J-J.Tyszler : The history of melancholy - 3

Seminar 3 - November 27, 2012

This is our third and penultimate seminar for this year. Next time, I’ll assign you a bit of reference work. You will summarize one of the authors whose work, in your view, seems necessary when thinking about melancholy from one of the four angles we’ve been discussing: passion, temporality, affect, or Freudian psychopathology (although I should warn you that Freud will take more time).

I should mention my conditions for this work: you have to really set out to meet an author. No cheating, meaning no googling. Information extracted from google is like the work of university psychology students – as a reader, you can see right away that it’s all patchwork. It jumps at you. But a reader can also tell when someone engages with a work deeply; the style of writing itself is infused with the reading of a specific author. Similarly, it’s sorely obvious when the work has not been read.

During our last seminar, we discussed the chiasm between the work of the aliénistes, who elaborate a clinique of passion, and Freud’s position. At our last meeting, we worked on the clinique of temporality. Today, I’ll use the Cotard delusion to focus on the clinique of affect, or the lack of affect rather, what we call “affective anesthesia” (anesthésie affective). This divergence is interesting, as long as you consider it difficult to fill and don’t rush to fill it. Don’t try to suture this gap forcefully.

First, there’s a nosographic chiasm. By “nosography,” I mean the way we move from the symptom(s) to the syndrome, and from the syndrome to the illness. When one reaches the “illness stage,” one talks about “nosography.” That’s what a doctor does: a symptom could be fever, for instance, but generally, the doctor’s work consists in linking the symptom to an illness. If the doctor doesn’t know what illness the symptom represents, there’s a real problem. Obviously, yes, it certainly is a problem if a fever last several months and the doctor has no clue which illness the fever is expressing. So, generally speaking (I say “generally” because of course, there are always exceptions – medicine is more of an art than a science, sometimes), we situate a symptom within a syndrome, meaning a series of signs, and then we make the effort to situate the syndrome within an illness. That work, which consists in moving from a symptom to an illness, is called “nosography.” or “nosology.”

So in 1924, Freud writes a text entitled “The loss of reality in neurosis and psychosis” (“Perte de la réalité dans la névrose et dans la psychose.”) In that text, he gives melancholy its nosographic status. The following portrait of melancholy is extremely simple, yet it raises considerable questions: “Regarding neuroses of transference, I shall say that the conflict is situated between the ego and the Id” (“Pour les névroses de transfert, je vais dire que le conflit se trouve entre le “Ich” et le “Es”). “Phobia,” “obsessional neurosis,” “hystéria,” “infantile psychosis”… We’re no longer allowed to use these terms. But we know that hysteria is a very common position of the unconscious; and it’s not going to simply disappear just because the term itself is taken out of the casuistry. “Ich” is generally (and abusively) translated in French as “Moi” until Lacan, after whom we began calling it “Je,” meaning the subjective position. The category of “Moi” requires pause, even with Freud, because for Freud, “Ich” is a kind of patchwork. It’s not identified as an entity of logic and reason, as people have tried to say. “Es,” translates into “ça” in French, meaning the drives (le “ça” du pulsionnel) which leads people always and without interruption to their impulsive thirst (jusqu’à leur soif pulsionnelle), what we used to call “instincts,” now replaced with “drives” (pulsions).

Regarding psychoses (schizophrenia, paranoia, paraphrenia), Freud says: “The conflict resides between the ego and the outside world” (“Le conflit se situe entre le “Ich” et le “Aussenwelt.””) Freud’s position seems full of common sense, really. He’s saying: “Basically, for the psychotic individual, insofar as things coming from the “outside world” are concerned, something goes awry.” You see how Freud’s nosographic work is rather simple. And then, his reader stumbles upon a surprise regarding melancholy, which Freud calls “narcissistic psycho-neurosis” (psycho-névrose narcissique). Here’s the “jump” I’m talking about (between Freud and the aliénistes): “I propose that for melancholy, the conflict resides between the ego and the superego” (“Je vais proposer pour la mélancolie que le conflit se passe entre le “Ich” et le “über Ich.””). So Freud interprets melancholy as a conflict between subjectivity and the instance of wild criticism (critique d’instance sauvage) that exerts itself onto the ego, which he calls “über Ich,” superego.
How does this shift occur between what had always been said and Freud’s nosographic tableau? Something happens indeed, and it’s not so easy to grasp. Freud does something, and since he doesn’t seem to be taking into account the current nosography elaborated by the aliénistes at the same period in time, it difficult to understand exactly what he does. Freud doesn’t use the work of the aliénistes. So when we read the texts, the clinical contributions, the semantic chiasms are really impressive. It’s hard to believe that both of these cliniques are happening at the same period in time. This is the same historical moment – but we find entirely different clinical and theoretical approaches.

