the presentation of patients[1]

Erik Porge

Another paper by Erik Porge entitled "The presentation of patients: Charcot, Freud, Lacan, today" was published in *The Papers of the Freudian School of Melbourne* in 1994. Here we publish a paper that was written around the same time as the former but it continues to hold our interest today, particularly through its close examination of the presentations of patients conducted by Jacques Lacan in the Sainte-Anne hospital in Paris and the elaboration Porge makes of both this and his own practice of the presentation of patients, in addition to an examination of what had been written up to that point. Erik Porge also refers the reader to a more recent text of his on the same topic and which appears as Chapter 23 of his book *Transmettre la Clinique Psychanalytique: Freud, Lacan, Aujourd'hui* published by Érès, Paris in 2005. That chapter is entitled "*La présentation de malade: une clinique de présentation*". Erik Porge is a psychoanalyst practising in Paris and is a member of *la lettre lacanienne, une école de la psychanalyse*.

Michael Plastow

By isolating as a special category, the *Witz*, that "is directed not at a person or institution but at the certainty of our knowledge itself" (If you say you are going to Cracow, you want me to believe you are going to Lemberg...), Freud poses the question:

> Is it the truth if one describes things as they are and if one does not worry about how the listener will understand what is said? Or is that not a Jesuit truth and does not the authentic truth lie rather in taking into consideration the listener and to procure (*vermitteln*) for him a faithful reflection (*Abbild*) of his own knowledge?[2]

I will endeavour to put forward that the presentation of patients is part of the problematic thus set out by this special category of jokes.

Although I have attended presentations of patients that were conducted with intelligence and tact (those of Daumézon for example) I would never have taken up this practice myself if I had not attended the presentations of Lacan. Lacan's presentations were a place of the transmission of psychoanalysis. The only way to assert this is to transmit something of these presentations. I will do so from both a place of having been a member of the audience of Lacan's presentations as well as that which today is that of presenter, attended by another audience.

I occupy this second place in a psychiatric hospital in greater Paris. The majority of the audience is constituted by the participants of M.-M. Chatel's course. I have never previously attended to the people who are presented. After the presentation there is discussion with the audience, who, following this, continue to elaborate upon the presentation.

Lacan's presentations[3]

The method

It is noteworthy, and Lacan himself emphasised this in 1970, that a large part of the audience was constituted by Lacan's analysands, in other words of those who were 'in the know', who shared a common experience of analysis. Lacan saw in this the possibility of locating an original semiotics[4], effected by the third, differing from the traditional psychiatric method and at that time he already envisaged the possibility of systematizing this experience:

> I think that it is profoundly justified in the structure, that it might have the following aspect, that at the end of the day he who might be able to inscribe the semiological benefit of the thing is not necessarily identical to the one who conducts the examination but who cannot conduct it in any other way because he is himself in a certain position which is that of the psychoanalyst.

And:

> what the person who heard is able to add is something which seemed to me to be very rich in a type of possibility of inscription, of crystallisation of the order of the thing which would properly speaking be semiological [...] In *Scilicet* there are a certain number of considerations regarding the question of the relations of the signifier and the sign, in other words regarding a certain means of triangulating it [...]: the question of what psychoanalysis brings to psychiatric semiology is that perhaps it gives to the term of the sign itself an articulated sense in a way that is quite different to what one takes to be the sign in general semiology.[5]

At no moment during the interview is there any complicity from Lacan, in any form whatsoever, with the audience. Occasionally there is a rupture of the invisible barrier by virtue of certain patients. This rupture then becomes significant and is incorporated into the interview. At a moment in which a subject says he is troubled by the presence of all these people and wants to speak alone with Lacan, the latter replies: "Why is it that we are told that in the street you treated women in a way that is not the usual one?", returning at this precise moment to one of the reasons that had led to the hospitalisation of the subject. (20/6/1975)

Lacan is focused, engaged in a very tight dialogue with the patient, and the audience listens on. He poses some questions dates, places, love relationships but he also answers, he comments, he interprets.

> Amongst his interpretations I will distinguish:
>
> * Direct personal interpretations:
>
> L: *What's your personality, a mother personality?*
>
> After the presentation he says: *"He only knows the mother-child dimension and it doesn't go any further than that."* (16/5/75)
>
> Another time:
>
> Miss B: *I can't find any place for myself because I don't have any place*.
>
> L: *Don't you want your place?* (16/4/1976)
>
> * Indirect personal interpretations which are like the commentaries of a chorus:

L: *In this family people spend their time sacrificing themselves for each other*. (16/5/1975)

Or:

L: *In this milieu a girl is brought up to be married*. (25/4/1975)

* The next step is that these commentaries become general statements in which the universality of their scope is proportional to the singularity of the message:

L: *Jealousy is regarded as something in which one participates*. (16/1/1976)

Or:
L: *This expression is your fundamental attitude*. (A pout in which the lower lip is pushed forward).

X: *I don't care*.

L: *What is particular in the expression is that it can't be translated*. (30/5/1975)

And:
L: *Is it true that you were forced to marry?*

F: *Yes, my mother wanted me to, she saw the Messiah in him*.

L: *The Messiah is for everybody*. (25/4/1975)

*Sometimes this general statement takes on a paradoxical form:

L: *I will let you speak. Try to say the truth. It's hopeless, one can never manage to say the truth, but if you make a little effort we won't be any worse off*. (20/1/1976)

Although he was very attentive to the nuances of the subject's discourse, Lacan did not attempt to be clever, to play on the subtleties that were not heard, or to try to interpret a slip of the tongue. He didn't "play" at being the analyst. Lacan endeavoured to experience the subjectivity of the person facing him. Moreover it is in this way that he gives an account in the *Écrits* of the lucky find: "I have just come from the pork butcher's Sow.":

> Let us say that such a lucky find can only be the prize of a complete submission, even if it is an informed one, to the very subjective positions of the patient, positions that are too often reduced to a pathological process in the dialogue, thus reinforcing the difficulty of being able to penetrate them by an induced reticence that is not unfounded in the subject.[6]

Lacan attempts to test out what has a hold on the subject and for a demand to possibly take shape through this ("For the time being there remains something stable in your life, in other words this little boy, this little girl and your husband, that is still something solid." 16/1/1976) He questions her in regard to what motivates her, how she situates herself in regard to what happens to her:

L: Do you think you are mad?

