic desire, leading to the fundamental question with which all subjects are faced: 'Who am I?' and 'What do you want from me?' (Fink, 1999: 122; Vanheule, 2014: 70). We attempt to calculate, through the mOther's absences and presences, what we mean for the Other in order to understand our existence and place in the world. Subsequently, an answer is constructed in and through the fundamental fantasy, the place in which the subject stages desire and the subject-object relation; a response which comes to determine formations of the unconscious and the nature and function of symptoms (Vanheule, 2014: 72). In other words, it is with a symptom one responds to the desire of the Other, and thus a symptom, from a Lacanian perspective, is inevitably a way of organising reality. The function of the fundamental fantasy is then twofold: to provide a meaningful existence in the world, an answer as to who I am or will be, and thereby to shield against loss and lack inherent in desire (Chiesa, 2007:142-143; Neill: 2014: 68; Žižek, 2006a: 59). The answer in fantasy follows a certain logic discernible by attending to the structure of a person's discourse, which is determined by the way lack (and loss resulting therefrom) is dealt with, or rather defended against.

I argue that for fatigue, the answer given in the fundamental fantasy is that of 'doing nothing', as a protection not just against the demand to 'keep going', the demand for constant presence and activity, but against incomprehensible and contradictory demands ('keep going' versus 'slow down'). Therefore, fatigue constitutes a protection against demands, life and language as such. While in the previous chapter I postulated how 'doing nothing' brings forth a void necessary for identity formation — which is arguably part of the fundamental fantasy but which occurs via the side of the subject (to preserve subjectivity) — providing an answer focuses on the 'second' function of the fundamental fantasy. This functions comprises a bulwark against lack and loss, which transpires on the side of the object. This latter moment coincides with the function of fantasy as a way of plugging up lack, which is not to be confused with the fundamental fantasy as such (Swales, 2012: 89), since the fundamental fantasy includes both moment as it stages the subject-object relation. Put differently, 'doing nothing' at this stage seems to be about disappearing into an abyss, a numbing into

nothingness, and through this, removing lack (and loss). It is especially sleep which appears to gain a prominent role here — sometimes depicted as the only thing which offers reprieve from a painful life.

The Desire to Sleep

Sleep as an escape from demands and the pain these bring is discernible in many of the participants' accounts. Beyond expressing an urge and desire to sleep, equating sleep with an escape can be traced in their complaints about not getting a good night's sleep and still feeling exhausted after having slept through the night — as if sleep would provide the ultimate solution to fatigue. Amy puts sleeping on a pedestal when she states: "'Cus I do sort of wonder if I could - I feel every day in life if I just go to my bed and wake up tomorrow and feel refreshed, it would be great" (A/L399-400). Accordingly, it seems like sleep, and only sleep, provides relief from pain for Amy: "This is like having that from the minute you get up - having the - the pain from when the minute you get up in the morning 'til you go to bed at night" (A/301-302). Saying that pain comes on only when awake is a testament to the fact that it disappears during the night. In this way, we can compare sleeping, together with the above-mentioned inhibitions involving a numbing the body (of language) into nothingness, with Lacan's notion of the 'desire to sleep'.

In seminar XIX, Lacan mentions a sleep which 'suspend[s] the ambiguity at work in the relationship of the body to itself, namely the enjoying'; 'To sleep, is not to be disturbed. Enjoyment, all the same, is disturbing' (Lacan, 2011 as cited in and translated by Zupančič, 2017: 90). The body can be related to both the body of language and the body in flesh, and 'the ambiguity' to the state of discrepancy between the two. The discrepancy stems from the fact that we say we *have* a body, which means we do not naturally coincide with our body — language and the body are ultimately incompatible. Moreover, the body has a life of its own and is affected by others' beliefs and words, an inescapable situation of alienation. This means there are always disturbing excesses ('enjoyment' as *jouissance*) which cannot be integrated into our sense of self. The discrepancy between the body and the body of language constitutes the divided subject, a division which can come to the fore and become unbearable at certain moments in our lives. This can be linked with the accumulation of demands as encountered by the participants during the alienating encounters, which represents for the

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subjects a disturbing excess, *jouissance*, related to a closeness of the Other's desire/demand/need and thus unable to be integrated into the subject's sense of identity. Alternatively or additionally, the drive to sleep, also related to *jouissance*, is experienced by the ego as an incomprehensible, out-of-control excess unable to be integrated into the image of being a hard-working person who 'keeps going'. Put simply, there is a difference between where one wants to be, or believes one should be, and where one currently experiences oneself to be. Falling asleep protects against such a division as it appears to contain the function of fantasy. The fantasy constitutes imagining a point in the future wherein one has no tension, where the imaginary (Lacan, Seminar XXI: X3-4) puts a stop to the circularity of language. In this context, fantasy linked to the moment of falling asleep has the ability of halting the piling up of incomprehensible demands and alongside this, the tensions of one's body, making it possible to forget the confines of the body and of society and more specifically to put up a barrier between the subject and the Other, to limit one's movement as related to the Other. The way in which this occurs is through providing the answer of 'doing nothing' in the fantasy, which constitutes a moment of concretising lack into sleeping: one moves away from incomprehensible desire and existence — not knowing what object one is for the Other as demonstrated through the movement and accumulation of demands — to the answer of sleeping whereby all problems are condensed into one specific, knowable entity. The 'nothing' as a void is turned into 'nothing' as an answer. This answer further involves a merging with the object of 'nothing' believed to exist in sleeping/disappearing, which is in line with what Lacan (2002/2006: 513) says about part-objects in fantasy, that: 'he is destroyed by them or preserves them, but above all he *is* these objects'. This explains the above section regarding the subject numbing him/herself into an object of nothing. The function of the fantasy is precisely to move from subject to object when 'the libidinal being threatens no longer to be able to maintain itself as the bearer of signifiers' (de Kesel, 2009: 33), that is, when one cannot tolerate the tensions which signifiers, *qua* demands here, bring in their movement. Fatigue here could then be a viewed as a way of falling asleep in the fantasy in order to avoid alienation and castration, and in which, in Lacanian language, one obtains real *jouissance* in the form of pure and limitless enjoyment protective against the excess of the body (of language). Lacan links the fantasy to a desire to sleep — and in his paper 'The Direction of the Treatment and the Principles of its Power' (2002/2006) he more specifically links the fantasy with the dream and falling asleep with desire, which is to be

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read metaphorically. However, we can say that fatigue presents itself as an almost literal incarnation of the fantasy, or rather brings out its fundamental nature, and more precisely, of desire.

Insofar as desire only functions in relation to an unattainable object — as soon as an object of desire has been obtained, desire moves onto another object in a metonymic movement — what is desired, in its most fundamental form is a type of nothingness. As Lacan (Seminar II: 223) states, a desire at the core of the subject is 'the desire for nothing nameable'. One desires both to lack, and that which is capable of imaginarily removing lack. To explain this in more detail, for the fantasy to work, a void is needed and desired, which is a type of nothingness on the side of the real put in place by making sure one does not obtain the objects one wants; that one has nothing (the object of desire). On the other hand, having obtained what is perceived as the object of desire would entail the end of desire and mean that one, thereafter, is complete and thus needs and wants nothing — another type of nothingness, although on the side of the imaginary. Desire is thus always about a nothingness, as the object is kept at a distance (devoured through consumption, or unattained). It is in this way that Lacan expounds on the paradox of desire and fantasy by stating that: 'To desire involves a defensive phase that makes it identical with not wanting to desire. Not wanting to desire is wanting not to desire' (Lacan, Seminar XI: 235). Where there is lack, to desire, there is also simultaneously a desire to do away with it, which would constitute the defence, to not desire. Focusing here on the desire to sleep as a moment of removing tension and lack, we are more on the side of not wanting to desire, which is the defensive part of the subject. In this case, the numbing of the body (of language) into nothingnesss is based on the belief that satisfaction is possible, that the place of Nirvana exists wherein one is free from the hunger and thirst of life and the pain this brings, and that an escape from the societal Other and one's body is possible.

This could be compared to Lacan's view of anorexia as satisfying the insatiable, or rather to satisfy the mOther's desire, in which case the child would make 'himself a deceptive object' (Lacan Seminar IV: 223-224), as s/he would postulate him/herself as the object of the mOther's desire as a way of defending against her impenetrable desire. Lacan (Ibid.: 214) further states that the object 'which appears under the sign of nothing' is 'annulled as symbolic'. We can bring forth another aspect of 'eating noting' here, which is turning the symbolic-real object (of lack) into the imaginary object through satisfying the insatiable,

thereby removing lack. The consumption of energy as an escape from the Other and from one's body through 'doing nothing' can be said to have this function of being fulfilled, of wanting and needing nothing and no one. Sleep becomes a means of establishing this and removing the tension of discrepancy as it is experienced as a place of bliss, comfort, safety, free from pain, responsibility and any restrictions (while yet paradoxically restricting lack/the movement of demands). This is also related to various forms of addictions and eating disorders where indulging in an object makes it possible to forget that one 'has' a body through merging with the object (alcohol, drugs, food, sleep).

For example, to not desire is in line with Valdré's (2018) take on anorexia, who recognises the increasing aspect of it today, not as the activity of starving oneself but as inclusive of all the forms in which desire and pleasure are inhibited (Ibid.: 90). Anorexia can be grasped as 'an aversion to desire in its different forms' (Ibid.: 3) where 'it is the desire of not having needs or desires' (Ibid.: 93). However, many other theorists, and particularly within the field of Lacanian psychoanalysis, arguably fail to acknowledge this type of defence when conceptualising modern symptoms as real, that is, viewing them as not structured symbolically or imaginarily. Verhaeghe (2004: 291) claims that in actualpathology, with which he links fatigue, any 'accompanying fantasmatic developments are completely absent'[29], and that in hysteria belonging to psychoneurosis, when the fantasy *fails*, depression comes to the fore through an experience of being and meaning nothing (Ibid.: 377) [30]. Rik Loose's (2002, 2015) argument in relation to addiction and modern symptoms takes on a similar viewpoint in that he claims that symptoms are not structured via the symbolic, which means they are unable to protect against the real. I argue that this line of reasoning neglects an important aspect of fatigue, and probably of many/some other modern symptoms. Following a Lacanian perspective, we can view the fantasy as something deceptive: the object of fantasy can on the surface come across as a void and a nothingness (the real), while it can be covered over imaginarily; with it sometimes being impossible to tell the two apart. This is due to their inextricability from each other, and due to the function

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[29] However, Verhaeghe's (2004) perspective here becomes confusing when he claims that for actualpathology, the 'relation boils down to the fact that the Other failed in its initial verbalisation of (a) [the original drive tension], with the result that the secondary elaboration was not set in motion, or only barely' (p. 308). It is not certain what the position of 'only barely' would entail.

[30] A similar line of thinking is also present from lay perspectives, where it is though that depression, for example, constitutes a more realistic view on reality since the person is in contact with the void or with the meaninglessness of life.

of language; that it simultaneously hides and reveals the unconscious. The confusing nature also stems from the fact that, as Žižek (2000: 107-113) recognises in relation to the notion of anorexia as 'eating nothing', the structure is included in the content. The content of fantasy does not include variability in terms of a displacement and movement of different objects as one would normally find here, but an object ('nothing') which is indifferent to all other objects — an object of fantasy nevertheless. In a way, the content is diminished, while the fundamental structure is strengthened as the desire to (not) desire. Not only that, but a void can be used as a protection and a defence. As long as nothing and everything is desired (using the void as a way of plugging it up), one need not make a decision with regard to providing an answer to one's identity, or in this case, one need not respond to a demand — sleep being the response of a non-response and a way of saying no to alienation and otherness. It is this bare minimum of an object inherent in 'doing nothing', or rather the object of a non-object, which I argue can give the appearance that there is no fantasy life, or that it has been diminished. This is in accordance with what De Rick (2002) calls an 'impoverishment of the fantasy life' which she claims frequently comes to the fore today. However, she follows Freud's line of reasoning inherent in actual neurosis in claiming that there are no secondary elaborations of the symptom present in terms of a 'symbolic-imaginary processing of the Real' (Ibid.: 127). I argue, in contrast, that desiring 'doing nothing' are signifiers framing the fantasy, and thus constitutes precisely such a processing, or at least an attempt of it. Of course, the object of 'nothing' can easily lose its imaginary clothes and turn into an encounter with the void, which will be discussed more in the next chapter. Nevertheless, given the fantasy's conceiving nature in this manner outlined, could it not be that what is thought of and comes across as a 'real symptom' is easily confused with the defence of the subject? Since this type of symbolically structured symptom is not entertained as a possibility in the theories just mentioned, we can consequently in relation to fatigue as presented here, question the division made between the symbolic-imaginary and the real in the formation of symptoms — or in other words; question the large division made between the mind and the body.

Returning to fatigue as not wanting to desire, there is a sense in which the subject's attempt of numbing into nothingness, alongside the complaints that life is inevitably full of demands, echo Oedipus' exclamation of *me phúnai*: 'Never to have been born'. It could amount to an impossible desire to eradicate one's existence, which would relate to wanting 'nothingness'. Lacan invokes this desire in relation to the pain of existence at the end of

desire, when 'suffering is excessive' and when one no longer has a 'desire to live' (Lacan, Seminar VI: 91) — resonating with what has been discussed so far. The wish for nothingness in this manner also echoes Freud's conceptualisation of the death drive as the aim to restore an earlier state, to return to the inorganic.

When hypothesising the origin of the drive (mistakenly translated as 'instinct' from the German 'Trieb' by James Strachey) in his text 'Beyond the Pleasure Principle', Freud (SE XVIII) places great emphasis on the death drive, which appears in agreement with Lacan's proclamation that all drives are death drives. The characteristic of a potential universal drive, Freud claims, is the aim towards death: 'the aim of all life is death' (Freud; SE XVIII: 38), amounting to a tension attempting to 'cancel itself out'. The cancelling out of itself ascribed to the death drive translates into 'the instinct to return to the inanimate state' in the face of life. This stands in stark contrast to the life drive, whose aim is to preserve life and to produce tensions (Ibid.: 40). Freud further argues for an inextricable relation between the death drive and the pleasure principle, the latter of which is a tendency with a function to 'free the mental apparatus entirely from excitation or to keep the amount of excitation in its constant or to keep it as low as possible' (Ibid.: 62). Hence, there is a large overlap between the death drive and the pleasure principle: 'The pleasure principle seems actually to serve the death instincts', because it is protective against 'increases of stimulation from within' (Ibid.: 63). Freud, however, writes that it cannot be decided which of the function is to be associated with the pleasure principle (Ibid.: 62); whether it is to eradicate all tension or keep it constant, or low. In the interviews, fatigue as a numbing into nothingness could be linked with the first function mentioned, to get rid of tensions entirely, echoing the exclamation 'never to have been born' as a means of protecting oneself against the tensions of demands. Because if 'nothing' is sought after, then the 'nothing' associated with sleeping becomes the promise of a complete break from all demands, decisions and bodily ailments (remember Brody's "get rid of *all* variables"); an eradication of one's existence. 'You want life? I'll give you death' appears to be the response at some level to the demand for constant presence and productivity, to the demand for life itself.

By bringing in Lacanian theory, we can link this imaginative moment, postulated by Freud to belong to both the aim of the death drive and the function of the pleasure principle, with that of impossible and defensive desire. After all, it is impossible to get rid of all the tensions of the body, or to put a stop to the demands of life, or to erase a lived life. Thus, the

aim towards the inorganic — Freud's terminology of such a Nirvana principle having given rise to many misunderstandings regarding the drive as wanting death — if focusing on the term 'aim', would better resonate with the desire not to desire, with that which imagines an absence and nothingness where things are still, dead, peaceful, and restriction-free — rather than ascribe it to the activity of the drive. Not only that, but in line with the Lacanian literature and that Freud's life drive can more adequately be assigned to Lacan's concept of the death drive as I argued in the previous chapter, desire can be viewed as a defence against the drive. This would be in line with the interviews where we can perceive that fatigue is a defence against pain, which will now be explored through Freud's and Lacan's notion of inhibition.

Fatigue as an Inhibition and a Defence Against Pain

The interviews are full of repetitive mentions of inhibitions which we saw above — probably the most repetitive aspect of the interviews. Inhibitions are expressed as "I can't" followed by a number of activities (Gail's "I *can't* really feel" and Lucy's "You *can't* process information"). Fatigue as a whole is an inhibition of physical and mental movements, a moment of inertia supposedly in the attempt to numb the body (of language) into nothingness. Fatigue as an inhibition thus includes a protection against pain, which we can trace in the interviews in the fact that exhaustion follows an increase of tension in the form of pain. We can further track this through certain utterances, for instance when Gail claims: "You're tired because the ME always comes on from the pain 'cus you're fighting pain" (C/L46-47). The process this entails can be elucidated with Freud's and Lacan's notion of an inhibition as a defence against anxiety.

Freud (SE XX) defined an inhibition in relation to a symptom, delineating both their potential overlap as well as difference. In terms of their difference, an inhibition, he argues, is a 'restriction of the function of the ego' put in place as a protection or because of an 'impoverishment of energy', due to an illness for example (Ibid.: 90). A symptom on the other hand does not reside within the ego but emerges from repression, 'proceeds from the ego', due to an incompatibility between the id impulse and the ego, for example a conflict created by the involvement of the superego (strongly related to societal ideals demanded by others). This means the symptom is a substitute for the repressed impulse (Ibid.: 90—91), disguising the impulse (Ibid.: 112). In short, if an inhibition works to avoid an occurrence of

anxiety then it has the function of a symptom, since symptoms are created to ward off danger (Ibid.: 144). Bogdan Wolf (2019: 25) in his book 'Anxiety Between Desire and the Body' postulates that Freud, as well as Lacan, separates an inhibition from a symptom, where he ascribes the inhibition to Little Hans' phobia and the symptom to the horse (as a signifier) being substituted for the father. This does not quite hold up reading Freud, who seem to profess an inextricability between a symptom and an inhibition; however it depends on how one interpret what a symptom is, as it has several components. Lacan likewise attributes to an inhibition the function of a defence against anxiety.

In seminar X, Lacan defines an inhibition in relation to an anorexic 'refusal of the breast', explaining that while the refusal brings out the void of 'nothing' *qua* lack (*object a* as the condition of subjectivity and desire), an inhibition is brought out by the anal object and has the function of working against *object a* by withholding it:

> That which is going to identify desire, primordially, with the desire to hold back
> is appended to this object as a causal object. The first progressive form of desire
> is, therefore, as such, akin to the realm of inhibition (Lacan, Seminar X: 328).

Lacan thus distinguishes between two types of desires: a primordial desire and a progressively formed desire. Primordial desire is linked with the presence of lack and an object 'primordially produced' which is a 'product of anxiety'. Progressive desire defends against the primordial anxiety, because it turns 'against the pre-existing function that introduces the object a as such' (Ibid.). An inhibition is thus a defence against lack and anxiety through a defensive 'progressive' desire, and therefore, both a Freudian and Lacanian take on inhibition resonate with the interviews and can be compared with the moment of holding back energy, of hoarding it, and not desiring. This depicts the subject-object relation, if relating the subject to the drive and lack and the object to (defensive) desire. We could further say that an inhibition comes to be a refusal of the refusal, or, put differently, a symptom of a symptom. This is in accordance with Lacan's excerpt outlined above in that primordial desire is linked with a refusal, while progressive desire is linked with an inhibition, and the latter has attached itself to the former and is a defence against it. In addition, Lacan (Seminar X: 316) claims there is a 'structural concealment of desire behind inhibition'. This would add another 'layer' or rather function to the symptom, one which

disguises it further and renders it a disguise of the impulse (the refusal), as expounded by Freud. We can argue based on this that tied to an inhibition, an "I can't", is desire as a refusal, an 'I don't want to'. Insofar as the inhibitions are tied to a numbing into nothingness with a protective function, this refusal of the refusal can be compared to alcohol addiction, where, as Adam Phillips (2017) astutely puts it: 'Drinking becomes a problem, but actually the problem is what's being cured by the alcohol'. Not only does the inhibition defend against anxiety — with which a decrease of tension is associated — but against the recognition of lack due to the involvement of repression.

We notice repression of lack at work in the interviews through the experience that the body is living a life of its own (remember from last chapter Lucy's proclamation "but what can you do if your body's acting like it - just wants to sleep all the time?"). That is, the body (or the illness as a "disease") is thought to represent an organism working independently of the subject which is to blame for one's inhibitions — hence why they are expressed as an inhibition in the form of "I can't". The endorsement of this idea keeps the subject from recognising any subjective involvement in their conditions, concealing the refusal fuelled by one's own desires and drives. This constitutes an externalisation of loss and lack, which we can compare to what Lacan terms a 'passion for ignorance'. Indeed, Lacan (Seminar X: 323) places an inhibition at the scopic level with a 'desire not to see' which can be linked with a desire not to desire, and the passion for ignorance.

The refusal, in turn, arguably hides fundamental lack insofar as it can be tied to the notion of primal repression, which is part of the theory of the establishment of the unconscious. Primal repression is the first moment of repression and occurs, according to Freud, when the 'psychical (ideational) representative of the instinct [is] being denied entrance into the conscious' (SE XIV: 148). According to Lacan, what is denied entrance into consciousness is lack itself, a refusal of lack, seen when Lacan says that a 'saying no' gets assigned to 'the unsaid' (Lacan, Seminar VI: 76), where the unsaid is equivalent to lack. Lacan follows Freud (SE XIX: 235-242) here by claiming that a rejection of an idea always entails an affirmation of that idea — a way and sometimes the only way in which an unconscious idea can enter consciousness. A negation of lack is simultaneously an acknowledgment of lack. In my interpretation, we can observe these two sides part of primal repression in the interviews. On the one hand, a void is acknowledged and attempted to be invoked in the social order through an unconscious refusal. On the other hand, lack is not

tolerated as seen from the arguments in this chapter, and is further attested to in the act of trying to introduce their bodies into the symbolic as a way of remedying lack — when being met with radical lack as a result of encountering the statement 'there's nothing wrong with you'. Introducing lack as enacted through the body could be a way of attempting to do away with lack through it coinciding with a diagnostic label. These two processes need not be in complete opposition to one another but could be said to be complementary, in the sense that there needs to be a disintegration *in order* to integrate: *object a* as the void is foundational for identification, because the experience of lack is what causes the identification with something which would do away with it. The latter could be understood more clearly in the appeal to a diagnosis as a totalising explanation, accompanied by the belief that the body can coincide with a label. However, at a more fundamental level, the refusal of lack can be witnessed in encountering the medical Other's 'there's nothing wrong with you'. As long as the statement is experienced as a dismissive one where the doctor does not wish to take an interest in you (thus *could* if the Other wanted to), which appears to be the experience of many of the participants, the subject fails to acknowledge that the medical Other does not *have* the answer — that the Other of the Other does not exist. Instead, the take-home message is that an answer is being refused them. We then observe the opposite situation play out through the formation of fatigue, where the subject refuses the Other.

To Sleep or Not to Sleep: Pain Versus Fatigue

Obvious by now is the fact that there is a significant contradiction present in the condition. On the one hand, the body is used to signal the subject's aliveness, for which tension is needed as a way of keeping desire alive. On the other hand, there is a numbing of the body into nothingness where desire and tension are (attempted to be) extinguished. The struggle is thus between to desire and not to desire, life and death, between presence and absence. This split arguably manifests in the interviews as pain/tension versus fatigue, where pain better represents the drive marking the presence of the subject, while fatigue better depicts an absence or disappearance. I argue that this contradiction is the fundamental split of the subject in terms of a split between the drive and desire. In this sense, Freud's life drive better represents the death drive from a Lacanian perspective, if following a simple reading of his text 'Beyond the Pleasure Principle'. Freud (SE XVIII: 63) claims the life instincts are

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'constantly producing tensions' and are 'breakers of the peace', which is in line with a Lacanian perception of the drive as brought forth clearly by Žižek (2006b): the drive is a surplus *jouissance*, an excess of life, in the form of a constant tension produced in order to keep desire unsatisfied, for it to keep persisting through the repetition of loss. Its aim is, contrary to popular belief, to remain alive and to keep going. Conversely, desire is about absence, about always being elsewhere than one's current situation as restricted by the big Other and the body, about being fulfilled, and therefore constitutes a point of imagining pure absence *qua* wholeness with which death and sleep are associated. More correctly, it amounts to imagining something positive in the place of loss (Žižek, 2006b), thereby removing it and the accompanying tensions. It comes very close to the (again simple) Freudian idea that an increase of tension is related to anxiety and a decrease to its absence. There is, furthermore, a sense in which this paradox mimics the sociocultural demands to 'keep going' and 'slow down', where the latter constitutes in the case of fatigue a shutting off of desire.

Lacan paraphrases Hamlet as a way of depicting the split of the subject: 'to be or not to be, to sleep, perchance to dream' (Lacan, 2002/2006: 524). To be the phallus (that which completes the mOther's desire), or not to be the phallus, to sleep or not to sleep, to maintain lack and desire or not to — that is the question of castration. The original quote from Hamlet goes: 'to die, to sleep – to sleep, perchance to dream – ay, there's the rub, for in this sleep of death what dreams may come…'. Sleep is equated to death, a 'sleep of death' in which it is not certain 'what dreams may come' considering one is dead. Death here can be read in two ways in relation to castration, thereby portraying the paradoxical nature of fantasy and desire giving rise to the two oppositional forces of the subject. Fulfilling one's desire — escaping castration — equals the death of lack and subjectivity, the inability to dream (to stage desire in fantasy, since Lacan seemingly equates the dream with the fantasy[31]); because if one merges with the object in fantasy, the object here being 'nothing' in sleeping, one is deprived of the object (Lacan, 2002/2006: 532). Conversely and paradoxically, not fulfilling one's desire — being castrated — also equals death, however a different kind of death. Entering into the symbolic realm results in the death of the pure being of the subject who is unable to

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[31] As seen in the following quote: 'It is, in any case, a fact of experience that when my dream begins to coincide with my demand (not with reality, as is improperly said, which can safeguard my sleep) – or with what proves to be equivalent to it here, the other's demand – I wake up' (Lacan, 2002/2006: 521) — here we also see how the dream represents the fantasy for Lacan.

be represented therein, which gives rise to the experience of lack and loss necessary for fuelling desire. The latter presents difficulties for the subject who cannot bear his/her lacking and constantly finds ways of escaping it. We could thus attribute to sleeping the place of no desire, to not desiring, while not sleeping, the *desire* (not) to sleep, amounts to keeping desire alive, the desire to desire. In relation to fatigue, if assuming sleep as the object of desire (with which this section deals), the subject coincides with it in terms of what has been described as becoming dead, numb objects in the form of being and having 'nothing', where there are no desires, needs or demands. Here, there is nothing to satisfy because all is satisfied. On the other hand, sleep as a satisfaction of desire never arrives, and instead there is an unquenchable tension moving towards sleeping — presenting an obstacle but simultaneously the foundation of desire; the latter since one can only dream of sleep if one lacks sleep.

The contradiction between these two forces also comes to the fore in the interviews through the concepts of 'starting' and 'stopping', echoing again the sociocultural contradiction between the demand to 'slow down' and to 'keep going'. To give an example, Lucy conveys the split and the attempt to defend against an "overload" in the following excerpt:

> … your system has started - your system's shut down. So you're in so much pain, you've got an overload of information coming in. So you're trying to figure this out with, a mental impairment (L214-215).

Something "start[ing]" and "shut[ting] down" are here depicted in opposition to one another, with presumably "started" being a slip of the tongue. We could interpret the "overload of information coming in", perhaps also inclusive of uncontrollable slips of the tongue, to be linked with "so much pain", which is in line with the movement of the signifier *qua* the drive as an incomprehensible and external force. Thus to shut down, to have "a mental impairment" where there is presumably an inability to "figure this out", could be interpreted as a defence against such an invasion. It would constitute a defence against the symbolic itself, against the very act of information coming in, which is what has been argued in this chapter: that the refusal of the Other through an in inhibition does not entail shutting down a *specific* meaning, but shutting down meaning as such, as a way of escaping the Other. Nonetheless, this paragraph demonstrates the split of the subject stuck between starting (presence, aliveness)

and stopping (absence, sleeping), and ultimately, the difficulty and impossibility of 'shutting down'. In accordance to this, despite there being attempts by all of the participants to shut off the Other, to shut off an otherness both in its symbolic and physical form, we discern how the moment of shutting off always fails.

Chapter 6: The Pain of Fatigue: The Failure of Mourning

The reason I'm painting this way is that I want to be a machine, and I feel that whatever I do and do machine-like is what I want to do.

— Andy Warhol

Observed in the interviews alongside the subject's attempt to numb the body (of language) into nothingness, is the failure of doing so. Instead of nothing, the participants stumble upon something in different shapes and forms, namely demands and tensions of the body. Not only that, but discernible is an appeal for a symbol to stand in for the subject, more precisely a medical diagnosis which would externalise subjective elements — an idea which, paradoxically, has links to that of 'the body as machine'. This chapter explores the failures of 'nothings' on these different levels and how they constitute a painful fatigue. It further contextualises the contradictions they bring forth, in combination with what has been explored so far in the thesis, by utilising the Freudian and Lacanian concepts of mourning and separation — the two being highly inextricable.

Pain as The Failure of 'Nothing': Too Much of Not Enough

The failure of 'nothing' is first and foremost evident in the presence of a demand in the place where the subject wants or expects 'nothingness'. This has to a certain extent already been outlined insofar as it was described previously how the realisation of the impossibility of stopping gives rise to a desire to "do nothing". However, the focus now is on how the presence of a demand — and its accompanying bodily tension — leads to a realisation of the impossibility of the desire itself, the failure of desire as opposed to its cause.

Mark's discourse illustrates this when comparing a "bad day" of his condition to having run a marathon:

> Well, imagine you've done the London marathon and you've been wrapped in a blanket and you're not one of the collapsy (sic) people. You've *managed* it, you're feeling a bit great, breathless, you're really 'I've done that and that's brilliant'. You are very tired. And then imagine that someone comes over to you

and says 'Right, now we start the day. It's time to go to work, have a shower, then you've gotta do some cooking'. You'd be-you would be *picking* yourself up off the ground to try and go and do things and… on a bad day that's what it's like (A/L289-295).

After such a strenuous activity as a Marathon and what is considered a huge achievement (having "managed it" and feeling "that's brilliant"), tiredness and a break is the logical next step. In accordance with this, being "wrapped in a blanket" exudes connotations with a bed, rest and sleep, and perhaps completion (covering up lack in blankets). Instead of a break, what Mark is presented with is the imposition of imperatives: to "work, have a shower" and "cook[ing]". He is describing something not restricted to the experience of fatigue but a lament of a life full of ceaseless demands. In other words, there is no space for fatigue, no space in a way to be allowed to be tired. There could even be a realisation of not being allowed to enjoy his tiredness; the word "brilliant" is followed by the sentence "you are very tired". This would resonate with the drive (demands *qua* signifiers) being an obstacle to desire (to sleep) and to the pleasure principle, as that which endeavours to keep tension constant or low (Grigg, 1997: 164). The drive is a constantly moving force messing up the stillness, silence and pause that life could contain, which exists in the fantasy of 'doing nothing'. Not only does this occur in terms of demands, but in the form of various bodily tensions, particularly — again — that of pain.

Stumbling upon a bodily tension instead of the peacefulness of nothingness is most evident throughout the interviews in the literal failure to fall asleep. This is the case for Gail who further illustrates how the failure of the fantasy to fall asleep removes the answer of 'nothing', and in its stead she is confronted with the unanswerable question of existence (radical lack). In her third and last interview, Gail explains that her pain and exhaustion is "all consuming" (C/L30), that she "can't really fall off to sleep" because of the "night sweats and the fire build up", and that her "ME tiredness is *unbelievable*" (C/L35). She is completely overtaken by pain and tiredness through a failure to fall asleep, confronting instead the enigma of existence: "it's reached a stage where I don't know why I'm living anymore. I have no idea" (C/30-31). The failure of 'nothing' is also demonstrated in Brody's following discourse:

But um you know what I mean if you run without stretching and you get like that ache, it can be like that from nothing at all. I could sit here all day and I would get that. Um, and that can be very - although it's dull…(A/L48-49).

