ON THE SPECIFICITY OF ELEMENTARY PHENOMENA by François Sauvagnat

Cultural differences and clinical definitions

From Psychoanalytical Notebooks, Issue 4, Psychiatry and Psychoanalysis, Spring 2000.

The expression 'elementary phenomena', as it is used in contemporary Frech psychopathology and psychoanalysis, *phénomènes élémentaires*, has been coined by J. Lacan[1] in his doctoral dissertation (1932) to designate minimal delusional phenomena, which, at least for a certain time, the patient can conceal or ignore, until they develop (if they ever do) into a full-blown delusional or hallucinatory experience. According to Lacan, these phenomena include the same structure as the delusional system which can develop out of them, and this is why, of course, the study of elementary phenomena has developed so strongly, as it became clear that they could express the core conflict the patient was besieged with. As we shall see, the Lacanian concept of 'foreclosure of the father's name' is very strongly related to this clinical concept.

Another noteworthy point is that this concept is strongly embedded in the continental psychiatric traditions, which can be opposed in this respect to the American or British psychiatric tradition, although Anglo-Saxon practitioners and researchers have made laudable efforts to integrate some French and German clinical research in the recent decades.

An excellent indicator of this is the way eponymy functions. To French clinicians, *le syndrome (d'automatisme mental) de Clérambault* and *le syndrome de Sérieux et Capgras*, are classical designations of two sorts of elementary phenomena, respectively:

1. Auditory (but also sensory, motor, ideational) hallucinations.

2. Delusional misinterpretations that tend to be logically structured.

According to Clérambault himself, the syndrome to which he vowed to give his name, had been previously described by Wernicke, a German psychiatrist from Breslau (now Wroclaw in Poland) under the name of *Halluzinose*, but he considered that his own description and etiological hypotheses were much more appropriate. In Eastern Europe, Polish and Russian psychiatrists traditionally refer to this syndrome as 'Kandinsky-Clérambault syndrome', considering that the Russian psychiatrist Viktor Chrysantevich Kandinsky (1849-1889) has been an important forerunner of Clérambault in describing this syndrome. Likewise, *le syndrome de Sérieux et Capgras* is a continental elaboration which was first inspired by one of Wernicke's followers, C. Neisser. Neisser particularised the *krankhafte Eigenbeziehung* symptom, which he considered as characteristic of paranoia (he called it the *Kardinalsymptom der Paranoia*), and in which the patient felt that he was being designated, pointed at, etc. Sérieux & Capgras added to this that the development of delusions, in this sort of case, followed usually a logical course, as the patient produced coherent and even rational interpretations about what he felt was happening to him, until he constituted a huge system encompassing all the prominent issues he was confronted with.

Both syndromes refer quite clearly to what Lacan has called 'elementary phenomena': a clinical disorder of reduced dimensions that gradually overcomes a huge part of the patient's personality, and of which it is the main symptom.

Now, if we ask what the names 'Clérambault' and 'Capgras' refer to in the Anglo-Saxon linguistic area, we will find that Clérambault is famous for having described the 'erotomania syndrome', better known as 'stalking', which happens to be one of the most fascinating plagues of Hollywood, and Capgras is associated with what is presented as a 'schizophrenic disorder' consisting in the misrecognition of

relatives, a condition which allows local clinicians to develop cognitive research programmes on perception disorders. *Automatism mental* does not seem to have attracted the attention of Anglo-Saxon clinicians, and the closest known syndrome is probably Kurt Schneider's (from Heidelberg) 'First rank symptoms', elaborated at the end of the 1930s, which provides empirical criteria to detect schizophrenic conditions, and has been integrated in psychiatric manuals in Great Britain in the 60s, and in the USA in the 80s.

If, on the other hand, you ask French clinicians how they feel about *l'érotomanie de Clérambault*, they will usually admit that it is a somewhat ill-constructed description of an unquestionably preoccupying disorder. As to the *illusion des sosies de Capgras et Reboul-Lachaux*, which is the exact designation of what is in English called 'Capgras syndrome', it is usually considered as a quaint patient observation of limited interest, which, according to its inventors, had nothing to do with schizophrenia as the patient was actually diagnosed *psychose hallucinatoire*.

