
Eugene Minkowski (c. 1890–1972)

Eugene Minkowski was born of Jewish parents in St Petersburg, went to school in Warsaw and studied medicine in Munich. He was persuaded to take up psychiatry by his wife, who was also to become a psychiatrist, and visited Bleuler in Zurich just before the First World War. He enlisted as a volunteer in the French army in 1915 and became a battalion medical officer, serving with bravery at Verdun, the Somme and the Aisne. He was awarded the honour of 'Chevalier de la Légion d'Honneur' at the end of the war. He loved France and settled down in Paris after the war. He never had an official post in a hospital but was highly regarded as a clinician and an academic by all who knew him. During the Second World War he was persecuted because of his Jewish status.

Minkowski's importance as a writer on the theoretical aspects of schizophrenia is still underestimated. He was much influenced by the philosopher Bergson, as well as by Bleuler, and tried to combine the philosophical and the clinical approaches. The following extract is taken from his book on schizophrenia, in which he tries to understand the nature of the condition, particularly the disorder of thinking, incorporating both Bergson's and Bleuler's ideas.

The essential disorder underlying schizophrenia and schizophrenic thought

E. Minkowski (1927)

(Chapter 2, *Le trouble essentiel de la schizophrénie et la pensée schizophrénique*, of *La Schizophrénie*. Payot: Paris)

Vital contact with reality

In forming the concept of dementia praecox Kraepelin fused several clinical conditions which hitherto had been regarded as more or less independent. These conditions included catatonia, hebephrenia and dementia paranoides. Later the condition known as simple dementia praecox was brought in to join them.

This synthesis posed a new problem. By becoming fused, the individual symptoms and even the syndromes lost their separate value. The symptoms, according to Kraepelin, were interchangeable, inconstant and all led to the same terminal state. There must, therefore, be some shared element. They could not merely be the accidental expression of an underlying morbid process. For this reason it became

necessary to reduce the richness of the symptoms and the various clinical pictures to a single fundamental disorder and to clarify its nature.

This disorder could not be sought among the ordinary clinical symptoms, such as hallucinations, delusions, catatonic manifestations or states of excitement and depression. These symptoms have nothing constant or characteristic about them as we shall see. The disorder, therefore, had to be sought on another plane. The efforts to perfect the synthesis of dementia praecox and to make a true nosological entity of it required a new look at elementary psychic functions. It is here that one hopes to find the key to the particular behaviour which all patients with dementia praecox present, despite the infinite variations which distinguish them from one another symptomatically.

Contemporary psychological notions, however, rapidly proved inadequate for this purpose. Take, for example, the traditional triad – intelligence, feeling and will. It is obvious that the disorder in question is not related to any of these faculties. Neither lack of will, indifference, inability to show emotion or, even less, intellectual deterioration are characteristic of dementia praecox. It is more a question of the selective eclipse of each of these faculties, occurring in relation to certain situations, rather than their total abolition.

Psychopathological concepts are not static. They take on new meanings as ideas about normal psychic mechanisms change. Kraepelin himself, after having talked about a weakness in the emotional impulses of will and a loss of inner unity, reduced these two disorders to a weakening of ideas and feelings, and a tendency towards a disorganised mental life. He was speaking, in this sense, of a disorder of abstraction. Under these conditions, a subject would no longer be able to transform perceptions into abstract ideas, simple feelings into more organised ones, or isolated impulses into more constant inclinations. Kraepelin even sketched out a psychophysiological hypothesis of dementia praecox, by localising this faculty of abstraction in the higher layers of the cortex. Masselon placed primary emphasis on a disorder of attention and regarded an individual with dementia praecox as being in a state of perpetual distraction. Weygandt took over Wundt's ideas and talked about apperceptive dementia. None of these concepts, based on ideas about normal psychological functioning, persisted in the long run. As they were unable to express the essential disorder of dementia praecox they eventually gave way to notions of a different type.

Expressions such as 'discordance' (Chaslin), 'intrapyschic ataxia'

(Stransky), 'intrapsychic dysharmony' (Urstein), 'loss of inner unity' (Kraepelin) or 'schizophrenia' (Bleuler) all imply that the disorder is not to be found in a particular function but rather in their total cohesion, in their harmonious interplay. To use a metaphor, the essential disorder does not affect one or more mental functions, whatever their place in the hierarchy, but is to be found among them all, in the 'interstitial space'. All these expressions constitute no more than an observation of fact, a description of the particular disturbance which occurs in dementia praecox or schizophrenia. This is already, however, an important statement, because the use of the term discordance neatly separates the condition from true dementia. But to a psychologist, and all psychiatrists should be that, this is inadequate. Chaslin's claim that hebephrenia consists of a discordance of psychic functions begs the question: what factors give rise to concordance of these same functions in normal people? This question remains for the moment unanswered. We have not yet achieved a clear idea of the fundamental disorder in dementia praecox, as we do not yet know to which factor in normal mental life it is linked.

For these reasons we have recourse to comparisons and metaphors. One might say that they suggest themselves in order to set the essentials of the condition in relief. Kraepelin talked of an 'orchestra without a conductor' and Chaslin of a 'machine without fuel' which, because it could be set in motion again, was entirely different from a broken-down machine. Anglade disliked using the term dementia praecox; he talked simply of 'dissociated patients'. To characterise their state, he compared them to a second-hand book: the pages might be out of place and the text partly illegible but none of the pages was actually missing. Compare this with a book whose pages have been irretrievably torn out. I myself, in thinking of the schizophrenic process, have been attracted by the following image: a building is made of bricks and cement; either the bricks *or* the cement can crumble; in either case the whole edifice can no longer hold up and it collapses; however, the ruins are not the same; they look different and have a different value; it is, moreover, easier to reconstruct a new house with intact bricks than with dust.

These metaphors express as well as possible the need to separate the schizophrenic process from intellectual impairment. But more than this, they seem to express the true nature of schizophrenia much better than any of the psychological definitions which we considered above.

Our sense of precision, however, is upset by these metaphors, which seem to be merely ingenious and pleasant methods of discourse.