That "it can be like that from nothing at all", from "sit[ting] here all day" means it is not just doing too much — this is told in conjunction with explaining how overexertion brings on aches — but likewise doing too little which can bring on pain. The body could be viewed as an inconvenience interfering with the act of 'doing nothing', which bears similarities to Schuster's (2016: 108) argument, following Nietzsche, that for philosophers, the body presents an obstacle with its inevitable needs (sleeping, defecating, eating), interrupting the activity of pure thinking (or in this case pure inactivity). In this way, the subject fails to fall asleep in the fantasy, since the fantasy of 'nothing' is nothing but a fantasy. The achievement of 'nothing' is impossible as there will always be either demands of life (earn money, shower, cook), biological needs (cook, eat, sleep), or tensions of the body. Put differently, disappearing is impossible. In accordance with this, when scrutinising the other participants' accounts of a description of their (overwhelming) fatigue, we find there, instead of a nothingness and a decrease, an increase of tension in the form of a heaviness.

Mark explains at the start of his condition: "…I remained tired and the tiredness just increased and other symptoms started to come in as well. Such as the cold and the…the pain in the legs and what not" (A/L664-665). Bodily tensions "coming in" and increasing ("the tiredness just increased") attests to the failure of nothing. Something similar is reflected in Amy's discourse:

I feel like a hypochondriac 'cus it's always - there's always something arrives or something like that. But I think predominantly the pins and needles and the jumpiness and the heaviness of just not feeling… like you want to get up and move (A/L336-339).

The failure of nothing occurs in that "something [always] arrives or something like that", which is precisely bodily tensions in various shapes: "pins and needles", "jumpiness" and the "heaviness" of fatigue. The latter is particularly important, since due to the pause indicated by the dots, it can be read as "the heaviness of just not feeling". This would suggest that the

defence of not having any desires, affects or needs and the hoped-for diminishment of tensions part of the desire to 'do nothing', fails and turns on itself: it becomes a heaviness of feeling nothing. Put differently, rather than the lightness of being as imagined by sleeping, one is met by the 'unbearable lightness of being' to quote Milan Kundera, the experience when an absence becomes an unbearable presence. This place is one of ambiguity since it constitutes a 'feeling of not feeling', the place where tension is mixed with (the thought of) an absence of tension. The tension of no tension can be observed in Gail's discourse when saying "you're feeling that you're feeling numb" (B/L339). This site of feeling nothing is linked to pain since she says thereafter "you're feeling pain". Lucy also describes fatigue as a heaviness and further the ambiguous place of too much and not enough tension:

> … so you're carrying on it's like your weight you're pulling behind you gets bigger and bigger and - but you're still, like you're still *alert*. You're still like, and you fe - but this is adrenal starting to kick in now so like the adrenal's hit you, and you're like *that* and you're drinking lots of sugary drinks and you're like, a wee bit like this. But on the other hand your body's like - it's a horrible, horrible, horrible, horrible feeling - it's not like a, feeling, it's like a wired but really really really fatigued feeling (L/508-514).

Lucy describes a place of too much tension ("alert", "adrenal starting to kick in", "wired") in conjunction with an opposite experience of not enough tension ("really fatigued feeling" and heavy "weight"), signalled by the words "But on the other hand". If reading the latter of Lucy's discourse structurally as opposed to two different sentences, she is saying 'it's a horrible feeling it's not like a feeling'. This could be read as the unbearable feeling of having no feelings, or in other words: 'too much of not enough'. In this way, we can interpret fatigue here being a sensation of 'too much of not enough' when the gap *qua* insignificance (not feeling, not existing) has become an overwhelming presence. It turns into the pain of fatigue. What is 'not enough' is not simply a tension which in itself becomes too much, but perhaps the unknowability, ambiguousness and foreignness of the tensions, that there is not enough understanding of the tensions felt at the level of the body; a mind-body divide. Lucy in the above quote keeps mentioning "you're like that" and "a wee bit like this": an unnamed but nevertheless present feeling. It tallies with what Lacan writes about the pain of existence: 'It

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was the sense of existing, as it were, in an indefinite way' (Lacan, Seminar VI: 90). We can link this with an awareness of one's alienation, insofar as being alienated, being alive, always comprises an ambiguous state since the symbolic order separates the subject from his/herself and there is a loss of the ability for a stand-alone existence, instead (dis)appearing through the symbolic. Gail alludes to something like this when mentioning in relation to her above quote about numbness: "You're here but you're not here", and likewise Lucy when she brings up the heaviness of her weight, which could be compared to an act of disappearing (insofar as it causes her to withdraw from activities), and the fact that she says "you're still alert". They are alert of the fact that they are disappearing, and that they reside, in a way, outside of themselves. In other words, one has not disappeared enough insofar as one is aware of having disappeared too much. More exactly, it points to the limit of life, the disjunction between being neither dead nor alive but in between the two as an embodiment of the un-dead, or the living dead.

Since fatigue as a desire to sleep was a protection against an enigmatic existence and against alienation, we notice the circularity and the failure of fatigue. The pain of existence was tied to either the participants' work, university studies, or encounters with medical doctor in the alienation chapter, where they were reduced to an object of nothing, albeit without an explanation as to what type of object one was. Through the formation of fatigue, arguably all that was done was displacing the tensions related to societal life and human interactions onto the body, instead getting lost in the incomprehensibility of bodily tensions. This is attested to in the fact that what was described at the onset of their conditions as being stuck in a movement with no escape, such as working, is now the way in which their conditions are being described, where there is no escaping their painfully fatigued bodies. This scenario points to the presence of repression (the return of the repressed), which will be discussed further down. Moreover, such a situation is not simply a return to the beginning where pain is experienced in the same manner, but could constitute a shift in nuance from 'the unbearable heaviness of being' to the 'unbearable lightness of being', which will likewise be discussed more below.

Not only can we designate the pain of fatigue as a state which passively 'happens' to you, but we could trace the subject playing a role in the sabotage of his/her desire. 'Doing nothing' is not fully desirable, which is suggested most clearly in the emergence of boredom when facing (a) nothingness —another type of experience which is 'too much of not enough'.

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Boredom as the Failure of 'Nothing'

Returning to Brody's excerpt delineated above where he speaks of the failure of 'nothing', even though he describes his pain as dull ("although it's dull"), this could be interpreted to mean that the activity of sitting down, to which he refers, is boring. The dullness of 'doing nothing' is attested to in Brody's second interview where he describes he is "trying to cut out the highs and lows and - of sugar and coffee and alcohol" (B/L265-266), thereafter announcing: "Great in theory. Boring." (B/L266). The absence of highs and lows suggest a homogenous level perhaps akin to that of 'doing nothing', which is considered boring for Brody. We can observe this moment to be present in the other interviews where the participants describe experiencing difficulties of resisting the urge to 'do'. In this way, boredom becomes another manifestation of the failure of the fantasy of 'nothing'. This is particularly observed in Mark's account, which corroborates that 'doing nothing', while being highly desirable as seen in the previous chapter, is at the same time not desirable and possibly feared.

Mark mentions boredom when explaining the inhibitions involved in the conditions. He is comparing his condition to that of having a lobotomy and conveys regarding this experience: "it's a bit like being sentenced to exile from the world" because "you're not allowed to go anywhere, you're not allowed to hold a meaning conversation" (B/L250-251). Within this context he makes an association between waiting (or 'doing nothing') and being bored: "You just have to sit and wait. I was gonna say you have to sit and be bored" (B/L250-254). Mark then expands:

> But that's one of the scariest things to me is that - I'm not bored by it, when it's like that. Um boredom requires energy. Boredom requires cognitive ability to know what you're missing out on. And on that sort of overwhelming fatigue, you're just…your - your higher mental functions just aren't there (B/L256-258).

That "one of the scariest things" follows and precedes the word "bored" could indicate that one of the scariest things is being bored, and this because "boredom requires cognitive ability to know what you're missing out on". In other words, boredom comes with the realisation of

loss. He is contrarily indicating that one of the scariest experiences is an overwhelming fatigue where lack is lacking; where one does not even feel loss because "your higher mental functions just aren't there". This could simultaneously be read as the defensive moment of protecting against loss, but also as the failure of it in line with what was just discussed insofar as he is aware of the "higher mental functions [which] just aren't there"; being engulfed by lack/loss itself, something missing, while not having the mental capacity to understand *what* is missing. Boredom could thus be read as a sign of anxiety, a fear of disappearing into nothingness, but simultaneously a protection, since it stimulates the subject to engage in activities in order to quench the surplus of restlessness and remedy loss, which is what Mark is describing in the following excerpt:

> I am now struggling to do as *little* as I have been doing. I'm starting to get a
> surplus amount of energy. And that makes me restless. And it gives me the drive
> to say 'ah, I can just nip to the shop, I can just do this…' (B/L169-174).

This is in line with Leader's (1997: 239) suggestion that 'to be bored one has to have a body', and that boredom comes not when desire ends but when it is maintained, desire 'in transition between the object we think we are searching for', as something 'puts in question the libidinal charge we gain from it' (Ibid.: 240). The interviews seem to reverberate with Leader's proposal insofar as the participants question, through boredom, the 'libidinal charge' gained from the desire to 'do nothing', which is basically turning off desire. Instead of finding no desire, what is found is the subject's desire.

The Pain of Fatigue as The Drive of Desire

What has been uncovered thus far is that fatigue as a moment of 'doing nothing' is impossible: numbing the body (of language) into nothingness is impossible insofar as there are always going to be tensions or thoughts present; excesses which cannot be accessed. Even when asleep we are dreaming and thus feeling and thinking with brain activity going on. Sitting down is the activity of sitting down, and importantly, if fatigue is used as a protest against the dominant sociocultural idea of 'the body as machine', then one is definitely doing something. There is no escaping our bodies or realities; disappearing is impossible. Shutting

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off desire is equally impossible, evident in that while one tries to do this, it ironically turns into a *desire* not to desire. This is explicitly and eloquently explained by Marya Hornbacher (1999: 6) in her memoir about the addictive nature of anorexia and bulimia: 'A wish to prove that you need nothing, that you have no human hungers, which turns on itself and becomes a searing need for the hunger itself'. Žižek (2000: 107) also points this out in relation to an anorexic refusal: a 'co-dependence between detachability from any determinate content and excessive attachment to a particular object that makes us indifferent to all other objects'. Or put differently, this moment constitutes an attachment to one's detachment (Cohen, 2018: 8) — in line with what was expounded earlier regarding the fantasy for the object of a non-object ('nothing'). There is always the presence of the subject in the negation of an activity, as elucidated by Lacan (Seminar VI: 83) when emphasising that one *does* not eat. As he further pronounces, to desire not to desire, or 'not wanting'[32] as he writes, are identical. More precisely however, they constitute different sides to the same coin/surface as illustrated through the Möbius strip (Lacan, Seminar XI: 235), which Lacan uses to depict the split subject. They are the same but different: different when it comes to the ambivalence of wanting to keep the object at a distance but also wanting to acquire it and be fulfilled — two forces working against each other — but the same insofar as one finds fulfilment by being unfulfilled. We come back here to the notion of the drive as a satisfaction of a non-satisfaction, even though such a satisfaction can be said to be accidental (Zupančič, 2017: 102). In the process of desiring to 'do nothing'/to sleep — a moment of defence which eradicates pleasures, desires, affects, and needs — the subject is the one sabotaging this desire, following Schuster's (2016: 5) useful depiction of the subject as emerging through 'the failure not to be'. Put differently, the subject is the one potentially gaining pleasure in the thought of no pleasure, or more broadly, in his/her suffering, portrayed in the interviews as a tension being present instead of no tension, and that this tension is associated with 'positive' affects. We saw this for Lucy when describing the place of too much tension (and not enough), being linked with adrenaline and a "wired" state. We reach here an ambiguity and contradiction where she appears to say that something is "wired" — tied to a state of adrenaline — but simultaneously a "fatigued feeling", with the word "but" implying that the latter constitutes something of the opposite to the former, or at least something different to

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[32] The reason Lacan uses the word 'not wanting' as opposed to 'not desiring' could be that he links the former more with the conscious ego, the ego who believes it to be sufficient who wants nothing or no one.

it. The place of fatigue in this instance suggests an ambiguous, obscure place akin to Lacan's notion of *jouissance*, where pleasure and unpleasure — and simultaneously presence and absence — are intertwined with each other and there is a difficulty of saying what belongs to what; a blurring of boundaries[33]. Analogously, Brody describes a "nerve pain which is a constant eh buzz, or sparks" (A/L52-53), where the word "buzz" is associated with being 'buzzed' and happy. As it is mentioned in relation to pain, it points to a blurring of the unpleasure-pleasure limit. The ambiguity of the presence-absence boundary might be a more apt way of describing fatigue as we cannot exactly say that there is a pleasure of the thought of no pleasure — the concept of enjoyment is a difficult topic. But we cannot entirely dismiss it either insofar as such a Freudian discovery explains why people will not easily relinquish their suffering (Schuster, 2016: 5). The sabotaging of desire in conjunction with enjoyment aptly illustrates subjectivity and in particularly a neurotic complaint, which can come to shed light on the structure of the participants' discourses. Schuster (Ibid.: 5-6) writes that the neurotic complaint presents itself as a 'double failure' in the sense that 'the human being is that animal that strives to sabotage its own being but is so incompetent it ends up bungling even that'. In other words, the subject attempts to sabotage his/her own desire but ends up enjoying the process of sabotaging — enjoying his/her suffering. This process does not simply revert the negative into something positive ('nothing' into 'something' in this case), but it is 'undermined or deviated from within':

> To vary a phrase from Freud, men enjoy less than they imagine (hedonistic fantasies and images of total gratification that fill their heads) and far more than they think (where and when it's least expected or even wanted, an insistent pleasure suddenly crops up) (Ibid.: 5).

In a similar manner, Žižek (2017) speaks about the negation of the negation where the failure of the negative is not simply turning the negative into something positive (again), but a 'less than nothing', where — when taking into account Schuster's description — that 'less' always contains something 'more'. Something like this could be said to be involved in the pain of fatigue as the unbearable lightness of being, where emptiness is not empty enough. This

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[33] We could maybe even say that it is the lack of boundary between pleasure and unpleasure which is (un)pleasurable.

convoluted way of describing the desire not to desire can for clarity's sake be compared with the inextricability between the life and death drive. Because we cannot speak of a pure passivity in relation to fatigue — as if fatigue is about simply turning into a passive sloth — but that there is an activity towards such a passivity. This is in agreement with Freud describing every drive as an activity 'whose aim is passive' (SE XIV: 122).

While I argued in chapter four of this thesis how Freud's life drive is more similar to Lacan's theory of the death drive, and Freud's notion of the death drive as the aim/return towards the inorganic is more in line with Lacan's concept of defensive desire as seen in chapter four, Freud's elaboration in 'Beyond the Pleasure Principle' about the relation between the life and death drives comes close to Lacan's theory of the inextricable nature between the two. Because Freud, early on in his paper, entertains the idea that 'the aim of all *life* is death' (Freud, SE XVIII: 39, my emphasis). This suggests that death is always present *within* life, a view which is attested to when he states that life is just a postponement (or deviation) of death: 'What we are left with is the fact the organism wishes to die only in its own fashion' (Ibid.)[34]. The inseparability of life from death and vice versa is further corroborated towards the end of his essay where Freud argues for the co-operation between the pleasure principle — whose function it is to reduce, keep constant or remove tension — and the death drive as the aim towards the inorganic: 'the pleasure principle seems to actually serve the death instinct' (Freud, SE XVIII: 63). In turn, the life drive as a production of tension through binding it (to an idea), he claims, is a 'preliminary function designed to prepare the excitation for its final elimination in the pleasure of discharge' (Freud, SE XVIII: 62). This goes with the interviews in that an increase of tension occurs sometimes *in order to* decrease, a process which can also be thought of in terms of a disintegration in order to integrate (in sleeping) — in line with Lacanian theory that lack is necessary for identification and completeness. Put differently, life and death are inextricable yet do not form a unity, following Lacan's logic of them being 'the same but different'. They are different when desire becomes a defence against the drive, where desire attempts to make less or extinguish the bodily agitations and tensions related to the drive (existing on the life-death, presence-absence poles), but they are the same or on the same level and in co-operation, as I argued, when the thought of no/less tension itself turns into a tension. Or put differently, when one

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[34] Schuster (2016: 34) aptly compares this with the psychic structures (neurosis, psychosis, perversion), each constituting a different way of dying.

actively (the drive) tries to achieve a passivity (desire). The same goes for pain and fatigue, something biomedicine aims to distinguish through separating them into two distinct diagnoses, CFS/ME and Fibromyalgia. The fact that they are repeatedly mentioned together points to an inextricable relation between the two; however, they can also constitute opposite experiences. This passivity within an activity, if we can put it like that, as a deviation of the negative, is what brings Zupančič (2017: 97) to formulate the death drive as an 'ontological fatigue' in her reading of the Freudian drive, where life is but an accidental deviation of the inanimate (the negative). She claims that it is not necessarily felt as fatigue, but instead refers to the aspect of repeating a negativity (a gap) which always comes with surplus satisfaction, the latter of which she argues is not the aim of the drive but something the drive pursues despite its emergence (Ibid.: 104). The drive is something which does not stop living but which nevertheless moves towards death, or to quote Schuster (2016: 125) again: 'the feeling that life is nothing but a chore and a drudgery and a burden, and cannot go on, yet does not stop doing so'. Nevertheless, this repetition of negativity is not the same as the repetition of sameness, the latter of which we could link more with desire and the stillness and completeness imagined by the fatigued subject to reside in sleeping (or working if following the imperative to 'keep going'). Since the drive involves the repetition of lack, no repetition is ever the same: we all die differently as Zupančič (2016: 106) highlights. Insofar as fatigue is potentially formed, as was postulated in chapter four, as a way of introducing difference in the face of a homogenous reality through a movement towards a non-movement, then fatigue constitutes an embodiment of the death drive. However, when difference and incongruity between the body and the symbolic-imaginary order is not tolerated and conversely a unity is strived for — more in line with defensive desire — then this constitutes a refusal of the movements, gaps, differences and ultimately losses produced by the drive. This explains the 'stuckness' of the subject between the imperative to 'keep going' and to 'slow down/stop'.

Accordingly, the object of 'nothing' constitutes a unity and therefore a type of sameness, the failure of which is precisely what is complained about in the interviews (however alongside or rather logically after complaints about sameness). The participants complain about fragmentary, unpredictable, and ambiguous tensions *in relation to* the idea of something complete. We can say that the complaints of these are about the drive, the complaint that something fragmented and incomprehensible exists and goes on despite the attempt to disappear and restrict them (in fantasy). The lament of the impossibility of

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'nothing' echoes the exclamation of the impossible desire to 'never have been born', in the form of frustrations about encountering demands or bodily tensions instead of a pure break from life (causing the desire to sleep as the drive towards 'nothing'). We can, based on this, come to the conclusion that the more one believes in the object of 'nothing' as the place of Nirvana (the object of desire capable of removing lack) the more one is driven to achieve it, or rather driven to maintain the fantasy. This involves constantly circulating around a void, so that one can fantasise about extinguishing it. Desire gives force to the drive. That is, the drive is necessary in order to sustain the fantasy to 'never have been born' — because it can only be thought of after having been born and from the standpoint of living. I thus conceptualise the inextricable relation between them as 'the drive of desire'. In this way, we can postulate that there has been a failure of separating from the image and the idea of 'nothing', which fuels desire and in turn fuels the drive.

Moving away from the concrete bodily enactment of the failure of 'nothing', we also find this failure on a symbolic level when the subject appeals to the Other as a system of knowledge, wishing for a symbol, often in the form of a diagnosis, to stand in for the subject.

Appearing by Disappearing

In contradistinction to the desire to disappear from society into the sweet release of sleep, there is also an appeal to be part of society. This takes the form of an appeal for validation and recognition for one's disappearance, where the object of 'nothing' is put on display for the Other in order to become something in the social order; constituting an inscription of lack in the Other. This comes close to the process of the naming of the void explored in chapter four, however now it is not a bodily tension signalling an aliveness, but a symbol signalling the body's disappearance and non-existence, which would inscribe the subject on a symbolic-imaginary level through a representation (such as a diagnosis), as opposed to a symbolic-real inscription.

First of all, we observe in the interviews an appeal to the Other where the participants' fatigue, as a disappearance from activities (society), becomes a message to the Other. Mark suggests this when conveying the following:

…by March I was coming home and unable to talk, cook, speak. Sometimes I was unable to move myself from the sofa to the bedroom, not even involving stairs. Um and my wife would have to lift me up from the sofa and help to carry - support me to the bedroom because my legs just didn't have the energy to support my body, um, and this was a very gradual decline, but I could see it happening and I was telling people 'this was what's happening'. Um…and telling my employer 'this is what's happening' (A/L219-224).

There is a retreat from activities ("talk, cook speak" but with an emphasis on speaking since it is mentioned twice), in the form of a disappearance, and a subsequent appeal to register this disappearance. Not only is there an appeal for another to help him physically (his wife, representing something external), but there is a desire to tell others about his disappearance: "but I could see it happening and I was telling people 'this was what's happening'. Um…and telling my employer 'this is what's happening'". There is a desire to be seen, more precisely to be seen as someone who disappears in "a very gradual decline"; being seen as the unseen. We notice how this relates to a desire for recognition, and indeed Lacan relates the scopic and invocatory drives to desire, whereas the anal and oral object are linked to demand. Lacan further emphasises an aspect of the drive as an activity, a 'making oneself', more precisely making oneself seen and/or heard (Lacan, Seminar XI: 195). He mentions that the scopic drive involves a loop which returns to the subject and closes it, which is absent in the invocatory drive since the ears cannot be closed. This can be understood as inscribing lack in the Other in order to close the gap between subject and the Other; to be one with the Other and thereby overwrite lack. More precisely, this is enacted when the subject disappears behind the object of 'fatigue/CFS/ME', allowing a representation in the Other to stand in for him/herself, and whereby fatigue/CFS/ME would be validated as a serious, real condition. However, the first step towards this is to mark one's disappearance, to inscribe lack in the Other. Sometimes we discern this when the participants mention their deaths or that they are planning their funerals. Gail states: "I've arranged my funeral" (A/L116), and Mark that he "was writing my will" (A/L73) and said goodbye to his mother, which immediately follows the sentence of having explained the difficulty of being seen and taken seriously ("I had to call around desperately in tears looking for a private consultant who could see me"). Invoking their own disappearance can be viewed as an appeal to the Other and can be compared to the

fantasy of one's death as a way of invoking the desire of the Other[35]. This is still in line with Lacan's take on 'anorexia nervosa', wherein one gives one's loss and disappearance to the Other:

> The first object he proposes for this parental desire whose object is unknown is his own loss—Can he lose me? The phantasy of one's death, of one's disappearance, is the first object that the subject has to bring into play in this dialectic, and he does indeed bring it into play—as we know from innumerable cases, such as in anorexia nervosa (Lacan, Seminar XI: 214-215).

We can then speculate that instead of simply becoming and embodying 'nothing', 'nothing' is produced by the fatigued subject for the Other in order to gain recognition and be something valuable (an object of desire), which relates again to the anal object as giving one's loss. One disappears in order to appear. The appearing part is best enacted through the biomedical diagnosis of CFS/ME, but more correctly through ME which better represents a biomedical condition.

It is under this name that the subject disappears, since the subject lets the symbol stand in for the him/her — another way the failure of 'nothing' manifests itself. The disappearance of the subject behind the name is attested to by the fact that the participants, and many patients in general, refer to ME as an "invisible illness", which relates to what was mentioned in chapter four about ME being a registration of an absence, a diagnosis of a nothingness. However, the structure of a disappearance being an appearance is most aptly captured by the campaign for ME promoted and embraced by the patients and their loved ones, entitled 'Millions Missing'. Through it, what they demand is recognition for their very disappearance from society: they want to be included in society as someone excluded, echoing the anorexic act to 'include me out!' as also mentioned previously. This is in agreement with other accounts of anorexia (as a form of starving). For instance, Hornbacher (1999: 9) in her experiences with bulimia and anorexia conveys: 'A disappearing act, the act of becoming invisible, is, in fact, a visible act, and rarely goes unnoticed' (Ibid.: 129), and: 'One's worth is exponentially increased with one's incremental disappearance'.

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[35] Imagining one's own death/funeral is appropriate for this because one imagines who and how many would turn up. In other words, one tries to imagine how desired one is by others (Verhaeghe, 2004: 224).

The presence of an appeal to the Other is contrary to what some theorists claim about modern symptoms in the field of Lacanian psychoanalysis. For instance, Domenico Cosenza (2015) in his discussion on anorexia claims that 'in the majority of cases', the symptom is neither a message nor an appeal addressed to the Other. This follows the line of reasoning of the theories claiming many contemporary symptoms are real, due to the lack of symbolism thought to be involved in them. The refusal is rather seen as a 'pure' refusal, as solely containing the function of separating. In relation to fatigue as presented in this study, and in relation to there not being an appeal to the Other, this cannot be maintained as there are several suggestions contradicting it.

Beyond a validation or a recognition of one's existence, what a validation of a diagnosis appears to encompass for the subject is a permission and an explanation for the drive/desire towards 'nothing', for disappearing. This is suggested by Beth when explaining the effects of receiving the diagnosis:

> …getting the diagnosis of ME is slightly a relief because it means you can stop, kind of, hoping that it will just disappear tomorrow. Um…and accept it uh but it's also really overwhelming (A/L382-384).

The name ME, because it is associated with a chronic illness, is something considered long-lasting which seems to be "really overwhelming" but simultaneously "a relief". The "relief" could be interpreted to be linked to having received, through the diagnosis, a permission to stop: "it means you can stop" (if we cut the sentence there). In other words, a permission to give into the desire to 'do nothing'. We notice here how the signifiers part of a scientific discourse, a medical name, sustains the fundamental fantasy. How well the fantasy functions depends on the amount of recognition and validation received through a medical diagnosis. The validation, in turn, seemingly depends on the explanatory factor: the medical label has the ability to explain, or rather (dis)place, the enigmatic functioning of the condition, the drive to 'do nothing', outside of oneself. This would entail an exoneration of responsibility, made possible by placing the cause of one's incomprehensible bodily tensions on the side of the biological body, onto something separate from oneself. The organic body represents here an entity independent of the subject, and is to blame for, all his/her shortcomings. A symbolic-imaginary inscription of lack thus externalises loss, corresponding to a defence on

the part of the subject against not taking responsibility for, or recognising, his/her subjective involvement in the condition (Vanheule, 2014: 134). This type of defence is in turn linked to the act of separating, which is about fantasmatically (dis)placing the lack and loss in the Other, thus offering a function and a place for it (Pluth, 2007: 87).

More precisely, the signification of a diagnosis can be compared to a symbolic identification and to a master signifier, or a *point de capiton*. A master signifier imaginarily halts the sliding of the signifying chain, in a pronouncement of 'it's like that', as opposed to it being many other possibilities, as presented by the void (for example other medical diagnosis such as IBS, cancer, depression, psychiatric labels, 'made up' or simply nothing etc.). The diagnostic label corresponds with the function of what Leader calls a 'representation of a representation' (Leader, 2008: 105) where an object is not merely an object 'but the representation of that object' which is 'situated in another register' (Ibid.: 102). In this case, fatigue as a representative of 'nothing' acts as an object put on display within a representation — indeed I argued earlier how the diagnosis is a registration of an absence, of 'nothing', which would fit here too. Leader (Ibid.: 105) further helpfully explains a symbolisation in terms of a frame, window or a stage which would emphasise the artificiality of an object. The artificiality of a medical diagnosis is particularly evident where a name is thought to unite the many various bodily parts (symptoms) and provide a totalising explanation of it (coming together under a 'syndrome'). We can compare this to Lacan's mirror stage whereby the ego is constituted, and add that this process, counted as an imaginary identification, is only possible through a symbolic identification. A symbolic identification is achieved through the process whereby the mother, or someone else, stands beside the child gazing at his/her own reflection in the mirror, or any other reflective surface, and is the one to confirm 'that's you!'. Thus, a symbolic identification — amounting to the notion of the ego ideal — determines and gives form to the imaginary identification, known as ideal ego. Žižek (2006a: 80) explains the difference between an imaginary and symbolic identification in a simple manner: the imaginary ideal ego is the image you wish to identify with, while the ego ideal represents the person/perspective for which the image is intended. In the case of fatigue, the image can be said to entail the bodily force towards 'doing nothing' as a real, serious illness, which takes on meaning from the perspective of the medical establishment. The medical establishment acts as a third external point guaranteeing the image and limiting it from spilling out everywhere to other unwanted labels such as

depression, pure laziness or simply nothing, and thus providing an explanation for it. The name ME/CFS becomes the symbol which imaginarily represents the subject, which means the imaginary is invoked in the symbolic, in contrast to the body as real (the void) which was summoned in the symbolic through the initial refusal. Now, the imaginary functions to remove the void and relatedly loss by representing loss. And the more the identification with the medical label has been established, the more lack is overwritten and the ego established — this due to an explanation, an answer, having been provided for the bodily force towards 'doing nothing' as a way of framing it. But to what extent has this occurred for the participants? When the ego is established and the fantasy 'functions', there is less anxiety, incomprehensible and unbearable tensions and probably ambivalence — since the indication that fantasy has failed is the presence of anxiety. Based on this, we can argue that the participants have achieved this type of identification to different degrees. In order to elucidate this, I will focus on Lucy who appears to have identified with the label ME to the highest degree, and who, to a certain extent, has made language her own — the process of separation whereby language has been subjectivised (Fink, 1999: 87).

The Biological Body as an Externalisation of Loss

When I met Lucy for her interview, she described her condition as being in remission, saying that she "solved the puzzle". She did this through taking low-dose Naltrexone, a drug usually taken to manage drug and alcohol addictions, which is a treatment she herself researched. Lucy identifies with the diagnostic category of ME, but only when it includes those people who have no colds, sore throats and hay fever[36] — something she herself has had all her life until they disappeared after her operation which precipitated her condition. Conceptualising ME in this manner is not particularly widely established, but rather appears to comprise a singular idea stemming from herself — hence alienation having, to a certain degree, been made 'her own'. Even though she is in remission, she explains she is not *fully* well since she is unable to participate in everything she used to, particularly extreme sports: there is still space for desiring the object (energy). The identification with ME allows an exoneration from

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[36] "I think a lot of people that don't get ill anymore like the people who lose getting colds, hay fever; those people that get that set of symptoms have got major immune element. There's a lot of other people with chronic ME or chronic fatigue that get loads of colds, loads of infections. I think they're in a different *section*, and their fatigue's caused by something a wee bit different" (L/116-120). The disappearance of colds and infections is thought by Lucy to be the reason she still has ME, even though she's in "remission".

responsibility by placing the emphasis, or rather the sole explanation in Lucy's case, on neurobiology. She elaborates on her condition with exclusive help from neurobiological explanations, and believes that these, embodied in the term ME as a metaphor and a unifying representation of the processes of her body, are accurate representations of what she has. This differs from the other participants where biomedical explanations are endorsed in a more speculative manner. She often says "that's *exactly* what happens" (my emphasis), for instance seen when she explains her panic attacks: "So that's exactly what happens. It's orthostatic intolerance, it's dyston – dysautonomia" (A/L84-85). The loss of colds and sore throats seems crucial for her sense of identity because it is at moments when she feels a sore throat coming on which leads to the onset of panic attacks — when identity disintegrates and *object a* becomes included (lack of a lack) as opposed to excluded. This showcases how loss necessitates identification. With the panic attacks now gone since the condition is in remission, Lucy has to a certain degree made sense of the loss of energy entailed in the drive and desire for 'nothing': she considers it part of the condition of ME, which is something she places outside of herself and onto the biological body, constituting a life from which she is largely separated. Lucy's discourse arguably showcases a separation insofar as there has been an establishment of the ego: an identification with ME has allowed an over-riding of lack (where lack and loss is nevertheless foundational) and there is additionally a (false) belief in having established an independent position from the Other. This latter is something discernible for the other participants too when expressing a positive sense of independence gained as a result of the condition, as having more time for themselves. It can be compared to the establishment of imaginary castration (Van Haute, 2002: 205), where the ego and a meaningful identity have been put in place. The ego organises tensions and excesses of the body, an organisation which Lucy assigns to the result of having taken the low-dose Naltrexone:

> The drug, it's only - it's - it's only scaffolding. It only stops your body from *over-reacting*, it doesn't fix your body it doesn't encourage it to work properly again. It just stops - it's almost like a damp in a river. It doesn't stop the water from flowing, it just stops it from reaching a cert - do you know - a cert - a certain area, so the water's still flowing you've still got to figure out how to then stop that

damm from overflowing by getting - maybe redirecting the water or using the water or doing something with it (L375-382).