As it may prove useful to be aware of such historical determinations I shall:

1. Produce a sketch of the historical developments that have lead to the theory of elementary phenomena.

2. Describe the main types of elementary phenomena.

Defining psychosis

As elementary phenomena are supposed to be pathognomonic of psychoses, we cannot avoid a few reflections on the nature of the latter.

The term 'psychosis' was first used by a German physician, Feuchtersleben,[2] in 1856, to describe an acute condition in which patients suffered from intense delusions and hallucinations, a definition which is still currently considered as the best possible by some clinicians.[3] As such, the term was opposed to neurosis, that is, the irritation of nerves. In the second half of the XIX century, psychosis was to be equated with madness, but what Feuchtersleben described would no longer be the only variety of it.

On the whole, Feuchtersleben's predominantly acute concept of madness was shared by most of the clinicians of the time. This was in particular the case of the French, who under the influence of Pinel and Esquirol, tended to consider that *aliénation mentale* was generally caused by the disappointment of passions, and that the disorder could manifest itself in several manners, such as *mélancolie*, *manie*,*démence* and *idiotie*; it was generally admitted that the same patient could show these derangements either separately or one after the other, but not necessarily in this order (that is, from the lightest to the more severe), this uncertainty corresponding to the very nature of passions. Another crucial point was that madness was thought to be curable through moral treatment, a liberal procedure applied under various names by that time throughout Europe and New England, which combined consolation, discussions, healthy food, lukewarm baths and more invigorating methods such as the administration of cold showers and even in extreme cases, superficial branding.

Nevertheless, by the same period, in France, there was a lively debate over a curious phenomenon called monomania, defined as*folie partielle*, that is, partial — or part-time — craziness, which appeared to be much more frequent than the other mental disorders. This was especially at issue when unlawful acts came before a court, as psychiatric experts claimed that some of the culprits, although they displayed few or even no apparent symptoms during the trial, had actually suffered from delusions at the time they had committed their crimes. Of course the right-wing prosecutors and the relatives of the victim held that this was sheer nonsense: you could not be a madman just for a few instants, they contended. Madness had to be obvious and constant, otherwise the person should rather

be considered as one of these blood-thirsty monsters who heartily operated the guillotine during the French revolution; no sensible being should pity them, and all they deserved was a death penalty.[4]

Over the decades, the concept of monomania was more and more criticised, not only on forensic grounds, but also because it was dependent on the more general assumption that madness was a substantially continuous disorder, of which you could only sketch clinical pictures determined by the delusional themes that came to the fore. Under the influence of Antoine Bayle's (1799-1858) 'general paralysis' model, the idea, inspired by Sydenham's theory of medical diseases, that there should exist several separate mental conditions, and that they should have a specific course, from the prodromes to a particular final state, began to gain ground. One of its most prominent defenders was Jean-Pierre Falret, who, in his *Leçons cliniques sur les maladies mentales* (1850-1851), tried to promote a scientific programme to define separate *maladies mentales*. This is for us an important moment as Lacan, one century later, was to take the opposite view to Falret's, as he wrote that the analyst should 'make himself the secretary of the insane'.[5]

Jean-Pierre Falret and the prohibition to 'make oneself the secretary of the insane'

J.-P. Falret began his investigation by criticising the current nosographic methods. The first method in use, which was especially characteristic of the founders of modern psychiatry, Philippe Pinel or Etienne Esquirol, was a 'literary' one, that is, it aimed at describing cases without much consideration for the actual circumstances of the disease, focusing mainly on the content of the delusions, and the result, he claimed, had only been the multiplication of unnecessary entities, like the dozen of monoamines described by Esquirol or his followers. Another method, trying to focus on different 'types of diseases', had not proved to be fruitful, for lack of clear principles on which it could rest. In Germany, two antagonist schools were confronted to each other, the *Psychiker* (contending that all mental diseases had an exclusively moral cause) and the *Organiker* (who elaborated exclusively physiological theories of mental conditions in spite of the paucity of actual knowledge in this domain), doing little more than adding to the reigning confusion.