To be clear, I’m not saying that Freud is “better.” He simply has another way of addressing questions. In fact, Freud’s approach will come with a cost: the status of melancholy and mania in the history of psychoanalysis has never been properly fixed, This is still true today. A price was paid for Freud’s approach, a kind of uncertainty results regarding the status to give these illnesses.

This conceptual contrast springs from the necessity Freud feels that analytic theory and practice ought to give primacy to the notion of “object.” For Freud, the object is a construction, a fiction. It’s a way of narrating the Real (une façon de raconter le Réel). Freud says that as soon as the baby is born, its body eroticizes itself (son corps s’érotise). And with this eroticization, something will form a circuit and end up back onto the body (pour finir par faire retour sur le corps). That’s what Freud calls the “drive” (la pulsion).

Equally important, the object of fantasy (l’objet du fantasme). Freud says: “All of human sexuality, all forms of eroticization depend on a tiny scene which the child imagines (que l’enfant se fabrique) very early in life, around two or three years old. And his/her entire adult sexuality will be totally dependent on these objects fixed in this initial scene. The reference is the magnificent yet very enigmatic and superb text A child is beaten. Of course, you can “believe” Freud or not. That’s not the issue. What’s important is to understand that this is the Freudian foundation (la mise en place freudienne). Your sexuality is founded strictly upon the intermediaries that are these objects, the intermediary of this particular scene.

This is crucial for Freud. In fact, this is one of the points on which Freud will prove to be unwavering. As soon as his colleagues, friends and followers wish to leave this particular terrain of infantile sexuality, Freud considers that they’ve placed themselves outside the field of psychoanalytic psychology (hors du champs de la psychologie psychanalytique). Freud was very harsh with most of them, like Otto Rank (and traumatic birth), Carl Jung (and archetypes), etc… Freud says: “No, none of that interests me. Either you accept the foundation of sexuality, or not. If you don’t accept it, you’re doing psychology, but not psychoanalysis.”

Objects – you have “objects” from the onset and throughout the entire history of psychoanalysis, like the great Melanie Klein with good and bad objects: the objects which the child retains, and internalizes as “good objects” and all those he rejects as “bad objects.” It’s a manner of speaking, of course. Don’t forget that psychoanalysts work with the imagination. They come up with fictions, with constructions that enable them to understand the experience of being alive (pour faire comprendre le vivant). It’s not as if I’m designating Mercury, Venus or Saturn when I’m speaking. It’s a “fiction” that catches the intra-psychic (l’intrapsychique).

What other “objects” do you know? Of course, there’s Winnicott’s famous “transitional object.” According to him, the baby “mediates” his relationship to the external world through intermediary objects. We know this is true. Who hasn’t seen babies holding on to their “doudous” (security blanket/comfort toy)? But you must also remember there are cultures without “doudous.” First, there are children who don’t have “doudous” and second, there are cultures without “doudous.” like in Africa and probably elsewhere. So be attentive not to be ethnocentric. Make an effort to remember that the whole world doesn’t function like this. All of this describes the way the “discoverers” (les découvreurs) of the unconscious set things up. Is it an absolute universal truth? No. All you need to do is take public transportation to notice just how many “doudous” are being used!! Everyone is either playing with their phone, or listening to music. We’ve basically become a society of transitional objects! So Winnicott’s intuition is dead on: we stay children our whole lives. And it seems that the great corporate managers of the world have read more about drives and impulses than we have! They know how to use and to exploit our drives to their own ends. Humans can be made extraordinarily dependent on any object. It really is a science...

What is Freud’s position on melancholy in regards to the object? This is a somewhat abusive synthesis on my part, of course. Now, first, make sure you remember that the prototype for Freud is always the question of mourning. He has a hard time separating the mourning of an object from melancholy. Consequently, he says: “When the subject is in mourning, when an object is lost, part of the ‘Ich,’ part of the subject, will “introject” this object (by “introjection,” he means the process by which the subject will take the characteristics of this object as his own”). When someone dies, for instance, that person is immediately idealized. Even if the guy was tedious his entire life, he becomes a “saint” the minute he dies. Part of us identifies
with the deceased, of course; and that’s part of mourning. We then incorporate his traits as our own, as ourselves. So Freud says: “The “Ich” is going to introject a part of this lost object. Strangely, however, another part of the “Ich” will reproach the lost object its disappearance. So the criticisms and reproaches of the melancholy individual are actually addressed to the object; they express the vengeance exerted by the “Ich” on this object.

