this mechanism which Kraepelin called *Sperrung* (blocking) as opposed to *Hemmung* (inhibition).

There are often physical signs to be seen: unequal pupils, dilated pupils, exaggerated reflexes, excessive salivation . . .

The condition may last a considerable time until dementia supervenes.

The differential diagnosis includes other conditions which produce catatonic features, although in these cases the catatonic signs are transient and incomplete: infectious delirium and dementia, traumatic and epileptic psychoses, general paralysis, cerebral tumour, idiocy, depression and hysteria.

Ernest Dupré (1862–1921)

Ernest Dupré was born in Marseilles but spent most of his life in Paris. His father became a teacher of rhetoric in a Parisian grammar school. After qualifying as a physician he studied general medicine for several years and then chose to specialise in psychiatry. He became the director of a hospital for the criminally insane and most of his publications reflect his interest in forensic psychiatry.

During the First World War he campaigned for more adequate psychiatric services for the French soldiers and described the frequent occurrence of a neurotic reaction among combatants, which one of his pupils termed 'Dupré's disease'. Dupré was a cultured man who tried, in his writings, to accommodate the 19th century views of Morel and Magnan on 'degenerates' with more enlightened and psychological notions of how disturbed imagination and emotional disorder could lead to antisocial behaviour.

Dupré is celebrated for inventing the term 'mythomania' – a tendency in some people to fabricate the events of their life. The article selected here, which he wrote with Logre, is an attempt to explain how this mythomanic tendency could lead to the development of a psychosis.

Jean Logre (1883–1963)

Jean Logre was born in Lisieux in Normandy. He studied medicine in Paris and then turned to psychiatry, first as a pupil and then as a collaborator with Dupré. He was appointed director of the hospital for the criminally insane in Paris on the death of de Clérambault.

Logre was a cultured man, an expert on Latin verse, who was respected by the French psychoanalytical school. He wrote a comprehensive textbook of psychiatry. The article translated here illustrates his interest in forensic and nosological issues.

Confabulatory delusional states

E. Dupré and J. Logre (1911)
(Les délires d'imagination, *Encéphale* **6a**, 209–32)

Introduction

In 1910 we introduced the term 'confabulatory delusional states' to designate those psychiatric conditions where there was a selective

disorder of the faculty of creative imagination. They are the result of a heightened creative activity, leading to the spontaneous association of images and ideas into new combinations. These inventive constructions, which correspond to some extent with reality, represent the subjective and autogenic products of the mind. Their content expresses the personal inclinations of the subject, and their complexity is a function of the strength and mobility of a subject's psychological make-up. Although imagination has a role in the formation of all delusions, it is never so exclusively involved as in those states that we are considering here. In other cases the crucial element in the formation of a delusion is an error in the way a subject views the world, or a perceptual disorder, or a pathological way of reasoning.

A more detailed comparison of the probable origin of various delusional states will serve to highlight what we regard as the characteristic feature of these confabulatory states.

In hallucinatory delusional states, whether acute (toxic delirium, delirium tremens, bouffées délirantes) or chronic (the hallucinatory psychoses described by Séglas and Cotard, the hallucinoses of Dupré), the predominant disorder is one of perception. The subject regards as real perceptions what are in effect subjective products of his mind. At the same time the perceptual disorder determines the content of the delusion by presenting the material to be incorporated. In pure hallucinatory states a patient may embroider what he regards as a genuine event in the outside world, but such interpretations are natural and logical. The position is sometimes complicated by the fact that patients may have an associated confusional state, and their interpretations may appear pathological for this reason, but the primary origin of any delusion is the perceptual disorder, and it is not necessary to introduce a disorder of reasoning or imagination to explain its development. In classic hallucinatory delusional states one may find abundant and absurd interpretations which go beyond what should be natural interpretations of their hallucinations; nevertheless, even in these cases the hallucination always plays a major role.

In misinterpretative delusional states one assumes that the disorder arises at a more advanced stage along the chain of operations which run from simple perception to states of belief and certainty. The error made by someone with hallucinations is in the sphere of perception. The error of a misinterpretation is in the sphere of logic, as in this case perception is not affected. The problem is not one of registering information, but of appreciating it, recognising its links with other phenomena and establishing its relative importance and significance,

in short, in its interpretation. The powers of argument, although not lacking in strength, are qualitatively affected. Subjects afflicted by this condition are worried by what they see, and have a continual need to fit it all together. They feel obliged to do this and, although they are remarkably skilled in arriving at subtle conclusions, these are in fact tendentious, specious and false. The plethora of arguments at their command hides, in reality, an impoverished logic. Their delusions reflect a dialectic distorted by a dominant emotion. Such patients proceed by induction and deduction; in short, by inference.