Obviously instructed by the debate over monomania, Falret proposed to envisage mental diseases as long-lasting processes, which could remain hidden for years, until diverse symptoms came to the fore — but even then, he contended, the symptoms were not necessarily a faithful image of the nature of this morbid process. The role of the clinician, he insisted, should not only be to portray faithfully what was before his eyes, but to trace out the nature of this inner process, no matter what its outer results could be. "We therefore declare, he wrote, that if you wish to discover the general states on which delusional ideas thrive and develop; if you want to know the tendencies, the directions of mind, the dispositions of feelings which are the source of all manifestations, do not reduce your duty of observers to the passive role of the insane's secretary, of the stenographer of their speeches, or narrator of their actions: be convinced that if you do not intervene actively, if you write your observations under the dictation of the insane (*aliénés*), the inner state of these patients will be distorted as it passes through the prism of their illusions and delusions (*délire*)".

What Falret insists on is that ordinarily mental patients are deceiving themselves and deceiving others, in a manner that is not very different from the narcissistic misrecognition that can be observed in normal persons: 'man never knows oneself', he wrote. Falret proposes the example of the melancholic who, overwhelmed with sadness because he believes that he has committed the most heinous crimes or lost all his fortune, believes that his sadness is determined by these imaginary disasters. "Instead of subordinating these painful preoccupations to the general feeling of sadness which pre-existed under a vague form".[6]

Hence, three major principles are to be followed, according to Falret:

1. The clinician should pass from the role of observer to an active role, allowing the patient to manifest what he would not spontaneously express.

2. The clinician should study and characterise the individuality of the disease, so as to "subtract oneself from dangerous influences and arbitrary classifications".[7]

3. The clinician should never separate a fact from its setting, from the conditions in which it has arisen, for "disease is nothing else than a series of more or less complex events, which the observer must present under their true colour, in their natural order of succession and filiation, and surrounded with all the circumstances in the middle of which they have occurred".[8]

This led Falret to privilege the study of what he called 'general states' or 'inner states', which, alone, can permit a 'scientific study' of madness, in so much as they have been separated from the prism of subjectivity, and are 'independent from the delusional ideas'. The result of this is that 1) the patient's testimony should be taken as strongly biased, and 2) there is no regular relationship between what the patient actually utters and the underlying process.

One of the main benefits of J.-P. Falret's positions was the delineation, in the next decade, of two different disorders, *folie des persécutions* and *folie maniaco-dépressive*, which could readily be viewed as having a specific course of their own.

Nevertheless, what Falret could not foresee was the rapid evolution of neurology, and especially the research on aphasias, which allowed to relate, in the 1870s and 1880s, motor and sensory aphasias to specific neurological lesions. It was rapidly assumed that whereas lesions could provoke obvious deficits in speech performances, local irritations of the brain were likely to cause delusional disorders. This paved the way for the study of what was rapidly coined *mecanismes de formation du délire*, as it became clear that discrete mechanisms, like hallucinations, could be the motor cause for the constitution of a delusional world.

The mental hallucinations and Séglas' syndrome

The first type of 'mechanism' that was described was the verbal hallucinatory mechanism. Hallucinations had first been defined by Jean-Etienne Esquirol in 1938 as 'perceptions without an object': "A man who is thoroughly convinced that one of his sensations corresponds to an actual perception, while no object capable of triggering such sensation is within the reach of his senses, is in a state of hallucination: he is a visionary",[9] and it was clear for Esquirol that this applied mostly to visual hallucinations. But at the beginning of the 1850s, a discussion came to the fore among Parisian psychiatrists as to whether this definition was appropriate outside a rather limited range of pathological phenomena. Baillarger reported several cases in which patients had the feeling of being invaded by thoughts which at certain moments were described as hallucinations without any sensory quality. This he called *hallucinations psychiques* (mental hallucinations), and discussed whether they should be entirely separated from delusional misinterpretations (*interprétations délirantes*). Even though the debates failed to reach a satisfactory conclusion, *hallucinations psychiques* became a classical issue, and as research on aphasia progressed, Jules Séglas,[10] at the beginning of the 1880s, proposed to consider that this delusional experience, which was also called 'pseudohallucination', to discriminate it from the official Esquirolian 'perception without an object', should be understood as 'motor hallucination', that is, as the autonomisation of the production of speech.