Where does Freud get this? From where does he get this way of thinking? He posits that a deathly struggle will ensue between two parts of the self, between the part that has idealized and introjected the object and the one that will accuse the object. These reproaches form the “self-accusations” (auto-accusations) of the melancholy patient: “I’m a jerk, I’m indignant, I’m a dog, a piece of shit,” etc… This aspect really fascinated Freud

This set-up is typical of Freud, and it belongs to him. Two processes take place at the same time vis-à-vis the lost object. Part of the “Ich” identifies with and idealizes the lost object, to the point of incorporating it as part of himself. But another part treats the object aggressively, with reproach. “Why did you leave me all alone like this? You’re leaving me with the children, with all of life’s difficulties, and you, you’re in heaven…” On one side, you have accusation; on the other, idealization. Freud says that what we call “self-accusations” are accusations transferred onto the idealized “Ich.” This dialectic is very interesting. It is what it is, but it’s rather subtle and well balanced. Now, if all of you think of your experiences of mourning, you’ll see the truth in what Freud is saying. He succeeds in describing the human experience of mourning (être endeuillé). Freud is very pragmatic, don’t forget. He’s an eminently concrete theoretician. When what Freud describes seems obscure to you, try to take pause and think about your own experience of life, and you’ll see that he often calls upon shared experiences of life. What he says about mourning, those of you who have been “lucky” enough to experience it know that what Freud is describing is within reach. Now, the theory he extracts from this experience, the theory about this cruel conflict between the “Ich” and the “über Ich,” that’s a supplement of theorization. You don’t have to accept what is Freud’s “translation” of the experience (sa traduction de l’affaire.)

When you shift from general psychopathology to psychoanalytic psychopathology (which is the purpose of attending this school), you must be able to understand the jumps, as well the difficulties that follow from making such jumps. They must be respected. You need to acknowledge them, to recognize that, yes, indeed, this or that is a problem. In this light, I’m only trying to underscore that each tradition has its own and powerful consistency. Of course, for now, they all seem juxtaposed to you rather than linked. Indeed, it’s not simple to link together what appears to be juxtaposed.

Let me rewind for a second so you can take stake of the question of affect vis à vis the object. I’ll read you a few notes from a session, and then I’ll tell you more about the nosographic framework in which to situate this patient (now deceased, and whom I saw for years. Sadly, just when I thought he was improving he died of cancer – which is very disconcerting with some patients. You realize they’re doing better, but their psychic improvement comes at a price. Unfortunately, that’s part of the pain of our practice: we never know to what degree someone has improved). As you listen to the notes from this session, try to have in mind the “loss of mental vision” (perte de la vision mentale) that we discussed previously. Why does the melancholy patient see the luminosity of spring as darkness? Think about the problem of the signifying gaze as you listen to the following passage:

“I feel like I see everything in grey. The colors are duller, and the reliefs have flattened. The colors can’t attach onto my eyes; my world is grey. I can’t see the flowers in the garden anymore (this patient was hospitalized in the clinic where I was working, so he could walk around in the park). My existence is grey also, without any relief. There’s no more bumps, no coarseness or texture. I see people more as shadows. It’s erased, like on a drawing. But I don’t really feel like seeing people. (What’s interesting here, and Séglas also remarks upon this, is that this patient thinks about the same scenes he used to look at with pleasure). The sight of the seaside where I used to go has also become grey (You see how interesting this is. It’s like the work of a clinician! Often times, patients are remarkable clinicians. This man is asking why the pleasure he used to feel has disappeared. The seaside that used to be blue is now grey). A mountainous landscape, the only effect is regret, the regret of being unable to feel attracted like before.”

J’ai l’impression que je vois gris. Les couleurs se sont atténuées, ainsi que le relief. Les couleurs n’accrochent pas mes yeux; mon univers est gris. Je ne vois plus les fleurs du jardin. Mon existence aussi est grise, sans reliefs. Il n’y a plus d’aspérités, de rugosités. Je vois les gens plutôt comme des ombres. C’est gommé, comme sur un dessin. Mais je n’ai pas tellement envie de voir les autres. La vision du bord de mer où j’allais autrefois est devenue grise aussi. Un paysage de montagne, le seul effet,
One of the cardinal signs of melancholy is this disaffected gaze. And the patient experiences this loss with cruel intensity. Regarding orality, he says (this man used to be a person of note (un notable), so he spent a lot of time in restaurants for business reasons; he was a “bon vivant”):

“I even struggle bothering to go out to dinner. It’s not natural anymore. I no longer sit down to the table with pleasure. I’m poorly seated; I have no appetite. The taste of wine is disturbed. I eat as fast as possible. The faster, the better. I’m eager for it to finish. At home, I even ended up eating standing, with the plate resting on the terrace railing. I just didn’t have the patience.”