We discern how Lucy conveys something uncannily reminiscent of Freud's concept of sublimation and the pleasure principle as keeping a tension constant. That is, there is not so much a release of tension but a containment of it, which can be compared to the process whereby the ego integrates drive tensions of the body into its image — the life drive as a binding force according to Freud. This keeps the death drive as the unsymbolised tension at bay. Even though Lucy is talking about the drug, we can hypothesise that this process is also tied to the explanatory power of the diagnosis — while not dismissing there may have been physical effects due to taking the drug — given the fact she says she "solved the puzzle" by taking it. However, not all subjects identify to this degree with the label, to the point where a more or less stable identification amounts to a more or less stable fantasy. For some/most, we discern anxiety and incomprehensible, uncomfortable bodily tensions often emerging, where the subjects are taken over by their unpredictable nature. The presence of these tensions points to the failure of the fantasy of containing/organising them. What is further present for the other participants is seemingly an ambivalence in terms of an identification with ME/CFS, and the possible explanations and answers deriving from them.

The ambivalence present for some of the participants in relation to the label ME/CFS can be explained by putting together the two opposite moments analysed in the interviews: an appeal to the Other and a refusal of the Other. The simultaneity of the refusal of the Other and the appeal to the Other — if operating strongly — gives rise to an impossible way of relating to the Other. This is illustrated in the interviews by the subjects demanding answers, while giving off an indication that an answer coming from an authority is not tolerated. Brody for instance relays that he "muddle[s] through until the answers [are] handed to me" (A/L548). However, at another place he says that the sessions with a psychologist were valuable, since they gave him "time to understand what was happening. It wasn't just 'here's the answer, go away'" (A/L184-186). The latter because maintaining lack, through not having been given an answer, would also entail maintaining someone else's desire (interest in you). Something similar is discernible for Tom when he conveys at one place that the diagnosis helped: "… I didn't know what it was and I like to have a - a label. And the label helped" (A/L361-363). Later on, in the same interview, he contradicts this by saying (when

speaking about the medical professionals): "If somebody's telling me they think it's this and that's what it is and [speeding up and making a mumbling sound]. I'll not go back to them. That's their stuff, you know what I mean?" (A/L477-479). Implicit in "That's their stuff" is the subject's attempt to escape/separate from the Other's symbolic-imaginary explanations and more generally the signifier in "it's this and that's what it is", in its metaphorical function which provides and pins down meaning. On the other hand, there is a difference between the two statements. "Somebody's telling me they think it's this" could indicate a lack of toleration of it coming from a person (of authority), but the "label" appears independent from a person and refers to the linguistic system itself, in which relief is supposedly sought through knowledge ("know[ing] what it was"). However, such a separation is of course impossible because the diagnosis needs to be confirmed and relayed through others with medical authority. Further, wanting to "know what it is" versus not wanting to be told "it's this and that's what it is" presents a contradiction. The impossibility is thus that the subjects reject the very system which would grant them recognition, and thus what seems to be observed is a very ambivalent relation for some of the participants: consciously, an answer for their condition is demanded, while unconsciously such an answer is not tolerated. This is in line with Lacan's view of the subject, someone who wants *some* recognition but not full recognition, because the latter would remove the subject — the subject being partly represented through a symbol (behind which it disappears). Nevertheless, those who have more or less established the ego/imaginary castration through a medical label, and those who have not to the same degree, have something in common. If the former can be argued to have established a 'higher' degree of separation, we can problematise this and ascribe a failure of separation to both groups. Instead of being unable to separate from the idea of 'nothing', which I discussed above, we now turn to the failure of separating from the idea of 'the body as machine'.

The Body as a Non-Functioning Machine

As might be evident by now, the appeal to biology as an externalisation of loss/lack/the patients' conditions, and the belief their conditions have an almost exclusive biological cause, have connotations with the concept of the 'body as machine'. Even in cases where the appeal to biology does not strongly operate, the body is thought of as an independent, external entity

entailing a type of machine-like mechanism. This is evident in the analogies used by the participants to describe a loss of energy pertaining to their bodies, which consist of references to different types of machine. Tom, for instance, explains that "becoming chronically fatigued, like somebody pulls your battery power out" and further compares it to an iPhone. Lucy likens her body to the engine of a car, to it being in "limp mode" (L280-288). More broadly, many of the participants frame their loss of energy, as a loss of a core part of themselves, in the form of mechanical power, where a loss of energy is equated to a loss of power, and even a loss of money; as if the body, and oneself, can be neatly measured in numbers. It echoes the idea that the body is a capital machine, and suggests that loss has been symbolised through the Other. When Lucy for instance, speaks about her body not functioning, she compares it to operating at the capacity of thirty-five percent at one point, after which she says: "That's no use to anybody. I wanted to be a hundred percent again, I want to be *me*. I want to be back to my normal self" (L/685-686). This showcases the structure of imaginary alienation: a separation of oneself from oneself, accompanied by the belief that the core of oneself can be (re)found in the Other. Indeed, the Other can be compared to a machine-like order insofar as it constitutes an otherness in which the subject gets caught. Beyond this, her quote showcases the body as a usable object for someone else ("That's no use to anybody"), and thus fatigue suggestingly as the refusal of it.

In the light of this refusal to be reduced to a bodily machine, we can state that the fatigued subject has merely turned him or herself into a *non*-functioning machine. The body as a non-functioning machine implicitly referred to by all of the participants signifies a foreign, external element working automatically and independently of the subject and the psyche. It mimics the denial of desire part of the defensive moment of fatigue, and ironically, echoes the big Other's statement 'there's nothing wrong with *you'* — showing how the subject's desire is always the Other's desire. Thus, it is irrelevant what type of machine the participants are referring to — non-functioning, moderately functioning, not-fully functioning — the reference to the body as a machine is clear. In other words, one paradoxically refuses to be reduced to a machine-like object by reducing oneself to a machine-like object. However, the difference could arguably be that the latter object (non-functioning machine) is not considered to belong to the Other but to oneself. Nevertheless, not only is there a failure of having separated from the idea of 'the body as machine', but there is an idealisation of it: a belief that the body *can* be a machine (Lucy's "I wanted to be

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a hundred percent again"), a constantly producing entity in motion — which is, of course, nothing but a myth. Not only do we witness this through references to their conditions, but such a belief was most likely present before their onset, or at least retroactively postulated to have been there before.

It is often understood that those who become fatigued are ambitious, those who 'dream big' and attempt to materialise their dreams. It implies that, first of all, one has a large appetite, and secondly, one believes this appetite can be satisfied. We can say that all of the participants tried to meet the big Other's demand for perpetual movement, and presumably did so quite well before getting ill, according to themselves, as they describe having good careers, being engaged in hobbies, socialising and so on. Put briefly, they 'worked hard and played hard', possibly reflecting an addiction to the activity of doing. Not only do they idealise the position of a constantly hard-working person and want to be seen as one, but they believe this position, the body as a machine, to be a possibility; that it exists. There is a belief they can keep going no matter what, and that one will get there in the end, accomplish the goal and attain a prize. Such an idealisation of the mirror image has indeed been identified by other researchers within the field, namely by Vanheule (2001), who claims that: 'In people who are engaged in this dynamic of idealisation, exhaustion is to be expected, for one's mirror image can never be reached'. One tires oneself out trying to achieve the impossible. Arguably, the more one believes in the existence of the image *qua* the object of desire, such as the idea of a constantly hard-working person, the more one will be driven to try to achieve it — resulting in a type of 'can't-stop-won't-stop' movement. Here is another indication of how the drive gives force to desire. Further, as we theorised previously, attempting to meet a demand — fighting against the impulse to 'do nothing' — is crucial for symptom formation. This process can be elucidated by Lacan (2002/2006: 698) when he writes that the neurotic takes the Other's lack as a demand, and this in order to protect against anxiety, in which case 'his fantasy is reduced to the drive'. Reducing lack to a demand involves reducing it to a known object so one can have the possibility of being the answer to the Other's demand/desire — the first solution the subject attempts in protecting him/herself against the Other's anxiety-provoking desire. It can further be related to Lacan's scopic drive in that one imagines oneself being seen as "a hard-working member of society" in the eyes of others/society (A/L604-605), as Amy puts it — the notions of visibility and invisibility being repetitive in the interviews. But bringing this more in line with fatigue as an inhibitory

moment, Lacan (2014: 316) states, paraphrasing Freud, that an inhibition of a body part takes place when that part has been eroticised; meaning a belief one can be 'one' with the body. This is nothing other than believing one can coincide with an *idea* of the body. An inhibition would thus occur in order to avoid the unity with an idea as a way of sustaining desire and, concurrently, the idea. Additionally, it would occur in order to avoid the loss and eclipsing of oneself imagined to be involved in meeting the Other's demand — something which becomes palpable when the mirror image is recognised in its alienating, foreign aspect.

There is in the interviews an inability to accept loss due to a belief that the ideal image is attainable, discernible in moments of frustrations where the participants explain that parts or a part of their lives have been stolen. This is in accordance with Lacan's notion of imaginary castration. Lacan (2002/2006: 698) explains that when taking lack as a demand, or rather when confusing the two, while this hides anxiety, it shifts 'the whole treatment toward the handling of frustration'. For example, Mark frustratingly speaks about how everyone but him is "superman" and how they have "magical powers" (A/L437-442). He believes to have failed to meet the demand (to 'keep going'). While this depicts an endorsement of the body as machine — a superman having magical powers is supposedly someone capable of constant productivity due to possessing beyond-human qualities — it also portrays a rejection of it. The subject could reject the existence of the ideal as an excuse of not having attained it, through postulating the demand as impossible, which is observed in Mark's discourse here as well as in the other participants' discourses. After all, having magical powers or being superman is impossible. It would follow the line of reasoning that it is not the subject who has failed to meet a demand which was perfectly able to be met, but it is the Other's fault for asking the impossible; consequently, freeing oneself from culpability. Nevertheless, in both cases, loss and lack are not accepted.

Thus, I have demonstrated various ways in which the ideal of the 'body as machine' is endorsed and held on to. This distinctively differs from some of the theories I introduced earlier, where it is suggested that fatigue, and many modern somatic symptoms, are not structured symbolically, such as Verhaeghe's theory of actualpathology, those theories building on Freud's actual neurosis, and the theory of ordinary psychosis (which will be discussed briefly in the next chapter). The symbolism present here for the fatigued is arguably that of 'the body as machine', where this is both endorsed and rejected. Further, as argued, both of these moments could be said to have a protective and defensive function, since it

offers a symbolic-imaginary solution of exonerating responsibility[37]. It differs from the aforementioned theories which state that 'real symptoms', with which fatigue and pain are associated, are not defences against the unsymbolised real (for example, Lose (2015); Verhaeghe (2004: 289-290)). However, when the ME/CFS diagnosis is not considered to exit or is not validated by the Other, which occurs often, then the fantasy fails and one is confronted with radical lack (the real). In this sense, it could echo something of these aforementioned theories, that symptoms are more often real than symbolic-imaginary. However, leaving it there and not exploring the symbolism potentially involved could miss out crucial aspects. Verhaeghe's theory is particularly relevant here, as he separates anorexia belonging to actualpathology and that part of psychopathology (hysteria more precisely), on the basis of a presence of a refusal. In anorexia belonging to actualpathology, which he argues is 'semi-independent' from a sociocultural Other, there is a refusal to incorporate the Other's ideas: the function of the symptom is to separate and gain an independent position of the Other. In psychopathology contrarily, anorexia is fuelled by a desire to incorporate sociocultural images, where one is dependent on the Other's gaze (Verhaeghe, 2004: 231-232). I mentioned this part of Verhaeghe's theory in chapter four and speculated that both aspects, a desire to identify/dependency on the Other and a refusal, is present for fatigue. Now we can make a stronger argument for this based on what has been uncovered in this chapter, where it appears that these two opposite functions are precisely what constitutes the split of the subject: refusing what one identifies with[38]. More exact, while Verhaeghe claims there has been no identification with signifiers in actualpathology (imaginary alienation has not taken place), and that these are rejected by the subject, I argue that it is both an identification (with the 'body as machine') and a rejection of it which has contributed to the formation of fatigue. The latter is in accordance with the Freudian-Lacanian theory of negation, that a negation is always an affirmation — and in this case an endorsement — of the idea being negated. This does not necessarily contradict Verhaeghe's (2004) theory, since he argues that a 'progression' from actualpathology to psychopathology will also contain the previous (actualpathological) moment (p. 460); that the two moment will be present

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[37] It will also be evident in the subsequent chapter, which has a more in-depth focus on the structure of the discourses, that other signifiers and ideas are possibly involved in the formation of fatigue.

[38] This comes close to what Verhaeghe argues is present in hysteria, that there is simultaneously an attempt to fulfil and escape the Other's desire. However, this does not address the extreme ambivalence found for fatigue, where the refusal is not just against being reduced to an object of the Other's desire, but for the Other as such (as I argued in the previous chapter).

concurrently. Nevertheless, he does not discuss their interaction and the way in which the two can turn against each other, but the focus is rather on the position taken up by the subject (either actualpathology or psychopathology in various forms). The treatment is dependent on the position, which consists of two opposite treatments for the two groups. The two, indeed, are opposites since the symptom is either a direct encounter with the real, or a symbolic-imaginary processing of it. This does not acknowledge their interaction in the sense that the real *qua* the void always emerges *in relation to* the symbolic-imaginary, in relation to the fantasy. Or rather, the void only appears retrospectively from the standpoint of the symbolic. For the participants of this study, the pain of fatigue as a presence of an absence is complained about by the subject precisely *because* the fantasy of 'nothing' as well as 'the body as machine' exist, as argued. It can also be elucidated by Lacanian theory with regard to the split of the subject that there is a discrepancy between one's current experiences and where one believes one *should* and *could* be. In this sense, Verhaeghe appears to be making too much of a separation between the positions, particularly in singling out actualpathology as an independent one and particularly in relation to neurosis. We can question if a separation between them is necessary or even possible, as is oftentimes done by Freud which was outlined previously — and the same goes with dividing symptoms into those which are 'real' and those structured symbolically-imaginarily.

Returning to the non-acceptance of loss as found within the participants' interviews, this brings us to the idea of the failure of mourning. A failure of mourning is coterminous with a failure of separation insofar as there is an inability of separating from an idea. I will now trace how the concept of mourning, as it relates to the interviews, can aptly elucidate what has been discussed so far in the thesis.

The Failure of Mourning

Almost all of the participants, either before or around the onset of their conditions, experienced loss in the form of a death of or a separation from a loved on[39]. The loss of a

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[39] The only person who did not mention a loss (apart from the physical loss of her operation) was Lucy. However, she did not return for a second interview and she spoke only briefly about the events she believed influenced the onset of her condition. I also did not ask, like I did with the others, what went on more generally in her life around the onset, which proved to be an important question which brought events to the fore (the omission of which was partly due to Lucy often speaking uninterruptedly).

loved one can arguably play a significant role in the onset of their conditions insofar as it involves the loss of one's identity — seeing as identity is defined in relation to others, in relation to the Other, which the loved one could be said to have embodied. If so, then fatigue could have arisen as an attempt to deal with the loss. The loss of identity in mourning is something acknowledged by both Freud and Lacan.

Freud points out that mourning is not the mere loss of the actual physical presence of a person, but includes the loss of abstract ideas and ideals (related to that person) which were significant to one's identity (Freud, SE XIV: 243). He further renders this process unconscious: 'he knows *whom* he has lost but not *what* he has lost in him' (Freud, SE XIV: 245). Lacan's view on mourning takes on a similar shape but adds more details surrounding this process. In Seminar X Lacan (2014: 333), compares mourning with separation insofar as he links it with the constitution of desire, stating that 'the problem of mourning is the problem of maintaining, at the scopic level, the bonds whereby desire is suspended, not from the *object a*, but from i(a)' (Ibid.: 335). The i(a) refers to the ideal image, the image with which one identifies. The image become suspended, or more precisely, the brackets ('the bonds') holding together the image are suspended. What holds it together is the exclusion of *object a* — hence it being in brackets — which keeps loss and lack at a distance. Thus, the suspension of them leads to an inclusion of *object a* within the image or in relation to it, a lack of a lack, consequently blurring it. In simple words, the subject loses the grounds on which lack was maintained (at a distance) and subsequently completed, thereby losing the anchoring point of identity. According to Lacan:

> We mourn but for he of whom we can say I was his lack. We mourn people that
> we have treated either well or badly, but with respect to whom we don't know
> that we fulfilled the function of being in the place of their lack (Ibid.: 141).

To have been someone's lack means to have been desired by the Other — desire only being possible through lack — which entails the possibility of completing the Other, being the 'missing piece of the puzzle'. This is precisely what love is about which is strongly related to being someone's lack; in line with Lacan's famous axiom that love is 'to give what one does not have'. To be in the position of lack can therefore be translated into being loved and desired, and this being something providing a meaningful existence for the subject. But as

Freud and Lacan state, one is unaware of having been in this position. Since most of the participants only spoke briefly about the lost one — most of them treated it as a tangent to their stories which could point to the unconscious nature of it as a displacement — we cannot say with certainty that they held this position in relation to the other. We can, on the other hand, speculate that it might have been the case insofar as they all state they were close to the loved one. We could trace the loss of the position of someone loved/desired/wanted in Mark's and Beth's accounts.

Mark explains how around the time he got ill, he was in a psychologically abusive relationship[40], and that the end of it was a "big shock" because of her telling him "I don't love you anymore" in the midst of planning their wedding. He states: "*suddenly* the blind folds fell away from all of us in more or less the same time. And we all went 'oh my god, she's just been playing this game. All along'" (B/L422-424). He is thus confronted with the indifference of the Other, and an experience of being reduced to the object of the Other's enjoyment. The latter could be inferred from the statement "playing this game" and from his description of her as "obsessively controlling" (B/L362); and more obviously from his statement: "And she gets this… this delight, it gives her *delight* to have control over the situation" (B/L412-413). In other words, he is reduced to an object for the Other's pleasure, who does whatever she pleases with the other and whenever it pleases her.

Beth, on the other hand, is confronted with her parents' divorce shortly before the onset of her condition, which arguably puts into question her subjective position: "So they just didn't think about it and they both like made new plans for their lives that didn't include me having anywhere to *live*" (B/L170-171). Again, here is found a lack of consideration for the subject, resulting in an experience of being reduced to a mere object of nothing — a lack of a lack — whose existence is irrelevant for the Other. This signifies perhaps a loss of the identity as someone lovable. We discern then how these experiences of a reduction to nothing, losing lack, align themselves with the alienating encounters expounded in chapter two, albeit they were there related mainly to work (Mark) and university studies (Beth). Based on this, we can hypothesise that repression is at work, where the more personal events, problems with certain personal others, are displaced onto more impersonal events, to the Other, to which they react against. This would keep the former events disguised and at bay;

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[40] The time of this in the context of his onset is ambiguous and confusing for Mark as he changes his mind a few times as to when it took place.

an attempt at a bulwark against the anxiety of the loss of a subjective place. It can more precisely be tied to Freud's and Lacan's notion of secondary repression. The first moment of repression is that of primal repression and occurs according to Freud when the 'psychical (ideational) representative of the instinct [is] being denied entrance into the conscious' (SE XIV:148). For Lacan (Seminar VI: 76), this moment constitutes assigning a refusal to 'the unsaid'; a repression of fundamental lack. I linked this to a refusal of lack in the previous chapter, where instead of acknowledging that the Other does not have an answer about the subject's condition (existence), the participants experience the answer is being refused them. Freud then explains a second moment of repression, 'repression proper' involving the following:

> …affects mental derivatives of the repressed representative, or such trains of thought as, originating elsewhere, have come into associative connection with it. On account of this association, these ideas experience the same fate as what was primally repressed. Repression proper, therefore, is actually an after-pressure (Freud, SE XIV: 148).

The 'trains of thoughts as, originating elsewhere' which 'come into associative connection' to the repressed representative (a representative of lack/loss essentially) can be said to constitute these impersonal events at work or at university which have become attached to the earlier more personal events where lack was repressed. In simple terms, we can postulate there was an enigma the participants dealt with during earlier events, or rather did not deal with, and hence the emergence of the 'return of the repressed' at another event which was linked to the former by an association. The later event also represses lack (Freud writes 'these ideas experience the same fate as what was primally repressed') — a link which will become more obvious in the next chapter — since traced here is the subject's refusal. Repression occurs based on the logic of retroactivity, as noted by Freud to be involved in the experience of trauma. An event is not in and of itself traumatic, but only becomes so after the fact; after having encountered a second event which retroactively frames the first event as traumatic. This could be due to the two events being linked by a factor of similarity, in which case one realises a gap involved surrounding an earlier occurrence. Or put differently, a gap can only emerge in relation to two events (to two signifiers). In this way, we need not be reductive and

give priority to the earlier events — to say that this is *really* what the problem is about — but we can recognise that both episodes possess equal significance.

What further links the two events together is the encounter with an enigmatic and painful presence. Contrary to what is generally considered about mourning, one does not deal with a hole or an absence in one's life after a loss, but with an overwhelming presence. This is in line with Lacan's theory in that, instead of the exclusion of *object a*, it is included in the image whereby, as a consequence, one gets lost in it. And, interestingly, Freud thought there was a strong link between mourning and pain (Freud, SE XX: 131). One is thus engulfed by an overwhelming presence, more specifically entailing the 'over-presence of the image of the other' (Boothby, 2013: 218):

> What was already impossible of determination, what remained unanswerable and inaccessible in the other, the enigma of the other's desire, is in death impossibly amplified, expanded and multiplied (Ibid.: 220).

Accordingly, we notice the participants' confrontations with a presence of an enigma, for example when Mark says it "was a big shock" and "*suddenly* the blind folds fell away". Perhaps, what was previously a reasonable and containable enigma 'Why does she love me?' (every person asks this to their partner and says 'I love you' repeatedly in order to gain reassurance; the repetition showcasing how the enigma is always there), now perhaps becomes amplified and turns into the question: 'Why didn't she love me?'. The emergence of fatigue could be said to have the function of questioning one's value for the Other, staging the question in one's body. However, since this is enacted unconsciously, we can say that the image and the presence of the other is not processed, as we see it repeating itself in the condition itself: it has transferred over to the enigma of their bodies.

Another attempt at a solution appears to be to identify with the lost object, either with loss itself, which would explain the numbing into nothingness as a defence, or with certain qualities the lost person had. Gail's discourse showcases the former when she relays about her sister who died in between her operations: "I believe she should be alive and I should be dead" (A/573-574). Amy's discourse illustrates the latter in that her symptoms come to mimic those of her grandmother's, who died of a stroke not long before the onset, a mimicking of symptoms which she puts down to a genetic cause. She describes herself as

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having stroke-like symptoms ("but it was like everything felt <u>heavier</u> on one side and that I was like - I was like dragging - dragging my leg", B/L49). This suggests the maintenance of an imaginary identification with the lost one. With these two last-mentioned points in mind — mourning being about an overwhelming presence and an identification with the lost object — we can perhaps appreciate and give context to the ambivalence and split of the subject found for fatigue, in terms of the increase and decrease of tension, related to the poles of appearance and disappearance.

The subject could endeavour to signal the presence of the body through a tension, as if trying to keep the other person alive by stubbornly holding onto a presence which is never enough there, while contrarily attempting to get rid of an unbearable enigmatic presence which is too much there. However, such a divide can also be flipped around since we can suggest that the removal of tension as a numbing into nothingness constitutes an identification with the lost object (with loss itself), while the signalling of tension could be the attempt to live one's (own) life — a pulling in the directions of life and death simultaneously. A failed solution to these two oppositional forces becomes the embodiment of the undead, which comes to the fore in the discourses. Indeed, there might be a sense in which both being dead and alive comprise a loyal pact to the dead/lost one.

The latter is very common when facing the death of a loved one, which we saw expressed by Gail: the guilt of being alive while the other person is dead[41]. Simultaneously, the importance of living one's life seems to be an attitude which had been embraced by the dead ones, as relayed by some. Gail conveys that her now dead sister "used to always say to me: 'don't be lazy [imperceptible] you have enough time to sleep in your grave'" (B/234-235). Similarly, Brody, whose grandfather died very close to the initiation of his condition, relays that he said to him: 'don't get old. *Do* whatever you can, but don't get old'" (A/L39-41). What is evident in both of these statements is the echo of the demand to 'keep going'; again, noticing how this demand might have then been displaced onto impersonal others (doctors, friends, work/bosses). The subject would in this case be unaware of the origin of the demand and the multitude of meanings and enigmas attached to it. That Brody failed to meet the demand is traced when he describes feeling like an old person, due to fatigue: "So it kinda feels, um like I'm in my 80's" (A/L44). Therefore, giving into the demand to 'keep

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[41] This might not work for those who lost someone not through death, such as Beth whose parents got divorced, and Mark whose partner broke up with him.

going' could thought of as meeting the loved one's request; while refusing it could constitute a 'revenge' on the loved one due to feelings of anger of having died, the latter of which is not uncommon in the event of loss. On the contrary, not giving into the demand, which is basically the demand for life as I argued in chapter three, could comprise a loyalty of meeting them in death. This split can also be framed in a different shade in terms of responsibility, because for many of the participants, we trace a sense of responsibility towards the loss, some of which explicitly acknowledge it.

Gail, for instance, brings up guilt over her sister's death. More precisely, what she feels guilty about is that her sister was "stuck with my parents, looking after them and things and I was out there having a life in some way" (C/L524-525). This brings us closer to understanding her potential self-inflicted punishment of 'death while alive' through pain and fatigue. She describes her condition as "it's like a death sentence while you're living" (B/L182), but elsewhere she says "life sentence" (C/L57); as if to signal she has been punished for not dying, and perhaps, in a way, wanting to. Amy does not explicitly mention guilt over her grandmother's death, but she does mention it in relation to having the condition. Nonetheless, there might be a sense in which it applies to the situation of her grandmother as well, related to not having believed her grandmother suffered from a real, biological condition when she was alive. She believes in hindsight that her grandmother had undetected strokes before dying from a stroke. Amy repeatedly mentions how no one in her family believed her grandmother had a serious illness and treated her as a hypochondriac (B/433), saying: "we used to joke…about her being a hypochondriac [chuckles]" (B/L400) — and she says herself she feels like a hypochondriac (A/337). Maybe more importantly she says: "They just could never work out why she just was… always so - so ill. But I was a child and didn't really understand it all". There could speculatively be a sense in which she feels guilty about not having taken her seriously. Likewise, there could be an implicit guilt in Mark's discourse when he says "*suddenly* the blind folds fell away"; implying perhaps that had he not been blind to his partner's deceits, he could have prevented the abuse from happening, which included death threats and being cheated on (B/450). This is all the more significant since he explains how he had at the time allowed a friend who became homeless to stay with them, whom his partner had also threatened; threats which had continued despite moving out and unbeknownst to Mark, which greatly exacerbated her existing mental distress, as relayed by Mark. Thus, he could have experienced guilt surrounding this event. Finally and in contrast,

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Tom, akin to Gail, mentions guilt over his mother's death, a death which took place in front of him when he was a child: "So I think I carried a lot of shame and guilt regarding…the last words I ever spoke to my mother was 'I hope - wish you had fucking died'" (B/L120-122). He recognises the impact of this trauma in the appeal to his addiction[42], claiming the latter masked his anxiety (B/L72), and also claiming he "shared it" during his recovery period, implying it is no longer relevant. We might have reasons to believe it is, particularly as there is a similar logic operating in his discourse at the time of his mother's death — having given into one of his needs/wishes — and around the event with the neighbours' noise which precipitated his condition, in which he had failed to take care of his own needs/wishes (which will be explored in the next chapter). The structure nevertheless illustrates the logic of trauma as retroactive, as highlighted by Freud. Thus, taking responsibility for the loss of the loved one implies that guilt has not been processed — in which case the only solution would be to take guilt upon oneself (Verhaeghe, 2004: 277-278).

In the light of this, we can elucidate the split of the subject as being one between taking/feeling responsibility for the loss as a way of holding on to the other person, and conversely, getting rid of a responsibility which is too much (through both the desire to sleep and the exoneration through a diagnosis). Indeed, the attempt to get rid of responsibility presupposes that the subject feels responsible. We can in this way understand the encounter with the castrating demand to 'keep going' insofar as it asks the subject to take responsibility and to lose something, because being represented in the Other — having a meaningful identity — entails the exclusion of all other identities, including those of the loved one. Not having processed guilt and the enigma of the other person, the subject is perhaps unable to give up loss and instead says no to it, no to castration and alienation — choosing instead to meet their loved ones in death. Of course, it represents a forced choice in the face of not having processed loss and guilt/responsibility, as a result of which the accumulation of responsibility could become too much. The body could thus become the place of attempting to process that which was not processed; asking questions of responsibility ('Am I responsible?') and of love ('Am I loved'?) — answers to which in the fantasy we see fail repeatedly. Amy potentially illustrates this failure and the attempt to process the image of her

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[42] Which he has had for twenty-two years but at the time of interviews he had been in recovery for twelve years (B/L356-357).

grandmother when speaking about grocery shopping, something her grandmother likewise used to struggle with:

> … sound, um the noise, the lighting it's like, total overload. And it just - it - almost puts me in a trance, that I become a bit…I just like forget where I *am* it's almost like you become stuck. Um and so I've just avoid them. So I can maybe understand a little bit about how she *did* struggle when, supermarkets first became - and she - she couldn't go around them (B/L450-454).

To forget where she is and to "become stuck" could potentially indicate a loss of identity (forget *who* she is), seemingly related to a "total overload" of sensory information — an experience of 'too much' potentially pointing to the presence of an absence related to mourning. We also discern, linked to this, the attempt to "understand a little bit about how she *did* struggle". Amy has, in a way, become stuck in her grandmother's image through an attempt to try to process it. The failure of mourning could here be present in the failure of having separated from the image of her grandmother — and something similar could be argued for the other participants.

What is important about the process of mourning is recognising the artificiality of an object (Leader, 2008: 105), or the image of an idea. It involves inscribing a loss or a disappearance in symbolic terms (Ibid.: 119), and separating from the image we had of ourselves in relation to the other; an image which functions as a way of rectifying lack (Leader, 2008: 132). Covering over lack is precisely what hinders mourning and separation as it offers an escape into the image which promises unity, infinite enjoyment and wholeness, and overrides loss and lack as points of uncertainty and randomness. We observe such an escape on two levels for the fatigued: firstly, in the failure of separating from the idea of 'nothing', since loss is positivised therein (the imaginary-real axis), and secondly, in the failure of separating from the idea of 'the body as machine', where more precisely ME/CFS represents an artificial entity which unites different body parts *qua* symptoms (the imaginary-symbolic axis). The idea of 'nothing' can be subsumed under that of 'the body as machine', insofar as the desire for nothing, to have no needs, desires, responsibilities etc., is akin to an impossible, robotic state. Mourning entails recognising that the ideas were merely ideas and not something one's whole being coincided with. As long as this mourning of images has not

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taken place, and a separation from them has not occurred, we observe the return of the repressed through the very condition and more specifically through the loss of energy related to a part of themselves, which is then not accepted. Indeed, the participants often mention how they are grieving this lost part of themselves. Loss has thus been displaced and the subject does not recognise the link between their conditions and what they lost in relation to the loved ones.