Scientific method and the search for truth should forbid such diversions. However, one should not forget that Henri Bergson, one of the most eminent of contemporary philosophers, believes that a whole side of our life, and not the least important, entirely escapes discursive thought. Things which impinge immediately on our consciousness, in some ways the most essential, belong to this category. They are irrational but are no less part of our life for that. There is no reason to sacrifice them to the spirit of precision. In fact, on the contrary, one should try and capture their true essence. The discipline of psychology has nothing to say on this matter as it is too constrained by the rules of scientific method. Were it to relax these rules it would be transformed from an arid subject to a fertile one, and would come to resemble life itself. How would we profit from this transformation in tackling the problem of schizophrenia?

It is at this point that the idea emerges of *vital contact with reality*.

Bleuler laid down what he saw as the cardinal symptoms of schizophrenia. They were all to do with the ideas, emotions and will of his patients. At the same time, however, his introduction of the concept of autism rendered environmental factors increasingly important. His emphasis on the lack of real goals and guiding ideas, and absence of emotional warmth, steered the concept of schizophrenia down a new path. All these disorders seem to converge on a single and unique notion, that of *loss of vital contact with reality*.

Vital contact with reality appears to be linked with the irrational factors in life. The ordinary concepts elaborated by physiology and psychology, such as excitation, sensation, reflexes and motor reactions, continue in parallel, largely unnoticed. The blind, the mutilated and the paralysed may be able to live in even more intimate contact with their environment than individuals whose sight is intact and whose limbs are whole; schizophrenics, on the other hand, can lose this contact even with an intact sensory-motor apparatus, memory or intelligence. The vital contact with reality is in touch with the depths, with the very essence of our personality, in which it links with the world around us. And this world is not just a collection of external stimuli, of atoms, forces and energy. It is a moving stream which envelops us at all points and constitutes the milieu without which we would not know how to live. 'Events' emerge from this like islets; they penetrate the personality by disturbing its most intimate parts. And then, by making these events part of its own make-up, our personality puts its own stamp on them, not by muscular contractions but through action, feelings, joy and tears. In this way there is established that

marvellous harmony between ourselves and reality, a harmony that allows us to follow the progress of the world while at the same time safeguarding the notion of our own life.

These considerations lead one to conclude that vital contact with reality concerns the intimate dynamism of our life. We can never achieve this through the rigid concepts of spatial thought. Metaphors, not definitions, hold pride of place in this sphere of our life. Only they can impart some clarity to the notion of vital contact with reality.

This notion is not new. In his theory of psychasthenia Janet talks at length about the reality function. This idea, although not quite the same as ours, has many points in common with it. And the fact that two different paths lead in the same direction suggests that we are dealing with real and important matters which are currently 'in the air'.

The notion of a vital contact with reality, and the interpretation of schizophrenia in terms of a loss of this contact, is both simple and plausible. The newcomer to psychiatry can pick it up quickly and use it without difficulty. I am tempted to say that the notion follows on naturally from the evolution of the concept of dementia praecox.

But then, one might ask, has the considerable knowledge about clinical psychiatry merely led, in the end, to no more than a single psychological and psychopathological idea? I do not think so. As we shall see, the idea is capable of fostering further developments, and even if this were not so it is of some consequence in its own right, as is the case with many other clinical notions in psychiatry. The term 'mental confusion', for example, owes its origin to the need to tighten up the boundaries of dementia. It replaced the category of acute, curable dementia introduced by Pinel. Originally a French idea, promoted by Delasiauve, it was then exported to other countries. In the course of its evolution, having undergone many alterations in meaning, it is again being studied in its country of origin, particularly by Chaslin. Finally, through the efforts of Toulouse and Mignard, it has come to mean a general disorder of mental functions. This pattern in the evolution of our clinical notions in psychiatry should not surprise us. Does not any clinical term become clear and precise when we have succeeded in giving it a solid psychological foundation? Also we should appreciate that modern psychiatry strives to uncover the *causative disorder* underlying the clinical conditions which it studies.

I believe that I have staked a claim for the correct paternity of the idea of vital contact with reality in respect of its central role in schizophrenia. I have certainly not invented it, for ideas which have no link with past

or present are usually of little value. On the one hand, the work of Bergson has influenced me greatly. On the other hand, Bleuler's book on schizophrenia contains the notion of a profound disturbance in the relationship with the outside world. Bleuler, however, laid most emphasis on the cardinal and elementary symptoms in this condition, symptoms which arise through the attrition of the ideas, emotions and will of the patient. Although he mentioned loss of contact with reality (autism), he did not regard this as the cause of these symptoms. A vital contact with reality, in his view, was not an essential regulatory factor in life to which other mental functions were subordinate. Faithful to associationism, he put forward, in his theory of schizophrenia, the opinion that a particular disorder in the association of ideas was at the root of this condition. He then looked for an underlying organic substrate.

In introducing French psychiatrists to the notion of schizophrenia, I cannot avoid a personal note. When one has genuinely tried to understand someone else's ideas, to live them rather than merely to adopt them, it is not always possible to be dispassionate. But this is of little significance. Science advances through the efforts of its practitioners, but we are merely agents and not part of the actual process.

In putting forward the idea that a vital contact with reality is central to the understanding of schizophrenia, I am aware that there is a certain conflict between Bleuler's work and my own analysis. The difference is well set out by Villey-Desmésaret, and the French psychiatrist Claude supports my point of view: 'We are struck by the fact that the profound disequilibrium in the contact with reality is not just a consequence of some other mental disorder, but is itself the underlying disturbance out of which emerge all the cardinal symptoms of this condition'.

The notion of a loss of vital contact with reality as the essential disorder in schizophrenia has led me to consider how this deficit could be formulated further. I shall try to present the evidence in the following pages.

Intellectual dementia and schizophrenic dementia

It is now necessary to look at the consequences of the disorder which we have just outlined. Bergson, in particular, has influenced my thinking on these matters. As we saw in the previous section, my notion of vital conduct with reality is itself a point of contact between

the Zurich school of psychiatry and Bergsonian ideas. I also believe that psychology and psychopathology benefit from having closer links with philosophy.

It is hardly necessary to set out Bergson's ideas in detail. The main thing to remember is his maxim that intelligence and instinct are in fundamental conflict. 'Instinct', says Bergson, 'is modelled along the same lines as life itself; intelligence, on the other hand, is characterised by a complete lack of understanding of life'.