Empirical evidence was soon to corroborate the idea that verbal hallucinations were generally not mere 'sensory disorders', but motor disorders, as it was shown that in most cases patients were actually pronouncing in undertones the hallucinations they claimed to be hearing. This led gradually to the idea that in a significant number of cases, the 'motor hallucinatory mechanism' was responsible for the

formation of a psychotic syndrome, which became extremely famous in France under the name of *psychose hallucinatoire chronique*. As the hopes to discover a specific neurological lesion responsible for this gradually decreased, the idea arose that it could be caused by some psychological determination, and the debate between these two hypotheses continued as the psychoanalytic movement gained ground in France. In the 1920s, G. G. de Clérambault presented himself as a faithful follower of Séglas, and claimed that most of the psychoses (not including schizophrenia and the 'passional psychoses') were actually determined by what he termed *automatisme mental*, which he suspected to be caused by a superficial 'serpiginous lesion of the brain'; his theory was immediately challenged by Henri Ey, who in his *Traité des hallucinations* advocated that the explanation could not be that simple, as according to him the syndrome showed the double neurological modification described by Hughlings Jackson (liberation and deficit), but also the influence of 'psychological complexes' described by Eugen Bleuler.

A few decades later,[11] Lacan will present himself as another follower of Séglas, especially when commenting on the patient who hallucinated the insult 'swine' as she thought to herself "I have just been to the porkbutcher's", or on Schreber's interrupted hallucinations. But of course his point of view was entirely distinct from that of Clérambault or Henri Ey, as he considered that this phenomenon was the manifestation of a 'signifier in the real', determined by the absence of a fundamental signifier allowing the subject to formulate a call and justifying his own separate existence. As a result, the basic Lacanian model of psychosis was not so much the Freudian concept of 'loss of reality' than the Schreberian *Brüllenwunder*, a phenomenon in which D. P. Schreber, when he refused to respond to the unceasing questions coming from God, felt that an unbearable yelling was coming out of his own throat, as he felt that the deity was abandoning him.

Clemens Neisser, the 'personal signification' and its therapeutic applications

Another sort of 'mechanism' was described by Clemens Neisser (from Leubus, Silesia) in 1892, at a time when German psychiatrists were attempting to reduce paranoia, and all-pervading category which was supposed to account for no less than 70% of the psychopathology, to more reasonable proportions — this dilemma was about to be solved by borrowing from the French their *délire des persécutions* and identifying paranoia to this sole syndrome. Neisser considered that *krankhafte Eigenbeziehung* was a constant phenomenon during the acute and stable phases of paranoia.[12] Patients with this symptom were certain that they were being pointed at, designated, etc. but claimed that they had no idea why this was done nor what it meant. By the same period, Meynert (Vienna) described what he called *Beobachtungswahn*, delusion of being observed, and most of the contemporary clinicians considered both syndromes as identical.[13]

Neisser set up a sort of a therapeutic programme in which incoming patients were to stay in bed for several days (*Bettbehandlung*) — a rather uncommon practice in mental institutions of that time — so that the 'clinical picture' should simmer down, as exterior solicitations were reduced to a minimum. Then in most cases, Neisser wrote, *krankhafte Eigenbeziehung* came to the fore, and it appeared that most of the patient's agitation had been nothing but an uncoordinated attempt to protect himself from it. As soon as the *Cardinalsymptome* had been confessed, the psychiatrist could get into therapeutic action, that is, show the patient that all his disorders could be reduced to the same symptom, and that it was some sort of an illusion. Although Neisser gives no indication as to the results, this method has become extremely popular in Germany at the beginning of the XX century, to such a point that when the promoter of *activere Therapie*, Hermann Simon, who was to become one of the main models of the French *psychothérapie institutionnelle*, tried to conceptualise his practice and find examples of what one should not do, all he could think of was the Neisserian *Bettbehandlung*, which he criticised for not being invigorating enough.

When *Eigenbeziehung* was incorporated into French psychiatry, it underwent a curious change: while Neisser said little of the delusional elaborations what were facilitated by the phenomenon, Sérieux et Capgras, in their book *Les folies raisonnantes*, considered that as a rule, *Eigenbeziehung*, which they translated by *signification personnelle*, was the core phenomenon of *interprétation délirante* (delusional

misinterpretation), a mechanism in which the laws of logic were duly respected while the premise was false, and the rigorous construction through which the patient tried to explain why he was being designated led to an all-pervasive delusional system, taking much of the patient's time and preventing him to become dangerous before long.