Not having accepted loss or the artificiality of a linguistic system — the artificiality of unity we can say — is related to a lack of symbolic castration and a lack of separation more generally. Symbolic castration involves transforming the imaginary object into a symbolic signifier (Van Haute, 2002: 205). As long as 'nothing' *qua* lack is positivised into something which has the ability to remove lack/loss, symbolic castration has not taken place. The latter would occur by viewing an object from many angles, in order for the symbolic object of lack to emerge, which is in contrast to the imaginary object with its fixed locus. Following Freud, the more we run through representations, the closer we get to its point of exhaustion where the object no longer exists (Leader, 2008: 101). This would supposedly make the 'drive of desire', as I termed it earlier, lose its charge due to an acceptance of the difference between desire and *jouissance*. Or rather, due to realising that the object of desire does not exist, the fascination of the imaginary wholeness which covers over the point of impossibility loses its charge (Van Haute, 2002: 280-281). We could not claim that this would automatically entail a diminishment of tension, however that might be the case. It would diminish the tension between wanting-to-be and being, but it could potentially be replaced by the agony of the meaninglessness of life (radical lack), which one would be met with instead. In this way, one would accept the movements of the drive around a gap, accept its aim (to maintain lack) instead of overriding it with the goal of it (to get rid of lack). This is in line with what Bruce Fink (1997: 41) claims is the goal of analysis: to remove the inhibitions of desire and accept the satisfaction obtained by the drive, to 'enjoy his or her enjoyment'. I would also add, however, that this involves less force given not only to the goal of the drive as quenching lack, but the aim of it in terms of circulating around a void, since a strengthening of this circuit is what maintains and strengthens the desire to get rid of it. Or in other words, this would entail an acceptance not only of lack but of a lack of a lack (the presence of an absence), subsequently diminishing the need to inscribe a lack in the Other. The tension

between the two would diminish, and one would be less caught and inhibited between two poles, between to 'keep going' and to 'slow down'.

Therefore, it is not enough to simply link an event with the emergence of one's condition — Gail for example is aware of the role of her sister's death in her condition — but to bring implicit ideas to the fore[43], ideas to which one was attached, and to recognise their artificiality. And further, the subject needs to recognise the ways in which s/he is implicated in these, instead of externalising them onto a biomedical diagnosis, or attempting to escape the symbolic Other altogether. Both latter ones present imaginary solutions, and solutions which come at the high price of creating more problems; the repressed returns in an unbearable form. The escape from the big Other into the imaginary world discernible in the interviews is strongly linked to the idea of 'the body as machine', as said, in the sense that 'nothingness', as well as a biomedical diagnosis, can be compared to that of an impossible machine where a subject's responsibilities, affects, needs — including the need to mourn — or desires are cut off. These were merely (attempted to be) withheld and displaced. Overall however, the belief in a unity with *any* idea represents an artificiality akin to that of a machine, since an idea is ultimately incompatible with the subject. Biology and culture do not (fully) integrate. This process of mourning is akin to that of separation as it relates to the constitution of the subject, for which there need not be real losses involved, and which is the goal of the practice of psychoanalysis.

Not only does that which has been presented so far constitute a failure of separating from the image of 'nothing' and 'the body as machine', but Lacan in Seminar V elucidates the consequence of a refusal:

> In his relationship to signifiers a subject may occasionally, insofar as he is asked to constitute himself in signifiers, choose not to do so. He can say 'No, I will not be an element in the chain'…What does the subject do, in effect, when he chooses in some way, not to pay a debt that he has not contracted? He does nothing but perpetuate it (p. 229).

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[43] However, from a Lacanian perspective, these ideas were not there *a priori* — that would render the unconscious as the place of hidden meaning. It is more correct to say these ideas are constructed in the process of exploring potential meanings surrounding an enigma. However, certain ideas are 'there' but displaced, such as potentially 'the body as machine', which is not hidden, but revealed in language. What is hidden — unconscious — for the subject, is the link between it and the impact on his/her condition.

The subject, having said no to partaking in the symbolic order, and said no to loss ('not to pay a debt') inherent therein, ends up perpetuating it rather than escaping, or in Lacan's words which are very appropriate in the context of fatigue: 'does nothing but perpetuate it'. In sum therefore, rather than accepting and acknowledging that the body cannot coincide with that of a machine and which never really existed in the first place — a process akin to mourning and separation — it is idealised and held onto by the fatigued subject. One ends up reinforcing what one tried to escape from in the first place.

Chapter 7: A Closer Look at The Structure of Fatigue

Throughout this thesis, I have argued how fatigue could be interpreted as a refusal and a defence against the demand for productivity (in the wide sense). However, since a refusal is the minimal sign of subjectivity as I argue, we need to go further in order to gain more insight into the details of the refusal. What is the refusal refusing precisely? What is the separation from? The details pertain to the function(s) of the subject's refusal, which has been touched upon and discussed throughout the thesis. This now necessitates an in-depth analysis in order to bring out differences and similarities between the discourses with more clarity, which will simultaneously highlight their structures. To this end, I will return to the alienating encounters and look at these in more detail, and more specifically, investigate their structure in relation to the response of the formation of fatigue. I will also explore the link between these onset events and the earlier events concerning loss. The reason for this focus is that, first of all, the events include an encounter with fundamental lack, which can be formulated as the question of 'What do you want from me?'. They put into question one's own identity and demands a response in terms of taking up a position in relation to the big Other. More importantly though, exploring two related events in relation to the formation of fatigue will bring forth more evidently the way in which the subject relates to lack, as a minimum of two events frame lack. This will consequently indicate the logic of the symptom.

It is Lacan's theory of the clinical structures which can shed light on the above-mentioned questions, insofar as it closely examines the logic of a symptom as embedded in discourse. A logic has a specific function immanent to a structural mode of relating to lack/absence/loss: either neurosis, psychosis, or perversion, which constitute three various ways of relating to lack; or arguably, three different ways of refusing lack. However, a word of precaution is warranted here prior to proceeding. The clinical structures are used in the practice of psychoanalysis by the analyst in order to discern the logic at work in the analysand's (patient's) speech. This is done, first and foremost, so as to guide the analyst's position *vis a vis* the analysand toward the establishment of a safe and fruitful investigation of the unconscious, since the treatment is dependent on the logic of a symptom[44]. To

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[44] A Lacanian way of diagnosing differs markedly from the biomedical approach, insofar as it focuses on the structure of a symptom, and not on the mere presence of isolated, surface symptoms. Further, the 'diagnosis', if arrived at, is never disclosed to the analysand, but its purpose is to guide the position of the analyst. It is also very possible to arrive at the conclusion that there is more than one logic at work, which is usually done in the

recognise the logic of the analysand's speech usually takes months and several meetings with the analysand, and even after a few years, a diagnosis may not be clear (Miller, 2015: 95). It is not my intention to diagnose the participants, with whom I met only twice, with an overall and/or permanent structure for each, since this would be impossible in this type of research; and maybe impossible at all, depending on one's view of the structures (if they are fixed, able to co-exist etc.). To repeat what I mentioned in chapter one, it is not the symptom of the individual I am investigating, but rather the symptom of a discourse — a discourse elaborated at a specific and unique time (of the participants' lives), in a specific context (with me, representing the university at which I am researching). Through a Freudian-Lacanian approach I 'follow the letter' in order to uncover the logic of the signifier governing the unconscious (Miller, 2011: 9). I am thus starting from the assumption that the clinical structures, constituting different ways of relating to lack, are fluid and do not exclude each other. I use them not as a way of diagnosing individual differences — seeing as the individual is inseparable from its social and linguistic context — but to open up a discussion surrounding the possible similarities and differences emerging in the discourses. A structural logic will be explored in this manner throughout this chapter, where for instance, using the same signifiers or concepts surrounding two different events points to a link between the two and a certain logic. It is to be noted, however, that since the participants do not go into many details about these events, particularly the earlier events — and some less than others — there could potentially be a myriad of (unconscious) associations present here, while I am only focusing, and only capable of focusing, on a few.

In what follows, I firstly compare the structure of the participants' discourses as outlined so far in the thesis, in relation to the theoretically complex neurosis/psychosis distinction. Thereafter, I explore in-depth two of the participants' discourses in a case-study approach — Tom's and Gail's — as a way of uncovering more details relating to their structure. I have included only two of the participants, and I have left out a comparison to perversion, due to the limited scope of this research, and because that the latter was deemed less relevant.

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manner of marking something as traits (for example a hysteric/neurotic logic with perverse traits). See Dor (1998).

The Experience of Invasion in Relation to Psychosis

A structure common to many of the participants' discourses around the onset events is the invasion of something coming from the outside to the inside. This was observed in chapter two where the invasion most often took the form of a demand, which was related to a number of various events. The interviews, in this way, appear to reverberate something of the paranoiac position, with regard to the invasive nature of the Other. The Other is experienced for the paranoiac subject as a threatening agent out to get him/her, and more specifically, aiming for an element/essence in the subject's being (Vanheule, 2014: 139). Amy, for instance, mentions how she was "forced" (B/L104) to have a vaccination at work in order to protect chemotherapy patients, about which she was "bitter" (A/L24-25). She could potentially refer to an experience of the Other wanting something from her, or rather, infecting her. Close to this experience could be said to be Lucy's and Gail's operations, who both mention they reacted to the anaesthetics given; it being potentially viewed as something external and harmful which was imposed on them. This is clearer in Lucy's discourse, wherein it is stated that the anaesthetics should not have been given to her, and that it went down her throat and caused an infection — leading to the presence of a foreign element in her body that "they left [something] behind" (L/292). Further, Tom experiences noise as an imposition of an externality and explains how he is oversensitive to it, as relayed in chapter three, which is related to the imposition of his neighbours' constant partying noise. In relation to describing this oversensitivity, Tom explains his fatigue as "somebody sticking a big syringe in your brain and s-sucking all the serotonin out". This clearly points to the invasiveness of the Other, where the Other wants his serotonin (however, here not only wanting it, but taking it). Mark describes something similar to this insofar as he conveys that the lack of energy, based on an analogy where someone is eating his biscuits, is the result of others stealing it: "they're reaching in aggressively and *stealing* your stuff" (B/L57-58). As has been seen in this thesis, energy, with which serotonin is associated, is considered something at the core of one's being, as life itself. These intrusions outlined are also experienced as enigmatic and puzzling, and further something which blur the boundary between self and Other, subject and Other, which is also in line with the structure of psychosis. For example, this is observed when Tom cannot interpret the noise, as it is connected to demands, and Lucy cannot understand why they would give her anaesthetics. Additionally, it was argued in the previous chapter how a usually earlier encounter with loss

(in mourning) is linked with the loss of one's identity, an identity which turns into an enigma. However, being met with the enigma of the Other's desire and thus with the enigma of one's own position is something all subjects go through, but it is experienced in different ways depending on the structure of the subject. It is thus helpful to outline this process in detail.

The process of socialisation and identity formation is one of separation where the child redirects his/her desire exclusively from the mother to something/someone outside of the family relations (McGowan, 2004: 12). The child encounters the mOther's enigmatic desire when s/he gets an inkling that there is a beyond of the mother-child unity through the comings and goings of the mother. These absences put into question what the child means for the mother in relation to her desire, and are accompanied by a sense of passivity and helplessness and the experience of the mother being omnipotent as long as s/he cannot figure out what motivates her absences (Vanheule, 2014: 59). A first solution attempted at in order to protect against this incomprehensible question is putting oneself in the place of the imaginary phallus for the mother: to imagine that it is the child she desires and keeps returning to. This cannot be maintained as the child notices that the mother desires something beyond the child, realising that the mother is a desiring being and thus a lacking being and is incomplete, followed by the logical realisation that so is the child. The Name-of-the-Father, or the 'No!' of the father since *nom* (name) in French is a homophony of 'no', constitutes a third point in the breaking of the mother-child unity. It comes to replace the mother's desire, by naming what she wants, and acts as a prohibition to exclusive access to the mother (and the child for the mother). This concedes the installation of culture and norms (Vanheule, 2014: 60). The Name-of-the-Father is a symbolic function, meaning it can be projected onto anyone and thus can be divorced from the physical father. The limitation imposed by the function constitutes a second signifier retrospectively signifying the loss of the mother-child unity (Fink, 1995: 56-57). It is thus arguably not so important *what* the mother desires, but *that* she desires beyond the child, installing loss and a search for that which remedies loss on the side of the Other (as a societal reference point). This metaphorical process of naming the mother's desire through the paternal function makes the mother's desire less enigmatic, a process whereby the subject adopts norms and thus a way of relating to others (Vanheule, 2014: 60). It offers distance from the mother's desire and a capability to self-reflect. In other words, the Oedipus complex/installation of the Name-of-the-Father constitutes a triangular logic necessary for meaning-making by introducing a third point acting as reference in

relation to which the subject can make sense of his/her own identity. This can be thought of in a simple way: the direction of left and right in a room only makes sense from the perspective of a third point therein (Verhaeghe, 2004: 194).

For the psychotic, however, the third term which would make possible an answer and install law and a meaningful and safe co-existence with others is foreclosed, consequently leaving the subject with no orientation in terms of formulating his/her existence (Leader, 2012: 40). This means that lack has not been registered, which it has for the other two possible 'outcomes', neurosis and perversion, where the Name-of-the-Father has installed cultural norms. While lack has a place in the two latter — it has been inscribed — it is not fully accepted (Van Haute, 2002: 232); thus, neurosis and perversion can be said to constitute different levels of refusing lack. For the pervert, lack is recognised to exist for his father and others, and has been registered for himself and his mother, though it is denied for the latter two (Verhaeghe, 2004: 411). Hence the illusion of unity with the mOther operates strongly therein as the pervert comes to adopt the position of the object of the mOther's desire (Van Haute, 2002: 234-235). In neurosis, lack is recognised for everyone, the Other of the Other does not exist, but pathology presents itself through a repression of lack, more precisely, by believing in the existence of a non-lacking Other. These defences against lack can be thought of three different ways of relating to, and ultimately refusing, lack: foreclosure (psychosis), denial (perversion) and repression (neurosis).

The adoption of the Name-of-the-Father is typically considered an all-or-nothing process within the Lacanian field, where it is either present in perversion or neurosis, or foreclosed in psychosis. That is, one is either psychotic or neurotic, as the comparison usually goes; constituting a qualitative as opposed to quantitative difference. Vanheule (2014: 164) problematises this categorical distinction by arguing that Lacan in his later work came to view the limit between the clinical structures as fluid as opposed to dichotomous. He emphasises instead the singular and complex way in which the subject deals with the three psychic realms — the imaginary, symbolic and the real — through what Lacan terms a knot, or a *sinthome*. In this way, a neurotic knot reflecting a type of psychic structure — a specific way of relating to language, authority and others — cannot (easily or always, and at least theoretically, as Vanheule claims) be differentiated from a psychotic knot. Van Haute (2012: 234, 236) also moves away from the considered all-or-nothing theory surrounding neurosis and psychosis and argues instead that there are different logical 'moments' or tendencies.

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These tendencies can be, and sometimes needs to be, present simultaneously, although they will have different weights for a subject, with various conflicts between them. Hence the three structures — and it can be questioned whether there are three or more — could be viewed as a continuum, with separation constituting an increasing factor. I will in what follows try to operate from this assumption when exploring the structures of the participants' discourses.

Returning to how the interview discourses potentially resemble a psychotic logic, we can compare the 'too muchness' of a situation with the experience of psychosis whereby the Other comes across as a threatening agent wanting to steal something from the subject. Lacan follows Freud when conceptualising psychosis not just as something rejected, but 'unthinkable' (Leader, 2012: 40), due to the Name-of-the-Father, and consequently norms and the means of meaning-making, not having been installed. This results in loss, *object a*, not having been extracted from the body and situated in the Other; the reason for which Lacan states that the psychotic has *object a* in his pocket (Vanheule, 2014: 137). The lack of separation/extraction from *object a* turns it into a 'strange internal element', with two structural relations possible in relation to this non-extracted object: paranoia and schizophrenia (Vanheule, 2014: 138). In schizophrenia, there is no relation between *object a* and the Other, instead there is a 'senseless ravaging force' and one which 'overwhelms the subject from within' (Ibid.: 140). Language becomes mad and chaotic (Lacan, 1973 as cited in Vanheule, 2014: 142) as there is no way of organising one's reality. In paranoia on the other hand, a surplus is situated in the Other and on the outside (Leader, 2012: 87), while the *object a* is on the side of the subject. This results in experiences of intrusions which are puzzling and shocking (Vanheule, 2014: 139), experiencing the Other as a threatening agent and out to get him/her. The participants' discourses as outlined above thus seem to echo such a structure, particularly that related to paranoia, and primarily in relation to the onset events, where a demand is experienced as an intrusive, external and incomprehensible otherness which is too much.

Relatedly, integral to the paranoid position is the passivity of the subject, 'as an innocent victim of a *jouissance*-driven Other' (Ibid.: 140). There might be a sense in which the operations for Lucy and Gail consist of them being put in a position of a helpless victim, since the anaesthetics put them to sleep where they literally become passive objects for the Other (to operate on). Gail alludes to a sense of helplessness after one of her operations, when

she is in disbelief that the Other would not give her water or food: "and it was after that operation when I just had to lie there and cry out and say I can't do a thing for myself" (C/L429-430). Something similar could be suggested in Tom's situation, as he portrays himself as a "prisoner" (A/L72) of his neighbours' partying noise. His symptoms also come to mimic those of his patients, suggesting there could be an identification with the passivity immanent to patients in the cardiac surgery whom are put to sleep and operated on. He explains the process of the surgery as "you gotta re-open the chest and suck them out and the pressures go really down" (A/277-278) — akin to the way in which he describes the serotonin being "sucked" out of him when explaining the loss of energy ("pressure"?) involved in fatigue[45]. Additionally and analogously, that life was "drain[ed]" from him, and that he describes these events in the cardiac surgery as "draining" (282-283), suggests a link between fatigue and the passive positions of his patients. However, at this place, and the other just-mentioned accounts, there are no references to anOther who enjoys the subject being in the place of a victim, which is what *jouissance* refers to in the statement a '*jouissance*-driven Other'. It could, however, be present for Tom's situation insofar as his neighbours' noise stems from them partying, thus implying them enjoying themselves. We also notice references to an enjoying Other in Tom's discourse, as well as in Mark's.

The manifestation of the Other's threatening *jouissance* aiming for an element in one's being manifests for the psychotic as 'a commanding voice that intrudes with jouissance-laden comments' (Vanheule, 2014: 139). In Tom's discourse, this aspect can be traced implicitly when he explains how he gets shouted instructions at work from "people getting all excited and shouting and pooff" (A/L617). We get the sense that those shouting instructions 'get off' from it. This would compromise a similarity to psychosis in that the Other, as someone out to get you, is experienced to be driven by a 'mad pleasure' (Vanheule, 2014: 139). An account of this could be traced most explicitly in Mark's discourse, who was "the victim of domestic abuse" (A/L245-246) during the time of the onset.

Mark's discourse hints at his ex-partner enjoying others suffering when he explains how she used to steal from others and blame someone innocent for it:

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[45] Here, however, since we are talking about a loss of energy (that the Other is not just wanting something but steals it, leading to the subject experiencing a loss), we are already marking a difference between psychosis and neurosis, which will be discussed more further down. Indeed, in the previous chapter, the experience of the Other stealing from the subject was linked to imaginary castration (present in neurosis).

And she gets this… this delight, it gives her *delight* to have control over the situation. To the extent that this other innocent person is now being blamed for something they didn't do. It - she - she loves the manipulation game. She thrives on it (B/L412-414).

There is a clear sense here of being in the position of a victim, and further that the person takes "delight" in victimising the other. Even though he is talking about someone else here, we could speculate it is also applicable to himself, insofar as he goes straight from here to talk about the ways in which his partner deceived him. If this is the case, then repression is at work, thereby entering a neurotic logic with the process of displacement (that what is relevant for someone else is relevant for himself, considering there is no repression in psychosis). In psychosis, there are no formations of the unconscious where symptoms are decipherable in this manner. An echo of the situation with Mark's ex can be found to occur at work, when his employer would not honour the GP's fit note:

I can't - yeah - I'm getting worse, and I need to change my hours and why are you as an employer, why are you obstructing me? Are you trying to make me quit? Are you trying to damage my health? (A/L181-183).

There is an experience of his employer as intentionally attempting to harm him, pointing to this position of a victim whereby the Other is out to get him. However, formulating it as a question ("Are you trying to damage my health?") highlights a crucial difference to a psychotic logic, and a similarity to a neurotic logic. Psychosis is hallmarked by certainty and neurosis by doubt (Fink, 1999), in the way in which existential elements are approached, which is oftentimes considered the most important distinction between the two. The neurotic poses the question through a symptom 'What am I for you?', while the psychotic *knows* what he is, in the form of an 'imposition of a solution' (Leader, 2012: 37-38). Leader gives the example of someone who is convinced of being evil and pregnant, where signs in the external world are read as being addressed directly to her sexuality: 'the sexual content of the thoughts is not repressed but rather attributed to others' (Ibid.: 39). There is something absolute in psychosis, in other words. This is not to say that the psychotic does not doubt, that doubt in itself should be read as a 'guarantee' of a psychotic logic. Instead, doubt, uncertainty, can

very much be found in psychosis, but pertaining to the *content* of a message as it is experienced as enigmatic, while the person is certain *that* there is a message addressed to them (Rogers, 2018: 13). In neurosis, one would doubt whether or not someone is out to get them, whether one is directly addressed, since the position of being a victim is not self-evident. We notice this in Mark's discourse in the excerpt just mentioned: the structure of a question implies it is not certain whether his employer, and potentially his ex-partner if they are linked, is trying to intentionally hurt him. Accordingly, there could be an unconscious identification in place for Tom with his patients, where the aspect of being passive is relayed in a roundabout manner.

In line with this, the invasion of the Other is put forth as a metaphor in the discourses. For example, Tom's description of fatigue ("it's like somebody sticking a big syringe in your brain and s-sucking all the serotonin out") is indicative of a metaphor insofar as he says "it's like". Mark likewise explains his condition using analogies, one of which was mentioned above, describing how others are unknowingly eating his biscuits, saying: "it's like they're reaching in aggressively and *stealing* your stuff" (B/L57-58). That others are *unknowingly* eating his biscuits, in combination with the situation at work, could again point to an element of insecurity with regards to whether or not someone is intentionally hurting him. This would differ from a psychotic logic, where the Other is seeking something concrete of the subject (Vanheule, 2014: 139), seeing as psychotics are unable to forge new metaphors (Fink, 1999: 90)[46]. Considering also that for the paranoiac subject, the Other is thought to have put something in the body/mind of oneself (Vanheule, 2014: 139), again on a concrete level. It differs significantly from the participants' interviews in the fact that the invasiveness pertains to the Other stealing energy, leading to the experience of loss which stands at the centre, which is absent in psychosis due to *object a* not having been extracted from the body. This aspect is of course blurred in cases where a physical intervention has taken place, such as for Amy (vaccination) and Lucy and Gail (operations), where they indeed received something physical, and the Other has literally 'taken' a body part. However, there is still a difference here to a psychotic logic insofar as it is considered that a *part* of them has been stolen/lost, and not the whole of them, and consequently that they entail the experience of loss. Tom lost

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[46] Another difference between the two is that the paranoid subject names the Other's desire in a non-conventional way — it has to be invented — for example, the CIA, FBI, or aliens are after the subject (Vanheule, 2014: 85), whereas this aspect is missing in the interviews.

something enjoyable "serotonin", Gail lost her "stomach" and Lucy lost "bits of me". This brings us to a discussion of the limits of identifications and identities.

The Limit of 'Too Much' in Relation to Psychosis

The identifications explored so far for the participants in this thesis, including the identification with passivity and the experience of disappearing behind the Other, come across as partial in nature in their discourses. The identifications related to this is that of 'nothing' subsumed under the desire to sleep, which can be conceptualised as an identification with loss. In this way, it comes close to that of melancholia as part of psychosis, where the subject merges with the lost object. However, for the melancholic subject, the identification is all-compassing, meaning that the self is completely equated with the lost object. Due to the absoluteness inherent in psychosis as discussed above, where instead of uncertainty there is certainty of being in a particular position, exclusive self-reproach is usually present for the melancholic, as well as, sometimes, a literal incarnation of the dead one through suicide (Leader, 2009: 169, 172). In the interviews and in relation to culpability, in contrast, we could trace the outline of implicit questions of responsibility, 'Am I to blame'? — which could hypothetically underpin Mark's question to his employer "Are you trying to damage my health"?. This will be explored more further on in relation to others' accounts. Nevertheless, a partial identification with the dead would explain the ambivalence and struggle between life and death, not just the equation with death, and between taking responsibility and an exoneration of it through a medical diagnosis. In fact, we have noticed how responsibility oscillates between these two poles, between too much and not enough, which could comprise the very questioning of responsibility, of a limit. This suggests that the limit is there between the subject and the Other. In agreement with this, there appears to be a limit in place for the participants when confronting an enigma.

When the psychotic is confronted with the enigmatic desire of the Other, there is a problematic encounter with the 'hole' in the symbolic: the imaginary and the symbolic do not work together but instead there is a confrontation with the real, an inability to signify, where words make no sense and there is no possibility of articulating anything regarding his/her identity. There is instead tension and enigma. What is experienced is an incomprehensible imposition coming from the outside, since there is nothing there (Rogers,

2018: 37-38). An element of this could be tracked in the participants' discourses insofar as they describe experiencing something shocking after the invasive imposition of the Other, where language becomes incomprehensible as they no longer understand what others are saying to them, and unable to form responses; constituting an encounter with the real. Of course, this confrontation with the real, the Other's unsymbolised and enigmatic desire, is not only particular to the psychotic but is something met by all subjects. But we could argue that there are different degrees of a lack of symbolisation as represented by the three clinical structures. The structure of the participants' discourses seems to lack the aspect of absoluteness inherent in psychosis, meaning that the experience of being taken over by the Other, or an otherness, is not the full story or a 'complete' takeover. In psychosis, due to the foreclosure of meaning and the fact that nothing is there, the enigma is disintegrative at a wide level, to the extent that, as Rogers (2018: 9) points out, one is unable to differentiate between one's own thoughts and that of others'. What is often noticeable for psychotics when recounting their experiences is the strange, confusing and threatening nature acquired not just by a bodily/mental sensation, but by the external world around them. This to the point where thoughts or messages perceived to stem from a wall, for instance, are impossible to be distinguished from that of one's own[47]. For all the participants, the disintegration does not seem to entirely extend past a limit between the subject and the Other, between the internal and the external world. Even when residing within a psychotic schizophrenic logic, wherein the enigma does not stem from the outside as in paranoia, but from within one's own body, there is still a difficulty of recognising that one's own body belongs to oneself. In contrast to the participants' accounts, enigmatic forces are experienced to stem from *their* bodies, held together by an ambiguous limit, but a limit nevertheless.

For instance, in relation to Tom's inability to stand noise and understand what others are saying, he says "I'm just so sensitive" and that "he was never like that", which implies an attribution of these 'symptoms' of incomprehensibility to his own self. Important here is that there is a self, even though that self is difficult to describe, as he says: "That's a [small laugh] - not a very good way of explaining it but that's how I feel". A similar discourse can be traced for the other participants, in line with the conceptualisation of a neurotic logic where the division of the subject is experienced as internal, whereas fragments in psychosis are experienced as external (Vanheule, 2014: 44, 138). An easy example of the former is that

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[47] See Annie Rogers' (2018) for a highly accessible discussion on psychosis and some accounts therefrom.

the incomprehensible dreams neurotics have, containing one's unconscious elements, are viewed and experienced by neurotics as ultimately stemming from themselves, produced by themselves, despite their foreign nature. More accurately, this showcases the structure of the unconscious as an internal externality. We notice something akin to this in Mark's discourse when describing his bodily tremors:

> I had lost - I had completely lost control of every limb. And when one considers oneself as an entity, as a mind and a body and your - your mind can control your body, it's absolutely horrifically terrifying to no longer be able to control your own body. Especially if it's still attached, you know I'd understand not being able to control an arm that had been amputated, but to have the arm there, to be able to see it. And for that arm to be moving under instructions which I haven't consciously given is very very scary (A/86-92).

Mark puts down the trembling body as something "no longer able to control", which is "horrifically terrifying". The terrifying aspect could refer both to a lack of control and the fact that this uncontrollable mess is "still attached". That is, his body is not his, in a way, since it eludes "instructions" related to consciousness. At the same time, the body belongs to him since it is "your own body", one which he can furthermore "see". It is therefore something simultaneously on the outside and inside, both belonging and not belonging to oneself. It is as if he sees his own disappearance, that the body has a life on its own: a presence of an absence he is unable to comprehend, yet attached to him. This attachment suggests that a limit is there insofar as the lack of control does not appear to spill over (entirely) to the external world, even though this barrier to an external world is ambiguous.

Such a relation to the body is in line with how Miller (2015: 156) differentiates between a neurotic and psychotic logic: in neurosis it is 'the body that has its own ways', whereas in psychosis there is 'a gap where the body is un-wedged, where the subject needs some tricks to re-appropriate his own body'. That is, the psychotic interprets a foreignness as either stemming from others or from nowhere: the body never really belongs to him/herself due to a lack of establishment of the mirror image whereby one acquires a sense of 'having' a body. A commonly cited example of how a psychotic relates to his/her body, a sense of not having a body, is taken from an episode in James Joyce's book 'A Portrait of the Artist as

Young Man', since Lacan refers to it as a way of illustrating the missing register of the imaginary. Therein, Joyce describes Stephen, the protagonist, being beaten by friends with no subsequent feelings aroused by it; there are no subjective bearings. Lacan interprets it as a form of disconnection from the body and likewise from feelings of anger, since Joyce writes they can vanish 'as easily as fruit is divested of its soft ripe peel' (Vanheule, 2014: 168). This is in line with Vanheule's (Ibid.: 142) interpretation of the psychotic's relation to the body in schizophrenia, where holes are created in the body in the sense that parts of it disappear into nothingness, by an 'unmotivated force'. It differs from Mark's and the participants' experiences of the bodies, who witness their bodies disappearing, and experience the horror involved in realising that their bodies, or a part of their bodies, do not belong to themselves; while they should and do to a certain extent belong to themselves. This could merely convey the mind-body divide in that their bodies are physically theirs, but not mentally. Ultimately, the division is thought to stem from themselves. Something similar in terms of an inside becoming an outside could be traced for Gail when she says that after her first operation: "Everything became exterior to my internal self. It was like I was out there watching *me*. It - it was very scary" (A/L312-313). These experiences seem to echo the structure of the mirror stage as part of alienation, which was outlined previously: the inmost part of oneself resides on the outside (an inclusion of an exclusion, a presence of an absence). It resembles more specifically the structure of imaginary alienation as made possibly by separation, which has not taken place in psychosis. It implies that the ego has been established and that it is the contrast between the ego and that which stands outside of it, *object a*, which gives rise to the uncanny experience.

A difficulty which presents itself in recognising this above-mentioned aspect is that the defensive moment of the subject as a refusal of the Other — the desire to sleep whereby there is an identification with dead, zombie-like objects — shares similarities with aspects of the real and with, as I said, the psychotic structure of melancholia. Further, the inhibitions elaborated in relation to this, particularly pertaining to the understanding of and usage of language, can come close to the psychotic's inability to signify. Therefore, if the defence is strong, it may be difficult to recognise the refusal as both wanting to be part of and refusing the symbolic order — an ambivalence which would be absent in psychosis since that would imply a limit between the subject and Other. Nevertheless, wanting to be part of the symbolic order is clear in the participants' appeals to the Other, which follows a neurotic logic in that

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object a is experienced to reside on the side of the Other (Vanheule, 2014: 139). *Object a* here is that which is able to imaginarily rectify loss and provide an answer for an enigma, the presence of which implies that the neurotic believes and aims to re-claim that which was lost through turning to the Other (Vanheule, 2014: 134) — believing in the 'subject supposed to know'. Furthermore, as opposed to psychosis, the identification with loss appears more protective due to the imaginary coating of the real (positivisation of loss). The difference could pertain to an inhibition, as found in the interviews, being more in line with 'not wanting to' (neurosis), as opposed to 'not being able to' (psychosis) recognise lack, with the latter being present in neurosis but not to the same degree and in the form of a failure of symbolisation as opposed to inability.