Intelligence, although it is the product of nature, has as its principal object inorganic matter. It can only reflect things which are discontinuous and immobile. It only feels at home when dealing with dead things. It always acts as if it were fascinated by the contemplation of inert matter. Hence it is disturbed when faced with living things and finds itself face to face with organisation.

From the very fact that it is always striving to reconstruct what is there, intelligence cannot capture what is new at any moment in history. It has no room for the unpredictable. It rejects anything creative. Preoccupied only by repetition and similarity, intelligence cannot appreciate the changes produced by time. It ignores the fluidity inherent in things, and petrifies everything it touches. 'We may not think in real time, but we live in it' (Bergson).

Psychopathology cannot be expected to provide a complete answer as to whether Bergson's ideas shed any new light on problems which current psychological thinking has by-passed. They may do so, however, because morbid processes, by acting selectively, can 'dissect' the various psychological functions and reveal them in their naked state. Pathology sometimes succeeds where physiological methods fail to unravel the complexity of the factors involved.

Intelligence and instinct, i.e. the part of our mind dealing with solid inert and spatial aspects of reality on the one hand, and the part dealing with temporal and dynamic considerations on the other hand, are normally fused harmoniously. On its own neither can account for existence, but together they are complementary while at the same time limiting the other's sphere of influence in an entirely natural and appropriate way. But can this harmony be undermined by pathogenic influences? Cannot instinct, for example, be damaged on its own? Would not intelligence, in such circumstances, freed from its natural restraints, try to make up for the missing instinct and come up with bizarre ideas? Conversely, could not intelligence be the seat of a primary lesion with secondary involvement of other factors, depend-

ing on its chronicity? Questions of this type do not lead to abstract speculations. On the contrary, they lead, as we shall see shortly, to a series of facts which have been neglected by earlier investigators of psychopathology.

First, let us compare, in this respect, the two major mental processes which psychopathology has so far separated – schizophrenia and intellectual impairment. Most writers in recent times have insisted on a fundamental difference between these two. Nonetheless, it is not easy to say precisely in what this difference consists. We can say with some certainty that intellectual impairment affects judgement and memory. But there is no such certainty about the schizophrenic deficit. The term 'dementia' provides a very poor description of its essential nature.

To quote Bleuler: 'In schizophrenia, even when well-advanced, all the simple mental functions, as far as we know, are intact. In particular, memory, unlike the case in true dementia, is unaffected . . . One may find surprisingly that under an apparent envelope of dementia the intelligence is much less affected than one might imagine, as if it were only asleep'. Or, as Chaslin noted: 'It is as if in discordant insanity (schizophrenia) the symptoms resemble those of true dementia. The cold delirious incoherence, the indifference, the bizarre acts, the complete cessation of intellectual activity and its substitution by behaviour of an inferior order, the stupor and bizarre postures, and the incoherent actions all suggest this. Despite the symptomatology, however, there is rarely any sign of true intellectual impairment, such as loss of memory or errors of judgement . . . In contrast to genuine organic dementia, where the intellectual functioning is actually worse than it appears at first sight, in the discordant form of insanity nothing seems to have been irretrievably lost and only a little effort seems to be required to revive the cerebral activity'.

What, then, is lacking in schizophrenia? And what is the key to the difference between it and true dementia? It is this very difference which we will try to uncover by making use of the opposition of intelligence and instinct which we discussed earlier. As well as noting the differences in psychological *deficits* between these two conditions we shall also draw attention to differences in *intact functioning* between them.

We will begin the study of the two processes by comparing the extreme degrees of deterioration which can occur in each.

We have chosen general paralysis of the insane as a good example of intellectual impairment. For our purpose this condition has the advan-

tage that it usually affects individuals in the prime of life. The intellectual impairment is not then complicated by other factors, such as the physiological consequences of old age, which affects senile dementia. It exists, therefore, in a relatively pure state.

If I ask someone with general paralysis: 'Where are you?' he will reply: 'Here.' Lest he is only responding in a purely verbal and automatic way, I insist: 'But where is here?' The patient taps his foot to indicate the place where he is, or points to it with his finger, or even demonstrates the room with a gesture. 'But here', he says to us, apparently surprised and annoyed by our insistence on the matter.

There is no question here of some simple semi-automatic response. This type of reply is found surprisingly often in these patients.

The schizophrenic, on the other hand, in reply to the same question, will give the name of the place quite correctly. But he will often say that, although he *knows* where he is, he does not *feel* as if he is in that place, or that he does not feel as if he is in his body. The term 'I exist' has no real meaning for him.

Two different types of factor are involved in our spatial orientation. There are those static factors concerned with the appreciation of how objects relate to one another in a geometrical space where everything is immobile, relative and reversible. But in fact we *live* in space, and we are always aware of the notion: 'I am here at this instant'. Under normal circumstances, therefore, our spatial concepts must accommodate this awareness. Our knowledge of things and our memory images come to be grouped around the notion of 'I am here at this instant'. This allows us to tell in any set of conditions where we are: in Paris, for example, or in Finland, or at our desk.

In patients with general paralysis, the static factors that I discussed earlier, the knowledge of things and memory, are impaired. Such patients are disorientated in space, in the usual sense of the word. Despite this, the structure of their notion of themselves as being 'me in this place' remains intact and active. Schizophrenics, by contrast, know where they are, but their notion of 'me in this place' has no longer its usual quality and finally breaks down.

At a less advanced stage of general paralysis we encounter reactions which are more complex, but whose general character is the same. To the question: 'Where do you come from?' the patient will reply: 'From over there, where I was before'. He is clearly disorientated in space, and unable to name the place where he came from. Nonetheless, the internal representation of a change in place – place X before and place Y now – remains intact.

The following statements belong to the same category:

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| Q. 'Where are you?' | A. 'Here where I was washing myself this morning' or 'Here where I have been for some time now'. |
| Q. 'What is this building?' | A. 'It is the building where I have been put'. |
| Q. 'Who is this gentleman?' | A. 'He is someone who is here'. |
| Q. 'What are you doing?' | A. 'At the moment I am staying here'. |

If we put someone with general paralysis in front of a mirror and ask: 'Whom can you see in there?' he will reply: 'Me'. But if we continue: 'But who is me?' he will not give his name or his job. This sort of reply is much less common in schizophrenics, even in states of deterioration. They will reply: 'Me' and then 'my activity, my personality', or 'It is energy', or, abandoning their delusions, simply state 'Me, the son of Claude Farrère'. One of our patients replied: 'I know who it is' but then admitted that she no longer experienced it in the same way: 'I know who it is, but this is merely an observation, there is nothing inside; it's a queer face; it has a fixed look, oblique and cold'.