“You see the problem of the oral drive (la pulsionnalité orale), mouth and taste. And that particular moment he describes, in which you might hear the category of what we call the “object” in psychopathology; how a subject can reduce himself to the category of object (la catégorie objectale), to nothingness (au “rien”). I’ll continue:

“During this or that period, I wanted to soil my suit with the oil dripping from the sandwiches I was eating. I ate kebabs, Turkish sandwiches with white sauce, and I wanted to stain my suit in order to dirty myself. It was stronger than me. It was meant to lower myself to what I considered myself to be.”

Picture that scene. This is a well-known businessman in his town, a man always impeccably dressed. He would go to whatever kebab shop and felt the irrepressible urge to soil himself, to become disgusting. Why? Because he was the disgusting object.

“I had a green summer suit. And to see it that clean made me want to soil it. I would resist this urge as much as possible, and I had to keep my hands at a distance from myself” (This man has to make a considerable effort to move his hands away). I was overwhelmed by this desire. I couldn’t even make my way home. I would just wander about, roam around. I felt dirty; and it’s not entirely gone yet (The phrasing is interesting, “it’s not entirely gone”… I began seeing this patient several years after this episode, but the mark had been made (la frappe est indélébile). I was still going to the office. Like one night… I drank tons of beer to get my stomach to explode. I would go to the tops of houses to throw myself down, and then I’d renounce at the last minute. One day, I swallowed gas, with the gas pipe in my mouth” (You can recognize the suicidal acting out of patients with major depression). I acted like a tramp waiting to be picked up. (And then, he finishes with something very intriguing, if you think about the question of the father in psychosis, one of Freud’s themes). At a bar one day, the owner asked me if I had lost a child… I was dripping with sweat…

“J’avais un costume d’été vert. Le fait de le voir propre me conduisait à vouloir le salir. Je résistais au point que ce n’est pas...
possible, et je devais tenir mes mains éloignées de moi. J’étais submergé par cette envie. Je n’arrivais plus à rentrer chez moi. Je divagais en ville; je trainais. Je me sentais sale; ça n’est pas encore tout à fait parti. J’allais encore au bureau. Comme un soir… J’ai bu plein de bière pour me faire exploser le ventre. J’allais au sommet des maisons pour me jeter; au dernier moment, je renonçais. Un jour, j’ai avalé du gaz par le tuyau dans la bouche. Faire le clochard et attendre qu’on me ramasse… Dans un bar, le patron m’a demandé si j’avais perdu un enfant. Je dégoulinais de sueur, etc., etc..

This final sentence is very intriguing: this man is at a bar, in a lamentable state. Given this state, it occurs to the bar owner that perhaps he’s lost a child. It’s the same question as Freud’s! “What are you mourning over?” This patient never had any children. But the inverted return of the sentence (le retour inverse de la formule) is truly intriguing.

You see how this is a straightforward melancholy episode (un episode mélancolique franc)? In this kind of narration, you have the cardinal signs of a melancholy episode. I think you can hear how much the subject, the Freudian “Ich,” resigns himself to the question of the object. This is an intelligent man, who’s capable of describing this long trajectory of subjective loss towards waste/garbage (trajet de déssubjectivation vers le déchet). This wasn’t a case of chronic melancholy. It was a case of erotomania. It’s rare among men. Generally, erotomania is a feminine psychosis. A woman will declare that a man (whom she basically doesn’t know) loves her. The problem is that once she pronounces the words “he loves me,” this passion remains indestructible for the rest of her life. And the love object wants to flee, of course. But that doesn’t matter in her eyes.

Erotomania is a very serious illness. In classical descriptions, the love object is often a doctor or a priest. De Clérambault used to say “a man of wealth” (“un homme de biens”). Today, these men are often journalists or famous singers, men often caught in the woman’s scopic field; and suddenly she says “he loves me.” What’s interesting is that this love is indestructible. The male patient I’ve been discussing was forcefully committed in the town where he was living. The police would pick him up every evening in front of the love object’s house until finally, he was “banished” from his town. That’s how I met him in Paris, where he remained hospitalized for a very long time.

In typical cases of erotomania, there’s only one object of love. I’ll skip the cases induced by the transference relationship. People who work in hospitals know that caring for a patient can produce forms of erotomaniac passion, that can pass from one doctor to another. These are called “transference erotomaniac” (érotomanies de transfert). They have the same structure as erotomania but they’re induced by the transference interest (l’intérêt transférentiel). That’s why we require great vigilance from the young colleagues who come to work inside hospitals. Often, these young people don’t believe in this “erotomaniac” attachment.