I argue that it is a difficulty of telling these two apart, due to a strong presence of the inhibition/defence of the subject, which could have contributed to the rise in theories where modern symptoms are conceptualised as states resembling, or linked to, psychosis. The most popular theory based on the structure of psychosis is Miller's (2009) coinage and concept of 'ordinary psychosis', which some theorists and clinicians have used as a way of understanding chronic fatigue and pain. This concept can easily be misunderstood to refer to a borderline category, residing somewhere in between a neurotic and psychotic logic. However, Miller (2009: 96) relates it to psychosis, while stating that it gives off the appearance of a borderline condition: 'some cases would *look like* they were between the two' (Ibid.: 95, my emphasis). Ordinary psychosis is what he calls a veiled psychosis, which can also be conceptualised as a mild psychosis, where the extreme disturbances usually associated and related to psychosis, such as dissociations and hallucinations, are absent. Those utilising Miller's theory in conceptualising fatigue and pain along these lines — for example Steven's (2009) and Barretto & Besset (2016) — tend to, alongside Miller himself, be reductive in what aspects are focused on, and to separate functions and categorise based on their mere presence — which does not stray far from the biomedical way of diagnosing. As not enough details are brought into their argument, it makes an application of them questionable. For instance, Barretto & Besset (2016) argue that chronic pain in 'the majority of cases', following other Spanish-speaking authors, does not align itself with the picture of hysteria and conversion symptom (where symptoms are symbolic formations of the unconscious), but with that of ordinary psychosis. More specifically, the symptom comes to act as a *sinthome*. To briefly explain this concept, Lacan coined the term *sinthome* — an old

spelling of the word symptom — to indicate a symptom with the same functions as that of the Name-of-the-Father, functions related to 'castration, social identification and naming' (Redmond, 2014: 120). A *sinthome* offers a supplementary function which links *jouissance* (as a force disrupting limits) to a signifier, which brings stabilisation and a sense of identity in the form of a social bond. It is the subject who singularly invents a *sinthome*, meaning it is self-made and does not depend on the Other's conventional ideas. The prime example here is considered to be that of James Joyce through his identification with being an artist (Redmond, 2014: 121-122), and through his singular, non-conventional work. The *sinthome* offers a way of knotting together the orders of the symbolic, real, and imaginary, through the use of a 'signifier in the real'. Body phenomena are thought to belong to a signifier in the real, where, instead of consisting of an eruption in an encounter with the hole in the symbolic, they offer stabilisation and a way of naming one's experiences. According to Barreto & Besset (2016: 192), pain is used in order to 'construct a body and to name a *jouissance* that lies outside meaning', following the imperative to delineate one's identity. This differs from the neurotic subject where pain acts as a denial of the possession of a body. Moreover, Barreto & Besset follow Gaspard (2012, as cited in Barreto & Besset, 2016) in associating hysteria with the function of a refusal, which they dissociate from the majority of pain as a 'body phenomenon' (Ibid.: 192), conceptualising pain here instead as a type of surviving strategy instead. This appears to echo Miller's theory (2009: 105) which links a rebellious nature with hysteria.

Barreto & Besset's conceptualisation of ordinary psychosis in this manner appears to be making too much of a separation between the functions of using the body for identity formation and a refusal, and also between signalling the aliveness of the body and denying it. This research has illustrated how, first of all, using the body to demarcate one's identity, the body in its real aspect, using it for the function of separation akin to the *sinthome*, is foundational and the first step to any symptom[48]. It has further been illustrated how the process of naming the body can be tied to a refusal — a refusal which, in the light of Lacan's work, can be conceptualised as the minimal sign of subjectivity. Indeed, as mentioned in this chapter, the three various ways of defending against lack (psychosis, neurosis, and perversion) can be viewed as three various ways of refusing lack. A refusal is perfectly

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[48] The act of self-naming the body could be relevant here as in line with the function of the sinthome, seeing as the patients are active in 'promoting' a type of diagnosing; however it is done through the conventional biomedical framework.

capable of being executed by the psychotic subject (see Leader, 2016: 29 and Rogers, 2018), but it will be enacted for primarily different reasons than those inherent in neurosis or perversion (this will be discussed below). Further, the subject can both use the real body as a way of marking the boundaries of the body, while simultaneously denying the body — this we witnessed present between the 'initial' refusal and the defensive desire to sleep. Due to not acknowledging this — and not engaging more in-depth in the neurosis/psychosis distinction — it makes the separation between ordinary psychosis and conversion symptoms, and ultimately the former's existence in relation to modern symptoms such as fatigue and pain, unconvincing.

However, bodily symptoms which are not symbolically structured — an element crucial to the theory of ordinary psychosis — has also been theorised as a possibility within the structure of neurosis. The main influence here stems from Freud's theory of the actual neurosis, which, as was mentioned previously, Verhaeghe's takes as his basis when theorising his concept of actualpathology[49]. He argues that actualpathology is a possibility within any of the three structures, neurosis, perversion or psychosis; that it constitutes a position *within* these structures, where the latter shapes the former (Verhaeghe, 2004: 307). That is, actualpathology and psychopathology are two various positions, each containing further 'subcategories' or structures which have achieved various degrees of separation. Actualpathology constitutes the least amount of separation, with which he links chronic fatigue, while psychopathology has achieved the most degree of separation (Ibid.: 285). There are also varying separations within the structures, for example in neurosis, obsessional neurosis is viewed to contain more separation than that of hysteria (Ibid.: 383). Verhaeghe thus puts forth a new theory within the field of Lacanian psychoanalysis: a position somewhat resembling psychosis can take place in neurosis. This appears untenable both in the light of Lacan's theory and the analysis of this research. The analysis just above illustrated how, even when confronting an enigma, *object a* as the void emerges in relation to one's mirror image which is symbolically structured; that the ego as that which establishes inside-outside barriers is still in place, although more ambiguously — mirroring the structure of imaginary alienation which Verhaeghe argues is absent for actualpathology. We can see this in Lacan's formula of the ideal ego, i(a), where *object a* is excluded from the mirror image, but when

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[49] The category of actual neurosis has also been suggested to constitute a fourth independent structure, in relation to the three existing Lacanian structures, by Rik Loose (2003) in his discussion of addiction.

the brackets are suspended, as discussed in relation to mourning, *object a* becomes included *within* the mirror image. The same can be said for the fundamental fantasy, which Verhaeghe also claims is completely absent in actualpathology and in fatigue, since it was argued how for the participants' of this study, the unbearable void appears in relation to the fundamental fantasy. It is in accordance with Lacanian theory that once the ego, alongside the fundamental fantasy, have been established — which they have in neurosis — they cannot then completely disintegrate. If a subject is already operating within a symbolic realm, with the installation of norms and culture through the Name-of-the-Father, is it then possible that bodily symptoms can appear without much or any reference to a symbolic-imaginary elaboration? I argue that it is unconvincing and unlikely. Even a largely biological occurrence would be given a meaning in a person's life, creating or reinforcing or altering an unconscious logic. One could even argue that this is the prison of the neurotic, s/he being someone who cannot help but to put meaning onto everything. Here is then another indication that the aforementioned contemporary theories could be confusing the appearance of a symptom with the defensive part; the defence of the subject which consists of a refusal of the symbolic order, giving the façade that the imaginary and the symbolic do not operate therein. Indeed, I will in what follows continue to explore the ways in which the formation of fatigue as seen in this research is symbolically structured.

Tom: Failing to Complete his Lack

Exploring the discourses around the onset of the participants' conditions, it is noticeable that they are confronted not only with the Other's puzzling desire, but also with experiences of disappointment, frustrations, and anger. The presence of these implies that the Other here is not always enigmatic, but indifferent, which arguably relates to experiences of loss as well as questions surrounding responsibility. This will now be explored by honing in on the structures of Tom's and Gail's discourses, chosen for the purpose of illustrating both similar and different aspects. For each, I will focus on the link between the triggering events and an earlier episode in which they experienced loss. I will firstly explore the logic of the two discourses respectively, and thereafter bring them both together in relation to relevant theory.

Starting with Tom, following the logic of his discourse, we notice a structural link between the event he associates with causing the onset of his condition, and certain episodes

occurring both immediately prior to the onset and in the distant past. Beginning with the former, it is the constant partying noise from his neighbours, from which "there was no fucking escape" (B/L463), which Tom relates leading to his "crash and burn" (B/L471), the initiation of his condition. As was argued in this thesis, noise for Tom could relate to his work, where "people [are] shouting commands, you know swearing "Where the fuck's this? I need that" (A/L617-618), explained by Tom as being frustratingly "too much". Noise is also associated with listening to conversations in a public space, "listening to others' things" (A/L293), which in turn is associated to the draining of the serotonin out of him since he mentions one after the other. All of this could potentially relate to an indifference of the Other pertaining to the subject's needs/wishes, insofar as they are centred on the Other's need ("I need that" as he explain what others are shouting, and that it is "other's things" he listens to). However, what is also of significance around the event of the neighbours' noise for Tom is the inescapability from asking others for help, or in other words, dependency. In the second interview he explains how his neighbours' noise led him to having to phone the police and ask for help, something he found "uncomfortable" (B/L471), "stressful", and "going against the grain" (B/475-476):

Well phoning the police when somebody's having a party, don't do. You just go down and deal with it yourself. Through whatever measures you need to m - to - to use to get your need met (B/L441-443).

This event seems to be linked with a potential failure of meeting his own needs, a failure of being independent, and inversely, a 'fear' of dependency on others insofar as Tom is of the belief that one should not need to ask for help. There could potentially be shame here associated with lack. If one is not lacking, one does not desire, and thus to want/to lack is shameful. Tom further indicates that to not lack ("to get your need met") — to be complete — is a responsibility on his part ("you go down and deal with it yourself"). Thus, this paragraph points to a failure of having completed his "need", through not dealing with his neighbours' party, and that as a consequence, an appeal to others/the Other (embodied by the police), is "uncomfortable" and "stressful", possibly feared. This could be related to an event occurring around the onset, potentially before, but the timeline is unclear. When I asked Tom what went on generally in his life around the onset, he replies: "I went through a relationship

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split which was of - of my own doing, because I was in a - a relationship that wasn't working for *me* (B/L473-474)". This is all he says about the separation, but it does suggest a link to having had to phone the police insofar he was meeting his own need here by splitting up with his partner (it "wasn't working for *me*"). The logic, for both events, circulates around meeting/not meeting his needs or wishes (in lay parlance these are interchangeable). Indeed, his condition on a whole is expressed as a relief of having more time for himself: "I never really had time for *me*. And this has certainly given me the opportunity to reflect and say well you know, eh" (A/L224-225). However, we discern around the neighbours' noise a failure of meeting his own wishes, or completed his lack, and a difficulty in asking others to satisfy it, which suggests this could be the place of an enigma or contradiction with which he struggles: trying to meet his own need while finding this problematic/not wanting to. The reason for the latter could be due to the details surrounding his mother's death, insofar as the discourse also circulates around his need/wish, albeit with grave consequences:

> … she died in front of us so there was a lot of guilt, I had said to her 'I hope you die' then - the - a - two hours before she did she had been in hospital, 'cus I didn't get my own way with something for a change, 'I hope you die' and then two hours later she did. So I think I carried a lot of shame and guilt regarding…the last words I ever spoke to my mother was 'I hope - wish you had fucking died' (B/L117-122).

That "I didn't get *my own* way with something for a change" is related by the same signifiers surrounding the separation from his partner: it was "of *my own* doing". Further, to "not get what I wanted" constitutes an unmet wish reminiscent perhaps of one related to the neighbours' noise. That he threw "abuse" at his mother for this failure implies there was an expectation for his mother to take care of his wish, that he may have appealed to her for help, but was left disappointed or angry that this did not occur. In this way, to ask others to meet his needs or demands could be reminiscent of his mother's death — a death for which he took responsibility since "there was a lot of guilt". We see clearer his sense of responsibility in her death when he says: "I've kept - a-almost thought I was powerful as well because if you say that and then two hours later that happens, you begin to think….my god. Maybe. But I don't know" (B/L126-128). It appears as if he is unsure ("I don't know") whether it was his

words or not causing her death, since this structurally comes after wondering if he is "powerful". The insecurity could imply he is unsure if/how much he is responsible for his mother's death, subsequently suggesting that responsibility has not been processed. Accordingly, observed in his discourse is a fluctuation between being responsible and being free of it, between a 'too much' and a 'not enough', the latter of which is evident when he explains the outcome of his twelve-step program:

> I always thought you know you didn't talk about this stuff, eh you didn't… [deep breath in] blame [deep breath out] eh parents or parent or whatever, brother. Family. Eh…about how you were. You only took drugs 'cus you took drugs (B/L104-106).

That he "blame[d]" his family — or as he says elsewhere, that other people also had a "dysfunctional family" and that it was "not just me" — follows the bio-psychology discourse wherein circumstances such as family become external elements from which one is separated [50]. On the other hand, the twelve-step programme involves "taking personal *inventory, on myself*" (B/L44), and in relation to explaining he was "resentful" at his mother (and "god") "for dying", he says: "so it's a bit looking and seeing my part in it" (B/L142). This oscillation between himself and his family, something seen in the other interviews as well, besides pointing to a potential unprocessed responsibility, suggests, like I argued before, that the limit is there between himself and others — in line with a neurotic logic — since it points to a questioning of the limit. For as Leader recognises, the neurotic asks him or herself 'Am I to blame?', while the melancholic in psychosis is certain, 'I am to blame' (Leader, 2012: 91). Therefore, the structure around Tom's discourse arguably circulates around meeting a need/wish of his, with a potential implicit question present regarding responsibility. By identifying with the patients going into "cardiac arrest" who are passively operated on, Tom could speculatively ask the question of 'Am I to blame?' through the body. It could further be a way for him to unconsciously appeal for help — by putting himself in a

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[50] This type of psy-discourse can be problematic for the subject who takes responsibility, feels responsible on some level, because it asks not to process responsibility but to ignore and externalise it (depicted in Black Mirror's Season 5 episode 'Smithereens', whose protagonist got angry when other people told him he was a victim, seeing as he did not feel like a victim). It can further be problematic due to the subject possessing a sense of loyalty to the family.

passive position — when he was unable to explicitly/consciously do so, since asking someone else to 'fix' his need/lack was problematic in the past.

Arguably, the symptom of fatigue could for Tom resemble that of a conversion symptom as elaborated by Freud, which I explained in-depth in the beginning of chapter four. To recapitulate, a conversion symptom is formed due to a psychical conflict, where an unbearable impulse (an affect accompanied by an idea) is repressed due to the consciousness refusing the idea; finding it incompatible with the ego's morality. The idea gets cut off from consciousness while the affect becomes transformed into a somatic tension (Freud, SE III: 49; Freud, SE XVI: 359). A conversion symptom in this way contains a symbolic message addressed to someone which can be deciphered; a formation of the unconscious in line with Lacan's axiom that the unconscious is structured like a language. For Freud, two forces are 'reconciled' in the symptom through a condensation (Freud, SE XVI: 359): the bodily symptom expresses both the unconscious idea deemed contradictory to the ego's ideals, and the refusal refusing it (Freud, SE V: 596). The selection of a symptom occurs through being able to express both of these pressures simultaneously (Freud, SE XIV: 182). For Tom, we could hypothesise that the passivity embodied by fatigue could represent an appeal to the Other to complete the subject (to get rid of his need/lack), while at the same time representing a fear of dependency and a subsequent attempt to complete his own lack by his 'own doing', through withdrawing from society/the Other. We discern how the symptom allows both a solution in the form of a focus on himself, but also the creation of more problems, and, probably and paradoxically, a stronger dependency on the Other insofar as the condition leads Tom to appeal to the medical Other (saying he never makes appointments unless necessary). There is a noticeable analogy in Gail's discourse regarding responsibility, but the accent appears to lie on *others* failing to meet her lack and her failing to meet someone else's lack.

Gail: Failing to Complete the Other's Lack

Gail links the onset of her condition with two operations having taken place, one in 2000 where she had an elective hysterectomy (A/L321), and one in 2008 where they "half re-made" her gullet in her stomach (A/L305-306)). With regards to the latter operation, she says she received "nothing" for her pain after the operation: "And they wouldn't give me anything for pain after the operation. *Nothing*. *Nothing*" (A/L350-351). Something similar takes place

after she collapsed and became hospitalised for six days, when they had to take out a stone from the gallbladder (A/L359). During that hospitalisation, she explains how "they didn't give me any food or water for six days. And they didn't give me a drip. So I was *starving* to death" (A/L323-324). Additionally, after this operation she conveys: "…and it was after that operation when I just had to lie there and cry out and say I can't do a thing for myself" (C/L429-430). Gail invokes here the notion of helplessness, akin to Tom's discourse of not being able to fulfil his own lack. However, she emphasises the Other's failure of meeting her need as opposed to it being a failure on her part: "*they* wouldn't give me anything for pain…Nothing"; "*they* didn't give me a drip", which was the reason for her starving. This marks the indifference of the Other not concerned with her need/lack, an experience possibly accompanied by disbelief and disappointment in the Other. Indeed, that she would "cry out" could amount to an appeal to the Other to remedy her lack (hunger, thirst and pain). The descriptions of these events are structurally related to the discourse surrounding her sister's death, which is the final factor she relates to the triggering of her condition, it being the "last straw" which "broke" her (A/L580).

Firstly, the way in which they relate to each other is through the idea of having "nothing" as seen in the following excerpt:

> And I believe that's got a lot to do with it. But I feel very, very guilty about my sister dying. I believe she should be alive and I should be dead. Not in a bad way, if you know what I mean, but if you look at it I mean I had everything in life, she, what did she have? Nothing (A/L572-575).

Instead of Gail receiving "nothing" from the medical Other at her operations, it is here her sister who has "nothing". Not only that, but her sister is thought to have received "nothing", and more specifically from herself (Gail), which is arguably what she relays feeling guilty about: her sister was "stuck with my parents, looking after them and things and I was out there having a life in some way" (C/L524-525). That Gail was "out there" means she had a job as an air hostess and was never around for her sister: "You know and, so I was never there. She took on all the problems and I was never there for her" (A/L566-567). We notice that she in a way blames herself for having failed her sister, having failed to complete her lack, in contradistinction to Tom where he failed to plug up his own lack. The hospitalisations

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could then depict a reversal of this situation, thus disguising the earlier event: instead of her failing someone else, the doctors are failing her. This could point to the presence of repression, where the hospitalisations could have invoked the trauma of her sister's death and questions surrounding Gail's potential role in it. It also suggests an identification in place with her sister, where Gail takes a similar position as her as having received "nothing".

Further following the logic of her discourse, the operation(s) and the details of her sister's death are linked by the same signifiers beyond that of "nothing". There is potentially another logic linking her sister's death with her hospitalisations, particularly the latest one where Gail explains how other people were prioritised, resulting in her operation being postponed:

> Because they just kept saying 'when the theatre is open, when it's open we can push you'. Twice they took me into theatre ready for the op, twice they brought me back (A/L362-364).

Something being "open" could relate to a space for her on a wider, symbolic level, with the theatre being closed potentially signifying an exclusion of her subjective place: the Other did not care (for her lack). The signifier "theatre" could relate to the circumstances around her sister's death insofar as her sister died coming out from "a movie" (theatre):

> She just dropped dead. Walking in the mall and she dropped dead. Wasn't sick, nothing. Just walked in the mall. She went to a movie and she came out. And she was just walking through the mall to come out. She dropped dead (B/L263-264).

Even though Gail does not mention the word theatre here, she saw a movie at a movie theatre[51] and thus a conceptual link is present. Additionally, the word "nothing" is present again, this time referring to the lack of (clear) signs/causes of her sister dying. Not only that, but what led to her last hospitalisation was a collapse during "walking": "I was walking past here to work, 'cus my work was just down there, [name of place removed], and I collapsed on the road" (A/L355-356) — reminiscent to the process of her sister dropping dead. More

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[51] This is the North American way of referring to the cinema, which could be relevant in Gail's case seeing as she lived there for "a long time": she says she speaks with an American "twang" (A/L208).

importantly though, she says her sister "came out" from a movie, something she repeats, thus the operating theatre being something they took her into ("they took me *into* theatre"), is something she would come out of after the operation was done. Indeed, the problem around the operation, according to Gail, which led to her fatigue, was that she never "*came out of the anaesthetics*" (A/L310-311, my emphasis).

This implies that there is, for Gail, an unconscious identification with her sister: someone who 'comes out' of a theatre and dies, who is "nothing", who is dead. This identification with "nothing", which is a repetitive one in her discourse, could further be a way of holding onto the image and presence of her sister, and as an attempt to process it. There is conversely a difference here between her and her sister, insofar as her sister "came out", while Gail did *not* come out of the anaesthetics. Gail could have considered that the formation of fatigue, being dead *in* life, constitutes an appropriate punishment for potentially being responsible for her death, or at least, for having lived her life while her sister had "nothing". She thus withholds life. The place of the pain of fatigue here is simultaneously a place of 'too much' — Gail saying the pain and exhaustion is "all consuming" (C/L30) — which would indicate that the image of her sister has not been processed, and potentially, her part (responsibility) in her sister's death. Because of this, and on the other hand, she could be attempting to separate from the image of her sister and to live her *own* life, by retreating from society into her own flat, a flat which she associates with an "independence [which is] really is good. I love that." (A/L525). After all, Gail did come out alive after the operation, and she was "out there" as she says, living her life. Another indication that she is attempting to live her own life is her reluctance to give up her studies, even though it is something knowingly contributing to her condition, due to the stress and her "pushing" herself despite becoming fatigued. She says: "I'm gonna get this degree even if it kills me" (B/L609). She never finished her honours degree in the past, and she never had the choice of studying the degree she is studying now. She relays that she is the only one, together with her dead sister, whose picture and degree certification is not up on the wall in her family's house. This would elucidate the split and ambivalence of the subject as explored in this thesis, particularly in relation to mourning; as one between life and death. With regard to responsibility, there is an ambivalence here too which points to a lack of having processed it and the attempt to do so: we see her take responsibility for her sister's life/death, but at the same time, fatigue is a form of forgetting and numbing, which is particularly emphasised by Gail who says she forgot a

large part of her childhood — pointing to an attempt to escape responsibility. Also, she emphasises her having a (self-made) diagnosis of Post-traumatic Stress Disorder, which could exonerate responsibility. Thus, the experiences surrounding the operations could have retroactively framed Gail's sister's death as something for which she was responsible, or rather something she asks if she was responsible for, hypothetically putting into question whether she deserves to live or not.

The structure of the logic of something (not) coming out is echoed in her body, particularly as she describes the ingestion of food: "And up 'til today, because of that I can't swallow well. I can't eat bread and stuff 'cus it, just gets stuck and I start choking" (A/L409-410). That food "just gets stuck" is linked to her situation as a whole of being both symbolically and physically inhibited ("But I couldn't move" (A/L346)) and could further point to an identification with her sister, seeing as her sister was "stuck" with her parents[52]. Moreover, she explains how "my bowel doesn't assimilate my body properly. So anything - everything you eat just *comes out*" (A/L647-648, my emphasis). We thus see the structure of something both not coming out, being stuck, and something coming out ("everything" "comes out"). Both moments could mark the failure of a bulwark against an unbearable presence — one which cannot be "assimilate[d]" "properly", in terms of it not being susceptible to an understanding (particularly in terms of her sense of identity); the point at which symbolisation fails.

Analogous to Tom, fatigue for Gail, as representing the living dead, could thus be in line with a conversion symptom where it acts both act as an appropriate punishment — a way of simultaneously attempting to process the image of her sister by identifying with her (not coming out/withholding) — but also as an attempt to live her own life and escape the image of her sister (by coming out). The latter of course fails, since this also constitutes an identification with her sister. When talking about how she pushes herself, meeting the demand to 'keep going', Gail explains that she "think[s] it's got a lot to do with my sister that died" (B/L233-234), since her sister used to tell her "don't be lazy [imperceptible], you have enough time to sleep in your grave" (C/L234), and that she is now in "in a way" "trying

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[52] In relation to being stuck, she refers to her husband and the demand to 'get on with it': "But eventually I had to get on my feet and do something 'cus I had a husband that was sitting on top of me and saying like 'get with it' you know healing *yourself*. And I couldn't explain to him what I was feeling, why I was so tired, why I was in pain. But…and it was after that operation when I just had to lie there and cry out and say I can't do a thing for myself" (C/L426-430).

to live for her" (C/L234). Considering Gail thinks her sister lived a life of "nothing", it is not surprising that attempting to live for her or live her own life fails (that living her sister's life simultaneously means not living) — the identification with the dead object of 'nothing' being overdetermined and spilling over here too. Not to live her own life could be a way of evading her sister's demand in an act of separation, which, of course, also fails. After all, she announces herself in relation to having said that she will pursue her studies "even if it kills" her: "well actually it's now killing me" (B/L611). As long she has not finished her degree, both her and her sister's pictures are missing (from the wall), but we could also view her attempt to finish her degree as a way of compensating and live the life her sister never had.

It is thus clear that trying to live *a* life is problematic for Gail: there are two forces working against each other, each overdetermined. These fluctuations between life and death, between too much and not enough, could potentially echo the question 'Am I to blame?' and 'Do I deserve to be alive?' which become inscribed in the body. The result is being stuck between the two poles as the living dead.

Neurotic Logic: Obsessional Neurosis and Hysteria

In relation to what has been analysed for Tom's and Gail's discourses, we can make some tentative comparisons to the theory of structural differences. First of all, the presence of disappointments, frustrations and blame seem to appear in relation to lack (something which was not good enough, either oneself or the Other), which implies that lack has been registered. This is in line with what Vanheule (2019: 79) observes regarding the Name-of-the-Father having been installed in neurosis: it represents an agency one can trust, in which case not living up to expectations results in anger, disappointment or shame. For were it not this way, the Other's intrusion would be experienced as more — or exclusively — puzzling and shocking due to the foreclosure of the Name-of-the-Father (Vanheule, 2014: 139). We can trace experiences related to disappointments — accompanied by explicit acknowledgments of disappointment directed especially towards the medical Other — in all of the participants' discourses. Symptoms emerging after such episodes suggests that a symptom is used as a way of questioning one's value for the Other, whereby the symptom invokes the Other's desire through one's disappearance, asking the question 'Can he lose me?' (Lacan SXI: 214).

However, comparing Gail's and Tom's discourses, this might be more relevant for Gail, whose discourse seems to accentuate the indifference of the Other, or in other words, the absence of the Other's desire: the Other did not address or even consider her lack. In contradistinction, Tom seems to struggle with the presence of the Other's desire (the police), as he has difficulties invoking support from an authority, something other than himself, to deal with his lack. The two thus showcase oppositions, a difference which is usually how the neurosis/psychosis distinction is conceptualised, particularly between hysteria, as part of neurosis, and psychosis. In psychosis, a symptom is used to deal with the proximity of the Other, while the hysteric would invoke the Other's desire as a way to ask the question 'Am I loved?'. In this way, Leader (2016: 29) recognises that while a psychotic can mimic a refusal linked to this question of one's value, the difference is that in psychosis the aim is not to produce a question but to gain distance to the threatening proximity of the Other. It may be impossible to tell which one is more prevalent in the discourses explored, particularly within the scope of a qualitative research study, and particularly for some of the participants who emphasise the invasive 'too muchness' of a demand *qua* otherness (such as Tom and Brody). It could also be that a symptom moves through different phases with different emphases on functions. As Vanheule (2012: 164) points out, there is no strict rule or single criteria that can differentiate between the two types of logic. Furthermore, the theory of the clinical structures is complex with sometimes contradictory statements found within the secondary resources of the Lacanian literature. Nevertheless, I am not grouping each participant, or all of them, into an overall structure, but merely suggesting links to theoretical elements. I argue that there are traces of both separating from the proximity of the Other and constructing a question within the discourses — with the presence of traces inferring the unconscious nature of the question. While the question of love might be more prevalent for Gail and for some of the other participants whose discourses also emphasise the absence of the Other, there is a sense in which the question of responsibility is present for both Gail and Tom. They were confronted with a moment, a triggering event, in which they were asked to take responsibility for one's own lack, which, hypothetically, framed an earlier loss as traumatic and unprocessed, or more simply framed a gap. However, there is a contrast between Tom's and Gail's discourses, considering that Tom illustrates a failure to complete his own desire *qua* lack, and Gail emphasises a failure to meet someone else's desire, both, however, with grave consequences (the death of a loved one). These differences could be elucidated through

Lacan's theory of obsessional neurosis and hysteria respectively, as belonging to the structure of neurosis. Indeed, in obsessional neurosis there is a similar threatening 'proximity of the Other' as that present in psychosis, making it difficult to tell the two apart[53].

Lacan (2002/2006: 698) highlights that the hysteric's unconscious operates on the side of the object, 'slipping away as its object' in relation to the Other's desire, thereby creating a lack in the Other. The obsessive, on the other hand, 'negates the Other's desire, in forming his fantasy by accentuating the impossibility of the subject vanishing'. This means the obsessive operates on the side of the subject by refusing to fade away as an object, or rather, by denying a dependence on an object [54] (Van Haute, 2002: 250). What this implies is that one overcomes separation either through completing the Other in hysteria, or completing the subject in obsessional neurosis (Fink, 1999: 157). It is in this way the structures are 'illuminated by the other' (Lacan, Seminar VI: 301). Obsessional neurosis constitutes a 'strategy of mastery', trying to annul or neutralise the Other's desire in order to illustrate that one is a master of one's own desire (Soler, 1996: 270), meaning that one attempts to erase traces of dependency on something/someone else. The hysteric, in contrast, is more in tune with the Other's desire, always trying to calculate what the Other wants in order to situate her/himself as its (missing) object.

We could compare Tom's and Gail's discourses to these two structures, where Tom failed to complete himself — the refusal being partly against a dependency on the Other as seen in that he was uncomfortable to resort to ask the Other *qua* the police for help — and Gail failed to give her sister a life of fulfilment, failed with completing the Other's desire. This could fall in line with Verhaeghe's (2004: 384-385) distinction between the two, where the obsessional is anxious about satisfying the desire of the Other too much to the point of disappearing, whereas the hysterical subject is anxious about not satisfying this desire, and indeed hysteria is oftentimes associated with experiences of not being good enough (Dor, 1998: 80). For Tom, satisfying the Other's desire could perhaps amount to being seen as a lawful citizen, if asking the police for help. And we could add to this that there could be a

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[53] This could perhaps explain the differences noticeable in the alienation chapter where some emphasise the lack of address from the Other (an absence of desire), while others speak about the proximity of the Other through demands (a presence of desire). However, both of these are also present for one person, depicted through various events.

[54] It may however make more sense to reverse these positions, insofar as subjectivity is linked to elusiveness, corresponding to hysteria, and the ego as mastery is linked to an object of wholeness, corresponding to obsessional neurosis. Also considering Lacan says the obsessional neurotic accentuates the 'subject vanishing', meaning the subject is not there.

fear of satisfying his own desire (the desire of the subject always being the desire of the Other), since it was problematic in the past. I argue, however, that it is difficult, if not impossible, to go after hallmarks such as not being 'good enough', since Tom also indicates an insufficiency pertaining to himself, but *for* himself as opposed to for others/the Other; thus one would have to put these characteristics into context.

In terms of neutralising or annihilating the Other's desire, the obsessional element complicates the neurosis/psychosis distinction, making it more challenging to discern an appeal or question directed to the Other. Not only that, but such an annihilation is strongly tied to that of the ego and can be compared to the defensive moment of not desiring as explored for fatigue in this thesis, which can further be linked to the desire to sleep. In this way, the structure of obsessional neurosis shows something fundamental for neurosis, but also for fatigue. More specifically, what appears appropriate is what Lacan terms, in relation to obsessional neurosis, a 'masturbatory *jouissance'*, which crushes desire and demand (Lacan, Seminar VI: 306). The relevance of this is clear in the desire to sleep where the subject attempts to eradicate demands, desires and tensions — or in other words any excess and ambiguity. Or more correctly, these are *withheld*, which is the term Lacan (Seminar X: 328), uses in describing an inhibition, 'to hold back', an inhibition which he further strongly relates to the structure of obsessional neurosis (Ibid.: 317). This is appropriate seeing as I argued that fatigue can be a hoarding of energy/tension. The act of hoarding energy (which thereby turns it into a tension), could be an attempt by the subject to separate from the Other and not satisfy its desire — energy being the object of the Other's desire. Indeed, obsessional neurosis is linked with the accumulation of objects (Gessert, 2014: 61), and thus hoarding.