The patient with general paralysis, even in the final stages of mental deterioration, retains some sense of awareness of self. The schizophrenic, on the other hand, does not, and is always affected by a sense of depersonalisation.

A sort of commonsense and a knowledge of where to find things is also retained in general paralysis. One such patient, when asked the date, picked up a newspaper. Another very demented patient on being asked 'What day is it?' replied: 'I have no means of knowing'. Another, asked to give his date of birth, replied: 'I can't say; I haven't got my wedding ring'. On his wedding ring he would not find his date of birth but the date of his marriage [French tradition, Tr.] but that is not the point; he knew that there are ways of compensating for a failing memory and instinctively used them.

The behaviour of a schizophrenic is quite different. He usually knows the date, but the knowledge has no precise meaning for him; he cannot use it in a fashion appropriate to his circumstances. The *pragmatic* use of things is affected early in this condition.

A patient with general paralysis, in a state of profound dementia, was asked: 'What are you doing?' He replied: 'I am waiting for something to happen and making plans'. Another patient, although so deteriorated that he could no longer speak, still noticed that I had left

my hat in his room one day and laughed about it. For the schizophrenic such events or manoeuvres would pass him by.

These various comparisons establish what is a fundamental difference between the intellectual impairment in general paralysis and schizophrenic deterioration. We must not confuse them. In the former case the deficit is in static mental functions; in the latter dynamic factors bear the brunt of the morbid process.

This formula is obviously too schematic. The word 'dynamism' for instance is ambiguous. It can be given a physical interpretation. But here, as in the study of movement, as Bergson pointed out, time is already conceived as a straight line and assimilated within a spatial context.

True dynamism, as it relates to our actual experience of time, is entirely different. We can only glimpse its real nature in an imperfect and provisional way. A solid base for our ideas about it does not exist. To make some advance in knowledge we can only describe and group the phenomena in our life which have a bearing on real time and then see how they fit together in both normal and morbid states of mind. In this way we can begin to construct a psychology and a psychopathology of time as we experience it. This is undoubtedly a difficult task, but one which is indispensable for anyone who wants to understand the normal and pathological functioning of the human mind.

While awaiting further studies on these matters, I believe that my own formula provides a reasonable summary of current knowledge . . . Let us examine general paralysis in more detail. In early cases the characteristics which I have just outlined are attenuated but can still be discerned. The appreciation of the passing of years, months or weeks, i.e. the notion of measurable duration linked to spatial events, is often lost, but this does not mean that such patients lose all sense of time. They may be able to give a correct account in chronological order of what they did during the war, but are no longer able to say when the war started or finished. Their memory for a succession of discrete events is preserved but their ability to relate this to a fixed point in time seems to be lost.

Spatial images to do with the passage of time also disappear. In their place, certain elements of the notion of time, now freed from the constraints of these spatial images, become more prominent and pervade the entire psychological apparatus. All the crazy ideas and plans of such patients have the quality of immediacy and have to be carried out quickly. Expressions such as 'soon', 'immediately', 'not long ago' and 'shortly' appear with surprising frequency in the things

they say. One patient was always talking about how her husband, according to her, had to come and find her. She believed that he was already there, climbing the stairs or actually in her room. Or patients may talk about cars speeding at 500 miles an hour, or journeys they have made to Argentina which lasted only five minutes.

This dynamism invades the entire being of the patients, overwhelms them and appears to open up the entire universe to their stream of thought. These, then, are the symptoms of the delirious phase of general paralysis. The patient makes plans for the immediate future, grandiose schemes with no limits. He aims to go straight away to the racecourse and then make a world trip. He will blow up all the islands in the world and then collect the moon to put in a glass. He is all-powerful, feeling that he can do whatever he likes: undertake organ transplants, engage in cross-breeding animals, bring the dead back to life. He extends his extraordinary powers to all living things. He distributes his millions, wants everyone to be happy and invites all the doctors and nurses on his fantastic voyages. He is going to go to Rome to demand that all priests and nuns should be allowed to marry; he wants to set free all the fish in the world.

Everything has to do with movement here. There is nothing but vast, rapid movement. No obstacle is considered, no distance is too great and no time limits are set. The patient interprets this state of affairs in everyday language, with the help of ideas which everyone knows are absurdly grandiose.

Let us now compare this picture with the way a schizophrenic, after several years of illness, depicts his state of mind:

Everything seems immobile around me. Things present themselves in isolation, on their own, without evoking any response in me. Some things which ought to bring back a memory, or conjure up a thought or give rise to a picture, remain isolated. They seem to be understood rather than experienced. It is as if a pantomime were going on around me, one which I cannot take part in. There is nothing wrong with my judgement but I seem to lack any instinctive feel for life. I don't seem to be able to act with any vigour. I can't change from one emotion to another and how can you live like that. I've lost contact with all sorts of things. The value and complexity of things no longer exists. There's no link between them and me. I can't immerse and forget myself in a task anymore. There's a barrier all round me. I've even less flexibility when I think about the future than I have about the present and the past. There's a kind of routine affecting me which does not allow me to contemplate the future. The creative ability in me has gone. I see the future only as a repetition of the past.

This account is taken from a patient who spent all her days in bed in a state of complete inertia and who, when she got up, behaved like an automaton. She had auditory hallucinations and delusions of bodily change, and on one occasion had set fire to her clothes in order, as she explained, to experience real sensations which were totally lacking under normal circumstances.

Do not such statements give a clue to the disorder underlying schizophrenia? They are so common in the histories of schizophrenics that we cannot avoid giving some weight to them. Time and again we hear them say: 'My ideas are immobile like a statue' or 'I feel static and lack a sense of reality'. These and other similar expressions reflect the fact that they are gradually being taken over by a sense of immobility, which, if they are aware of it, they find very unpleasant. Their posture and behaviour bear the stamp of this morbid immobility. It shows itself in their stereotyped movements, which are a kind of perpetual repetition of one movement.