Those subjects affected by a confabulatory delusional state, on the other hand, are not at all worried by what they see in the outside world; nor do they feel an urge to embark on elaborate logical proofs of what is there. Instead they express ideas or recount stories without caring whether they conform with reality. Reality to them is their own association of ideas and subjective creations, which they invest with all the characteristics of objectivity. They proceed by intuition, autosuggestion and invention. The point of departure for their mistaken view of the world is not an idea about some external event, exact or inexact, or a false way of reasoning, or a false perception, but a fiction of endogenous origin, a subjective creation. Misinterpretation is a cognitive process, confabulation a poetic process.

In confabulatory delusional states certain events and emotions may act as a trigger, but even here misinterpretation and invention can be distinguished. Confabulatory delusional states do not arise from a sense of necessity or an examination of the logical consequence of an event. Ideas are not linked by formal rules but are more like scenes in a story, outside the operations of discursive thought; they spring up spontaneously. Even if the patient draws attention to the source of his observation, he does it in an episodic and casual manner. Reality merely furnishes his mind with a theme on which his imagination can work at its leisure, to provide variations and improvisations. If he does argue, it is not through any spontaneous urge to do so, but merely to counter the objections of others . . .

In subjects with a misinterpretative delusional state, belief cannot grow without the help of perceptions and logical operations; in confabulatory delusional states the belief is already present by virtue of the immediate evidence. There is also a real temperamental difference between subjects who rely on reasoning, who are prone to misinterpretations, and those who rely on intuition, who are prone to confabulations.

These distinctions between hallucinatory, misinterpretative and

confabulatory delusional states, it should be stressed, are schematic and largely artificial. All have elements in common, and mixed states may occur . . .

The further development of a delusional system is determined by the same factors which gave rise to it in the first place. Delusions based on misinterpretations grow because the subject continually consolidates the system by noting further incidents and making further inferences. Delusions based on imagination are enriched by further fictions and their most distinctive feature is the richness of the creative imagination, particularly the tendency to fabricate in an extempore manner.

The tendency to alter reality, to lie and to fabricate, which one of us previously referred to as 'mythomania', derives from a 'disequilibrium in the imaginative faculty', and provides the basis for this condition. All 'mythomanic subjects', including children and mentally deficient individuals who often lie deliberately, are credulous and may come to believe their own stories. In confabulatory delusional states, however, there is, in addition, the setting up of a collection of systematic and more or less permanent beliefs, and this passes beyond what can be considered normal.

The development of the condition, in brief, can be regarded as a morbid exaggeration of a constitutional tendency towards 'mythomania'. In its pure form, however, the condition is rare, certainly less common than the pure forms of hallucinatory and misinterpretative delusional states . . . In clinical practice one often meets examples of 'simple fabrication', where fictional events are accepted as genuine, and various transitional states between these instances of a simple fabrication and the rare systematised confabulatory delusional states.

Another reason for its apparent rarity is the tendency among doctors to interrogate patients rather than to let them express their thoughts freely . . . In consequence some patients with a confabulatory delusional state appear to be suffering from a misinterpretative delusional state because they are compelled to justify every idea. In this way, some misinterpretative delusional states may represent, like hysteria, a collaborative effort on the part of doctor and patient.

Confabulatory delusional states can occur as a relatively pure condition, as a particular kind of paranoid or grandiose syndrome, associated with some other condition, or as an episode in the course of a variety of psychiatric disorders.

The following case, in which confabulatory delusions were seen in relative isolation, illustrates the condition. There were no hallucinations and hardly any misinterpretative elements.

Case history:

On 24th May 1908 the police brought to hospital a woman who gave her name as X and was about 25 years of age. She claimed to be a painter and the divorced wife of Mr K. She was accompanied by two children who, she said, were the offspring of her ex-husband and her own sister. She announced that this sister had died that very day. She had been brought to hospital following complaints to the police that she had been behaving and talking in an extravagant fashion.

For some time she had been moving from hotel to hotel in Paris, staying no more than three days in each, and leaving without paying her bill. She had taken taxis without paying her fare, and had told the police that she was the victim of numerous thefts, swindles and confidence tricks, and that she was related to several European royal families. On enquiry, it transpired that she was actually homeless and penniless.