This does not mean we can 'diagnose' the structure of the participants' discourses as obsessional, but, to follow Lacan (Seminar X: 317) when speaking about obsessional neurosis in relation to a defence against the Other's desire: 'the obsessional has the most exemplary value for us'. Hence, there is something relevant for obsessional neurosis which showcases a fundamental element in neurosis in general, or maybe even subjectivity at large. However, perhaps there is a difference in the defence pertaining to the distinction between obsessional neurosis and hysteria, if we ask the question *whose* desire is being eradicated: the subject's or the Other's (if we can separate them like that)? Maybe we can argue that the hysteric attempts to eradicate his/her own desire in an attempt to focus on the Other's, or as a punishment when the latter has failed, having felt guilty about giving into one's own desire,

seen when Gail was "out there" living her life while her sister was stuck. However, the numbing into nothingness and merging with the object of 'nothing', does not allow to distinguish between the subject and the Other insofar as the distance between the two is sought to be eradicated: demands, and thereby desires, are crushed in the face of the pressure or accumulation of demands. It could be that there are different emphases beyond the defence — the defence which is similarly expressed in everyone's discourses — but I cannot make any such claims in this research. If only focusing on the triggering events and only on Tom's and Gail's discourses, the perceptible difference is that Gail puts emphasis on others failing her and her failing others, and Tom (in relation to his neighbours' noise) on him failing himself and being unable to 'take care of it' himself. The similarity here is that, through the formation of fatigue, both evade the demand/desire of the Other while nevertheless being faithful to it; endorsing, more generally, the idea to 'keep going' and to 'slow down' plus the ideas that the subject is capable of being fully in control of him/herself and independent from the societal Other. It echoes the overarching idea of 'the body as machine'. This is in agreement with a neurotic structure, since the Other's desire is also evaded in hysteria (although not annulled, quite the opposite): to be the object of the Other's desire means to never fulfil it — hysteria being characterised as an unsatisfied desire.

Therefore, fatigue could be both an attempt to satisfy one's own desire and thus not desiring — maintaining a position of independence in relation to the Other akin to masturbatory *jouissance* — while simultaneously keeping the desire unsatisfied, since having satisfied it at other moments has proved problematic. The formation of fatigue in this way could paradoxically act both as a self-inflicted punishment by 'dying while alive' (or a "death" and "life sentence" as Gail says) through various inhibitions, and a way of staying alive as an individual in the face of the enigmatic desire of the Other. This constitutes two contradictory forces working against each other, yet also in harmony.

Chapter 8: Conclusion: Putting Forth an Alternative Approach to Fatigue

The most dominant approach to fatigue, as explored in chapter one, follows a view of the mind-body relation as shaped by the biomedical discourse and practice whereby the mind is increasingly excluded and rendered non-existent. The body is separated from the mind and is thought to be a mere vessel of an illness and detached from social, cultural and political influences.

Through having conducted interviews with people suffering from fatigue and diagnosed with CFS/ME, and by carefully tracing the structure of their discourse with the help of techniques part of a Lacanian Discourse Analysis and with Lacanian theory, my analysis has illustrated that symptom formation cannot be thought of without the context of subjective elements; that symptom formation is inextricably linked to identity formation. Subjective factors involve experiences linked to various life events and physical occurrences, as well as the very view of the mind-body relation — as shaped by and in discourse. These subjective factors do not exist in an individual vacuum but within a social sphere as they are formed by the dominant views operating in society, and also in combination with biological factors since a focus on subjectivity does not exclude these. This research project has brought the importance of such subjective factors to the fore, as the analysis showcased in the sense that others' words and beliefs — in the form of dominant, sociocultural demands — have a significant effect on the formation and development of fatigue. More specifically, the demands crucial for the emergence of fatigue stem from a dominant view of the body in the context of the mind-body relation, as formed not only by the scientific discourse but by the discourse of late capitalism. I will outline the main arguments from the analysis of this thesis in what follows in the context of the mind-body relation, and will thereafter discuss some implications of what has emerged and suggest future recommendations for a more fruitful and ethical approach to fatigue.

Demands Dividing the Mind and the Body

The two most prevailing imperatives exerting a large influence on the condition, as depicted in the interviews, are the commandments to 'keep going' and that to 'slow down'. These appear to follow a mind-body divide, which is evident not only in the interviews conducted

in this study, but by taking into account the wider and dominant sociocultural views and the practices giving rise to and sustaining them.

Starting firstly with the former, the demand to 'keep going' obeys one of the most dominant Western metaphor the 'body as machine', as it exists both in the discourses of science and capitalism. This metaphor views the subject as a constantly producing machine-like entity, an almost automatic and manic state where subjective factors such as stress, emotions, symptoms, resting, and sleeping do not exist. It promotes the injunction to 'just do it, don't think about it', whereby the mind is ignored. The demand further dismisses subjective factors such as individual differences through its universal characteristic — requiring constant productivity for everyone, and requiring it in specific ways, for instance to do a certain job for a specific number of hours. This ignores the fact that people have different preferences and/or working capacities. However, the demand to 'keep going' is not just related to work for the participants, but all aspect of life such as socialising, enjoying, eating, cooking, and small yet necessary tasks such as showering. I compared the concretisation of the subject in this manner to Lacan's notion of a reduction to a need, as part of his theory of alienation. To reduce something to a need involves believing a demand can be satisfied. Therefore, if meeting a demand, the subject — being inextricable from elements of indeterminability, or lack as an absence — is reduced to a known object. This constitutes a strengthened version of alienation. Alienation for Lacan is inevitable since the subject is irreducible to a symbolic-imaginary network. However, s/he comes to be largely determined by it anyway and comes to be represented in the Other, but at the price of only being partially represented therein; there is loss and exclusions. Lack in this manner can be compared to the activity of resting and sleeping, insofar as the (conscious) subject is absent from societal obligations/activities or in the very least absent from conscious activity and effort. When this element of partiality is not acknowledged, when it is believed that the subject can be reduced to a bodily machine in constant motion, then the subject disappears. The subject is reduced to 'nothing', or rather, to nothing more than an exchangeable object part of a bigger system. This is expressed by the participants through references to inescapability (of their situations), pointing to a reductive aspect where their whole beings are caught up in certain representations, where they are solely serving others in the name of productivity. There is no space for the subject's desire, and its absence from these activities. While the subject's exclusion is strongly tied to the triggering events causing the participants to seek help from

the medical establishment, we find via the encounters with the medical establishment a perpetuation of this situation.

It was seen how the absence of concrete biological results leads the GP to either explicitly or implicitly pronounce 'there's nothing wrong with you'. I argued that this statement constitutes a reinforcement of the demand to 'keep going', since if nothing is biologically wrong, there is no excuse to stop. Not being considered (biologically) 'ill', is simultaneously coterminous with a psychological condition such as stress, anxiety and/or depression, which is here rendered non-existent. The mind/body divide becomes an objective/subjective divide existing under the real/unreal split. This absence of subjectivity, or the absence of an absence (a lack of a lack in Lacanian terms), is linked with an absence of unknowability and indeterminability; elements which are today foreclosed by the discourse of science. The pronouncement of 'there's nothing wrong with you' constitutes a complete answer which forecloses other potential answers. It halts any subjective explorations or further investigations. Uncertainty here, such as bodily symptoms unable to be absorbed and explained by the biomedical model, does not remain uncertain, but is turned into the certainty of a non-existence. Chronic Fatigue Syndrome/Myalgic Encephalomyelitis becomes the diagnosis of a nothingness. The mind and the subject, with all his/her various experiences and symptoms, are deemed unimportant and not worthy to even consider or pay attention to; they are reduced to nothing ('there's nothing wrong with you').

Conversely, the imperative to 'slow down' appears linked with the mind as it follows the belief that it is crucial to allow space, by stopping and slowing down, wherein one can reflect on the activity of 'doing', events or other occurrences in one's life, in order to mentally process and understand them. The demand to 'slow down' is typically experienced by the participants as one stemming from the psychologist and is linked with the activity of 'pacing': a popular management method for fatigue. Pacing is about finding a balance between resting and engaging in activities, which one would achieve by first and foremost becoming aware of when, how, and how often to rest and when to engage in activity, for example. At a wider level, it is related to the principles of yoga and meditation, which have today increased in popularity. The latter is now widely used within the medical setting as a tool of dealing with a range of conditions. In combination with the imperative to 'keep going', the participants are met by contradictory and confusing demands, which arguably contribute to the worsening of some of the participants' condition. For the two demands are incompatible insofar as to

'slow down' and to 'keep going' — if thought of in terms of the activities of sitting down and exercising, for instance, or working and not-working — are impossible to meet simultaneously. This evidently represents a mind-body divide, since the demand for exercise is action-focused in terms of physically 'doing', or rather doing without thinking, while the demand to 'slow down' involves not-doing, or rather doing less, as a way of being able to reflect on the activities of doing, and eventually, changing one's relationship to those activities. This is reflected in the two dominant treatments for fatigue/CFS/ME: Graded Exercise Therapy (GET) and Cognitive Behavioural Therapy (CBT). However, while the demand to 'slow down' values resting and sleeping, the mind is more often than not negated, reduced to nothing, insofar as it comes to take the form of the demand to 'keep going'.

The way in which the two commandments resemble each other is through its universal quality involving a reduction of a need. The subject, mainly via the medical establishment, is told to 'slow down' in a pre-determined and concrete manner: to engage in certain activities for a certain amount of time, which constitute ideas *qua* rules applied to everyone[55]. Furthermore, all the steps involved in the activity of slowing down, the breaks and pauses taken during the day and in what ways and for how long, alongside the person's energy levels, are commanded to be registered in numbers through documentation. In this way, what is supposed to be an absence becomes *yet another presence*, and subjective differences are again ignored. It also removes factors of unknowability — subjectivity as such — by believing the mind and the body can be adequately captured in numbers and words, that there is a harmony between them. Involved in this process, particularly as part of CBT, is making the unconscious conscious in an attempt to master the mind through an exploration of the subject's thoughts, choices, and intentions; and here staying on an individual level. Thus, either get rid of thinking ('keep going'), or control it ('slow down'). The latter also (attempts to) ultimately gets rid of thinking, particularly of that related to excess and the unconscious, through concretising, registering and fully 'understanding' something, and consequently supposedly controlling the body. This line of reasoning focuses on the imaginary aspect and is strongly tied to the idea of 'the body as machine', both in terms of thinking the body can be registered and controlled, as if the body can be programmed to turn on (keep going) and

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[55] Of course, sometimes these can come to be adapted to the individual, but they still constitute pre-determined, universal ideas.

off (slow down) on demand through following specific instructions, which is in line with the sociocultural motto 'mind over matter'.

Not only that, but what is supposed to be a break from the life of demands becomes yet another demand, as the demand to 'slow down' is ultimately a demand for productivity. One is asked to temporarily 'slow down' *in order* to increase one's productivity level, or as is commonly the goal with short-term, cost-effective, treatment, to get 'back to work' so that society does not lose too much money. I argued that a synthesis of the two injunctions is depicted socio-culturally through the popular British expression 'keep calm and carry on' — echoing another robotic state in that one need not be affected by life. This makes it apparent that it is *life itself* which is demanded through the imperative to 'keep going', and further, impossible life. The commandment for perpetual productivity and constant presence is thus one for life in various forms: to work, enjoy, learn, relax, consume — and preferably all at once[56]. The two dominant commandments thus present a paradox at the level of content, but that paradox dissolves at the level of structure insofar as both demand (constant) productivity and presence. At a structural level, both demands end up excluding the mind, and the unconscious Other, and further exist under the overarching imperative for endless robotic productivity, control and autonomy. This seems to take precedence over the imperative to slow down that considers the processing mind, where unknowability is allowed to exist. Thus, the two demands are not primarily reflective of a mind-body *gap*, a gap between two entities both equally considered to exist, but there is a *negation* of the mind. Alongside the negation of the mind we can say, in line with Schuster's (2017: 101) thesis, that there is a foreclosure of impossibilities, and inversely, an injunction for possibilities. This is recognisable in what has been explored so far and in general in contemporary society: believing the body can be a perpetually producing machine and that this opens up many possibilities, as reflected in the omnipresent attitude governed by the ideologies of late capitalism: 'you can do anything you set your mind to'. These ideas just outlined stand in contrast to the participants' experiences at the onset of their conditions, where they encounter an accumulation of demands as an imposition of something other than themselves, an unpredictable and incomprehensible otherness on which they are forced to depend. There is either too much meaning (a reduction to a concrete, pre-determined place) or not enough meaning (contradictory or impossible demands). The two are highly linked as they both lead

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[56] It is in this way the word 'productivity' has been used throughout the thesis.

to a confrontation with radical lack and anxiety, with not knowing what to do with one's body and not having a stable sense of identity. It follows Lacan's view on anxiety where the subject is addressed as an object but knows not what kind of object s/he is, seeing as demands — an expression of desire — are incomprehensible. As a consequence, and following the accumulation of demands, bodily tension accumulates and existence is experienced as overwhelming and heavy, which is expressed in the interviews through elements of dependency, suffocation, inescapability and impossibility. In other words, the negation of the mind leads to an ever-increasing mind-body divide, where the physical experience of the body stands in stark contrast to the ideas attached to the two dominating imperatives, existing under the overarching metaphor of 'the body as machine'.

The Mind-Body Divide at the Core of Symptom Formation

As a response to both specific imperatives which reduce the individual to a bodily machine and demands which are incomprehensible and 'too much', the subject via the body unconsciously refuses to meet the demand to 'keep going'. We witness this for the participants, as was relayed in chapter four, in the fact that there is an increase in bodily tensions in various forms (pain, vomiting, shaking) in conjunction with trying to meet the demand to 'keep going'. The refusal is enacted through an increase of activity, or in the very least a continuation of it, since all the participants here express they 'kept going'. It nevertheless leads to fatigue or less/no engagement in activities. The expression 'I kept going' showcases that the refusal is unconscious, and further the unconscious/conscious split, which can be compared to that of the mind-body division. To the conscious mind, one is attempting to meet the demand to 'keep going', while the body unconsciously refuses the demand and is that which does *not* keep going. Two opposite ideas — to keep going and, if you like, to slow down or stop — condense in the body since they cannot be worked out mentally. The body then becomes the place of an inscription of an impossibility. This was explained through the psychoanalytic theory of symptom formation, mainly through Freud's concept of a conversion symptom, where an unacceptable idea to the ego (to 'slow down') is repressed from consciousness and its affect transferred onto the body. Thus, at the very core of symptom formation is a mind-body divide.

I further utilised Lacan's notion of anorexia in order to shed light on the refusal. Since the subject can only emerge through lack, through not having a place, fatigue can be understood as refusing the demand of the Other, a demand negating the mind and closes up lack, in order to introduce a void, a space, wherein the subject can emerge. That is, in the face of being suffocated by the Other's desire via demands, the subject refuses the Other's demand in order to take distance and create a path for one's own desire and position independent of the Other. In line with anorexia as 'eating nothing', I argued that the fatigued subject is 'doing nothing'. To 'do nothing' consists of making room for *object a* as the void, a nothingness which is embodied by the subject via various bodily, incomprehensible, tensions. Also, 'doing nothing' — considering Lacan emphasises it is not a negation of an activity and the fact that there is an increase of tensions in the interviews — is arguably a hoarding of energy through the production of it for oneself (through the activity of 'doing'), in which case it accumulates and turns into a tension. This tension is then 'given'/'presented' by the subject to the Other as something to be considered and taken seriously in the social order. One could say that the mind-body gap is desired here in the sense that the subject gives a lack of energy, paradoxically an unsymbolised tension, to the big Other. Or put differently, the mind-body gap, being something negated and repressed, turns into the return of the repressed where it comes back with a vengeance.

The refusal of the demand to 'keep going' via bodily tensions would also have the function of self-other differentiation, which is in line with Lacan's theory that lack is necessary for identity-formation, that a disintegration is crucial for an integration of identity. In the interviews, this is a function best accorded to pain, and can more generally be attributed to that of the (death) drive, which for Lacan is a constant tension arising in relation to the Other's demand. I argued that the drive explains the various tensions found at this 'initial' refusal, since they are subsumed under the 'drive to sleep'. Due to the intervention of the demand to 'keep going' on the body, and the subject refusing the demand, it turns the activity of sleeping — which is temporarily satisfied after each night — into an unquenchable tension, constantly seeking a discharge (through sleeping). Since the latter is not achieved, it is a tension which marks a void, and where the subject is constantly *pushed* towards sleeping, has an urge and necessity to sleep, not always necessarily sleeping more. The mind-body divide is here experienced as horrific and uncomfortable, insofar as this process is

unconscious and thus elusive to the conscious mind (the ego), who finds the drive to sleep unacceptable. Thus, the solution becomes the problem and vice versa.

Other influences on the formation of fatigue was discussed in chapter four, such as biology, given the fact that a symptom is over-determined — several factors need to come together concurrently — and that most of the participants conveyed their condition starting with a virus, a vaccination or an operation. The topic of biology was brought up in relation to Freud's theory of the actual neuroses, where the two-subcategories, neurasthenia and anxiety neurosis, come close to the picture of fatigue as presented by the participants of this study. Anxiety neurosis is especially relevant in relation to this 'initial' refusal, since it constitutes an unsymbolised, accumulation of excitation in the body. This also occurs in a conversion symptom belonging to the psychoneurosis, which I utilised to explain fatigue in this chapter, but Freud distinguishes it from anxiety neurosis on the basis of its origin: a conversion symptom stems from a psychical conflict, whereas anxiety neurosis is purely somatic. It was argued that from a Lacanian perspective, the question of cause in this manner is an impossible one akin to the question of 'which came first, the chicken or the egg?', which in this case would be a thought or a bodily sensation. The reason being that the mind and the body cannot be separated: there is no such thing as a purely physical event — stepping outside of one's alienation in the symbolic — but the physical and the symbolic are always intertwined. That bodily tensions arise in relation to the demand to 'keep going', and that these are not linked to positive biomedical results (or that treatment for this does not help), suggests that the formation of fatigue goes beyond biology; it has turned into something else and something more.

I thereafter argued in chapter five that a second moment of a refusal, a refusal of the refusal, is tied to the function normally attributed to fatigue: a shutting off and diminishment of tension. We can view this moment as a way of remedying the mind-body gap, to remove the gap between them and the loss and lack accompanying it (since the body represents a void). This is achieved by concretising lack into sleeping, paradoxically disappearing into the void as a way of removing the void. Sleep is used as a form of disappearance and escape from the big Other and the life of demands, as well as from the tensions of the body. It constitutes a merging with the object of 'nothing' — a numbing of the body (of language) into nothingness whereby one turns off the mind and the body in their excessive forms, instead embodying dead, numb and zombie-like objects. Here, desires, tensions, and

responsibilities cease to exist. The subject, in this way, says no to alienation and castration. I used Lacan's theory of the desire to sleep as linked to the fantasy to elucidate this process, where falling asleep in the fantasy and merging with an object (of 'nothing') could be seen as a protection against the accumulation and movement of demands. This is done by imaginarily putting a stop to the demands, imagining a wholeness in which one forgets that one *has* a body — a defensive moment I compared to Lacan's notion of not wanting to desire. Freud's and Lacan's concept of an inhibition was brought in here in order to shed light on how fatigue also constitutes a defence against the knowledge of subjective involvement. By arguably disguising the refusal, an 'I don't want to', as an inhibition, an 'I can't', the subject engages in the process of repression and attempts to exonerate responsibility. It keeps elusive and unbearable subjectivity at bay through, in a way, reducing oneself to a pure bodily, numb object, in line with Lacan's theory of the paradoxical fantasy where one both is the object, and where the object does not exist. The second refusal *qua* an inhibition thus further strengthens the negation of the mind by refuting subjective factors — in line with reducing the mind to nothing as explored through the sociocultural demands — and trying to *be* one with the body, however one that is also numbed into nothingness. This chapter, in conjunction with the previous one, illustrate the split and ambivalence of the subject in terms of trying to signal the aliveness of the body through tensions, while simultaneously attempting to extinguish tensions and embody a disappearance. It ironically echoes the contradictory sociocultural commandments to 'keep going' and to 'slow down'.

The Failure of Separating and Uniting the Mind and the Body

Chapter six subsequently explored the impossibility of escaping subjectivity and one's desires and bodily tensions and excesses, considering the fact that to not desire constitutes a *desire* not to desire. We can conceptualise this as a failure of having separated the mind and the body and negated the mind, but also as a failure of having attempted to unite them through the desire to sleep, following Lacanian theory that lack, separation, is needed in order for identification, a unity, to occur — a unity which in this case would reduce the ambiguous relation between them, the gap, to nothing.

This failure and impossibility of achieving a state of nothingness inherent in not desiring is traced in the interviews through the frustrating presence of a demand, bodily

tension, guilt, boredom, or even possibly derived enjoyment in the place of the idea of 'nothing'; coming to enjoy the thought of no pleasure, for instance. That is, there is something rather than nothing. Falling asleep in the fantasy fails as it is impossible to disappear (in or through it). Or put differently, reducing oneself to a bodily object, to 'nothing', spirals out of control as the subject gets lost in its unpredictable, uncontrollable, and ambiguous nature, where the boundary between self and other, pleasure and unpleasure, is questionable. This simultaneously strengthens the mind-body gap in that one is unable to have mentally apprehended the body. There has thus been a return to an encounter with alienation, albeit in a different form: the 'nothingness' sought after turns on itself and becomes a presence of nothingness, the feeling of not feeling enough. It represents an unbearable absence. Since fatigue is here described as a bodily heaviness, I argued that it can be described as 'too much of not enough', linked to the pain of fatigue. This was compared to the notion of the drive as an excess of life, as an activity towards a passivity, something which cannot stop living and presents itself as an obstacle to desire (for 'nothing'). I also stated that the more one believes in the existence of the object of desire, here a 'nothingness', the more it gives force to the drive (to sleep) in what I termed the drive of desire. Another failure of 'nothing' discussed in this chapter is that the symbolic Other is appealed to and relied upon by the subjects in order to symbolise the loss of their bodies, or the state of nothingness, mainly through a biomedical diagnosis. To acquire a diagnosis with a medical status, as opposed to psychological, would validate their existence by providing recognition and an explanation for their conditions, to symbolise loss, and would also relinquish the subject from responsibility. The exoneration of responsibility here occurs on an imaginary-symbolic level rather than at the level of the real-imaginary linked to the desire to sleep. Through a diagnosis, or through references to broken gadgets, the body is symbolised as a biological and external entity functioning automatically without the involvement of the psyche or subjectivity. In other words, the body is thought to align itself with a *non*-functioning machine, following the idea of 'the body as machine'. This, also, ironically echoes the big Other's statement 'there's nothing wrong with you'.

Therefore, there has been a failure of separating both from the idea of 'nothing', and that of 'the body as machine', and more generally from the Other; however the former idea can be subsumed under the latter insofar as desiring nothing is akin to an impossible, robotic-like state. This failure stems not only from negating the mind, but *idealising* such a negation

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insofar as the idea of 'the body as machine' is put on a pedestal. It is thought that one *can* and *should* operate like a machine and be unaffected by, cut off from, subjective factors such as life events and affects, that one can just 'keep going'. This was illustrated to be the case for the participants when describing living highly active lives before the onset of their conditions, that they 'worked hard and played hard' (which also showcases the drive of desire). The idealisation of the negation of the mind and 'the body as machine' simultaneously points to the impossibility of separating the mind and the body and particularly cutting off one's desire, since what it shows is, as was just mentioned, the desire not to desire, that one's desire (on the side of 'mental' factors) is inevitably caught up in the attempt to cut it off. Such an endorsement contributes to symptom formation in that the more something is repressed, the more it will return to haunt the subject and create two forces working against each other (to desire and not desire), the latter of which for Freud is the precondition for forming a (psychoneurotic) symptom. In other words, the appearance/strengthening of a force, to slow down, contradicts the drive and desire to 'keep going', and for this reason is attempted to be kept at bay. I argued that mourning could elucidate this process, insofar as all of the participants experienced a real loss or a separation before or around the onset of their conditions. Also, in mourning, one loses one's identity and anchoring point in the Other, albeit one does not know what is lost. One thus becomes unable to 'keep going' and stuck in the image of the Other considering the circular, internal process involved: (unconsciously) rejecting the idea of 'the body as machine' ends up perpetuating that idea.

The failure of mourning also presents itself in the fact that loss has not been allowed to enter consciousness, or linked to its proper 'source', since loss is attributed to a loss of energy instead of the loss of a loved one and the ideas linked to it, which can be understood more generally as the constitution of the subject and the failure of separation; that symbolic separation/castration has not taken place. The notion of retroactivity is crucial in understanding the formation of a symptom here, since an event can only be understood from the perspective of other events. The triggering events are linked to other usually previous episodes, suggesting a link between them and a displacement from one to the other. The more personal events involving the loved one are displaced onto the more impersonal episodes constituting the triggering events, circulating around work, university studies, and operations; thus disguising the former. This displacement represents a mind-body divide

which leads to an ever-greater gap between the two insofar as the loss emerges through the unconscious body via the return of the repressed, something cut off from consciousness. However, the displacement illustrates both how the mind and the body are separated, but also inevitably linked. If focusing on the conscious-unconscious relation as I just explained, these remain separated insofar as the subject is unaware of the unconscious symbolism potentially residing in the body; the unconscious always being the gap where consciousness is not. On the other hand, they are linked if comparing the relation between the unconscious and the body: the body becomes the place of unconsciously attempting to symbolise that which could not be symbolised, where certain ideas or questions are inscribed. The relation between the mind and the body as not-one but also as not-two is further illustrated by the way in which the demands become inscribed in the body. The demand to 'keep going' and to 'slow down' are irreconcilable and in opposition to one another in terms of the production versus the extinguish of tension, but compatible and inseparable when thought of as an activity towards passivity, or a movement towards non-movement.

I explored the above in more depth in chapter seven through an appeal to Lacan's theory of the clinical structures, where the structures of the participants' discourses were compared to the logic of neurosis and psychosis. It was delineated how the discourses both resonate with and are dissimilar from a psychotic logic, and the ways in which they resemble a neurotic one. The latter was done in depth through the lens of Tom's and Gail's discourses, where one could discern a logic of the signifier at work between various events, suggesting a symbolic structuring of the symptom. Their discourses elucidated more details surrounding the process of mourning and the ambivalence of the subject, where one could trace questions pertaining to responsibility and one's existence: 'Am I to blame?' and/or 'Am I loved?'. This could be tracked in fluctuations between too much and not enough responsibility, and in general in the discourses, between too much and not enough disappearance, pointing to an uncertainty and questioning of a limit. Further, Tom's and Gail's discourses were linked to obsessional neurosis and hysteria respectively, where Tom's logic circulated around having failed to complete his own lack, while Gail's approached the idea of having failed to complete her (now dead) sister's lack. It was then discussed how fatigue could constitute a self-inflicted punishment.

Overall, while a symptom will be particular for a specific subject, the physical form of fatigue appears to lend itself well to certain functions and meanings. Apart from perhaps

acting as the most appropriate protest against the cultural imperative to be awake and 'keep going', it can further aptly represent an accumulation of responsibility in the body, an increasing heaviness, related to carrying a heavy burden, a guilt. After all, the expression goes that we 'carry the weight of the world on our shoulders' when experiencing a heavy burden of responsibility. Simultaneously and conversely, the physical sensation of fatigue appears to capture the opposite phenomenon of a release of responsibility, as it aptly depicts a disappearance and loss (of energy), involving a diminishment of tension. This would then relate to the defensive moment of fatigue as explored in this thesis, as an escape from the confines of society and one's body. It would also be adept at signalling the two sides simultaneously, a 'too much of not enough', capturing the experience of being stuck in between the two through an inhibition of movement, or rather a movement towards a non-movement, to keep slowing down. In this way, fatigue takes the function of a conversion symptom where two forces condense in the body, and a part of the body is 'chosen' in order to adequately express the two contradictory ideas concurrently. This, however, is not to say that fatigue cannot take other forms which it no doubt does, most notably as coloured by other structures (perversion and psychosis), and in the next section I will discuss how the structure of this research has likely encouraged subjects with certain structures to participate, or has allowed this structure to come to the fore.

Nevertheless, this topic brings us to the discussion engaged in throughout this thesis about the structure of symptoms in comparison to contemporary Lacanian theories on modern symptoms, and more specifically to the argument that the findings of this thesis is incompatible with these theories. Therein is an increasing trend to conceptualise symptoms, including chronic fatigue and pain, on the basis of either Freud's theory of actual neurosis, or the concept of psychosis, through the notion of 'ordinary psychosis'. According to these perspectives, symptoms are considered to constitute a direct encounter with the unsymbolised real where a symbolic-imaginary structuring is missing: there is no formation of the unconscious whereby a symptom is a decipherable message in an appeal to the Other. As I mentioned in the reflexivity part of chapter two of this thesis, I myself was seduced by this viewpoint that many symptoms today are devoid of meaning early on in the analytical process and wanted to fit the interviews into this theoretical framework, but ultimately found this untenable as I returned to the interviews and closely considered their nature. The structure, more specifically, took the form of multiple symbolisations in various ways in an associative

network between different events, strongly tied to the metaphor of 'the body as machine' as argued above. These indubitably stem from and circulate around an encounter with the unsymbolised real, as the place of the break-down of symbolisation and an absence of meaning, thus arguably showing how actual neurosis may have a place here, particularly considering that the biological body may play a role for some and especially in the initiation of the condition in the form of the acquirement of viruses and bacteria, or the presence of physical sensations and effects due to operations. However, what this structure implies is that these more or less physical sensations become intertwined with symbolisations and subjective factors, or more accurately are always already intertwined with them as they have influenced the initiation and course of them. Therefore, instead of there being an incapacity of symbolisation, there are symbolisations present around fatigue and pain with various content; symbolisations which have been determined by, and also determine, the subject's mode of relating to the Other. This relation comes to significantly impact the nature and course of the condition as this research has showed. As I argued in chapter six, however, these symbolisations repeatedly and ultimately fail, meaning that bodily tensions have been unable to be integrated into a symbolic network and thus come across as unbearable, unpredictable and at large enigmatic. Thus more appropriately ascribed to fatigue as presented on in this research is the failure of meaning/symbolisation to contain the body, but equally the failure of escaping meaning and the Other, highlighting the struggle between too much and not enough meaning, with the subject symptomatically emerging between the movements of these two poles, as an embodiment of the failure of having integrated the body into a meaningful, mental comprehension. This depicts the mind-body relation in the sense of showcasing, on the one hand, the impossibility of collapsing them into one unity (the failure of symbolisation), and on the other, the impossibility of separating them into two separate entities (the failure of escaping meaning). The failure of escaping meaning was particularly significant as this was the most unexpected — and in my subjective view undesirable — aspect, as it entails a determination by and dependency on the Other, or in simpler terms, that we are dependent on society and to a certain extent a product of it. Certain meanings, most particularly those surrounding the mind-body construction, come to inevitably influence symptom formation and the experience of it. This does not mean that fatigue is a pure effect of society, as if the subject passively receives ideas therefrom, but what appears crucial here, as read from the discourses of this study, is the subject's

endorsement of the ideas linked to dominant demands, and ultimately, an idealisation of the impossible idea of 'the body as machine'. This leads to the attempt to negate the mind and ultimately a perpetuation of the idea; something found omnipresent at a sociocultural level.