It is hard to imagine a more extreme contrast between this clinical picture and that of general paralysis described earlier.

This contrast is also stressed by other writers on the matter. Kraepelin, for example, gave the specific nature of the terminal state an important role in his notion of dementia praecox. He talked in this case of '*Verblödung*'. Nayrac, discussing the meaning of this term, wrote:

Most writers have translated this word as dementia, but this has led to much confusion. In my view the word *Verblödung* means something different. I do not say this because of a desire to be pedantic. I genuinely think another word is needed. *Verblödung* denotes making someone feel shy and ashamed to such a degree that they look intellectually backward. For want of an equivalent expression in French, we have translated *Verblödung* as 'paradementia'.

Bleuler talked about *affective dementia* in schizophrenia, emphasising yet again the fundamental difference between the deterioration in schizophrenia and the intellectual decline in dementia. I myself am more concerned with factors underlying the disintegration of the personality, and I prefer to talk about *pragmatic dementia*. The juxtaposition of these two terms (pragmatic and dementia) is not altogether fortunate. I think that it would be better to omit the word dementia altogether, if this expression denotes a progressive decline in intellectual functions, and to talk instead of a *pragmatic deficit*. Whatever one thinks of this proposed term, it seems to hit on some grain of truth about schizophrenia. Claude and his pupils came to a similar conclusion in their study of schizomania, suggesting that in these cases there was an incongruity between intellectual and pragmatic activity.

Finally, I should like to draw attention to the definition of dementia praecox put forward by Dide and Guiraud:

The condition is characterised by the sudden weakening, at an early age, of the instinctual drives of mental life, stemming directly from organic brain damage. Purely intellectual operations are only affected secondarily; they do not disappear, but are obstructed and made to work in a contradictory manner. The decline in vital spirit and strength of emotions is the necessary and sufficient element by which we can characterise the illness.

Dide and Guiraud suggested the term 'juvenile athymhormia' as a replacement for dementia praecox.

Putting on one side the organic interpretation of Dide and Guiraud, I agree with their ideas on the psychological nature of schizophrenia. They also confirm what Kraepelin and Bleuler have taught for some time, namely that dementia praecox is not a true dementia because spontaneous cures, impossible to predict, may occur years after the onset of the illness, in subjects who have had all the external signs of a complete and permanent deterioration.

Spatial thought in schizophrenia (morbid rationalisation and morbid preoccupation with geometry)

This is not the place to review all the psychopathological consequences of the primary disorder discussed earlier. I shall restrict myself to one or two examples, and indicate the direction in which I think psychological research should go. We shall see that schizophrenics, deprived of the ability to assimilate those aspects of reality which have to do with movement or time, tend to rely on the logical and mathematical side of experience. Life itself cannot be reduced to these latter factors, and any attempt to do so can only lead to a distorted view of it.

Consider the following case history which I have published under the title 'morbid rationalisation'.

The patient was a teacher, aged 32, who was referred to us at the Clinic for the Prevention of Mental Disorders. He complained at first of a 'physiological decomposition' which was causing him discomfort, and an 'emptiness in the head' which he attributed to excessive salivation. His voice, he maintained, was influencing him in a suggestive way; it seemed 'dead' and seemed to be a 'ghost voice'. His whole being had undergone 'a regression', and he felt as if he were again 15 years old, when he was a young student.

The patient had neither hallucinations nor delusions. There was no sign of intellectual decline, but from the first interview we were struck

by his behaviour. This impression grew stronger in the course of subsequent interviews. His profoundly morbid attitude led to a diagnosis of schizophrenia, of a severe and well advanced form.

It is this attitude that I shall now try to describe as well as possible. The following incident was very characteristic. The patient told us that for several years now he had been interested in philosophical problems. He had been in the habit of writing down his thoughts and had amassed a considerable stack of notes. We asked him if he had read many philosophical works. He replied: 'No, on the contrary, I purposely avoided them so as not to spoil my own thoughts'. He shunned the company of other people, 'so as not to be disturbed in my reflections'. His morbid attitude is here shown in its clearest form. He was isolating himself from the world in order to keep within himself the source of his philosophical thoughts. We were not at all surprised to find that one of his theories concerned 'the way acid acting on nerve terminals gives rise to human behaviour'.

This strange attitude cannot be regarded as a disorder of judgement because then it would be necessary to ask why it takes this form rather than any other. In my view it has more to do with the morbid attitude which I have been discussing in this paper.

All of us need from time to time to withdraw from our surroundings and to commune with ourselves. In this way we draw strength to continue our mental activity and work. But we do not then totally reject all outside influence on our personality. On the contrary we allow our environment to interact with ourselves and recast our inner life according to the elements of this environment which affect us deeply. At the same time we do not allow our surroundings to dictate our entire life because we would then be enslaved by it. There must be some mechanism in normal people whereby the influence of one's environment and one's originality are kept in balance. It seems to me that this is an essential part of the human condition, and one which is difficult to describe in logical terms. We might designate it as a *feeling of harmony with life*.

It is essentially irrational, in the sense that our intellect cannot comprehend it completely, but this feeling enters into all the important situations which we encounter and is the source of most of our conflicts. Moreover, it is the basis for most of our decisions about the way we live because it gives *limits and strength* to these decisions which our intellect alone cannot provide.

Every major decision is determined by this feeling of *harmony with life* but, because the latter is not open to our scrutiny, its precise influence

can never be quantified, and the decisions themselves may, therefore, appear irrational. As Pascal said: 'The heart has its reasons which pure reasoning can never uncover'. I am tempted to alter this to: 'Life has its reasons which pure reasoning cannot formulate'.

Returning to our patient's strange attitude, we can describe his psychological state in the following way. His mental energy, instead of being directed towards an integration with reality, entirely ignores the real world around him, and without any natural anchor for it to function the patient loses himself in the clouds. Not being a philosopher, even a second-rate one, our teacher ties himself up in knots with his own philosophical speculations. At the same time he rationalises his feeling of isolation by developing the notion that he does not want to be disturbed in his thoughts, and by doing so he cuts himself off from human contact.

The richness and variety of life disappears in the course of this process. However powerful an intellect may be, it cannot be entirely self-sufficient. Thinking and acting without taking into account the ideas of others or external circumstances is bound to lead to errors and absurdities.