One day, I even had to let go of a young psychology intern on account of a paranoid patient with extreme interpretive leanings. This young woman wanted to take care of this patient all the time. “Be careful,” I would warn her. She didn’t listen and.. Sure enough, a few weeks later, the patient unleashed a “love” on her from which she wasn’t able to detach herself. So she was asked to leave, for her own protection. There was no choice. And unfortunately, we had to take forceful measures to insure the patient remained hospitalized. So there is indeed a cost for all this. It’s an interesting zone, but it poses many difficulties.

In the sessions I’ve just narrated for you, I think you can hear the question of the object, the question that was so important for Freud and for psychoanalysis. There’s a long trajectory that goes from the lively subject, a subject full of desire (un sujet présent à la vie, présent à son énonciation, à son désir) towards something that goes awry, something that corrodes the whole of the individual’s drives (son appareil pulsionnel). It corrodes the way he eats, the way he sees and remembers. Everything is affected and culminates into the feeling of being nothing else but this detritus (rien que ce déchet même), the detritus that remains after this change (le déchet de cette opération). Hence the suicide attempts of such patients, or their demands that the doctor make them disappear. Often, these are patients who beg to be killed by the doctor. They say: “Well, why don’t you do it? Since you, doctors, know how. Shorten the pain (abrégez la souffrance).”

This is a melancholy episode within an entirely different nosographic framework, since we’re talking about a passionate psychosis (une psychose passionelle). Therefore, it belongs to the larger framework that is paranoia. So, this is interesting: we have a very passionate, very paranoid patient who suddenly breaks, probably out of exhaustion form this pointless struggle (épuisement de la lutte vaine), year after year… He still loves this girl and will love her until he dies. He loved his whole life, but in vain. And I think the psychic exhaustion that results from this struggle made him experience very serious melancholy episodes.

Now, let’s move on to the Cotard Delusion, or Cotard’s syndrome. This is around 1880, so before Freud. That said, Freud’s studies on hysteria date to 1895, so it’s about the same time period as Cotard, really. Still, as you’ll see, the vocabulary is very different. The first contribution is called “About hypochondriac delirium in a serious form of anxious melancholy” (“Du délire hypocondriaque dans une forme grave de la mélancolie anxieuse”).
In this text, Jules Cotard posits the necessity to individualize a certain form of melancholy, which he defines with the following criteria: like with all melancholy, there’s this phenomenal anxiety, with ideas of domination, of possession (on a side note, this may seem bizarre to you, but you can still come across patients who think they’re possessed by the devil, and these aren’t always religious people), with a propensity towards suicide and voluntary mutilations and, like with this patient, a form of analgesia (which is interesting for doctors…). You find hypochondriac ideas of non-existence, of destruction of their organs. Of course, when a GP or surgeon sees a patient who says: “I don’t understand, I don’t have a liver anymore; nor a digestive system,” this creates a certain stupor. And often, doctors call their colleagues in psychiatry and refer these patients to us. But the idea of negating one’s organs, which, as Jules Cotard says, spreads to the entire body, to the “soul” and to God, is indeed striking. The negation of God’s existence, not from an atheistic point of view (this isn’t a philosophical idea), but the God “in whom I believed” is dead; he no longer exists. And finally, the idea of immortality (I’ve met a few patients with this very intriguing idea), of being unable to die (ne jamais pouvoir mourir). When someone is burdened with immortality (frappé d’immortalité), I can assure you his main priority is to shorten his existence. The very idea that he’ll become infinite is intolerable.

Jules Cotard’s work is truly remarkable. Each flower is incredible. And he makes a bouquet out of all these flowers, a bouquet that will need a name. The term “melancholy” won’t do. It’s too specific. And this syndrome isn’t made from the usual bouquet. It’s so special that it ends up being called Syndrome de Cotard.

In 1882, Cotard write the magnificent article “On the delirium of negations” (Du délire des negations). What a title! I would love to come up with a title like that some day, for a real princeps article. Like Freud, Cotard takes a firm stand and offers a synoptic tableau. He moves from the delirium of persecutions, which is representative of paranoia, to the “delirium of negations.” Cotard assembles hycopcondria, self-accusations (the theme which interested Freud so much), indignity, culpability, damnation, requests for punishment (châtiment), suicide, mutilation, sensitivity disorder (trouble de la sensitivité), anesthesia, rare hallucinations.