In the light of these interpretations and considering the deceptive nature of fatigue as I highlighted particularly towards the end of this thesis, I presented some counterarguments to the popular contemporary theories within the Lacanian field in relation to chronic fatigue. I argued that there is a possibility that these theories confuse the defensive moment of the symptom (a symptom of a symptom; a refusal of the refusal) with the structure and *appearance* of the symptom. The defence, constitutive of a desire and aim for a nothingness which showcases the fundamental nature of desire, can mimic the appearance of being cut off from the symbolic Other, if persistent enough. This begs the question: do these theories not *themselves* contain the fantasy of escaping from the big Other? In other words, these theories arguably participate in the dominant mind-body dichotomy where the mind and the body are too separated and the mind is negated (in the form of a lack of symbolisation), and left is the body in isolation to it. While I am not generalising the findings of this research, in which I conducted an in-depth analysis on seven participants' interview transcripts, to everyone who experiences chronic fatigue and/or pain, the lack of consideration of the deceptive nature of fatigue — most likely a quality shared with other dominant symptoms manifesting today — puts into question the conclusion stemming from some of these contemporary theories that the majority of symptoms today, particularly those thought of as 'psychosomatic', lacking imaginary-symbolic material and 'coating'. If anything, it would not be surprising if, on the contrary, symbolic elements and repeated appeals to the Other are today increasing, considering the omnipresent sociocultural tendency to concretise and externalise a person and his/her suffering into images and numbers, and attempt to eradicate suffering with pills and quick solutions. If symbolism has been repressed, then a return of the repressed is to be expected. This brings us (back) to the importance of maintaining an ethical position *vis a vis* the subject, be that either in research or in the medical or psychotherapeutic/analytic clinic, of maintaining a constantly critical, open-minded perspective which would allow a thorough investigation of fatigue/symptoms, and the space for a more complex view on the mind-body relation which does justice to subjective, lived experiences.

Reflections on and Recommendations for Future Directions

In response to the pervasive negation of the mind promoted in modern society at the level of the scientific and capitalistic discourse, I propose that adopting and implementing a view of the mind and the body in line with Lacan's theory will enhance the prevention and treatment of fatigue. This approach includes a perspective of the mind and the body wherein the two form not a unity, nor two separate entities, but an inseparable relation — following Lacan's Möbius logic of them being 'the same but different'. In other words, the gap between the mind and the body needs to be acknowledged; a gap which ultimately means they are forever linked, for if there were no distance, there would be no way of meaningfully relating to one another (the mind and the body, the subject and the Other). Adopting this approach would (re)establish the links between them, considering the dismissal of their relation ends up perpetuating subjective factors and unconscious ideas ('the body as machine') unbeknownst to a subject. Acknowledging the intricate relation between the mind and the body means, as argued in this thesis, recognising that the question of cause is impossible to answer — that of 'is it biological or psychological?', particularly that pertaining to a *single* cause. Not only is an answer to this impossible, but it is arguably unimportant, considering a biological and subjective exploration are equally important in the investigation of fatigue. The crucial aspect here is to refuse to reduce the condition to either sides, and consider the over-determination of a condition and the complex interaction between the mind and the body, and between the subject and the sociocultural Other.

Regarding biological investigations, it would benefit the patient if the clinician recognises the limits of capturing the body within the framework of a biomedical model. For instance, there needs to be more flexibility in how clinicians use the idea of universally valid numbers, an acknowledgment that the cut-off threshold used for determining if a 'pathology' is present and a treatment is necessary, are somewhat arbitrary and will differ for each person. This is not to include a wider spectrum of 'abnormality', but to recognise that what may be considered a problem for one person, will not necessarily be so for another person. The same goes for interpreting the presence of a condition without biological testing, something that needs to be taken more seriously. Because the presence of biological markers should not be the only thing capable of conferring validity on a condition, and we should not shy away

from the fact that subjective factors will play a large, or even the main, role in some conditions — why should this not be taken as seriously as biology? Perhaps we can follow Freud's viewpoint here on what constitutes a symptom: a symptom, according to Freud, is what the person complains about. This would avoid reaching the conclusion 'there's nothing wrong with you' and instead take seriously that which cannot easily be captured and concretised in numbers, images, and even words; most notably the unconscious. Could the medical setting be a place wherein the unconscious is taken seriously? I argue that, to a certain extent, it can.

The medical professional can establish a more fruitful relation with the patient by approaching and listening to the him/her in a way which considers lack. This would include staying clear of pre-conceived notions regarding what would be 'good' for the patient (and for everyone), for example through demanding him/her to exercise. However, it is not just specific, foreign demands the subject struggles with, but demands in general. Psychoanalysis recognises that a pathological symptom always involves difficulties with the Other's demand, as a demand is an interpretation of desire and thus of one's place in the world, and a symptom is an attempt to articulate this, thus becoming problematic when it repeatedly fails. Indeed, we have observed how the accumulation of demands in fatigue — the fact that one cannot escape the life of demands — is problematic and unbearable. In the light of this, throwing *more* demands at patients, particularly those involving a reduction to a need, will be counterproductive and will contribute to the perpetuation of their conditions. It can, however, become difficult not to, given the ambivalence found for some of the participants of this study in the sense that they demand an answer and a cure to their condition — in a way demand the demand of the practitioner in which specific instructions can be followed since it would do away with unknowability and anxiety — but simultaneously and unconsciously they do not want or tolerate an answer. The clinician could perhaps adopt a position akin to that of the psychoanalyst here, considering the major common thread existing between medicine and psychoanalysis as recognised by Lacan: they both involve responding to a patient's demand (Leader & Corfield, 2008: 317). Also, as Balint (1955) identifies, psychoanalysis has more guidelines when it comes to handling the clinician-patient relationship.

The analyst does not give into the demands of the analysand, but keeps the space open for exploring the possible unconscious meanings and functions surrounding the demand of the patient — a demand recognised to go beyond the immediate setting in which it is made

(the existence of transference). The way in which this is done, however, differs depending on the structure of the analysand's speech. The main question is if it follows a neurotic or psychotic logic, since these can involve opposite responses of the analyst. The analysis of this research has focused predominantly on a neurotic logic since it has been deemed more appropriate in shedding light on the participant's discourses. This is not surprising given the procedure of this research. People volunteer to participate, which presupposes a desire to be heard by anOther. It would appeal to subjects of a neurotic logic, or if viewing the structures as fluid, it would influence this logic to emerge. More research is therefore needed pertaining to subjective differences in the experience of fatigue, crucially within different settings and different groups of people.

Regarding subjective differences, the area of fatigue and in general the area of health would benefit from further explorations into other discourses and practices attached to the mind-body construction and most notably the metaphor 'the body as machine', particularly those related to class, gender, sexuality, ethnicity, race, ability etc. These are not only connected to current sociocultural discourses and practices, but the very materiality of the body. Lacanian theory aptly deals with this, which is evident in his theory on the drive and the mind-body relation. The drive is a force linked to and dependent on the biological structure of the body in terms of erogenous zones *qua* rims (especially important surrounding questions of gender), but simultaneously independent of it as it has been formed by the structural incompleteness of language, and thus the drive is reducible to neither biology nor culture. Acknowledging this complex relation between the mind and the body allows an ethical way of exploring various cultural factors, factors which no doubt give various meanings to 'the body as machine' and which, in turn, influence symptom formation. While I did not explicitly ask the participants about these aspects — since I attempted to keep the direction as open as possible in relation to fatigue in order for them to bring to the table the most important elements — they have influenced the content of the participants' interviews, which is more obvious in some areas than others. For instance, Gail, who comes "from an Asian family" as she explains, spoke about the importance of this background on her choice to push herself to obtain a degree while already having obtained several others, since, as she relates, this culture puts much emphasis on education. In other words, her cultural background determined the *content* of the demand to 'keep going' (it being focused on obtaining degrees), while the structure of this demand remained the same in terms of it being

a reduction to a need and/or an encounter with radical lack, particularly as it contrasts to the demand to 'slow down' with which she was repeatedly confronted via the medical establishment. In terms of gender and sexuality, Amy illustrated, and to a similar degree Gail surrounding the onset events in relation to her sister, that the imperative to 'keep going' involves taking care of others in her role as a mother and a nurse, and that a focus on other people's desire/lack without a goal for oneself (arguably Amy's studies which I discussed in chapter three), is more significant in relation to fatigue than a high level of activity. It is known that more females suffer from fatigue and in general 'psychosomatic' conditions, which could very well be linked to the close focus on, or sensitivity to, the Other's desire. This need not be the case though as Tom's discourse illustrated, where arguably the attempt to shut out a dependency on the Other, the separation to the Other's desire, has failed, resulting in the accumulation of overbearing demands, arguably more linked to the discourse surrounding masculinity in the sense that obsessional neurosis has been argued to be linked with it. This follows the idea that identity formation contains a universal structure which comes to be filled with different content depending on cultural and individual differences, differences which also, of course, influence the more specific structure pertaining to various clinical categories. It would have been insightful and useful to learn more about how these factors just mentioned come to impact symptom formation and experience. If time and space allowed, I would have liked to deepen the understanding surrounding this; however for a more productive and meaningful discussion, I would have had to ask the participants about them from the start. One has to wonder, too, beyond my omission, the influence of the biomedical discourse in giving rise to a deceivingly 'neutral' discourse, and thus the reason for the participants' of not having stressed these factors, potentially following the (false) belief that a biological illness does not discriminate between cultural factors. Nevertheless, even within a group with a presumably shared commonality, such as a certain gender or class or those whose discourse follows a neurotic logic, fatigue is not manifested and experienced in the same manner, as I hope this research has demonstrated. Despite many similarities, there are different emphases on different aspects of, for example, the alienating nature of subjectivity and the way in which separation occurs via the body and in discourse due to the singularity of subjectivity. This returns us to the importance in the clinic — any clinic — to meet the patient with as little pre-conceived notions as possible, to constantly maintain an

open and critical stance, and importantly one which opens the clinician's ears to the unconscious logic potentially at work in a demand.

Paying attention to the unconscious includes appreciating the structural incompleteness of language; the fact that when a patient seeks help for a condition, s/he is not aware of the multiple influences on it or even aware for what she is seeking help, and further not capable of giving an 'honest' or 'direct' answer. Full self-consciousness is not possible; language is not transparent but needs to be interpreted. It then becomes crucial for the practitioner to ask fruitful questions in the right way and with the right timing. It is not feasible, or probably desirable, to propose that the doctor *engage* in psychoanalysis, given the time constraints of contemporary medical practices and other practical factors. Rather, the medical clinician could adopt some techniques used in psychoanalysis, or in the very least, consider some issues dealt with therein, which are also applicable to the medical field. These matters entail the wider implications of a patient's demands, and the response to them, which are commonly discussed within a Lacanian psychoanalytic setting.

Leader & Corfield (2008) put forward a number of fruitful and important considerations related to this in their discussion of the potential bridge between psychoanalysis and medicine. They discuss, for example, the ethics surrounding the biomedical goal of removing symptoms, seeing as a symptom has several protective functions, such as symbolising that which was not symbolised, a considered well-deserved punishment, or a desire to be heard and validated. Recognising *that* symptoms have functions can massively benefit medical professionals and patients. Pertaining to the desire to be validated, and in the light of this research, just paying serious, close attention to the patient in a way which makes him/her feels heard, can arguably in some cases be all it takes for a condition not to worsen/develop, or in the very least, to stabilise it. Recognising that symptoms have functions would also, as Leader & Corfield observe (Ibid.: 303), instead of sending the patient to a number of different specialists cut off from communication with each other, enable the clinician to recognise a potential link between various surface symptoms (considered from a biomedical perspective to constitute a different condition with a different cause), which would consequently inform and facilitate treatment accordingly. If, for example, a symptom is used as a way of dealing with loss and the guilt stemming therefrom, then the production of a new surface symptom — say the disappearance of fatigue and the appearance of anorexia as starvation — could still have the same function; hence the use in

psychoanalysis of the singular word 'symptom' as opposed to the plural 'symptoms' in biomedicine. This research has demonstrated that isolating pain from fatigue is not straightforward. It then becomes important to treat the symptom as a structural function instead of over-focusing on its content. Within the psychoanalytically oriented clinic, such a focus on content is known for exacerbating a symptom as it feeds it with meaning and identification.

In order to recognise the potential functions of a symptom (as expressed through demands), one needs to pay attention to the link between various life events and the symptom. I argue that the clinician could at least initiate this process or make the subject aware of certain links by asking certain questions in certain ways. A question I asked the participants of this study which proved fruitful in bringing to light various events related to the condition was: 'What went on more generally in your life at the onset of your condition?'. If recognising that there was a loss involved here, then one could entertain the idea that the symptom could correspond to a failure of mourning, and subsequently proceed accordingly. This could, however, be considered a sensitive topic for the patient since it potentially points to a subjective involvement, and could reinforce the defence of the subject, thus one needs to act in a sensitive and timely manner.

The medical field, however, is not blind to the link between fatigue and mourning since there is much literature suggesting the two are strongly related. However, it appears that fatigue is linked to the *process* of mourning where it is indicative of a sign of it, and is not recognised as a *failure* of mourning; that the formation of a symptom could be a way of avoiding to mourn. This is critical to recognise since it constitutes the difference between providing an explanation and an answer ('you're just mourning') which dismisses a subjective exploration, and facilitating the means through which the latter and the mourning process can be initiated. While mourning is a highly singular process in the sense that people will have various ways of dealing with loss, if the person does not know s/he is avoiding to mourn, then help and support needs to be put in place to help the person commence the process.

I am not purporting to hold the answers here regarding the best way for the clinician to respond to the patient and what would be the best treatment if, for example, mourning is considered a problem. For some people, therapy could be useful, but it would probably not benefit everyone, particularly for those who are against talking therapies. However, regarding

the participants of this study, they showed an openness to this and indeed all of them underwent some form of counselling, with many expressing the usefulness of it in dealing with the losses and limits of the condition. More research and discussions are needed in this area, which could touch upon questions such as: given the contemporary constraints on medical encounters, what *can* the role of the clinician be? Should it include a probing into subjective factors? How would one go about doing so, and *when* should one do so; when is it better to leave it alone? What is the best treatment for those presenting 'psychosomatic symptoms' and a lack of openness to 'psychological' investigations and treatment? Is a treatment in terms of removing a symptom even necessary, desirable, and safe? Can psychoanalysis be useful in medicine? Regardless of the potential answers to these question, the first step is undoubtedly to listen carefully to the person in order to make an appropriate judgement on an individual basis, in order to 'decide what to treat, when, and how' (Balint, 1955: 685). In fact, a link between psychoanalysis and medicine has already been established by so called Balint groups. Based on the work of the psychoanalyst Michael Balint, a Balint group is led by a psychoanalyst and offers a space for GPs to discuss their relationship with their patients, and their interventions in specific cases. This has been set up by National Balint Societies in different countries and has been suggested by some studies to be beneficial to the medical practitioner (Lipsitt, 1999; Kjeldmand & Holmström, 2008). The reader is recommended to turn to Balint's (1955) early work 'The Doctor, His Patient and his Illness' where he first discusses these group seminars.

Moving away from the context of medical practice, even those patients who would benefit from therapy, and those who themselves seek out therapy/psychoanalysis, can end up challenging the clinician and the purpose of the therapy if endorsing the view that their condition is strongly linked to biological/external factors. That is, there is less willingness to link the emergence and function of their condition with various thought processes and experiences around life events. How then does one work with such a resistance? It has been suggested by Verhaeghe (2004: 291), when working with people of an actualpathological position for whom analysis presents a difficulty, that there should be a focus on subject amplification rather than analysis. That is, the therapeutic goal should be the construction of meaning as opposed to a deconstruction, with a particular focus on the primary subject-Other relation. However, since Verhaeghe's position is that in actualpathology there is no symbolic-imaginary meaning — that there is 'nothing to analyze' (Ibid.) — and I argue, on the contrary,

that in this thesis we can detect a symbolically structured symptom for the participants, his recommendation may not be applicable here. I nevertheless suggest it still is, considering that a symbolic construction is always the first step in order to allow a deconstruction of it. From a Lacanian perspective, these two processes are strongly intertwined insofar as meaning does not exist *a priori* or is unconsciously hidden, but language is reflexive and the unconscious is the place of meaning (logic) and non-meaning. If there is a stubborn refusal of the Other present, it may be that the construction of the relation between the subject and the Other needs more focus and time in the beginning of the analysis, regardless of what initiated the symptom formation. One would perhaps need to enable the analysand to realise that the subject is not cut off from the Other. This could entail pointing out to the analysand that instead of 'nothing' — the analysand might repeat this nothingness as a refusal and defence, particularly when asked for associations — there is something. The analysand may have given some minimal associations or material, or in any case will have some minimal thoughts and impressions, which needs to be emphasised, something Freud (SE XII: 138) also suggests when dealing with a patient's resistance as manifested in the utterance of 'nothing' at the cost of the thoughts it replaces. Alternatively, and if the analysand gives literally nothing, one could use the 'nothing' pronounced/implied as material and ask the analysand to associate to it. However, this research has not interviewed those involved in the analytic process and thus I tread carefully in giving recommendations here. Future research and work is needed directly with analysts and analysands in order to develop fruitful guidelines.

What additionally needs to be taken into consideration in the subject's relation to demands are their wider, sociocultural influences. We then move away from less individualistic solutions within a medical/therapeutic setting to more social solutions. In line with the former psychoanalytic solution of (re-)establishing links between one's condition/symptoms and events, I argue, following Mark Fisher (2009: 77), that instead of individualising a problem and remaining blind to its larger fuel, what is needed is to link the effect of modern phenomena with their structural influences. In the case of fatigue, this process would entail connecting the condition with the ideas endorsed in the revolt against those ideas, the idea of 'nothing' as well as the idea of 'the body as machine', and specifically, to explore which ideologies and practices sustain them. The ideal of 'the body as machine' has been shaped not only by the medical discourse but in combination with the discourse of late capitalism, both strengthened by the advancement of technology. This has given the

impression that the body *can* and *should* function like a perpetual, productive machine — which gives rise to the drive and desire for 'nothing' (likewise resembling a robotic state existing under the idea of 'the body as machine'). While I have referred to certain ideologies part of late capitalism throughout this thesis, this has not been the focus, and more research and theoretical considerations are needed here in relation to the experience of fatigue. More precisely, it would be beneficial to uncover details surrounding the societal structures and practices shaping the idea of 'the body as machine' existing under a mind-body dichotomy. The most invaluable insight offered in this area, to my knowledge, is the work of Anson Rabinbach's (1992) 'The Human Motor: Energy, Fatigue, and the Origins of Modernity', which I recommend the reader to turn to. It is important, however, not to fall into the trap here of reducing a phenomenon to a sociocultural effect, but to acknowledge that links need to be established both to one's singular subjective history, to one's own responsibility, *and* to sociocultural influences, where one also bears a certain degree of responsibility.

But would establishing links be sufficient, both or either at an individual and social level? Would it prevent some from experiencing debilitating fatigue? I argue that it could provide a solid first step, but more research into fruitful societal solutions, and their practical implementation, is needed. For in Lacanian practice it is well known that making the unconscious conscious, which this process could be said to entail (to the extent that it is possible) — connecting the affect back to its origin — is not enough for a 'change' to take place. Freud noticed that such conscious knowledge does not always dissipate symptoms. Instead, what is needed is a change at the level of *jouissance,* affect (Fink, 2017: 235). Lacanian practice aims at this at not through understanding, but on the contrary, through non-understanding, such as punctuating the person's speech and any ambiguities found therein. That is, by constantly challenging and deconstructing any fixed ideas the subject is believed to coincide with — which involves in every case to first and foremost identify those ideas and its links as I argued above — lack/loss comes to the fore as something one accepts rather than rejects. The more one notices, through speech which creates gaps, that one keeps on chasing one's own tail, that what one is looking for does not exist and thus the ideas one held about oneself were 'false' in a way (lacking), the less desire fuels the goal of the drive, the goal of the drive being to get rid of lack which would also fuel less the aim of it, to circulate around a void (a void being necessary for extinguishing it repeatedly). Accepting lack would entail accepting that desire cannot be satisfied, that there will always be a surplus, which

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simultaneously means that one cannot coincide with an image or an idea; that nature and culture — the body and the mind — are incompatible. In other words, it would commensurate to accepting the mind-body gap, that they cannot be one. Concurrently, this process involves accepting the presence of a bodily force seeking satisfaction, and moreover one that is an effect of the sociocultural Other's discourse and practices; that lack never lacks enough and there is a lack of a lack, or put differently that 'nothing' is never empty enough, accepting the impossibility of separating the mind and the body. Through this process, the seeking force would lose some charge/not be taken so seriously (but also not disappear altogether). It is debatable within the field of Lacanian psychoanalysis what exactly constitutes the end of analysis, and we can speculate whether this is possible to occur socially. For what allows such a process to take place is that the subject's speech is directed to anOther, to the analyst. The analyst adopts the position of *object a*, suspending as much as possible his/her subjectivity in order for the analysand's subjectivity, and thus lack, to come forth. The opposite appears to occur today, where the sociocultural Other is dictating our every single move, telling us who we are, who we should be, what we feel and should feel etc.; in short, making demands which entail a reduction to a need and/or a confusing radical lack. This has the consequence, as I have argued in this thesis, of subjects making repeated appeals to the Other, for the need to both 'create' a lack in the Other and oneself, and to find protection against such lack.

In the very least, I claim that we can start by changing our perspective on the mind and the body by taking seriously their gap and relation *qua* inseparability. If we believe less in the ideas put on a pedestal such as that of 'the body as machine', both collectively and individually, and the false idea that our whole worth depends on *what* we do and how *much* we do, then the need to revolt would allegedly diminish. It would most likely not remove revolting altogether, and this would probably be undesirable, but it could diminish highly unconscious forms of revolting. Josh Cohen (2019) in his book 'Not Working – Why We Need to Stop' discusses burnout amongst others and proposes something akin to this, in terms of accepting and allowing space for non-activity, or for 'not doing' as evidenced by his title. Ideally, this would be reflected in social practices, where we would create, for instance, more humane and reasonable working conditions. Our obsession with using benchmarks — considering the requirement of employees to quantitatively measure all types of performances for evaluation purposes (a practice which has seeped into all fields) — adds

tremendously to the already-heavy work load many occupations possess. Furthermore, universal and pre-conceived ideas of success, performance and working capacity need to be challenged. Some reasonable solutions in relation to the omnipresent tendency to quantify human nature has been proposed by Verhaeghe (2014: 219) in his book 'What about me? The struggle for identity in a market-based society'. Therein, he argues for a qualitative as opposed to quantitative approach to labour organisation, one based on meritocracy and not financial incentives. That is, we are to treat and approach the subject, and any subject, not as an entity reducible to a number, but within its complex, social environment. The same goes for the activity of resting and other areas of life, which this research has showcased can align itself with the demand for constant productivity, thus becoming problematic. Life itself becomes work and one is constantly in the presence of the Other when an absence becomes registered as a presence through documentation and a reduction to numbers or universal ideas. It is therefore not enough to focus on improving working conditions as many are inclined to believe, because the question is if another equally consuming presence replaces it.

However, by prioritising the aspect of 'not doing', which Cohen does in his aforementioned book, there is a risk of romanticising the idea of 'nothing' attached to it — something part of the fatigued subject's unconscious fantasy and defence as argued in this thesis, which can subsequently end up perpetuating the condition. I propose instead that there should be an acceptance of the idea of doing *less* through the process of mourning, which simultaneously and equally involves an acceptance of the fact that 'doing nothing' is impossible, an acceptance of the presence and inescapability of demands, and ultimately, society. This would change one's relationships with demands and society as such. For certain demands cannot be bypassed. The presence of the perpetual needs of our biological bodies means we are forever slaves to the activities of eating, drinking and sleeping if we want to stay alive; if we want to be part of a social order we are demanded to speak in a certain language, and the demand to work and earn money is something not everyone has the luxury to evade. We would, in other words, need to recognise our alienation and our *dependency* on something other than ourselves, that we are ultimately human, social beings unable to escape certain determinism and demands. At the same time, we need to acknowledge that we play a role in these societal structures, and thus are not *fully* dependent on the current ideology and society — that 'we *are* the system that we complain about' (Verhaeghe, Ibid.: 236). It

constitutes accepting the presence of both alienation and separation in our lives. I am in turn advocating, following Verhaeghe's (Ibid.: 218) advice, for more of a balance between the two, between social organisation and autonomy, seeing as today responsibility fluctuates between too much responsibility put on the individual (influenced by neoliberal ideologies and practices), and not enough on the individual (influenced by the ideologies and practices of biomedicine and technology). This involves, first and foremost and alongside Fisher's (2009: 78) proposal, saying goodbye to our romantic attachment to the ideas of failure, hopelessness, and impossibilities. These ideas, particularly that of impossibility, are omnipresent in contemporary society and strongly related to the metaphor of 'the body as machine', the endorsement of which, as this thesis has illustrated, exerts a large influence on the formation and experience of fatigue as elaborated by the participants of this study.

In other words, the first inevitable step towards achieving a balance between separation and alienation — achieving a reasonable sense of responsibility — is through mourning. We need to start mourning. We need to mourn that which never was, never is, and never will be. In so doing, we can start making space for that which is *really* lost today, which is precisely loss itself. Only by losing can we create something new.

Bibliography

Afari, N., & Buchwald, D. (2003). Chronic Fatigue Syndrome: A review. *American Journal of Psychiatry*, 160(2), 221–236.

Anderson, V. R., Jason, L. A., Hlavaty, L. E., Porter, N., & Cudia, J. (2012). A Review and Meta-Synthesis of Qualitative Studies on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome. *Patient Education and Counseling*, 86(2), 147-155.

Bazelmans, E., Vercoulen, J. H., Swanink, C. M., Fennis, J. F., Galama, J. M., van Weel, C., et al. (1999). Chronic Fatigue Syndrome and Primary Fibromyalgia Syndrome as Recognized by GPs. *Family Practice*, 6, 602–604.

Banks, J., & Prior, L. (2001). Doing Things with Illness. The Micro Politics of the CFS clinic. *Social Science and Medicine*, 52(1), 11–23.

Barreto, F. P., & Besset, V. L. (2016). Chronic Pain and Psychosis: Beyond Sense. *Research in Psychoanalysis*, 2(22), 190-199.

Berger, D. (1999). A Brief History of Medical Diagnosis and the Birth of the Clinical Laboratory. Part 1 — Ancient times through the 19th century. *MLO Med Lab Obs*, *31*(7), 28-30.

Briggs, N. C., & Levine, P. H. (1994). A Comparative Review of Systemic and Neurological Symptomatology in 12 Outbreaks Collectively Described as Chronic Fatigue Syndrome, Epidemic Neuromyasthenia, and Myalgic Encephalomyelitis. *Clinical Infectious Diseases*, 18, S32–S42.

Boothby, R. (1991). *Death and Desire: Psychoanalytic Theory in Lacan's Return to Freud.* New York, NY: Routledge.

Boothby, R. (2013). The lost cause of mourning. *Continental Philosophy Review*, *46*(2), 209-221.

Bowen, J., Pheby, D., Charlett, A., & McNulty, C. (2005). Chronic Fatigue Syndrome: a survey of GPs' attitudes and knowledge. *Family Practice,* 22(4), 389-393.

Carruthers & Van de Sande (2005). *Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A Clinical Case Definition and Guidelines for Medical Practitioners. An Overview of the Canadian Consensus Document*. Retrieved from: http://www.investinme.org/Documents/PDFdocuments/Canadian_ME_Overview_A 4.pdf

Chiesa, L. (2006). Count-as-one, Forming-into-one, Unary Trait, S1. *Cosmos and History: The Journal of Natural and Social Philosophy*, *2*(1-2), 68-93.

Chiesa, L. (2007). *Subjectivity and Otherness: A Philosophical Reading of Lacan*. Cambridge, MA: MIT Press.

Cohen, J. (2018). *Not Working: Why We Have to Stop*. London: Granta Books.

Cosenza, D. (2015). Silence and the Voice in Anorexia Nervosa. *European Journal of Psychoanalysis*, 3.

Cox, D. (2016, April 4). Is Chronic Fatigue Syndrome Finally Being Taken Seriously? *The Guardian*. Retrieved from: https://www.theguardian.com/lifeandstyle/2016/apr/04/chronic-fatigue-syndrome-cfs-taken-seriously

Crary, J. (2013). *24/7: Late capitalism and the ends of sleep*. London, UK: Verso Books.

David, A., & Wessely, S. (1993). Chronic Fatigue, ME, and ICD-10. *The Lancet*, *342*(8881), 1247-1248.

De Kesel, M. (2009). *Eros and Ethics: Reading Jacques Lacan's Seminar VII*. New York, NY: SUNY Press.

De Rick, A. (2002). Freud's clinical category of 'actual neuroses': The Return of the Repressed. *THE LETTER (DUBLIN)*, (25-26), 120-132.

De Vos, J. (2012). *Psychologisation in Times of Globalisation*. East Sussex, UK: Routledge.

Deale, A., & Wessely, S. (2001). Patients' Perceptions of Medical Care in Chronic Fatigue Syndrome. *Social Science & Medicine, 52*(12), 1859-1864.

Descartes, R. (2002/1641) *Meditations on First Philosophy.* Retrieved from: http://www.vahidnab.com/med.pdf

Dickson, A., Knussen, C., & Flowers, P. (2007). Stigma and the Delegitimation Experience: An Interpretative Phenomenological Analysis of People Living with Chronic Fatigue Syndrome. *Psychology and Health, 22*(7), 851-867.

Dor, J. (1998). *The Clinical Lacan*. New York, NY: Other Press LLC.

Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science*, *196*(4286), 129-136.

Evans, D. (1996). *An Introductory Dictionary of Lacanian Psychoanalysis*. London, UK: Routledge.

Fink, B. (1990). Alienation and Separation: Logical Moments of Lacan's dialectic of Desire. *Newsletter of the Freudian Field*, *4*(1/2), 78-119.

Fink, B. (1995). *The Lacanian Subject: Between Language and Jouissance.* Princeton, NJ: Princeton University Press.

Fink, B. (1997). Desire and Drives. *Umbr(a), A Journal of the Unconscious*, (1), 35-51.

Fink, B. (1999). *A Clinical Introduction to Lacanian Psychoanalysis: Theory and Technique*. Minneapolis, MN: Harvard University Press.

Fink, B. (2004). *Lacan to the Letter: Reading Écrits closely*. Minneapolis, MN: U of Minnesota Press.

Fisher, M. (2009). *Capitalist Realism: Is There no Alternative?*. Hampshire, UK: John Hunt Publishing.

Fukuda, K., Straus, S. E., Hickie, I., Sharpe, M. C., Dobbins, J. G., & Komaroff, a. (1994). The Chronic Fatigue Syndrome: A Comprehensive Approach to its Definition and Study. International Chronic Fatigue Syndrome Study Group. *Annals of Internal Medicine*, *121*(12), 953–959.

Foucault, M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception.* (A. M. Sheridan Trans.). Bristol, UK: Tavistock Publications Limited.

Freud, S. (2001). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, (J. Strachey, trans & ed.) 24 vols. London: Vintage Books.

Friedberg, F. (2016). Cognitive-behavior therapy: Why is it so Vilified in the Chronic Fatigue Syndrome Community?. *Fatigue: Biomedicine, Health & Behavior*, *4*(3), 127-131.

Frosh, S., & Baraitser, L. (2008). Psychoanalysis and psychosocial studies. *Psychoanalysis, culture & society*, *13*(4), 346-365.

Frosh, S. (2003). Psychosocial Studies and Psychology: Is a Critical Approach Emerging?. *Human Relations*, *56*(12), 1545-1567.

Frosh, S. (2007). Disintegrating qualitative research. *Theory & Psychology*, *17*(5), 635-653.

Frosh, S. (2014). Disintegrating Narrative Research with Lacan. In Parker, I. & Pavón-Cuéllar, D (Eds.), *Lacan, Discourse, Event: New Psychoanalytic Approaches to Textual Indeterminacy* (pp. 17-27). East Sussex, UK: Routledge.

Gessert, A. (Ed). (2014). *Introductory Lectures on Lacan*. London: Karnac Books.

Greenshields, W. (2017). *Writing the Structures of the Subject: Lacan and Topology*. Cham, Switzerland: Springer Nature.

Grigg, R (1997). Dualism and the Drive. *Umbr(a), A Journal of the Unconscious,* (1), 159-164.