Or:

L: What did you think of the interview?

For that purpose Lacan has recourse to very different means in each case.

He becomes reassuring, making his questions legitimate: “If I ask you this question it’s because I am trying to understand... ” (16/1/1976)

Elsewhere he becomes provocative: “*There is not a single moment in which you tell me what is in your guts!”* Or: *“What do you like in a relation with a woman? To be frank, how do you fuck her?”* (16/5/1975)

He can stress what the patient says, or even authenticate a judgement that he gives regarding the patient: for example in the case of someone who considers himself to be a piece of dung. (20/1/1976)

On the contrary, he can become the devil’s advocate: addressing a transsexual, in a change of tone: *“Listen old boy, you still have whiskers on your chin, there’s nothing you can do about it!”*, such that at the end of the interview he proffers that the subject can only ape a man. (7/2/1976)

The presentation gives the impression of a tapestry that is tied around a restricted number of themes. In general there is less material at the end of the presentation than what is in the file. The object of the presentation is not as subject matter for the file, it is a subject matter of a dialogue, of two in the presence of a third. This is also apparent at the moment of Lacan’s commentaries after the presentation; these are to be understood simultaneously on two registers: whilst on the one hand referring to the patient, they also imply a slight gap which is directed at, in an indirect way, the way in which the patient was previously presented (by the registrar or the psychiatrist of the Unit), or the way in which the audience as a whole, or one person in particular, responded to the presentation.

Similarly, there are things that were able to go unnoticed at the moment of the presentation, whilst they were there, and which only appeared at the moment of the discussion. Once Lacan got the patient to come back after a first discussion which raised a contradiction regarding what he was saying. (30/4/1976)

What was brought up, during the interview and afterwards, most often was a wager, a wager for a structure, for a development. “It is a case where we have to lay our bets. Certainly there was a year in which, properly speaking, she had a psychotic episode. And the bet is precisely about that. In other words that it will not last.” (16/1/1976) Or regarding the transsexual: “ He will end up getting an operation. Why did he feel obliged to pretend to be a man? Because that’s the only link he has to being a man. In this case it would only be a pretence of psychoanalysis.” (27/2/1976)

Or regarding someone “asocial” given that he is “not caught in any discourse”: “He is not on the path to wiping everything out. I don’t think there is any risk of that order. I can only see things going further by him attempting to wipe himself out.” (16/5/1975)

Some moments of acceleration during the interview emphasising a word, interrupting or repeating the beginning of a sentence, prolonging a sentence of the patient or by leading him to extend that which Lacan begins introduce the dimension of haste which make the wager stand out.

But simultaneously Lacan shows a sort of slowness to understand. The attention that he pays to the patient is characterised by a certain way of not understanding. This means is not feigned but it is utilised during the interview to put the certainties of the patient to the test.

With a woman who was persecuted by secret agents:

L: Am I part of the secret agents?

F: No.

L: How can you be sure?

F: I don't know. I didn't think that you'd have dedicated so much time if you knew, if you were a secret agent.

L: You feel that you are putting me on the spot... and shortly afterwards:

I am a bit stupid. I should be in the picture. (25/4/1975)

In another case, that of the "imposed speech" regarding which we will return, and who also had the feeling of being able to read minds:

G: I am not transmitting any messages to anybody. What happens through my brain is understood by certain people who are telepathic receivers.

L: For instance am I a receiver?

G: I don't know... because...

L: I am not very receptive because I am obviously floundering in your system. The questions that I put to you prove that it is precisely from you that I would like explanations. I have therefore not received everything that constitutes what we will provisionally call your world.

And further on:

L: Me for example, have I received you?

G: I don't think so.

L: No?

G: No.

L: Because everything demonstrates that I was wading about in the question that I put to you; it was quite the testimony that I was wading about. Who here has received outside of me? (13/2/1976)

Thus a certain means of not understanding, stated as such, is integrated into the interview, as a positive element, it supports an enunciative position and presents itself like, if not substituting itself then at least counterbalancing the hold of the parasitic interference, of the forced dialogue that the subject has with his voices.

This means of not understanding is not within the grasp of all and sundry; rather it gives testimony to something close to learned ignorance. It is a means of measuring oneself, despite understanding, against a possible beyond of the patient's speech, and which would put a stop to its invasive proliferation: this stop being broken precisely in the hallucination which Lacan was still saying in 1970 that, as far as knowing what it is "we are still at the very beginnings".

In so far as there might be this measurement against the beyond of speech, the subject who questions must himself be really in the grip of a work of actual research and does not come to the presentation having given up wanting to know better.

The clinical contribution of Lacan's presentations

What clinical knowledge, outside of a *savoir-faire* and a method, have Lacan's presentations produced?

The presentations, for a time, gave rise to the creation of workgroups. Today other analysts, Lacan's pupils, practice presentations of patients themselves.

It is astonishing that this has given rise to so little theoretical elaboration. Admittedly, in the rare publications dedicated to this subject[7], the presentations are extolled, calls are sent out but there are no results, practically none at all. Up until the present only Jacques-Alain Miller[8] has attempted an elaboration precisely at the moment in which we undertook these workgroups. In his article, whilst refraining from "over-theorising perhaps upon Lacan's fleeting indications", Miller puts forward a distinction between mentality illnesses, in which "the imaginary relation, the reversibility a-a' is emancipated, beside itself in no longer being submitted to symbolic scansion" and "the illnesses of the Other where the subject believes in a complete Other, who lacks nothing, nothing from itself in any case".