A quick word about hallucinations: in doctrine (I know you don’t like the term “doctrine” because it sounds old-fashioned and evokes a school elaborated around a single dogma), nonetheless, the interpretive heart of what we call “psychosis” in doctrine is hallucination (le phénomène hallucinatoire). The heart of the study of psychosis has always been hallucination. Because it seems that the phenomenon of hallucination commands all the other problems of psychosis. Paradoxically, however, there are also psychoses without hallucinations. Hallucination is the heart of all “doctrines” of psychosis (until recently, of course, because nowadays, no one cares…) yet at the same time, there are some psychoses, like the Cotard Delusion, that are devoid of acoustic and verbal hallucinations. Unlike most psychoses, the Cotard patient doesn’t hear voices.

Back to our discussion: the negation of organs, the feeling of being dead or the idea of immortality, delirium of annihilation (délire d’anéantissement). This is extraordinary. I’ve witnessed this myself. Patients deny everything. They no longer have parents, nor a family; everything is destroyed. One day, I observed the following scene: it’s a Saturday, and a family comes to visit a patient, but the patient says “who are you?” This evidently warrants pause. After a while, the little girl says: “Daddy, it’s me. Don’t you recognize me?” “No, you’re dead; it can’t be you.” That’s why Cotard’s term “délire des négations” is so extraordinary. Everything is treated at the level of negation; it’s a cosmic negation, which comes from the Real – “it” (negation) has destroyed everything. It’s not easy to handle this kind of case, I assure you. Imagine what it’s like from the family’s point of view! As a doctor, you must protect the patient, and attempt to make this pass before he dies, so to speak; but at the same time, you have to take the family into account. Imagine what it’s like for children to hear their father or mother saying “you don’t exist; this can’t be you, you’re dead.” Psychiatric psychopathology covers zones that require a lot of exigency and finesse (doigté) on the practitioner’s part, because these types of negations are indeed cosmic, all encompassing.

Interestingly, all of these great entities (like Cotard Syndrome, erotomania, etc.) are fairly rare from the statistical point of view. And thank God! Their clout comes from the questions they ask the living – the way they express themselves (leur façon de s’énoncer), which make our way of conceiving all other mental illnesses possible. Such a determining position, like you find in the Cotard, gives us the means to think about the ways in which the living can deny life, negate life, life’s fundamental negativism (le négativisme foncier du vivant.) Freud was deeply interested in this problem. For Freud, there’s a force that pushes us towards life, eros, and one that pushes us in the opposite direction of destruction, thanatos at every minute of our existence. Of course, he wasn’t the only one to think this way. Freud borrowed this idea from philosophers. But the point is this: although such cases are rare, they nonetheless determine the entirety of questions. What is life? What is the negation of life? What does it mean to be “damned/doomed” (damné)? What does it mean to feel guilty, to no longer have any feelings for the Other, to the point of being “anesthetized”? What is negativism?
In fact, you can almost interpret everything that happened during World War II through this kind of negativism, to the point of reducing the other to a pure number, to nothing. For this to be possible implies that human beings have a propensity towards this “delirium of negation.” In this sense, these large clinical *tableaux* help us think through such questions. Similarly, passionate psychoses (*psychoses passionnelles*) and erotomania make us ponder what we call “love.” What does it mean to “love”? How do we love? Who loves?

So you need to distinguish between these great nosographic fictions, which are very rare, and the fact that from these great fictions we can read all of psychopathology. Is it so surprising? If you think about it, a great novel or poem works in the same way: you reinterpret life, and all other texts through its lens. A very great text is a very rare thing. For instance, Tolstoi’s *War and Peace* helps you read just about the entirety of the Russian soul. Similarly with nosography. A case like this, described by Cotard, makes us review things entirely differently through its paroxysmal trait.

**Student Question:** Is there an evolution over time in these syndromes? For instance, it is said that we no longer come across great cases of hysteria, etc…?

**Answer:** That’s a very interesting question, and one of a different order. One can say this: hysteria has changed. Symptomatically, hysteria has changed. Those of you who have seen the film about Charcot *Augustine*, for instance… Such unbelievable cases of hysteria are extremely rare nowadays. Even pains, paralyses, etc… they aren’t so common anymore. So where has hysteria gone? Well, it’s found refuge in other syndromes that doctors know better, like fibromyalgia, etc… These strange bodily syndromes that make the body suffer, and whose pain the medical establishment can barely explain, or even name for that matter, but which it must still accompany. Hysteria has also “found refuge” in mood disorders (*troubles de l’humeur*), these various expressions of “depressivity” (*dépressivité*) that aren’t forms of melancholy, of course.