Guise, J., McVittie, C., & McKinlay, A. (2010). A Discourse Analytic Study of ME/CFS (Chronic Fatigue Syndrome) Sufferers' Experiences of Interactions with Doctors. *Journal of Health Psychology*, *15*(3), 426–435.

Han, B-C. (2015). *The Burnout Society*. Standford, CA: Standford University Press.

Harper, D. (2011). Online Etymological Dictionary. Retrieved from
http://www.etymonline.com/index.php?term=diagnosis

Hart, B., Grace, V.M. (2000). Fatigue in Chronic Fatigue Syndrome: A Discourse Analysis of Women'S Experiential Narratives. *Health Care for Women International*, 21(3), 187–201.

Hawkes, N. (2011). Dangers of Research into Chronic Fatigue Syndrome. *BMJ*, *342*(1), 3780–3780.

Hoens, D. (2018). Is Life but a Pascalian Dream? A Commentary on Lacan's Louvain Lecture. *Psychoanalytische Perspectieve*n, *36*(2), 169-185.

Holmes, G. P., Kaplan, J. E., Gantz, N. M., Komaroff, A. L., Schonberger, L. B., Straus, S. E., Brus, I. (1988). Chronic Fatigue Syndrome: A Working Case Definition. *Annals of Internal Medicine*, *108*(3), 387–389.

Hook, D. (2015). Mapping Anxiety. *Psychol. Soc,* 48, 114-120.

Hornbacher, M. (1999). *Wasted: A Memoir of Anorexia and Bulimia*. London, UK: Harper Collins Publishers.

Horton-Salway, M. (2002). Bio-Psycho-Social Reasoning in GPs' Case Narratives: The Discursive Construction of ME Patients' Identities. *Health (London), 6*(4), 401–421.

Horton-Salway, M. (2004). The Local Production of Knowledge: Disease Labels, Identities and Category Entitlements in ME Support Group Talk. *Health (London, England: 1997), 8*, 351–371.

Horton, S.M., Poland, F., Kale, S. et al. (2010). Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) in Adults: A Qualitative Study of Perspectives from Professional Practice. *BMC Family Practice,* 11 (89).

Jennings, D. (1986). Philosophy of Medicine: The Confusion Between Disease and Illness in Clinical Medicine. *Canadian Medical Association Journal*, *135*, 865–870.

Kirshner, L. A. (2009). Biopolitics and the Transformation of the Psychiatric Subject. In S, Binkley, (Eds), *A Foucault for the 21st Century* (pp. 92-103). Newcastle upon Tyne, UK: Cambridge Scholars Publishing.

Lacan, J. (1977). *The Four Fundamental Concepts of Psychoanalysis*. (*Book XI*). (J-A. Miller, Ed). Translated by A. Sheridan. London, UK: Karnac Books.

Lacan, J. (1991). *The Seminar of Jacques Lacan: Book II: The Ego in Freud's Theory and in the Technique of Psychoanalysis: 1954-1955*. (J-A. Miller, Ed). Translated by S. Tomaselli. New York, NY: Cambridge University Press.

Lacan, J. (2002/2006). *Écrits, The First Complete Edition in English*. (B. Fink, Trans). London, UK: W.W. Norton & Company.

Lacan, J. (Unofficial). *The Seminar of Jacques Lacan: Book XIV: The Logic of Phantasy: 1966-1967* (Trans. C. Gallagher). Retrieved from: http://www.lacaninireland.com/web/wp-content/uploads/2010/06/THE-SEMINAR-OF-JACQUES-LACAN-XIV.pdf

Lacan, J. (2014). *Anxiety: The Seminar of Jacques Lacan Book X*. (J-A. Miller, Eds). Translated by A.R. Price. Cambridge, UK: Polity Press.

Lacan, J. (2015). *The Seminar of Jacques Lacan: Book VIII: Transference*. (B. Fink, Trans.). Cambridge, UK: Polity Press.

Lacan, J. (2017). *The Seminar of Jacques Lacan: Book V: The Formations of the Unconscious: 1957-1958*. (R. Grigg., Trans.). Cambridge, UK: Polity Press.

Lacan, J. (2019). *The Seminar of Jacques Lacan: Book VI: Desire and Its Interpretation*. (B. Fink, Trans.). Cambridge, UK: Polity Press.

Lacan, J. (Unpublished), *The Seminar of Jacques Lacan, Book IV: The Objects Relation*. (L.V.A Roche, Trans). Retrieved from:

Lacan, J. (Unofficial). *The Seminar of Jacques Lacan: Book XXI: Les Non-Dupes Errent: 1973-1974*. (C. Gallagher, Trans.). Retrieved from: http://www.lacaninireland.com/web/translations/seminars/

Leader, D. (1997). *Promises Lovers Make When It Gets Late*. London, UK: Faber & Faber Limited.

Leader, D., & Corfield, D. (2008). *Why Do People Get Ill? Exploring the Mind-body Connection* London, UK: Penguin Books.

Leader, D. (2008). *The New Black: Mourning, Melancholia and Depression*. London, UK: Penguin Books.

Leader, D. (2012). *What is Madness?* London, UK: Penguin Books.

Leader, D. (2016). 'Hysteria Today' In A. Grose (Ed.), *Hysteria Today.* London, UK: Karnac Books.

Leader, D. (2017). *Hands: What We Do with Them – and Why*. London, UK: Penguin Books.

Legrand, D. (2011). Ex-Nihilo: Forming a Body out of Nothing. *Collapse. Special Issue on Culinary Materialism*, *7*, 499-558.

Loose, R. (2002). *The Subject of Addiction: Psychoanalysis and the Administration of Enjoyment*. London, UK: Karnac Books.

Loose, R. (2014, March 6). *The DSM: A Development Towards a Clinical Impasse* [Video file]. Retrieved from https://www.youtube.com/watch?v=WlN3jRXeQEI

Loose, R. (2015). The Hijacking of the Symptom and the Addictification of Society. *Subjectivity*, *8*(2), 165-179.

Ludlam, S. (2018, May 11). To the #MillionsMissing with ME/CFS, Something Remarkable is Happening. The Guardian. Retrieved from https://www.theguardian.com/commentisfree/2018/may/12/to-the-millionsmissing-with-mecfs-something-remarkable-is-happening

Mackie P., Dougall R., Conacher A. (2011). *Health Care Needs Assessment of Services for People Living with ME-CFS - Short Version for Patients, Scottish Public Health Network*. NHS Health Scotland. Retrieved from: https://www.scotphn.net/wp-content/uploads/2015/10/Report-Health-care-needs-assessment-of-services-for-people-living-with-ME-CFS-Short-Version-September-2011.pdf

McGowan, T. (2004). *End of Dissatisfaction? Jacques Lacan and the Emerging Society of Enjoyment*. New York, NY: State University of New York Press.

McGowan, T. (2013). *Enjoying What we Don't Have*. Lincoln, NE: University of Nebraska Press.

Miller, J-A. (1977-1978). Suture (Elements of the Logic of the Signifier). (R. Jacqueline, Trans). *Screen*, *18*, 24-34.

Miller, J. A. (2009). Ordinary Psychosis Revisited. *Psychoanalytical Notebooks*, *19*, 139-67.

Miller, J-A. (2015). Ordinary Psychosis Revisited. *Lacanian Ink, 46*, 90-115.

Miller, M. J. (2011). *Lacanian Psychotherapy: Theory and Practical Applications*. New York, NY: Routledge.

Moncayo, R. (2012). *The Emptiness of Oedipus: Identification and Non-Identification in Lacanian Psychoanalysis.* New York, NY: Routledge.

Neill, C. (2013). Breaking the text: An introduction to Lacanian discourse analysis. *Theory & Psychology*, *23*(3), 334–350.

Neill, C. (2014). *Lacanian Ethics and the Assumption of Subjectivity*. London: Palgrave Macmillan.

Neill, C. (2016). *Ethics and psychology: Beyond codes of practice*. Oxon, UK: Routledge.

NICE (2007). *Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management*. National Institute for Health and Care Excellent. Retrieved from nice.org.uk/guidance/cg53

Nietzsche, F. W. (2014). *Beyond Good and Evil: On the Genealogy of Morality*. Stanford, CA: Stanford University Press.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London, UK: Sage Publications Ltd.

Parker, I. (2005a). Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. Theory and Psychology, *15*, 163–182.

Parker, I. (2005b). Qualitative Psychology: Introducing Radical Research. Maidenhead, UK: Open University Press.

Parker, I. (2007). *Revolution in Psychology: Alienation to Emancipation*. London, UK: Pluto Press.

Parker, I. (2010). Psychosocial studies: Lacanian discourse analysis negotiating interview text. *Psychoanalysis, Culture and Society*, *15*(2), 156–172.

Parker, I. (2015a). *Psychology after Discourse Analysis: Concepts, Methods, Critique*. East Sussex: Routledge.

Parker, I. (2015b). *Psychology After Lacan: Connecting the Clinic and Research*. East Sussex: Routledge.

Page, L. A., & Wessely, S. (2003). Medically Enexplained Symptoms: Exacerbating Factors in the Doctor–Patient Encounter. *Journal of the Royal Society of Medicine, 96*(5), 223-227.

Pavon Cuellar, D. (2010). *From the unconscious interior to an exterior unconscious*. London, UK: Karnac.

Phillips, A. (2017, May 1). Interview with Adam Phillips: The Art of Nonfiction No. 7, Adapted from the Paris Review. (P. Holdengräber, Interviewer). *Nashville Psychotherapy Institute*. Retrieved from: https://nashvillepsychotherapyinstitute.org/news/interview-with-adam-phillips-the-art-of-nonfiction-no-7-adapted-from-the-paris-review-may-1-2017/

Pluth, E. (2007). *Signifiers and Acts: Freedom in Lacan's Theory of the Subject*. New York, NY: State University of New York Press.

Prins, J. B., van der Meer, J. W. M., Bleijenberg, G., Meer, J. W. M. Van Der, & Bleijenberg, G. (2006). Chronic Fatigue Syndrome. *Lancet, 367*(9507), 346–355.

Rabinbach, A. (1992). *The Human Motor: Energy, Fatigue, and the Origins of Modernity*. Berkeley, CA: University of California Press.

RACP (2002). *Chronic Fatigue Syndrome. Clinical Practical Guidelines*. Working Group of the Royal Australasian College of Physicians. Retrieved from: https://www.mja.com.au/system/files/issues/cfs2_2.pdf

Redmond, J. (2014). *Ordinary Psychosis and the Body: A Contemporary Lacanian Approach*. Hamsphire, UK: Palgrave Macmillan.

Rogers, A. G. (2018). *Incandescent alphabets: Psychosis and the Enigma of Language*. Oxon, UK: Rouledge.

Salecl, R. (2000). *Love and Sexual Difference: Double Partners in Men and Women.* Durham, NC: Duke University Press.

Salecl, R. (2004). *On Anxiety*. London, UK: Routledge.

Schur, E. A., Afari, N., Furberg, H., Olarte, M., Goldberg, J., Sullivan, P. F., & Buchwald, D. (2007). Feeling Bad in More Ways Than One: Comorbidity Patterns of Medically Unexplained and Psychiatric Conditions. *Journal of General Internal Medicine*, *22*(6), 818–821.

Schuster, A. (2015). Lecture on *The Lacan-Foucault Relation: Las Meninas, Sexuality, and the Unconscious*. Personal Collection of A, Schuster, Sandberg Institute, Amsterdam.

Schuster, A. (2016). *The Trouble with Pleasure: Deleuze and Psychoanalysis*. Cambridge, MA: MIT Press.

Schuster, A. (2017). Impossible Professions, and How to Defend Them. In D. Mangano, M. van Rooy & N. J. Lekkerkerk (Eds). *Homestead of Dilution* (pp. 89-103), Eindhoven: Onomatopee.

Shepherdson, C (1997). The Elements of the Drive. *Umbr(a), A Journal of the Unconscious* (1), 131-146.

Smith, C., & Wessely, S. (2014). Unity of opposites? Chronic fatigue syndrome and the challenge of divergent perspectives in guideline development. *Journal of Neurology, Neurosurgery & Psychiatry*, *85*(2), 214-219.

Soler, C. (1996). Hysteria and Obsession. In Feldstein, R., Fink, B., & Jaanus, M. (Eds.). *Reading Seminars I and II: Lacan's Return to Freud* (pp. 248-82). New York, NY: State University of New York Press.

Stevens, A. (2009). Mono-Symptoms and Hints of Ordinary Psychosis. *Psychoanalytical Notebooks*, *19*.

Swales, S. S. (2012). *Perversion: A Lacanian Psychoanalytic Approach to the Subject*. New York, NY: Routledge.

The ME Association. 2010. *Managing my M.E. What People with ME/CFS and their Carers Want from the UK's Health and Social Services: The Results of the ME Association's Major Survey of Illness Management Requirements*. The ME Association. Retrieved from: https://meassociation.org.uk/wp-content/uploads/2010/09/2010-survey-report-lo-res10.pdf

Tucker, I. (2004). "Stories" of Chronic Fatigue Syndrome: An Exploratory Discursive Psychological Analysis. *Qualitative Research in Psychology*, *1*(2), 153–167.

Turner, B. S. (2003). Social Fluids: Metaphors and Meanings of Society. *Body & Society, 9*(1), 1–10.

Turner, B. (2004). *The New Medical Sociology: Social Forms of Health and Illness*. New York, NY: W.W. Norton.

Valdrè, R. (2018). *Psychoanalytic Reflections on The Freudian Death Drive: In Theory, the Clinic, and Art*. Oxon, UK: Routledge.

Van Haute, P. (2002). *Beyond Adaptation: Lacan's "Subversion" of the Subject: A Close Reading*. New York, NY: Other Press.

Vandenbergen, J., Vanheule, S., Rosseel, Y., Desmet, M., & Verhaeghe, P. (2009). Unexplained Chronic Fatigue and Interpersonal Problems: a Study in a Primary Care Population. *International Journal of Psychiatry in Medicine*, *39*, 325–340.

Vanheule, S. (2001). Burnout and psychoanalysis: A Freudo-Lacanian point of view. *Journal for the Psychoanalysis of Culture & Society*, *6*(2), 265-271.

Vanheule, S., Lievrouw, A., & Verhaeghe, P. (2003). Burnout and Intersubjectivity: A Psychoanalytical Study from a Lacanian Perspective. *Human Relations, 56*(3), 321–338.

Vanheule, S., & Verhaeghe, P. (2004). Powerlessness and Impossibility in Special Education: A Qualitative Study on Professional Burnout from a Lacanian Perspective. *Human Relations*, *57*(4), 497–519.

Vanheule, S., & Verhaeghe, P. (2005). Professional Burnout in the Mirror: A Qualitative Study From a Lacanian Perspective. *Psychoanalytic Psychology*, *22*(2), 285–305.

Vanheule, S. (2014). *Diagnosis and the DSM: A Critical Review*. London, UK: Palgrave Macmillan.

Vanheule, S. (2018). On Ordinary Psychosis. In J.Mills., & D, L, Downing. (Eds). *Lacan on Psychosis* (pp. 77-102). New York, NY: Routledge.

Vanheule, S. (2014). *The Subject of Psychosis: A Lacanian Perspective*. Hampshire, UK: Palgrave Macmillan.

Verhaeghe, P. (2004). *On Being Normal and Other Disorders: A Manual for Clinical Psychodiagnostics*. New York, NY: Other Press LLC.

Ward, C. D. (2015). *Meanings of ME: Interpersonal and Social Dimensions of Chronic Fatigue*. London, UK: Palgrave Macmillan UK.

Wessely, S., Nimnuan, C., & Sharpe, M. (1999). Functional Somatic Syndromes: One or Many? *Lancet, 354*, 936–939.

White, P. D., Goldsmith, K. A., Johnson, A. L., Potts, L., Walwyn, R., De Cesare, J. C., & Bavinton, J. (2011). Comparison of Adaptive Pacing Therapy, Cognitive Behaviour Therapy, Graded Exercise Therapy, and Specialist Medical Care for Chronic Fatigue Syndrome (PACE): A Randomised Trial. *The Lancet*, *377*(9768), 823-836.

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method* (2nd Ed.). Berkshire, UK: Open University Press.

Wolf, B. (2019). *Anxiety Between Desire and the Body: What Lacan Says in Seminar X*. Oxon, UK: Routledge

Žižek, S. (1996). Love beyond law. *Journal for the Psychoanalysis of Culture and Society*, *1*, 160-161.

Žižek, S. (2000). *The Ticklish Subject: The Absent Centre of Political Ontology*. London, UK: Verso.

Žižek, S. (2006a). *How to Read Lacan*. London, UK: Granta Books.

Žižek, S. (2006b). *The Parallax View*. Cambridge, MA: MIT Press.

Žižek, S. (2017, May 5). *Slavoj Zizek - Hegel's Negation and Repetition*. [Video file]. Retrieved from: https://www.youtube.com/watch?v=Mq6cMwrOScU

Zupančič, A. (2017). *What IS Sex?*. Cambridge, MA: MIT Press.

Appendix 1: Recruitment Poster

Edinburgh Napier
UNIVERSITY

LOOKING FOR VOLUNTEERS

Do you experience fatigue?

The purpose of this research study is to find out about the personal experiences of those who experience fatigue/ME/CFS.

I am looking for volunteers in the central belt of Scotland who:

. are 18 years or older

. experience constant or intense fatigue that is different from everyday tiredness and that has affected your life negatively

 OR

• consider yourself to have Myalgic Encephalomyelitis/Chronic Fatigue Syndrome

 OR

• have been diagnosed with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome

The study involves taking part in an interview, that will take around an hour.

If you are interested in taking part and/or would like more information, please contact:

Amanda Diserholt
Postgraduate Research Student
Email: ████████████████████

Appendix 2: Recruitment Sheet

Title: *The Language of Fatigue*

My name is Amanda Diserholt and I am a postgraduate research student from the School of Life, Sport & Social Sciences at Edinburgh Napier University. My research project focuses on fatigue/Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS). More specifically, this study will explore the personal experiences of those experiencing fatigue.

I am looking for volunteers in the central belt of Scotland who:

. are 18 years or older
. experience constant or intense fatigue that is different from everyday tiredness and that has affected your life negatively

   OR

• consider yourself to have Myalgic Encephalomyelitis/Chronic Fatigue Syndrome

   OR

• have been diagnosed with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome

What is the purpose of the study?
Symptoms of fatigue and ME/CFS are not well understood. It is the intention of this research project to deepen the understanding of the lived experiences of those with fatigue/ME/CFS. By feeding the findings of this project to health professionals and the public, it is the aim to provide with knowledge that will aid the approach to people with fatigue/ME/CFS.

What does it involve?
Taking part in the study means that you will be asked to take part in a face-to-face interview, taking place at a location of your choice (for example at home, a quiet café or at my university campus in Sighthill) at a time of your convenience. The interview will be recorded on a tape recorder and should take around 60 minutes. I will ask some questions about your experience with fatigue/ME/CFS, when and how it started, and your experience of any contact with health professionals, if you have any.

You have the right to withdraw from the study at any stage without giving a reason. To make sure enough data is gathered, I will interview a total of 15 people. However, while all interviews will be carefully looked at and analysed, there is a chance not all analyses will be included in the final thesis. There might be an opportunity to take part in follow-up interviews.

Will my information be kept confidential?

All data will be anonymised, but you may be identifiable from tape recordings of your voice. However these will not be public and will be destroyed at the end of the project. Your name will be replaced with a pseudonym, and it will not be possible for you to be identified in any reporting of the data gathered. All data collected will be kept on a password protected computer to which only my supervisors and I will have access.

If you have any concerns of questions regarding this study, you are welcome to contact me or my Director of Studies, Dr Calum Neill:

Amanda Diserholt

Research Student

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus

EH11 4BN

Email: ▮▮▮▮▮▮▮▮▮▮▮▮

Dr Calum Neill Postgraduate Lecturer

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus Sighthill Court Sighthill Court

EH11 4BN

Email: ▮▮▮▮▮▮▮▮▮

Tel: ▮▮▮▮▮▮

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact **Dr Geraldine Jones**, Senior Lecturer from the School of Life, Sport & Social Sciences, Edinburgh Napier University. You can contact her via email: ▮▮▮▮▮▮▮▮▮▮▮, or telephone: ▮▮▮▮▮▮▮

I would greatly appreciate any time you could spare to participate in this research. If you are interested in taking part, please contact me by email or mail at the above address.   If you are unsure about taking part and/or have any questions, please don't hesitate to get in touch.

Thank you very much in anticipation.

Kind regards,

Amanda Diserholt

Appendix 3: Participant Information Sheet

Title: *The Language of Fatigue*

My name is Amanda Diserholt and I am a postgraduate research student from the School of Life, Sport & Social Sciences at Edinburgh Napier University. My research project focuses on fatigue and Chronic Fatigue Syndrome (CFS)/Myalgic Encephalomyelitis (ME). More specifically, this study will explore the personal experiences of those experiencing fatigue. Before deciding to take part, please take the time to read the following carefully. I am looking for volunteers to participate in the project who:

. Are 18 years or older
. Experience constant or intense fatigue that is different from everyday tiredness and that has affected your life negatively <u>OR</u>
. Consider yourself to have Chronic Fatigue Syndrome/Myalgic Encephalomyelitis <u>OR</u>
. Have been diagnosed with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis

What is the purpose of the study?
The findings of the project will be valuable both for theoretical and practical reasons. It will contribute to the research and knowledge of the lived experiences of those suffering from fatigue/CFS/ME. The key findings will be fed to researchers, health professionals and to the public as the aim is to improve the approach to fatigue/CFS/ME.

What does it involve?
If you agree to participate in the study, you will be asked to take part in an interview. The interview will be recorded on a tape recorder and should take no longer than 60 minutes. I will ask some questions about your experiences with having fatigue/CFS/ME, when and how it started, and your experiences with any contact with health professionals, if you have any. To make sure enough data is gathered, I will interview a total of 15 people. However, while all interviews will be carefully looked at and analysed, there is a chance not all analyses will be included in the final thesis. There might be an opportunity to take part in follow-up interviews.

Will my information be kept confidential?
All data will be anonymised as much as possible, but you may be identifiable from tape recordings of your voice. Your name will be replaced with a pseudonym, and it will not be possible for you to be identified in any reporting of the data gathered. All data collected will be kept on a password protected computer to which only my supervisors and I will have access. These will be kept for ten years after the completion of my degree, following which all data that could identify you will be destroyed. The results may be published in a journal or presented at a conference.

Do I have to take part?

You are under no obligation to take part in the study. If you decide to volunteer to participate, you can still withdraw at any time during the interview without giving any reasons. If you change your mind after the interview and would not like your interview to be used for this study, you can contact me at any time to withdraw. You also have the right to skip questions and to stop the interview at any time.

If you have any concerns of questions regarding this study, you are welcome to contact me or my Director of Studies , Dr Calum Neill:

Amanda Diserholt

Research Student

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus

EH11 4BN

Email:

Dr Calum Neill Postgraduate

Lecturer

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus Sighthill Court

Sighthill Court

EH11 4BN

Email:

Tel:

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact **Dr Geraldine Jones**, Senior Lecturer from the School of Life, Sport & Social Sciences, Edinburgh Napier University. You can contact her via email:

, or telephone:

What next?

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

Appendix 4: Consent Form

Edinburgh Napier University Research Consent Form

Edinburgh Napier University requires that all persons who participate in research studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

1. I freely and voluntarily consent to be a participant in the research project on the topic of fatigue/Chronic Fatigue Syndrome (CFS)/Myalgic Encephalomyelitis (ME) to be conducted by Amanda Diserholt, who is a postgraduate research student at Edinburgh Napier University.

2. The goal of this research study is to explore the personal experience of those with fatigue. Specifically, I have been asked to take part in an interview, which should take around 60 minutes to complete.

3   I agree that the interview will be recorded on an audio recorder.

4. I have been told that my responses will be anonymised. My name will not be linked with the research materials, and I will not be identified or identifiable in any report subsequently produced by the researcher.

5. I also understand that if at any time during the interview I feel unable or unwilling to continue, I am free to leave. That is, my participation in this study is completely voluntary, and I may withdraw from it without negative consequences.

6. In addition, should I not wish to answer any particular question or questions, I am free to decline.

7. I have been given the opportunity to ask questions regarding the interview and my questions have been answered to my satisfaction.

8. I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

Participant's Signature   Date

I have explained and defined in detail the research procedure in which the respondent has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

Researcher's Signature   Date

Appendix 5: Interview Schedule

Introduction

- Ask participant to read over information sheet
- Go through the main points verbally (anonymity, their right to withdraw/skip questions/take breaks)
- Ask if they have any questions
- Give consent form to sign
- Agree on a pseudonym

Questions

- Could you please say your pseudonym and age? So I can identify you later on.

- How do you meet the requirements for taking part in this study?
    Prompts: Can you tell me a bit about it? What is it like ((the fatigue/condition/symptom(s)? Do you have any other symptoms? If yes, can you describe them?

- How does the condition influence your life? What areas of you life does it impact on most?

- Can you tell me a bit about when you first felt your symptoms/fatigued. When did you first feel any symptoms?
    Prompts: How did you experience fatigue/symptoms in the beginning? What was going on in your life more generally then? How did the symptom(s)/condition develop? What do they feel like today?

- Have you ever sought the help of any health professionals (such as GP, nurses or alternative doctors)?

    Prompts: *If yes, what have your experiences been like? What happened? What did you find helpful? What did you find not helpful? If no, what has stopped you from seeking help?*

- If applicable: What is it like living with the name CFS/ME?
- *Prompts: What does the name mean to you? What was it like being diagnosed/realising you had CFS/ME? If applicable: How do you cope with issues of diagnosis/stigma?x*

- How do you think others (friends, family, society) view fatigue/your condition/ME/CFS?
If applicable: What role does support groups play in your life?

Appendix 6: Debrief Sheet

The Language of Fatigue

Edinburgh Napier UNIVERSITY

Thank you very much for participating in the interview - it is extremely helpful for my research. I will write down the conversation we just had into a document, which I will then then look at to try to understand your experiences living with ME/CFS/fatigue. This will be done through a method called 'Lacanian Discourse Analysis'. Your experiences will stand at the centre of my research and analysis. Your contribution to this research is valuable both for theoretical and practical reasons. Symptoms of fatigue and Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS) are not well understood. It is the intention of this research project to deepen the understanding of the lived experiences of those with ME/CFS/fatigue. By feeding the findings of this project to health professionals and the public, it is the aim to provide with knowledge that will aid the approach to people with fatigue/ME/CFS. You are at any time free to withdraw your contribution from this research without giving any reason. To do so, please contact me on the details below. Similarly, if you have any questions at a later stage, please contact myself or my supervisor:

Amanda Diserholt

Research Student

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus

EH11 4BN

Email: ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

Dr Calum Neill Postgraduate Lecturer

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus Sighthill Court

Sighthill Court

EH11 4BN

Email: ▮▮▮▮▮▮▮▮▮▮

Tel: ▮▮▮▮▮▮▮

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Dr Geraldine Jones. Her contact details are given below.

Dr Geraldine Jones

School of Life, Sport & Social Sciences

Edinburgh Napier University

Sighthill Campus

Sighthill Court

EH11 4BN

Email: ██████████████████

Tel: ████████████

Should you feel distressed after participating in this study and would like to talk to someone, you can contact the following helplines:

Samaritans: 116 123 (open 24 hours)

Breathing Space: 0800 83 85 87 (Open Monday-Thursday 6pm to 2am, 24 hours on weekends)

ME Connect: 0844 576 5326 (Open everyday 10am-12pm, 2-4pm, 7-9pm)

Appendix 7: Interest Sheet for Follow-up Interview

Title of Study: *The Language of Fatigue*

Interested in a follow-up interview?

There may be an opportunity to take part in follow-up interviews. If you are invited for a follow-up interview, I would contact you about 1-3 months after today to see if you are still interested. If this is the case, you would be invited to take part of an interview. You would have the opportunity to read the written version of this interview, which will be sent to you three days before the next interview. At the next interview you would have a chance to further explain and expand on things you said in this interview. Please leave your preferred contact details below if you are interested in being contacted to take part in this second stage:

Name:

_____

Contact details (email or post address):

_____

Appendix 8: Recruitment Sheet for Follow-up Interview

Edinburgh Napier
UNIVERSITY

Dear participant,

About two months ago, you took part in my research study where I interviewed you about your experience with ME/CFS. I am contacting you to ask if you would be interested in taking part in a follow-up interview.

If you are interested in taking part, you would be asked to take part in an interview taking place at a location of your choice (for example at home, a public place or at my university campus in Sighthill) at a time of your convenience. Before the interview you would have a chance to read over the written document from your first interview. This document will be sent to you three days before the interview, either through email or post, in order to give you time to read through it. You can ask for more time if you feel you need it. Please note that you can still take part in the interview without having read the written document.

The interview will be recorded on a tape recorder and should take around 30 - 60 minutes. In this interview you would have the opportunity to expand on and further explain things that you said in the first interview, and I will ask you some questions about it. You have the right to withdraw from the study at any stage without giving any reason, and just like your first interview, all collected data will be anonymised and kept on a password protected computer to which only my supervisors and I will have access.If you have any concerns of questions regarding this study, you are welcome to contact me or my Director of Studies, Dr Calum Neill:

Amanda Diserholt
Research Student
School of Life, Sport & Social Sciences

Edinburgh Napier University
Sighthill Campus

EH11 4BN

Email: ▇▇▇▇▇▇▇▇▇▇▇▇▇▇

Dr Calum Neill Postgraduate
Lecturer
School of Life, Sport & Social Sciences
Edinburgh Napier University
Sighthill Campus Sighthill Court
Sighthill Court
EH11 4BN

Email: ▇▇▇▇▇▇▇▇
Tel: ▇▇▇▇▇▇▇

If you are happy to take part, please contact me on the details above.

Kind regards,
Amanda Diserholt
Postgraduate Research Student

Appendix 9: Participant Information Sheet for Follow-up Interview

Title: *The Language of Fatigue*

My name is Amanda Diserholt and I am a postgraduate research student from the School of Life, Sport & Social Sciences at Edinburgh Napier University. My research project focuses on Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS). More specifically, this study explores the personal experiences of those experiencing ME/CFS. Before deciding to take part, please take the time to read the following carefully.

What does it involve?

You have been invited to take part in the second stage of this study. If you agree to participate in the study, you will be asked to take part in an interview. The interview allows you the chance to expand on and further explain things you said in the previous interview. I will also ask you some questions about it. A written document of the first interview was sent to you before this interview, which you may refer to. However you can still participate if you have not read it. The interview will be recorded on a tape recorder and should take around 30 to 60 minutes.

The findings of this research will be useful as they will help deepen understanding of the lived experiences of those suffering from ME/CFS.

Will my information be kept confidential?

All data will be anonymised as much as possible, but you may be identifiable from tape recordings of your voice. Your name will be replaced with a pseudonym, and it will not be possible for you to be identified in any reporting of the data gathered. All data collected will be kept on a password protected computer to which only my supervisors and I will have access. These will be kept for ten years after the completion of my degree, following which all data that could identify you will be destroyed. The results may be published in a journal or presented at a conference.

Do I have to take part?

You are under no obligation to take part in the study. If you decide to volunteer to participate, you can still withdraw at any time during the interview without giving any reasons. If you change your mind after the interview and would not like your interview to be used for this study, you can contact me at any time to withdraw. You also have the right to skip questions and to stop the interview at any time.

If you have any concerns of questions regarding this study, you are welcome to contact me or my Director of Studies, Dr Calum Neill:

Amanda Diserholt	**Dr Calum Neill** Postgraduate
Research Student	Lecturer
School of Life, Sport & Social Sciences	School of Life, Sport & Social Sciences
Edinburgh Napier University	Edinburgh Napier University
Sighthill Campus	Sighthill Campus Sighthill Court
	Sighthill Court
EH11 4BN	EH11 4BN
Email: ██████████████	Email: ██████████
	Tel: ████████

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact **Dr Geraldine Jones**, Senior Lecturer from the School of Life, Sport & Social Sciences, Edinburgh Napier University. You can contact her via email: ██████████████ or telephone: ██████████

What next?

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.