It is to be noted that this distinction was not taken up by Miller's pupils in the discussion that they dedicated to the presentations.[9] This distinction, however, is well supported by two very different clinical cases. One of them is that of a young woman, Miss B., regarding whom Lacan gave a psychiatric diagnosis of paraphrenia and which he interpreted as an "illness of having a mentality"; the other is that of the patient who considered himself to be like a piece of dung. The latter was previously a prisoner who, when the date of his release from prison was approaching, was overcome by phenomena of thought broadcasting[10], and insults that were addressed to him.

Nonetheless, Miller's categorical opposition does not seem apt to us. On the one hand the term "illness of the Other" is too general to be opposed to what is presented in the form called paraphrenia. On the other hand, the illness of having a mentality cannot be attributed to a lack in symbolic scansion of the imaginary relation but much more fundamentally to a property of structure, in so far as it is supported by the Borromean knot, and it does not portray the fixed category of a mental illness. We will take this up below.

This immediately raises the question of the links between the clinical teaching of the presentations and those of the seminars and writings of Lacan.

Certain of these links are more or less explicit, others are to be constructed.

Lacan's explicit references to his presentations can be found in *Écrits* and his Seminars.

The presentation, being a localised situation that is limited in time, is nonetheless retained as being worthy of producing some paradigms: for example that of the implication of the subject in the rupture of the signifying chain, since it is a case from Lacan's presentations that he chooses in order to introduce "On a Question Prior to Any Possible Treatment of Psychosis".[11]

One other presentation case which Lacan called a case of Lacanian madness was taken up in the *Sinthome* seminar. The patient, G., transmitted to Lacan the expression "imposed speech" which passed into the Lacanian vocabulary and which Lacan commented upon in these terms:

> Why is it that we do not all feel that the speech upon which we depend is not in some way imposed. This is exactly the point upon which what we call a patient will sometimes go further than what we call a normal man. The question, rather, is to know why a normal man, said to be normal, does not notice that speech is a parasite, that speech is a veneer, that speech is the form of cancer with which the human being is afflicted.[12]

But besides these explicit commentaries, after the presentations there are commentaries whose enigmatic character is more or less elucidated by reading the seminars, in particular those that take place around the same time as the presentations. More or less, because a reading of the seminars is also enigmatic. But the crossing of these enigmas can in certain cases, and only by working them to come to a solution (Lacan said of the enigma that "it is an enunciation such that the statement cannot be found"[13]), in other words, to some statements that might be considered to be derived from those of Lacan.

What strikes me in reading the presentations that cover the period that we are studying is the insistence of the implicit Borromean reference that seems to guide Lacan's commentary

Now, with the Borromean knot, Lacan refashioned his approach to the psychoses.

In *Encore* the rupture of the phrasal unity presented by Schreber's sentences is identified with the rupture of the Borromean rings.[14]

In *The Sinthome*, Lacan states "paranoid psychosis and personality are the same thing". "The imaginary, the symbolic and the real are one and the same consistency and that's what constitutes paranoid psychosis".[15]

Still in *The Sinthome*, Lacan presents the Joycean knot where one consistency the Ego repairs the "fault" of a crossing of two consistencies that then liberates the imaginary, in order to make the real, the symbolic and the imaginary hold like a Borromean knot .[16]

The Borromean knot is also what will, in some way, give the proof of what Lacan had put forward already in his "Presentation on Psychical Causality", regarding the link, through freedom, of madness with normality: "The being of man can not only not be understood without madness, but it would not be the being of man if it did not carry madness in itself as the limit of his freedom".[17]

The structure of this link is supplied by the Borromean knot of which Lacan says, referring his "Presentation on Psychical Causality":

> If it is the case, when there is one of these circles of string (of the Borromean knot) missing in you, you must become mad. And that's what a good case consists of, in other words that if there is something normal, it's that when one of the dimensions hits you for whatever reason, you must become really mad.[18]

This clarifies Lacan's enigmatic assertions regarding certain presentations according to which the subject, psychiatrically mad, is "normal" since he is not caught in any discourse, "he is a normal madman" or like G. to whom he says during the interview "I don't think you're delusional" and regarding whom he comments afterwards "it's a Lacanian psychosis. I am not optimistic". The Borromean knot is the place of the enunciation of the statements, surprising in the moment in which they are pronounced. Moreover we can note that they are not applied to all cases of psychosis and that they distinguish between madness and delusion. They relate to certain cases where Lacan, at a certain level, can no longer differentiate between madness

and the theory that he invents, that he creates, by virtue of the fact, structural no doubt, of the subjective position in which the creator is placed.

There are other cases regarding which Lacan did not take up again to decipher at his seminar but regarding which, nonetheless, the openings he made in his seminar allowed him an approach that was disconcerting in the presentation, and becomes even more so when one refers back to the text of the seminar. One case is exemplary in this regard, that of Miss B. Here are a few samples of the speech (*dits*) of this young woman:

> I imagined that she looked like me. What I was looking for in my idea was to look like someone. It's the condition of life.
>
> There are false patients, false files, false doctors. It's a game, a technique to make people realise what they are in relation to others.
>
> I don't care about my son, he's not my son, he's the son of others.
>
> I am a temporary [employee] of myself.
>
> If I feel like being a real patient, I'm a real patient. If I don't feel like it I'm not a real patient.
>
> I've always torn up my payslips. I worked anywhere everywhere. They are slips that are good for nothing.
>
> My things are all over the place. But I can't manage to work out where they are, what there is in each place.