We have analysed in some detail a single statement of this patient – i.e. 'I do not want to be disturbed in my thoughts' – because it seems to contain a distillation of his whole way of being and his relationship with the outside world.

Any act that we carry out can be regarded as an antithesis between yes and no, between good and bad, between what is allowed and what is forbidden, or between what is useful and what is harmful. We can talk in this sense of an antithetical attitude. It is the result of a lack of the irrational feeling of harmony with oneself and life, which we mentioned earlier, and indicates a total loss of ideas about the limits and strength of our intellectual activity. A person who follows this course will only behave in accordance with his own ideas and will become as a result doctrinaire and pedantic. It may be an advantage when it comes to solving mathematical problems, but it is morbid and dangerous when we are faced with practical issues and need guidance in our actions and our decisions. An example should make this clear. Our patient said that he 'always examined actions with a fine tooth comb' to see if they were in accord with his principles. His desire to be spiritually perfect led him to 'banish from existence all material work'. Before his illness he would devote all his leisure time to bee-keeping, but then, because he regarded it as material work, he completely neglected it. Whenever his parents, with whom he lived, brought up the question

of money, he would see this as an attack on his ideals and avoid the conversation. He regarded his visit to the clinic as 'moral suicide', because he believed that 'man should be self-sufficient and should be under no other authority'. This is in itself logical, but is here taken to extreme lengths. His comment shows that principles can have absurd consequences by reason of inappropriate generalisation. Life is not made up of rigid and universal principles; there is always a built-in measure of irrationality which determines the limits of reason.

The patient's moral regeneration, he stated, began in 1918 while he was in a prisoner-of-war camp in Germany. He tried at that time to detach himself from material things and be directed in his behaviour by impersonal principles. He thought it right to achieve wisdom as the only true form of happiness, but for this purpose he had to be alone, removed from any disturbing elements. Under the influence of these ideas his personality was transformed. He devised a set of rules by which to live. These included temperance, silence, and the application of a new principle every week. He virtually ceased talking and would only answer questions when these were in conformity with his principles. His actions were regulated minute by minute. He believed that his problems only began when he allowed himself, against his principles, to talk impulsively. After the war he returned to his job as a teacher. At first he tried to apply to his teaching the principle of absolute indulgence, because he believed that his pupils were irresponsible. They laughed at him and had no idea what he was getting at. Next, at the suggestion of his headmaster, he applied a strict military regime. Then there followed a period of 'liberalism and gentleness'. He wrote in his diaries at this time:

I put into practice, until last June, an impersonal discipline, firm and confident in my mind that I was encouraging a dignity in behaviour and thoughts. Inspired by logic, I had to stifle my idealist tendencies for a whole year in order to maintain military discipline. I carried out one or two manual tasks to please my parents, but this subordination of my actions to the wishes of two old people made me even more vulnerable to their sentimental assaults, which hitherto I had been able to withstand by my powerful humanitarian feelings. I soon found myself an obedient child. Any attempt at initiative seemed futile and I felt suffocated.

This, in brief, was the patient's attitude. In keeping with his antithetical outlook, he saw any outside force as an attack on his personality; if he succumbed to it he would be dragged down and engulfed. He could only register outside influences as having a hold on him or as a trap.

How different he is in this respect from normal people! The bonds which attach us to our environment are infinitely more rich and complex. We may try to impose our will on others and dominate our immediate social circle; at the same time we know how to do our duty, to respond to love or pity, to recognise the authority of others and to follow their advice, without feeling any constraint on our freedom. Our teacher recognised only two categories: independence, which through his egocentricity he only achieved at opposite poles of his intellectual antithesis; and domination, which he continually suffered. He would only admit to being ill for two months, although in our view it had been much longer. He attributed the onset of his illness to his succumbing to suggestions from his parents which had affected his voice and made him emit ideas which went against his principles. He felt that he had lost control over himself and that he was behaving as if he were carrying out orders from another person. Whereas before he had felt master of the way he looked or talked, now, when teaching in class, he felt in the sway of the sound of his own voice, and his gaze would fix, against his wishes, on the pupils. He had lost his desire to teach because he felt that his work and principles were being directly controlled by the headmaster.

It is unlikely that the way in which the teacher behaved was really a result of a conscious effort on his part, as he would have had us believe. It is more probable, as discussed earlier, that a regulatory factor in his life was missing and that the remaining elements regrouped to form some unifying whole. The patient then interpreted this intellectually as a coherent system, but it was in fact distorting his whole action and turning him into a 'stranger', we might almost say an 'alien', in his relationship with his environment and ourselves.

I should also like to comment on the way in which the world around him affected the patient's altered mental state. In this respect, his lack of vital contact with his environment and the disharmony of his mind are the main factors.

The patient's state of consciousness may be compared to that of a stage on which abstract principles enter and compete for attention. It was altogether a very impersonal stage, and he must have treated these principles accordingly. We saw that his pupils took no notice of his doctrines, probably because there was no warmth, no intimacy and no personal touch in the way he applied them. He had lost, one might say, the sensitivity which allows us to communicate with others, to feel with them and to enter into their concerns. The ability to make personal rapport was shattered and he no longer knew even how to look at

people in a natural way. His sphere of interest might seem much wider than is usual, indeed almost boundless, but this is an artefact of the despair of a spirit deprived of affinity with normal concerns. He would tell us that he had become 'detached from material things and was only governed by impersonal principles', and that he was no longer under the influence of a *restraining milieu* but of the *entire* world. He lived for ideas and saw people as impersonal objects. He was kept going by thoughts, not people. He could appreciate a sense of humanity but always sought to achieve the absolute in this regard. His filial love was drowned by a much grander love. It is not surprising therefore, for someone who saw things in this way, that minor arguments between him and his parents became in his mind a veritable battle of giants. His parents, concerned at his bizarre attitude, tried to intervene. His father pointed out that if you cannot carry a load of 100 kilos on your back, you should try 50 kilos. In response to this and other such statements involving material topics, our patient only became more convinced that his ideals were under attack. His belief that his parents were trying to undermine his personality became stronger, and if he tried to make the slightest concession he immediately felt he was renouncing his ideals on a massive scale.