A third type of mechanism, the *mécanisme imaginatif*, was proposed by Dupré, as the main way to constitute a *délire d'imagination* — what continental clinicians were to call paraphrenia after Kraepelin proposed this term in 1913. But it soon appeared that this mechanism was in fact a compound one, that could not be presented as a 'primary' elementary phenomenon. In fact the only elementary phenomena which can be claimed to have been sorted out later on are those of manic-depressive psychosis, schizophrenia and autism, as we shall see.

What can we expect from elementary phenomena?

Lacan has given to the expression 'elementary phenomenon' at least four sorts of meanings:

1. The possibility to isolate discrete pathognomonic symptoms.

2. The possibility to sort out in non-triggered psychotic cases minimal symptoms which can sum up most of the following delusional developments, in a way quite similar to the 'fundamental fantasy' in the neurotic cases.

3. The possibility to find hints of the modes of stabilisation's that can be foreseen in a given patient.

4. Most of the elementary phenomena imply some sort of a 'subject supposed to know', which characterise the structure of the Other.

These phenomena can be dissimulated for a certain time, masked behind acting-out behaviours, personality traits, reluctance, etc.

What is at stake in the enquiry about elementary phenomena is to find out what is the implicit structure of the Other, and how the subject tries to calculate his own existence; it is also clear that elementary phenomena are predominantly linguistic phenomena.

Two sides can be differentiated:

1. Elementary phenomena as questions: this is evidenced by a perplexity, the feeling that one is confronted by an enigma, in a direct confrontation with the foreclosure of the Name-of-the-father.

2. Elementary phenomena as attempts to answer to the foreclosure of the Name-of-the-father ('personal signification', hallucinations, etc.).

Most of the therapeutic manoeuvres that have been proposed are actually using these two sides, for instance in showing that the certainty about a delusional idea is in fact an attempt to respond to the perception of an enigma.

Four main types of elementary phenomena have been described, which seem to be characteristic of paranoia, schizophrenia, manic-depressive psychosis and autism.

Paranoia

As we have seen, the elementary phenomenon of paranoia was the first to be described. It can be characterised as an *essai de rigueur*, as Lacan put it, or, if we use Frege's (1892) differentiation between *Sinn* (meaning) and *Bedeutung* (denoting, designation), as an attempt to propose a hypothesis allowing to harmonise the discrepancy between the total lack of meaning experience by the psychotic confronted with perplexity (not only in his relationship to the outside world, as it can also manifest itself in bodily feelings in the case of hypochondriasis), and the unbearable designation he feels submitted to.

S_1.....S_2

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Subject S_1=*Bedeutung*, S_2=*Sinn*

Paranoia can be seen as a monstrous instance of Lacan's definition of signifiers, i.e., "a signifier is what represents the subject for another signifier" — which in its turn represents the persecutor.

These patients have usually a particular talent to articulate a relatively systematised problematic, that can go as far as the 'loss of contingency' (E. Minkowski, P. Berner). The articulation between S_1 and S_2 allows a certain localisation of the *jouissance* of the Other (in a persecutor for instance), which makes paranoid delusions sound 'understandable' in a number of cases, and this in turn is susceptible to generate a so-called *folie à deux*. As we have shown, the analyst's position should be one that allows to show the relativity of the link between S_1 and S_2, in order to allow the patient some doubt about his ideas of reference; a classical manoeuvre consists in showing that the analyst does not know anything about the persecution, even if he is personally interested in the patient's fate.

Schizophrenia

While in the German and in the Anglo-Saxon linguistic domains, the term schizophrenia tends to encompass several sorts of psychoses, in the French tradition, it only designates cases in which the delusional experience includes a notable degree of disorganisation and inadequateness. The RSI problematic, proposed by Lacan in the 1970s, was an attempt to elucidate this clinical issue. In his *RSI* seminar, Lacan considers the possibility that the real, the symbolic and the imaginary should not be articulated to each other; this is obviously an attempt to address the issue of 'discordance', such as it was described by Philippe Chaslin (1857-1923),[14] a Parisian logician and psychiatrist.