In this regard she recounts an episode in which she recognised a girl "so-called patient" in the hospital who was wearing her vest: "she was taking my identity", "to terrify me, to annoy me, to make me panic". Nonetheless she never dreamed of approaching this "so-called patient" to ask her to give back the vest. The interview, moreover, did not give any evidence of phenomena of mental automatisms. Lacan made the following commentary:

> She does not have the least idea of the body that she will put into this dress. There is nobody who slips in there to inhabit the clothes. She is a rag. She illustrates what I call the semblant. Her only existing relations are with clothes. Kraepelin isolated these curious clinical pictures. You can call that a paraphrenia and why not pin onto it the label imaginative. Except for Miss O., almost all the other people are clothes. It would be so much better if someone were able to inhabit the clothes. It's for that reason that I speak of mental illness. Paraphrenia is the mental illness above all else. You can distinguish different varieties. It's like the symbolic, the imaginary, the real, it's a mental illness par excellence. It is the illness of having a mentality. It's not a serious and easily spotted and characterised mental illness. It's not one of the one of those forms that can be found again and again. She will be one of those normal mad people who constitute our surroundings. Currently anything might happen: it might crystallise into a very characteristic mental illness. She can still find a place for herself.

In order to decipher Lacan's commentary, we must refer to the way in which he uses the term *mental*. Its meaning is tied to the elaboration of the Borromean knot in the seminars *RSI* and *The Sinthome*. Mentality would be situated on the side of the imaginary[19], an imaginary tied more specifically to the fact that we think in two dimensions. Lacan will go as far as to say, contradicting Descartes, that thought is extension in two dimensions. The same applies to the Borromean knot as soon as we think of it: we lay it flat, on a plane. It is the mental knot[20]. However, since Dessargues, and in the framework of projective geometry, it can be demonstrated that there is an equivalence between the circle and the infinite straight line, in

other words a form of rupture of the former. That is why Lacan was able to replace one or two of the circles of the Borromean knot laid flat, by one or two infinite straight lines. It is, I would say, a mental equivalence. But this equivalence makes an abstraction of the consistency of the cord, that of each Borromean ring, a consistency that Lacan identified with the body. And, "the body does not evaporate, it is consistent, antipathetic to mentality".[21] Discord is born from this antipathy: "the unconscious is discord".

When one is dealing with a Borromean knot made of cords, of tori, which is not laid flat, any rupture of one of the rings brings about the separation of the three. In other words, for a Borromean knot to not be undone, when a ring is broken, it has to be the case that this ring has been identified with a circle by the laying flat, a circle therefore that can open and be transformed into an infinite straight line without bringing about a liberation of the three rings: this can only come about in the case of the mental knot.

It seems to me that by making use of the conjecture of this schematizion of several of Lacan seminars, we can interpret, if not the case of Miss B., at least the commentary that Lacan makes upon it. It would be a form of illness (rejection of the discordant unconscious) where there is a Borromean knot (she is a normal mad woman), despite the rupture of consistency (she does not have the least idea of the body that she will put in this dress), since the latter comes from the laying flat (it is an illness of mentality). The knot holds through the mental; the rupture of consistency would be that made possible by the laying flat of the fact of thinking. But this form of illness dictated by the structure of the knot and its being laid flat would not be a characterised madness, it would be the emergence of a potentiality of madness dictated by the structure. This madness would not be stable, fixed like a category; it could turn into another more characterised, more symptomatic form.

It would designate a place of mental enunciation regarding the Borromean structure.

This case can be set against that of Miss X, of whom Lacan said that she considered her life like a voyage. She was the one who had the pout in regard to which I related Lacan's interpretation. Following the interview, to someone who said "*she is not really tied down, she passes by*", Lacan replied: "*on the contrary, I think that she is absolutely oralized. She is an open mouth ready to devour everything, in other words anything*". Her body was not reduced to the laying flat of the infinite straight line but remained a "bag" with an orifice, the consistency of a cord. She was not "normal" and her abnormality constituted a possible means of hooking in with her. "*She is not at all asocial. It's not because this institutional vagrancy is common, it's not for that reason that it is any more normal. Because of this very voracity itself I cannot consider her as normal, in other words as asocial. One has to play on her abnormality*." (30/5/1975)

Furthermore, it is possible that the case of Miss B. played a decisive role in Lacan's lucky find of the Joycean knot since this presentation took place in April and it was at the following seminar that Lacan produced the Joycean knot. Despite the differences, in the two cases it is a question of the body that is not tied to the unconscious.

One other lesson can be drawn indirectly from Lacan's presentations. It is the rarity of the diagnosis of schizophrenia. It is true that a few patients labelled psychiatrically as such were presented to him but when this was the case either Lacan took things otherwise whilst confirming the psychosis, or he rectified the diagnosis in the direction of neurosis, either hysterical or obsessional. Only once was this diagnosis pronounced but in a very particular way:

> S.: But we have to encompass everything. I am also an animal... in transition... to have no fear of death. The error does not come from us. If my guru is false, no he cannot be false, I believe in him.
>
> L.: Why does this "I believe" matter so much to you? Your "I believe" is a means of saying "I". Your "I believe" is a means of compensating for the effect of the medication. It has all the weight of the effect of the medication.
>
> The patient makes a few more replies and, after he has left, Lacan says: "I think he is a schizophrenic." (11/3/1977)

This is not fortuitous and reflects the lack of affinity psychoanalysis has with schizophrenia following Freud, unlike psychiatry in English-speaking countries. This lack of affinity, which Lacan did not deny, is not without a relation to the fact that the symptomatology of schizophrenia rests principally on a very intersubjective assessment of the disturbances by the psychiatrist. It is constituted by what resists, is dissonant, and dissociates itself from the understanding of the psychiatrist. It is a reflection of a certain transference of the psychiatrist regarding the madman.