When recounting the story of his life he would merely give a list of the ideas and principles which he had adopted, as in the account of his teaching career – the periods of indulgence, of military discipline, and of liberalism. His whole life seemed to have evolved in fits and starts. It was not a continuous line, supple and elastic, but one that was broken in several places. The ideas which he had entertained seemed also to have appeared in isolation, with no links between them. This had also been the case with the rules governing his life, which were self-contradictory or incompatible with each other. Emotional factors and, even more striking, the sense of time seemed to have entirely disappeared from our teacher's existence. He was also continually in 'conflict with life'.

Let us compare this man with another patient who said that he could not be sure of the importance of money, because money did not take up much space. This patient had also said that he did not find change very interesting because everywhere he went he was always finding 'too much change, too much mobility'. Instead, his attention was completely absorbed in a project to enlarge the Gare de l'Est in Paris, which was in all the newspapers at the time. He invested it with enormous importance, exceeding all other events in his life.

In this case there seemed to be an abnormal generalisation concern-

ing ideas about spatial order which had a morbid hold on his thinking and behaviour. This involved the application of mathematical criteria to determine the value of objects and events solely in terms of their dimensions or geometrical characteristics.

Do we not see here the first signs of what might be called a *morbid preoccupation with geometry*?

The same patient revealed that from the age of 16 he had been 'obsessed', as he put it, by the subject of construction. He would doubt the solidity of things and wondered if the walls of his school were straight.

'I was tormented,' he wrote in his autobiography, 'by the vaults in churches. I could not accept that all that weight could be supported by ribs, pillars and a keystone. I could not understand why it did not fall down. I could not see why the cement in the free stones did not crumble because it must be a particularly vulnerable pressure point. I concluded that houses stayed up only through some terrestrial attraction. I came to doubt my own senses.'

A 'mania for symmetry' then took hold of him, and also an 'obsession with pockets'. He wanted to know what difference there was between putting one's hands straight into a normal jacket pocket and putting them into the sloping pockets of an overcoat. He solved this problem by concluding that 'in the first instance you establish a feeling of parallelism between extreme things, arms and legs'.

He also had the habit of standing in front of a mirror, legs together, trying to place his body symmetrically, to achieve, as he said, 'an absolutely perfect position'. To this end, he would hold his breath as long as he could.

During his military service he had once been given an injection. The idea had then grown on him that a piece of cottonwool had entered his body along with the injected fluid. He then constructed a vast series of ramifications from this single idea, all following a geometrical and rational pattern:

The obsession grew and grew. It was no longer just cottonwool that had been inserted, it was the metal from the needle as well, the glass from the syringe; each organ in my body was systematically affected, until my brain was involved. I thought the substance which they had injected was poisonous, and so were all the injections I had had afterwards. And I also drew things which had happened before that into my obsession. Any treatment was useless. I had to uncover the cause of it all right down to its roots, right down to the foundations, and then build myself up again. It did not matter that an unpleasant treatment might have good results, because good results which

stemmed from a bad event would be cancelled out by this event. I could not accept the illogical idea of a good thing emanating from a bad, for instance a cornerstone resting safely on rubble despite the evident fact that this could happen.

It is hardly necessary to point out the richness of architectural, spatial and geometrical images in this reasoning.

The patient wanted to put a bolt on his door. In case it would not fit the bolt-hole he replaced the latter with a bigger one. But he then noticed it was now higher than before, although of the same diameter. 'I said to myself', he reported, 'that logically, because it is higher, it ought to be wider and so I enlarged the hole'. There were more difficulties and more mathematical considerations, and eventually he ended up with a massive hole in the door and in the wall.

'Planning is everything for me in life', he went on, 'I wouldn't upset my plan for anything. I would rather upset my life. It is a taste for symmetry, for regularity that attracts me in planning. Life has no regularity or symmetry, and for that reason I manufacture my own reality. I attribute all my energies to my brain.

What I am going to say may seem fantastic, but there it is. My state of mind consists of having no faith in anything except theory. I don't believe in the existence of anything until I have demonstrated it. For example, a woman's body has an effect on a man. Why? This is something that I doubt because I cannot prove it. I don't see myself giving way to such things, being carried away and relying only on my impressions. I would feel as if I were in the air, and that would be illogical.'

In the street, however, he was sometimes struck with the appearance of a woman. He would then return to his house, sit down on a chair, cross his arms and take up a position as symmetrical as possible to reflect on the event. He would try to solve the problem of why a woman's body made a particular impression on a man. He hoped that it could all be explained 'by mathematics, medicine and sexual impressions'. It was in this manner that he sought an answer. He wondered whether the human body cannot be reduced to geometry and therefore whether the highest form of beauty did not consist in having a spherical body, this being the perfect form.

He wrote:

I want to examine my sexual impressions, even though this is a formidable problem, because the more I try to analyse these in terms of similar impressions, sub-impressions for instance, I only end up by deriving more impressions. And so it goes on.

He thought about what it would be like if he left hospital. He would become perplexed; his spatial thought, uniquely adapted to things which were durable and immobile, was totally incapable of taking in the slightest change. Here is his train of thought: 'I imagine myself leaving here. It is essential that I still keep some impression of being here and for that to happen I have to have something which represents my stay here'. And so when he left the hospital he took away with him all the bottles and all the empty boxes of pills used during his stay, and arranged them carefully in his house in order to have proof that he had been in the hospital and to have the impression that he was still there.

'I am always looking for immobility', he announced to us. 'I tend towards rest and immobilisation. I also have within me a tendency to prefer immobility in the things around me in my life. I like immovable objects, boxes and bolts, things that are always there, which never change. Stone is motionless, whereas the ground can move and inspires no confidence in me. I attach importance only to solidity. A train goes past on the embankment; the train doesn't exist for me: I want only to build the embankment.

The past is a precipice. The future is a mountain. It occurred to me that it would be a good idea to have a buffer-day between the past and the future. On this day I would do nothing at all. In this way I once went 24 hours without urinating.

I would like to recall my impressions of 15 years ago, to do away with time, to die with the same impressions that I was born with, to make circular movements, to stay in the same place, and not to be uprooted. All these things I would like.'

It would be hard to find a better example of the processes involved in purely spatial thought, which when liberated from the influence of the intuition which is indispensable to life tries to govern its own activity. We have seen the objectives which it sets out to achieve and the monstrous constructions at which it arrives. Can one imagine a better confirmation of those ideas of Bergson which were the point of departure of our analysis?