In this case, the question is not that of the articulation and separation of S_1 and S_2, but the point is that the subject is not submitted to a S_1 that allows him to be identified, and the S_2 lacks a sufficient consistency to localise the *jouissance* of the Other. The lack of articulation between R (the real), S (the symbolic) and I (the imaginary) has several consequences:

1. Lack of articulation between S and I, especially the incapacity to articulate the mirror image with the ego-ideal, and, as a result, the feeling of 'identity' will be artificial ('as if personalities' in the best cases, or various types of disorganisation of the body-image).

2. Lack of articulation between I and R, and the impossibility to localise the *jouissance* of the Other. We would be inclined to think that the so-called 'paraphrenic' phenomena (*délire d'imagination* in Dupré's terminology, or psychotic mythomania, such as in the *illusion des Sosies* or *illusion de Frégoli*) are, above all, attempts to designate this lack of articulation.

3. Lack of articulation between R and S, determining an absence of articulation of the phallic *jouissance* and the capacity of separation.

What is particularly striking in these cases is the variety of results of these lacks in articulation; while some patients will be able to stick to artificial 'false selves', others will tend to 'let themselves go', showing a predominantly 'negative' or 'deficitary' clinical picture. In other cases, the patient will manifest what has been termed 'schizophrenic irony', manifesting or acting out what he feels to be the total inconsistency of the Other. Among the reliable therapeutic manoeuvres that have been proposed for this lack of articulation, it seems that attempts to give the Other some sort of structure through a specific 'knotting' can be recommended.

Manic-depressive psychosis

There have been major variations within the psychiatric literature on whether specific mechanisms of manic-depressive psychosis are to be found; it seems clear that the predominantly 'affective' approach which has been advocated by a number of clinicians, as well as most of contemporary biological approaches, rule out the very possibility to find any.

We have shown that it might be useful, as German psychiatric phenomenology advocates, to consider the question from the viewpoint of the 'flight of ideas' (*Ideenflucht*), and consider that melancholia (psychotic depression) is nothing else than a reversal of the flight of ideas, that is, the patient finds no sort of limitation to his guilt-feelings.

In this case, the most obvious elementary phenomenon is an impossibility that the real should interrupt the chain of signifiers (R/S), and this is probably what Lacan means when he speaks about the 'touch of the real' in *Television*, or what he alludes to in the seminar on*Anxiety*, where he presents the flight of ideas as resulting from the fact that the subject is not ballasted any more by the object *a*. This would explain why, in the case of the mathematician Georg Cantor, who has been diagnosed manic-depressive, his main preoccupation was to construct several types of infinite, each of which is the limit of the previous one. In a recent book, I have shown that a Swiss writer, C. F. Meyer, who was hospitalised twice for melancholia, presented in his youth some elementary phenomena exhibiting the impossibility to give some limits to the chains of signifiers he was confronted by; later in his life, he invented a special style of historical narratives (*récits encadrés*, i.e., 'framed narratives') which limited the expansion of the signifiers, and his psychosis was triggered again when he gave this method up.[15]

Autism

It might seem surprising to envisage autistic elementary phenomena, since the obviousness of the disorders, in most cases, seems to leave little interest to the research of hidden elementary phenomena. However, the evolution of autistic children towards less pathological presentations is not seldom, and one should remember that Leo Kanner himself described cases in which patients, after years of evolution, could be presented as 'pseudoneurotic'; besides, there has been a growing interest in the last decades for 'Asperger' cases, in which the Kannerian symptoms were not always easy to retrieve.

The impossibility to bear designation — be it by calling the person's name, by touching his shoulders, or by eye-contact — is certainly a good candidate to be an elementary phenomenon of autism. But we must also remember that this impossible designation also refers to a second signifier, whose effects of meaning are usually experienced as totally disorganising, and autistics usually try to respond to it through stereotypes, in an infinite series of S_1 which are designed to avoid an unpredictable S_2. In fact, two sides of the symptomatology are often to be observed: on one side, the subject attempts, through his stereotypes, to stop the hole of the Other, in a parody of 'transitional object'; on the other side, he arranges a series of objects in an immutable order, in which he is in no way involved. This refusal to be

involved is also manifested by the refusal to use properly personal pronouns of the first person. What is at stake is not the 'absence of a theory of mind' — as many autistic persons show that they accept indirect contact, and even use echolalia to ensure some sort of communication — but the structure of the Other, an Other which seems to be experienced as extremely threatening. It seems that in the case of autism, some ameliorations can be expected if the subject manages to elaborate differently the hole in the Other (i.e., the *jouissance* of the Other), by building up trajectories or objects that allow him to have a different relationship to this perplexing lack.[16]