From the moment in which this incomprehension is given a positive status, the diagnosis of schizophrenia totters on its base. That does not mean that such a diagnosis does not correspond to a clinical reality. But this reality appears much less structured, starting from the moment in which the primacy of understanding is renounced, and in which the forms that become paranoia — already recognized by Freud — are closely studied, and in which the transformations are located in relation, for instance, to the passage to the act like in the case of the Papin sisters.[22]

Unlike paranoia in which everything is brought back to the subject, speaks to him and watches him, in schizophrenia there is a centrifugal aspect. In the delusion things that seem to be without relation to the subject are agitated: abstract notions, the order of the world. The subject must reassure himself regarding the Other's consistency, or of the Other's transference. ("*If my guru is false*... ") in the case of the Papin sisters, the diagnosis of schizophrenia regarding Christine's state was given by psychiatrists after the passage to the act; according however to what was able to be reconstructed, the passage to the act correlates to a rupture of Christine's transference to Madame Lancelin.

After the passage to the act and the trial that followed, Christine allows herself to fall, literally: she falls to her knees at the moment of the sentence of death and does not get up again since following this she allows herself to die. If as Lacan[23] put forward "for the mother of the schizophrenic, her child in the belly is a convenient or embarrassing body, the subjectivation of *a* as real", Christine, by allowing herself to fall, perhaps identifies herself with this piece of flesh that she had been for her mother, and schizophrenia would be nothing other than that.

Many other remarks regarding and emerging from Lacan's presentations are possible. There is one thing that stands out regarding which all of those who have written about the presentations agree: the presentations concern first and foremost the psychotic subject. The psychotic is the privileged interlocutor of the presentation of patients. Is this a coincidence or is there a structural reason? We are inclined towards the second hypothesis. The presence of the public at the presentations cannot fail to resonate with what is witnessed as a massive investment of the audience in the delusion. Before considering what might lead to this hypothesis, I will add that in regard to Lacan's presentations that it is not a question of

transmitting a knowledge regarding psychosis from a point of view that could be called healthy without further ado, but to transmit a knowledge with and through psychosis. How is it that this knowledge, coming from psychosis at the precise moment in which we are deaf, we resist and we no longer recognise ourselves in the dialogue with the subject? Hence the importance of an audience, a third, that is able to hear otherwise, at that very moment.

Lacan himself was led to analysis by his thesis on psychosis and it was in finding what was lacking in his thesis (the mirror stage) that he began to transmit psychoanalysis.

In his last presentations, Lacan does not so much put the question "why is he mad" but rather "why are we not mad?" "We ask ourselves why not everyone is subject to mental automatisms[24]." (24/6/77) Taking into account Lacan's conception of the ego as primordially alienated, of desire as desire of the Other and of the real as impossible, the question of knowing how Lacanian theory accounts for the fact that there are people who are not mad is a question regarding which we must say that not only has it not been answered up to the present day but moreover that it has not been carefully formulated.

Structural factors in the presentation of patients

The stage

I have attempted to describe the means that Lacan provided himself with in order to make the presentation into something that concerns the transmission of analysis. Of course what I have described is what seems to me transmissible by these means, and this prompts me to want to practice this exercise myself with a view to transmitting something through it once more, without prejudging either whether I would be up to the task, or of being able to transmit precisely what I judged to be transmissible from Lacan.

Amongst these means there is one that has remained a little obscure and which I will take up in its own right since it concerns the structural conditions of the presentation, of how it operates in practice and of the evaluation of its results: I want to speak of the attendance of the audience.

Curiously, the structural place of the audience is unrecognised in all of the articles written about the presentation. J.A. Miller who is sensitive to the dramatisation of the presentation, makes an allusion to the audience "who if it spoke, would speak like an ancient chorus".

There is a principle of these presentations that to me seems fundamental to respect: it is that of a separation between on the one hand the audience, on the other two people who speak. Even if it happens that the audience is interpellated by the presenter or the patient, the difference of places is marked: the audience remains those who attend to the interview.

It is the presenter's responsibility for this separation to be respected. This is why he must show no collusion with the audience; which would be all the more misplaced moreover, since it would prejudice identifications on the part of the audience. This separation, this invisible line for which the presenter is responsible, is precisely what defines a stage, a theatre stage. The theatre stage substituted a "theatre of the gaze" for a participatory theatre and for religious ceremony based on communion. Contemporary innovations have changed nothing in regard to the fact that "the actor, even if he were sitting on the knee of the spectator, would still be separated from him by an invisible rail or a 100,000 Volt current".[25]

The theatre audience does not have the same mode of attending as the cinema public; at the cinema it does not participate in the creative moment of the stage as a limit, since it consists of images already recorded. The cinema becomes a screen to the stage.

With the theatre stage, a limit which is not representable but which is nonetheless as real as a 100,000 Volt current, is made present. This limit is the gaze, it is the voice, it is the body.

To recognise the presentation as theatrical fact does not only have the advantage of allowing us to take account of the phenomena and effects of the presentation which otherwise would go unnoticed or would be unclear, it also allows the unfurling of a structure that additionally functions in analysis and plays an important role with psychotics.

One of the functions of the audience is to limit the omnipotence of the one who questions. By tempering what for the patient might appear to be omniscience on the side of his interlocutor, the audience has an anti-persecutory effect. The audience incarnates a third that is interposed in a dual relation: it is interposed to the extent that neither of the two actors is master of it. If there has to be mastery, it will not come through the confrontation of the two actors but by the apprehension through speech of something in which this audience will be the place of realisation of an intention (like the *Witz* according to Freud) that is not formulated in advance and which is not able to be mastered by either of the two interlocutors.

Nonetheless, and different to the theatre, even if it is in part spectacle — like in any dramatisation — the audience is not especially convoked in order to see, nor to follow an intrigue, an action, but in order to hear the dialogue of two people, seated, neither knowing from the outset what might come up. The audience does not so much incarnate a function of deciphering the saying (*dire*), but rather of recognition of speech as a possible dramatised event. The presentation is a dramatisation of the saying. It is through dramatisation that there is writing. The dramatisation is writing in speech.

This conjunction of the saying as event and the dramatisation is tied in the presentation through time.