It should be added that when invited to write an account of all this our patient did so over numerous pages. Characteristically, he only mentioned objects, walls, boxes, bolts and bolt-holes; not one living person entered his description. One would say that his whole life was made up of solid and immovable objects.

It was equally clear that he never sought to combat his abnormal attitude. Not only did he accept it, but he continually tried to demonstrate its solid foundation with supra-logical and supra-rational

We cannot imitate the states of mind described by our patients, and so, when we try to deepen our theoretical and practical understanding of the human personality, we need not be afraid of applying our own instincts and our own intuition to the task.

Jacques Lacan (1900–81)

Jacques Lacan is regarded as the father of French psychoanalytical thinking. He trained in mainstream psychiatry and his doctorate thesis was supervised by Gaétan de Clérambault. After the Second World War he became a cult figure in French intellectual circles, mixing Freudian ideas with social comment. As with many French intellectuals, he founded an ephemeral one-man movement with many followers, who have dwindled sharply since his death.

The following extract from his thesis contains one of the clearest expositions of a psychogenic psychosis, the life history of the patient whom he calls Aimée, after the heroine of her own romantic autobiography, which is described affectionately and with insight.

The 'case of Aimée' stands as a sensitive and understandable rendering of the links between a certain personality and a certain psychotic development.

The case of Aimée, or self-punitive paranoia

J. Lacan (1932)

(Second Part, *Le cas Aimée ou la paranoïa d'auto-punition*, of *De la Psychose Paranoïaque dans ses Rapports avec la Personnalité*. Le François: Paris)

This paper examines the theoretical basis and the developmental origins of paranoid psychosis in terms of the personality development of a single case presented in detail . . .

Case history

The assassination attempt. On 10 April at eight o'clock in the evening Mme Z., a celebrated Parisian actress, arrived at the theatre where she was playing that evening. She was accosted at the stage-door by a stranger, who asked her: 'Are you Mme Z?' When she replied in the affirmative, the stranger, according to Mme Z., assumed a different facial expression, quickly took a knife out of her handbag and, with a look of hatred, raised her arm ready to strike her. Mme Z. tried to protect herself by seizing the blade, in the course of which she severed two tendons in her hand. By this time, the stranger had been overcome by two stagehands and the police were called. The stranger, whom we shall call Aimée from now on, was taken to the prison of Saint-Lazare,

arguments. He consulted us, not to be rid of his 'obsessions', but solely to 'rest', as he put it, in order to return to his bolts and other objects which were the mainstay of his life.

Madame Minkowska who examined this patient at length summarised her findings in the following way:

Life in his case is opposed to planning;
instinct to the brain;
feeling to thought;
 the *faculty of penetration which synthesises* is opposed
 to analysis of infinite details;
 whereas we rely on *impressions*, he demands proof;
movement is set against immobility;
events and people are opposed to objects;
realisation counters representation;
time is in opposition to space;
succession is contrasted with extension; and the *end*
 is set against the means.

In this scheme the first element in each contrasted pair (in italics) is deficient, the second element hypertrophied.

I subscribe to this analysis. One can interpret them as an atrophy of those factors which have to do with instinct, 'modelled on life', and a compensatory hypertrophy of everything which concerns intelligence, or as Bergson put it 'has as its principal object things which are inorganic solids, dead, or not renewed at any moment in time and which are characterised by a lack of natural understanding of life'.

Here is an account by another schizophrenic:

Apart from my reason, which is intact, everything else is in complete disarray. I have suppressed my emotions as I have all aspects of reality. My body has an existence but there is no internal sensation in my life. I don't feel things any more. I don't have normal sensations. I make up for this lack of sensations with reason. Since my illness began I have suppressed the impression of time. Time doesn't matter any more. I can set aside an infinite amount of time to accomplish the most trivial act in my current life. I feel that I can reason quite well, but only in the absolute, because I have lost contact with life.

Another schizophrenic, in an advanced stage of her illness, passed the time making hats for herself. She had made 16 of them. One day, she lost two of them. As a form of retaliation against this she decided to break two of her mother's 16 cups.

Another patient, on being asked, after a visit to her mother, if she had been pleased to see her, replied: 'There was a lot of movement. I don't like that'.

One schizophrenic that I saw showed none of these obsessional phenomena, but needed to give some durable form to events in her life. She had collected newspapers and various scraps of paper relating to herself: 'This happened at this time and on this day (whereupon she indicated the exact hour and date) and I wrote this with a glass beside me which was exactly two centimetres from the paper I am writing on'. As she had done with the glass, on another occasion she took as her support, her witness as it were, any inanimate and immobile object which she found in front of her, e.g. a lamp.

One patient got hold of the idea that someone had put inside his stomach all the left-overs and all the scraps of a meal. He then interpreted everything that he saw in front of him in the light of this idea. His thoughts immediately took flight in the presence of an object, and he went into all the ramifications of how such an object could be related to him. The packet in which he received his copy of the newspaper *Figaro* made him think of the wrappings of all the other newspapers which had been delivered that day and then of all the wrappings of all the daily newspapers in France. One of his family had bronchitis and was bringing up phlegm. This led him to consider all the phlegm produced by patients in all the tuberculosis hospitals in France and then all the refuse of all these hospitals. He thought that all this had been put into his stomach. His son was shaving in front of him; the soldiers in the neighbouring barracks must therefore be shaving and then he thought about how the whole regiment must be doing it. A ticket for the Metro made him think of all railway tickets, Metro tickets, bus tickets and tram tickets that had ever been issued. The individual appearance of an object, event or person was thus wiped out. His thoughts took flight into infinite space with no boundaries.

One young patient with such morbid rationalisations spent a lot of time and energy setting up a programme for allocating his time minute by minute. He would set aside two minutes for washing himself before each meal. The whole plan was a failure as he could not carry it out. The same patient tried to keep his bottles of pills, so as to have a trace of things which would otherwise vanish with time. One day he was annoyed with himself because he felt well, when according to his calculations he should have felt tired. 'It's not logical', he told us.

All these observations have also been made by other writers on the subject. But I hope that I have been able to view them from a new angle, to group them in a more adequate way and therefore to promote a better understanding of them . . .