She was transferred from hospital to prison to stand trial on the charge of fraud. More details about her behaviour prior to her arrest then emerged. For example, between 9th and 12th May she had stayed at the Hotel Chateau de Madrid at Neuilly-sur-Seine, where she had run up a bill of 443 francs and made several telephone calls to the British, German and Spanish ambassadors.

Her own account of her life was as follows: 'I don't know where I was born. I don't know who my parents were nor what nationality I am. I was married about seven years ago in Saint-Germain to a man called Mr K. and have been divorced for four years. My husband was instructed by my solicitor, Mr B., to pay me an alimony of 38,000 francs, but I received none of this. This is why I have got into debt. The two children who are with me, Suzanne aged 11 and Edward aged 9, are the children of my husband and my sister, Rosine, now dead. I was given custody of them after my divorce. I cannot explain the complaint of the taxi-driver, as I instructed him to get his fare from my solicitor Mr F. at 26 Rue d'Alger'.

When again questioned about her identity, she replied: 'My mother was travelling when I was born. She took me all over the place, Valparaiso, Cyprus, and two other places which I don't remember. I have 11 names. I was sent to school at Montmorency and Princess Mathilde paid for my education. A few months ago the King of Spain, whose portrait I painted, made me a member of the Bourbon family, and so today I am related to the Spanish royal family . . .'.

Her real background was eventually uncovered. She had indeed been married and divorced and her alimony had never been paid, but

the years she mentioned were incorrect and the sum only involved 200 francs a month. Her two children were really her own. She continued to fabricate during her stay in prison; her son was the heir to the King of England; she had vast sums of money in the bank; important people were trying to rob her of this money. None of this was true. She remained in prison for five years and was then sent to an asylum, her inventions still unchanged.

Discussion

Her delusional state was remarkably free of any psychopathological element outside the sphere of confabulation. There were no hallucinations and few misinterpretations. This latter fact needs to be carefully examined, as there are several ways in which her inventions might be taken for misinterpretations. For example, it might be that she was remembering an event which she had misinterpreted at the time; or that she had a correct memory for a real event, but was now misinterpreting it – a retrospective misinterpretation; or that the incident mentioned by the subject did not correspond to any real event at all. In our view, the patient's inventions cannot be accounted for in either of the first two ways. It is not a question of misinterpretation in her case, but of retrospective fabrication. This phenomenon is sometimes referred to as an hallucination of memory, but in effect the disorder has more to do with imagination than memory. Her creative imagination was presenting its fabrications in the guise of memory, and she then believed that she remembered something. Memory itself has nothing intrinsically to do with her inventions. She merely has the *illusion* of a memory.

Mrs X. asserted that her husband owed her a substantial alimony, but a tribunal had ordered him to pay a monthly figure of only 200 francs. This is an exaggeration and distortion of the facts, an invention and not an inference. As with her other fabrications, it was as if she were telling a tale, one incident following another, and one anecdote suggesting a new one. Even the documents which she claimed to have in her possession were inventions. There was no fact or event which we can say that she had misinterpreted. There was only a fabrication of material proof, the exact opposite of what happens in misinterpretative states.

In some cases external incidents are not invented but merely used to justify original fabrications. For instance, the patient showed us a scar on her face which she claimed was the result of an assassin's attack.

The scar was in fact there, but had nothing to do with any assault on her person . . .

The patient can justifiably be regarded as a 'constitutional mythomanic'. Her real mother, who was finally traced, told us that her daughter had always had a 'rich imagination' which led her into trouble. One of us had previously listed the varieties of mythomania as malign or perverse, defensive, and conceited or indulgent. Our patient illustrates all three. She had pretensions to be an artist of note; she invented to protect herself and to satisfy her erotic and acquisitive nature; and she fabricated in a boastful way to show herself in the most favourable light.

We are particularly struck by the method by which such patients develop and embroider their themes. It is usually done in an extempore way, off the cuff, so to speak, in response to questions by the doctor. Thus, as noted earlier, the doctor participates in the inventions. Suggestibility and 'passive fabrication' go together with spontaneous invention and 'active fabrication'.

As each invented idea is produced, it is then registered as if it were an incontrovertible fact, inscribed, as it were, on a 'mythomanic dossier'. After a while, secondary interpretations and the guiding influence of emotional preoccupations then consolidate a complex system which constitutes the more or less permanent phase of a confabulatory delusional state.