A logic of the wager; haste

In so far as it is an event that is in general unique, appreciated and which provides a scansion of the indeterminate duration of hospitalisation, the presentation is a dramatised situation for the patient, but also for the presenter. For the presenter also exposes himself: his misunderstandings, his awkwardness and his selective deafness are all unveiled. His *savoir-faire* is put to the test: in a limited space of time he must gain and retain the confidence of the patient. He starts off from a very succinct knowledge of the patient, preferably with an absence of prejudice, and must quickly get an idea of what counts for the patient, to make a selection of his words (*dits*), that is neither too partial nor too suggestive. It is the presence of the audience that gives this approach the sense that a risk has been taken. Moreover, the presenter has an engagement towards the audience of transmitting something but he doesn't know what and it doesn't belong to him, it is what is particular to the patient. The presenter can never be certain of being up to the task and this is the way it has to be. The logic of the presentation is not that of exhaustion, or of the clinical picture, but a logic of what is at stake. This introduces a wager. Something is at stake because a wager has been placed. The presenter stakes his wager, his narcissism for example, in order that the patient might also stake a wager. The times (the time to understand, the instant of seeing, the moment to conclude) are part of the wager of each one.

The time to understand is the duration of the presentation.

The instant of seeing is what is exchanged in the glances between the presenter, the patient presented, and the audience. It is the synchrony of the three places that establishes the cut of the scene. Each place acts on the other simultaneously. It is the synchrony of the split of the message in which the same speech is addressed to one and sent to the other, or even between the speech that I address and the object in whose name I speak.[26] This synchrony is also in play in analysis: for example in the most obvious instance, the reclined position takes the place of the stage; since the analysand does not see the person to whom he speaks, this allows the address of its destination to come unstuck.

As far as haste concerned, in a general way it is tied to the stakes of the presentation and it will emerge in various forms (some of which I have noted in Lacan's presentation), each time that such stakes are in question.

With the delusion there is something like a simultaneous two speed race: one has to go quite slowly in order to understand what is said and to enter into the delusion, but sufficiently quickly at the same time so as to not be encompassed by the delusion to the point of rendering all dialogue impossible, which after all is not the worst thing that could happen, but which risks masking the signifying elementary phenomena[27] in which the subjectivity of the patient is really engaged.

The dimension of urgency is ready to emerge at any moment. When it emerges it gives a tragic turn to the presentation, which is not surprising since one of the characteristics of tragedy, Greek tragedy in any case, is to present the time of urgency.

In effect, Greek tragedy, which is localised and limited in time, marks a turning point not only for the conceptions of the will and the responsibility of the agent[28], but also for the conception of time.[29] "Tragedy is devoted to one sole event, which overturns the established order, changes the situation of one or several characters and turns their lives upside down. It plays on a contrast between before and after".[30] "The tragic action is established in a unique present in which we are obliged to participate minute by minute. There arises from this an internal tension that is attached to its development and gives the sense of an extraordinary crisis".[31] Whether it is in the tragedies of Aeschylus, Sophocles or Euripides, in each case it is a question of the urgency of the crisis, of the always growing tension, of the convergence towards a decisive moment, of haste in the face of the imminence of the crisis. But the chorus, by interrupting the tension entailed in the tragic crisis, gives, for Romilly, the appearance of the refusal of time. The chorus ties the present to the past and considers things in their aspect of generality and permanence, that is, of the atemporal. These are pauses dedicated to meditation.

This is not a refusal of time, it is the presentification of the discontinuity of the temporal dimensions: the interventions of the chorus are scansions: the chorus represents the putting into play of a temporal dimension other than haste or duration, it represents the instant of seeing: "what matters is the way in which, at the most pathetic moment, the action is immobilised such that the chant sends the faithful image of similar misfortunes back to the spectator, as with a series of mirrors, so that by their very resemblance these misfortunes are subtracted from time".[32]

If one other aspect might connect the presentation and Greek tragedy, particularly with the psychotic, it is the knot between intentionality, personal responsibility and something which,

coming from the real, is imposed upon him. In Greek tragedy there was not yet a complete psychological interiorization of the action and the Gods represent something that comes from the real: "The true domain of tragedy is situated at this border zone where human acts are articulated with divine powers, where they gain their true meaning, unknown by the agent in so far as they are integrated into an order that goes beyond man and escapes him".[33]

The presentation of patients is also situated at a border zone and a zone made of borders.

The attendance of the audience allows a locating of what passes or does not pass through the border with the audience and also contributes to the creation of something specific to the presentation in the locating of the symptoms and potentially to their resolution.

It is a place in which affects are palpable: anticipation or even anguish can be felt. The audience is also a place in which something that traverses the imaginary barrier between those who speak is manifested and can be in the form of laughter. This then ratifies the joke. It is not inconsequential that someone for whom persecutory interpretations take plays on words as their point of departure, realises that a joke might also make a third party laugh, in other words that it creates a social bond. Freud uses "Jokes as a social process" as a title in his book on the *Witz*.[34]

The stage upon the stage

From the moment in which there is a theatrical stage, we can isolate a particular formation that may intervene in certain moments: the stage upon the stage or the theatre in the theatre.

In studying Hamlet[35], Lacan recognised a function of a decisive imaginary structuring for Hamlet's conduct in the stage upon the stage. This function operates in terms of two phases. First phase, the world: this is the place in which the real compels. Second phase, the stage: this is the dimension of history, of the signifier.[36]

Theatre in the theatre experienced a great success in the baroque era. In it, moreover, madness was dramatised.[37] The chorus is the ancestor of theatre in the theatre and represents one aspect of it.[38]

There is theatre in the theatre from the moment in which at least one of the actors of the "reference play" is transformed into a spectator of what we will call the "embedded play". It is "founded on the silent gaze of a spectator upon an actor, but careful to keep, vis-à-vis the audience, a symbolic place on the theatrical area in which he had once given the impression of being directly invested (in mediaeval theatre) or indirectly (in Greek theatre)".[39] This proves that the stage is not a border separating an outside from an inside.