Conclusion

We have seen that the first attempt to consider psychosis beyond its obvious pathological manifestations had led J.-P. Falret to advise his colleagues 'not to be the secretary of the insane'. We have tried to show that the consideration of elementary phenomena could help us to go one step farther, in so much as discrete elementary phenomena can give us hints on the structure of the Other by which psychotic patients are confronted. This leads us to a concept of 'elementary phenomena' which is quite different from what is usually suspected. While it has been upheld that the Lacanian concept of elementary phenomena derived directly from Clérambault's theory of *phénomènes basaux*(indicative of a brain lesion), we have seen that this could not be the case. Lacan's concept of elementary phenomena is mainly based on the assumption that the subject acquires a sense of being through his representation, or his supposition, in language; a direct consequence of this is that elementary phenomena always have some sort of relationship to transference — even if it is a heavily delusional one — and this is not without consequences as to the position we should hold with these patients.

1. Although the same expression has been used separately by Henri Ey in his *Traité des hallucinations* (Paris, 1934) to designate sensory phenomena related to localised lesions of the nervous system, as opposed to primary delusional experiences, it is quite clear that Henri Ey and Lacan are using the same phrase for entirely different phenomena; it is also clear that Henri Ey's notion of elementary phenomena is in fact exclusive of psychotic cases.

2. On Feuchtersleben, see Hofmann, W.: Einleitung, in Hofmann, W. & Schmitt, W. Hrsgb.(1992): *Phänomen, Struktur, Psychose*, S. Roderer Verlag, Regensburg, p. 3.

3. The discussion on the 'visibility' of psychoses (psychosis understood as an acute state vs. psychosis as a process or a vulnerability) has been in constant debate since then. We shall see that the hypothesis of the 'foreclosure of the father's name' has the advantage of being rooted in something else than the ambiguous notion of 'loss of reality' which is at the basis of the orthodox Freudian concept of psychosis.

4. In spite of what Ian Goldstein writes in her book *Console and classify*, International University Press 1981, monomania was not just an instrument used by alienists to acquire an official professional position; it was also a real clinical issue! For more details on the controversies over monomania, see F. Sauvagnat, *Le clinicien saisi par le passage à l'acte* in *Revue Actualités psychiatriques*, 18e année (Janvier 1988), No 1, p. 36-45.

5. J. Lacan, *Le séminaire III: Les psychoses*, Seuil, Paris 1981.

6. J.-P. Falret, *Leçons cliniques de médecine mentale faites à la Salpêtrière par M. Falret*. Extract from *La Gazette des Hôpitaux*, 1850-1851. p. 21.

7. J.-P. Falret, *ibid*. p. 22.

8. *Ibid.*

9. E. Esquirol, *Des maladies mentales*, Paris, 1838, t. I, p. 159.

10. J. Seglas, *Leçons cliniques sur les maladies mentales et nerveuses*, Asselin et Houzeau, Paris 1895.

11. J. Lacan, *D'une question préliminaire à tout traitement de la psychose* in *Ecrits*, Seuil, Paris 1966.

12. For more details, see our article: *Histoire des phénomènes élémentaires* in *Ornicar*, No 44, 1988.

13. This was constantly the case in Freud's first papers on paranoia, between 1894 and 1896.

14. Chaslin (1912): *Eléments de sémiologie et clinique mentales*, Asselin et Houzeau, Paris, p. 176.

15. For more details, see our paper: *Conrad Ferdinand Meyer ou le dévoilement mélancolique*, post-face to *Conrad-Ferdinand Meyer: Les souffrances d'un enfant*, *Editions Anthropos*, 1997, p. 55-110.

16. For a comparison between current cognitivist views and Lacanian approach of autism, see our paper *L'autisme à la lettre: quels types de changements sont-ils proposés aux sujets autistes aujourd'hui?* in *Du changement dans l'autisme, Actes de la Journée d'Etudes de l'Association Cause Freudienne-VLB, et du CEREDA*, Rennes 1999, p.9-43.