It is worth considering the theme of the delusions as well as their mode of development and the abundance of their content. The incidents referred to are always rare, singular and extraordinary. They remind one of the scenes from romantic fiction or adventure stories. They portray events which are impossible and extreme. Patients talk of immense wealth, of princes and of kings. A woman is not only the mistress of some powerful person, she is the mistress of all the kings of Europe, and of Asia as well. Not content with possessing millions, they distribute them to everyone. In some ways the condition resembles general paralysis but, unlike the latter, inventive delusional states contain a strong element of persecution and complaint. One is reminded of Renan's observation that 'imagination has more links with desire than with fear' . . .

In their general structure these delusional states are remarkably complex and polymorphous. They are made up of the juxtaposition of a large number of themes which have in common elements of grandeur and persecution and a flavouring of erotic and political preoccupations.

Sometimes the multiplicity and incompatibility of their beliefs make the patient appear incoherent, but usually the logic behind them can be identified.

A further characteristic of the fabrications of our patient was the paradoxical combination of both sincerity and simulation, of naivety and duplicity. Mrs X. was a liar, a deceitful rogue, a joker and a hoaxer. But she was also a victim of her own tales, gained little profit from them, and eventually suffered by them. This occurs in nearly all cases and can be regarded as a 'deficit in the sense of verification and a distortion of the notion of reality'. This childish naivety, lack of judgement and absence of a critical sense are also seen in mentally deficient individuals.

Finally, one should note that the behaviour of patients with this condition accords with their inventions. Although their conversation often resembles that of a liar, their behaviour is undoubtedly that of a deluded person. As Bain noted, action is the ultimate criterion of belief. Mrs X. rented expensive flats which she could not inhabit, ran up debts which would only lead to imprisonment, wrote letters to kings, and telephoned ambassadors. And when her extravagant behaviour led to complaints and legal repercussions, she responded indignantly, demanded redress and believed herself to be an innocent victim.

Medicolegal considerations

The medicolegal consequences of this condition are, to a certain extent, its hallmarks.

The behaviour which brings the patients into conflict with the law is as varied and exuberant as their delusions. Their police dossier is as voluminous as their clinical file. The patients have usually written to innumerable people, and telephoned all kinds of officials. Their behaviour in this respect amounts to a veritable 'graphorrhoea'. The most characteristic features are the habit of bearing false testimony, claiming descent from a royal or noble family, fraud and vagrancy.

Bearing false testimony takes the form of accusing supposed persecutors with having committed certain acts. Our patient claimed to have documented evidence on such matters. Sometimes patients mention the existence of some secret information which they have at their disposal, and mention decisive documents or a hidden chest whose contents they cannot divulge. In this way they can be sure that no-one will discover their secret.

Claiming decent from a royal or noble lineage is purely and simply a

romantic notion. Their mother is its heroine and, but for political intrigues, their true father, a king or nobleman, would be acknowledged.

Fraud, more or less consciously executed, is a direct consequence of their condition.

Vagrancy partly stems from the miserable situations in which they find themselves, but also from their taste for adventure. Spurred on by their perpetually changing ideas, they adopt a wandering life, which represents, as it were, imagination in action. Their intellectual instability reveals itself in locomotor instability. Mrs X.'s children were drawn into this shiftless life. Sometimes those around them are not only passive instruments in this activity, but enter into the delusions themselves. The result is a *'folie à deux'* or *'délire collectif'*.

Most of these patients end up in prison. Magistrates find it difficult to accept that the mixture of lucidity and incoherence which characterises this condition is a sign of mental illness. Furthermore, the inventions are taken as evidence that the person is an impostor, an adventurer, a fraud or a blackmailer, and doctors encounter resistance from the legal profession when they argue that there is a psychiatric disorder at the root of these antisocial acts. Even if admitted to a psychiatric hospital, the patients employ their literary skill and fertile imagination to such effect, in writing letters to magistrates and appealing to public opinion, that it is difficult to insist on their detention.

Conclusion

In studying the evolution of our patient's psychosis we were struck by its persistence and how it became consolidated, partly through secondary misinterpretation but chiefly through the accumulation of further inventions and fabrications.

We believe that it represents a pathological exaggeration of a mythomanic temperament, and in this respect it resembles the misinterpretative delusional state described by Sérieux and Capgras. In this latter condition, however, it is the powers of reasoning, not imagination, which are exaggerated.

These two clinical conditions, although distinct in respect of the mechanism which gives rise to them, can be regarded as nosologically similar. In both cases, a particular mental constitution is the basis of the emergence of a profound error in mental functioning. In one case, it is an error of reasoning, and in the other a deficit in imagination. In both cases, however, the initial disorder leads to a systematised collection of delusions, without any sign of intellectual impairment.