The embedded play can be of differing lengths in the play and with which it maintain relations that are more or less integrated into the action, ranging from simple juxtaposition, having no more than an ornamental function, up to complex links in which the embedded play becomes one of the mainsprings of the reference play. Forestier notes that in certain cases it is only "the silent nature of the gaze of the characters in the principal action that circumscribes the internal space by imparting it with its status as a spectacle".[40] Or it may be a matter of the reflection upon a statement that might last only the time of a retort.[41]

The theatre in the theatre corresponds to several significations. According to Forestier, it is the notion of the mirror that acts as common denominator.

> The theatre in the theatre is always the theatre that is redoubled. It is, on the one hand, the reflecting mirror that returns the image of the theatre world to the audience. Then there is the distorting mirror that plays with resemblances and makes one hesitate between reality and its double. A redoubling of the action, a redoubling of the spectator [...] There is, furthermore, the oblique mirror or the convex mirror, neither reproduction nor illusion but revelation: the theatre is redoubled in order to teach the spectators [...].[42]

Thus the theatre in the theatre, the stage within the stage, is a turning mirror, a mirror function that operates simultaneously in several places.

It seems to me that this function can be located at certain moments in the presentation of patients. First of all, as we have already noted, it can be suggested by the presenter himself when he makes what I referred to as personal indirect interpretations. Whilst staying upon the stage, the presenter expresses himself from an enunciative position which is that of an audience. He represents the audience upon the stage where the dialogue with the patient takes place.

Moreover, we can consider that this function is latent in the audience, in so far as the audience misrecognizes its participation in the presentation and in so far as it misrecognizes that whilst being the audience, it is also part of the scene. But this latent function can be transformed into a manifest function. This was the case one day in the presentation that I had of a subject said to be schizophrenic. Whilst speaking of his delusion, this patient fixed his gaze upon the audience. His face changed colour and after a little while he wondered what the point of his presence in the presentation was, as well as that of the delusion that he was "reciting". He considered himself to be upon the stage from the place of the audience. Whilst this was not his first hospitalisation, two days later he was discharged from hospital and now more than a year later he has not been readmitted. In this way he concretised the distance that he had been able to take from his character of "patient" thanks to the playing out of this stage upon the stage function.

Lastly, we must not forget that this function sometimes pre-exists in the patient, in spite of himself: in the various hallucinatory commentaries that he hears. Here it is a case of a stage upon the stage that could be called "defective" in so far as this function, in order to be played out, always requires the detour of an audience. This is the deferring, the effect of the audience brought to the stage itself; in the case of imposed speech, the commentary is anticipated and the role of the audience is short-circuited. But at the same time it is perhaps also because of this that at certain moments and in certain cases, an interaction with the stage upon the stage is produced which is imposed upon the patient and to which he exposes himself.

To finish this chapter I will put forward that the theatrical fact of the presentation is the condition of access to its truth. As Forestier says, the originality of the theatrical communication "is the double status of the message received by the spectator: on the one hand, upon the stage there are some people and some objects that are real, and on the other hand whatever the degree of realism attained by a spectacle, everything that appears upon the stage is perceived as non-real because the spectator does not have access to it".[43] In this mode of access to truth, Octave Mannoni sees the structure of the *Verneinung*.[44]

Stemming from this, for Forestier, since the theatre in the theatre is blemished by negativity and illusion, the function of the embedded play would be to impart the characteristics of truth to the rest of the work. Thus it would reinforce the appearance of truth of the reference play. But if the theatre in the theatre reinforces the appearance of truth, it is because this truth is

even falser; it is a reinforcement of the *Verneinung*. In other words it increases the value of truth, denied truth, of the embedded play.

This interpretation is identical to that of Freud for a dream within a dream: "To include something in 'a dream within a dream' is thus equivalent to wishing that the thing described as a dream had never happened. In other words, if a particular event is inserted into a dream as a dream by the dream-work itself, this implies the most decided confirmation of the reality of the event the strongest *affirmation (Bejahung)* of it".[45] In my experience I would say that, with a dream within a dream, it is more precisely a question of the symbolic recognition by the dream, through the means of the imaginary, of a traumatising event and that the affirmation is this recognition itself.

If, in an over-simplistic but evocative way, we can say that the neurotic is he who is unable to go upon the stage, or who, when he gets up there starts to talk gibberish, the psychotic, in his bouts of madness, acts as if there were no stage, as if he were in the world. The presentation, in so far as what its effectiveness resides in its ternary structure is a moment of *Bejahung* of the stage as such, of the reality of the stage itself as place of discourse, of a gaze in whose name one might speak.

Some additions on the function of the audience in the presentation

To conclude, I will add some remarks that stem more directly from my practice as a presenter.

There are some patients who, in an insistent way, in spite of the fact that I endeavour to return them to the interview, speak directly to the audience and request that members of the audience ask questions. Both cases in which this happened were people who had had acute psychotic periods with imaginary phenomena: misrecognition, panic, depersonalization...

In the first case, the triggering of the delusion was due to the fact that a cinema director, reputed for his realist films, had asked the subject to play the role of his own life in a film. The idea of "seeing himself in colour", he said, had "agitated him". In a certain way the presentation reproduced the triggering of the psychotic episode. The difference was that the audience was not a cinema audience, but a theatre audience. By instituting the real limit of a stage, the presentation, whilst reproducing the conditions of the triggering of the psychosis by modifying its place and function, was able to have a pacifying effect for the patient.