Another major change must be taken into account: hysteria isn’t just a neurosis; it’s a way of addressing the master (une façon de s’adresser au maître). Hysteria is a “position,” possibly a neurosis. But as soon as Freud returned from visiting Charcot, he said that despite the etymology of “hysteric” there is such a thing as “male hysteria.” In fact that’s why Freud was fired from the Vienna Society of Neurology. Similarly, Freud says there’s such a thing as “child hysteria.” Hysteria may be a feminine position, but it is one in which many men can plunge (dans laquelle beaucoup d’hommes s’engouffrent.) So, hysteria is also a form of discourse. It says: “You, you masters are telling me this and that; you’re telling me that I should be doing this and that. Well, no. It may be fine for you, but it’s not for me. For me, it’s NO.” Hysteria is a position of refusal. The hysteric refuses that the world be a world of masters. Nowadays the position of “master” isn’t so easy to determine, especially in medicine. In psychiatry, there are no longer any masters; it’s over. As a discourse, hysteria toils to find a place in a world where there are no masters. It doesn’t mean that the symptoms of hysteria have disappeared. But hysteria will be found (va se loger) in the faults of science, in its interstices.

The other “grand” mental illnesses, psychoses… I think the question needs to be really opened. Some of these, like Cotard, or erotomania, seem to have a kind of intangibility that appears to indicate that, whatever the social and political circumstances, certain fundamental elements remain open. In parallel, the tonality of certain psychoses seems to evolve. For instance, when I was a psychiatry intern, it was absolutely forbidden to mix antidepressants with neuroleptics. Why? Because psychiatry considered a patient to be either in the register of mood disorders (le registre de l’humeur) or delirium (le registre du délire). It was one OR the other. Nowadays, everything is blended, because patients have strange and intriguing typological dispositions. We see a lot of deliriums with thymic episodes, and vice versa. Also, we’ve always known that some people have acute episodes of delirium (*épisodes délirants aigus.*) But strangely, nowadays, you see patients with repeated episodes (*épisodes délirants à répétition*). Someone is suddenly completely off track and then, just as suddenly, seems to retrieve a certain position - until the next episode. We’re seeing new things. As always, you need to keep both aspects open: a certain amount of intangibility, with some movement.

I’ll finish with the “delirium of enormity” (*délire d’énormité*) Every two years, Cotard published an annex to his main work. His clinical tenacity was incredible. Cotard keeps thinking about his work, seeing his patients, discussing things over with colleagues, doing research… In 1888, he adds the “delirium of enormity,” and says: “Some of them are not only infinite in time, but infinite in space also. They are enormous; their size is huge; their head can touch the stars” (“Quelques-uns d’entre eux ne sont pas seulement infinis dans le temps, mais ils le sont aussi dans l’espace. Ils sont immenses; leur taille est gigantesque; leur tête va toucher aux étoiles”). There’s something Einsteinian about this. Not only are these patients “infinite” over time, Cotard says, but over space as well. As a result, during a congress in Blois a few years later, (a real congress, I mean, not a cocktail party sponsored by pharmaceutical labs; a congress intended for debate, for fighting over issues, genuine
disputatiois, true controversies), the great psychiatrist Séglas proposes to regroup all of Cotard’s discoveries under the term “Cotard Syndrome.” Nowadays, colleagues want to name their discoveries after their own names. But in the old days, of course, you couldn’t name your own discoveries! Other people named them after you. First, you had to defend your discoveries, and if they were honored, then maybe, just maybe, some brilliant and well-established colleague would propose to join these discoveries under your name.

So, what have you heard about the Cotard Syndrome today? First, I hope you heard the incredible richness and beauty of the descriptions, the signifiers themselves, which speak to Cotard’s incredible talent in semiology. How to describe life (comment décrire le vivant) in its most extreme forms… I think you also heard the degree to which, in this syndrome, the body, space and time as a whole disintegrate (se désagrègent), and how it reveals very strange colors of subjectivity (des colorations très étranges de la subjectivité) to the point of actually helping to reveal the nature of categories that psychopathology will later refer to as “objects,” objects which, in this case, all gravitate to say “NO” to everything. This “no” is nothing like a child’s “no” when he says “no, I don’t want this. This is a definitive and absolute “NO.” Everything is dead (tout est mort).

A final word, to link all of this to the history of psychoanalysis: You remember the great Schreber case? And of course, you remember that Schreber was not one of Freud’s patients. Freud never met him. He analyzed him through texts; it’s a textual analysis. Often, psychotic patients are unbelievably intelligent. By the way, I wanted to mention something, before I forget. What we call “psychoses” are far more colorful and vast than neuroses. The varieties, inventions, shapes and typologies of psychoses have nothing to do with the very narrow shapes (les formes tout à fait étirées) of what we call “a neurosis.” Neuroses are very few. Once you’ve said “hysteria, phobia, and obsessional neurosis,” even if you add things like “addiction” or whatever, that’s nothing at all; it’s very cursory. On the other hand, the shapes of madness (les formes de la folie) are infinite. It’s remarkable, and it needs to be acknowledged. Thanks to “madness” (la folie) or “insanities” (les folies), we know the world’s incredible variety, a far more vast sense of diversity than what “neurosis” gives us (nous donne à penser).

That’s why you can never get bored in this profession. I’ve been conducting patient presentations for fifteen years and I’ve never ever encountered the same case twice. This patient may be paranoid, like last week’s patient, but it’s never the same paranoia. Each case is always absolutely singular. One form of melancholy may basically look like another, but they’re still f different. You must accept this. And in order to reach such cases, you have to be working in the places where “madness” speaks and where it is heard (où la folie se dit et se recueille). If not, you can read about it in those old articles.

Back to Schreber. Schreber was a real paraphrenic (paraphrène), in the classical sense. He experienced a genuine “delirium of negations” during his first hospitalization in 1884 in the clinic of the University of Leipzig. And Doctor Weber mentions in his expertise:

“He mulled over hypochondriac ideas. He would say that his entire body was altered, that one of his lungs had disappeared. During the first years of his illness, he would experience some of his body organs as “entirely destroyed.” Following this, Schreber claimed to have lived for a while without a stomach, with barely any lungs, with a torn oesophagus, without a bladder and with broken ribs.”

“Il ressassait des idées hypocondriaques, disait que son corps était tout entier altéré, qu’un de ses poumons s’était totalement volatilisé. Il aurait, pendant les premières années de sa maladie, fait cette expérience d’avoir eu certains organes du corps entièrement détruits. Il aurait alors vécu tout un temps sans estomac, sans intestins, pratiquement sans poumons, avec un oesophage en lambeaux, sans vessie, les côtes fracassées.”

This is Schreber speaking to his doctor. So the doctor thinks: “This patient is completely hypochondriac. What it this delirium of negations?” This occurs in 1884, and you see it again during his second hospitalization in 1893. Interesting, isn’t it? Of course, when you talk about this, you might say “the Schreber case is what enabled psychiatry to formulate paranoia.” Nonetheless, the way Freud dealt with it needs to be examined more closely. When one looks at the actual expertise reports, one realizes that Schreber did experience frank “Cotardized” melancholy episodes (épisodes mélancoliques Cotardisés francs), episodes that Lacan will later describe as “subjective death” (mort subjective). That’s all in “Memoirs of my Nervous Illness.”

Freud was modest and rigorous. About Schreber, he says:
“I don’t want to miss the opportunity to point out here that I don’t consider valid any theory of paranoia that doesn’t include the hypochondriac symptoms that almost always accompany this form of psychosis. It seems to me that the relationship of hypochondria and paranoia is the same as between anxiety neurosis and hysteria.”

“Je ne veux pas laisser passer l’occasion de faire observer ici que je ne saurais tenir pour valable aucune théorie de la paranoia qui n’incluerait pas les symptoms hypocondriaques presque toujours concomitants de cette psychose. Il me semble que la relation de l’hypcondrie à la paranoia est la même que celle de la névrose d’angoisse à l’hystérie.”

That’s typical of Freud. He says: “All right, fine, I thought I knew what I was saying about paranoia. But what should we make of this hypochondria? These hypochondriac themes are proper to paranoia, but they’re present also in melancholy. What is this foundation?” Freud doesn’t answer; he simply asks the question. And he warns his colleagues that they’ll also need to deal with this question after his death. The question of the Real in the body (la question du Réel dans le corps) will know several developments: imago, body image, Lacan’s spectacular entrance into the question with the mirror stage, etc…

This will suffice for today’s seminar.

Today, we dealt with the question of negation. What is negation? What is a body? What does it mean for someone to be without affect, to the point of thinking it would be better if (s)he disappeared. The terminology relating to the object is indeed a bit complicated. It’s necessary to traverse the categories of these major illnesses in order to understand what an object is through the paroxysm of a complete loss of subjectivity, when the patient treats him or herself as an object (mentally). Also I hope you noticed that the aliénistes didn’t interpret a lot, neither did Cotard. They took note of their patients’ every utterance. But they considered that what is said is said. Period. They didn’t “psychologize” in the slightest. No contestation, no interpretation. So I encourage you not to try to understand too quickly. If you succeed in hearing what is said, that’s already a lot.

Paris, Fall 2012

URL source: https://ephep.com/fr/content/texte/j-jtyszler-history-melancholy-3