In the second case (in which there was also a reference to the cinema: "I saw my husband like a cinema") a phenomenon of panic with a delusion was triggered off in the Rehabilitation Centre in which she was recovering from a hysterectomy, a panic that was experienced in relation to the fact that the Rehabilitation Centre was "being emptied out". However the wish for the audience to put some questions to her was a wish to "frame the interview", which could be heard as a means of retaining something that was escaping, to fix it on the screen. Once again there was an affinity of the presence of the audience to the conditions of the delusion, allowing the reproduction of the moment of the triggering of the delusion, on this occasion the loss of an object. The audience was put in the place of symbolizing the loss of an object that she had experienced in a delusional way following her hysterectomy.

This leads us to pose the question, a delicate one, of the therapeutic gain, even partial, to which the presentation contributes for the person presented. It is true that it often exists. We nonetheless need to articulate what gain there is, as well as to explain it. In the first instance there are positive effects to be had from the fact that a diagnosis might be modified, or a new

light might be cast upon the patient, which leads to a change in the clinical management that has become stuck. A change can also simply come about by virtue of the simple fact that a patient is listened to with the idea that he is not so well known and an interest is taken in him once again, in agreement or not with what the presentation brings forward. This matters, and has to do with the place of the presenter in the Unit where the presentation takes place as well as to the dynamic of the presentation within the Unit.

There are also therapeutic gains that can be more directly related to the structure of the presentation. In this regard, I am putting forward a hypothesis that requires confirmation: the presentation of patients has a positive effect for certain subjects said to be schizophrenic. I have encountered two cases of this type. The first is the one of whom I spoke in regard to the function of the stage upon the stage.

The second case is that of a young man at the time of his first hospitalization. Here are some examples of his asides and of his "schizophasia"[46] during the interview:

> R.: my father insulted me.
>
> P.: what did you answer back to him?
>
> R.: I answered God's call.
>
> And: R.: I am called Rémy, I am the son of my father who was a Gypsy and didn't know it.
>
> P.: ?
>
> R.: because of (Greek) Y, Greek shepherd, wandering Jew, Gypsy [*à cause de Y, pâtre grec, juif errant, gitan*]
>
> (I learned in the discussion following the presentation that this was a song by Moustaki). Television advertisements and songs served as "patterns" for his delusion.

One of the things that troubled him during the interview, and which he questioned, was the fact of not being able to close his orifices. He farted all the time (which he commented on: "he who farts too fast shits/Petrovitshi... inch'Allah") ["*qui pète trop vite chie/Pétrovitchi... inch'Alla*"] and he complained of having become enuretic since the beginning of his disorder.

The day following his presentation his enuresis had stopped (he was still on medications) and did not return. Then an improvement in his condition began (his schizophasia became more like humour) and became more marked following an affective discharge at the moment of separation from his father.

This raises, in my opinion, two questions: to what is the therapeutic gain of a presentation due? The basis of the answer to this question is the action of the ternary structure of the presentation such as I have endeavoured to elaborate upon it. What is affected by any potential improvement? The symptoms or the psychosis? Or other symptoms? Those relating to psychosis or yet others again?

Effectively, it is not unusual that there are some symptoms, associated with or stemming from the elementary phenomena, that of themselves are not psychotic, although that might be taken up through a delusional interpretation: tics, aggressive acts, enuresis... They can be, for instance, symptoms of the transference.

Speech (*le dire*) can act upon these symptoms and their disappearance or amelioration can have positive effects on the psychosis.

There are other cases in which there is a repressed delusion and the lifting of the repression can be the condition of its possible resolution. This was the case for the presentation of Mrs C. By incarnating youth, the present of love, the audience allowed this elderly patient to retie the threads of her turbulent past to a recent event that had remained external for her. She had been accused of killing her alcoholic husband which she did not acknowledge (it had occurred in a confusional state in which she herself had no doubt drunk), persuaded that he had been killed by a gang of louts. The presentation effected a knotting such that she was able to make a tearful revelation: "he is not dead", she said, speaking of her husband. These delusional words had been repressed by the accusations brought against her, by the hearing that had only sought to know who was guilty. It was only following this avowal that a mourning could be envisaged for her.

The moment in which it is impossible for the subject to articulate the knot of what is imposed upon him is what constitutes the heart of the psychosis, the complexity and the variety of the hallucinatory phenomena: imposed speech, with or without reply from the subject, thought broadcasting or not, delusional interpretations or not, command hallucinations or not, speaking in the second or third person, attributed to one or several people or not...

In regards to this complexity, we notice that the presence of an audience allows things which escape from the presenter to be located in the moment in which they occur, and in this there is perhaps a reason that pertains to structure. Thus with Mrs A. Her birth signifies for her that she is dead... in another life. She is inhabited by a "little voice" whose literal aspect is difficult to pin down because it is also a personification to which she retrospectively [*après-coup*] attributes a number of actions. One statement was nonetheless acknowledged: "wait, you are going to get a spanking". This voice was that of a man or rather of several who were the transformation of a single one, who is himself definitively God. This man "stole her upper lip": he now speaks through her upper lip. She has only her lower lip left (although she says that at certain moments she has to retrieve it). But since one must move both lips in order to speak, by the very fact of speaking she was speaking *with* her little voice, in the two senses of this preposition. During the interview it took me a while to understand the second sense (the little voice that speaks through her mouth). When I was closest to the point of expressing this equivocation to her in a way that was, if not understandable, at least articulated, in the middle of attempting to separate out what might be hers and what might not come from her, deceived in some way by the apparent separation between the upper the and the lower lip, when I was deep in the imaginary of the separation, then Mrs A. no longer understood anything, she went blank, a "roadblock" one could say. The logic given by the delusion poorly covers over the rupture of thoughts, the strangeness of the hallucinatory phenomena as such. Between the imaginary delusional separation of the two lips and the verbal equivocation from which the hallucination arises there is a hiatus that no understanding can make good. And the audience was necessary for me to get back to this, because it is the sort of thing that is particularly difficult to hear at the moment in which it occurs. We resist speaking with psychosis.

Translated from French by Michael Plastow. Thanks are due to Jean-Louis Chassaing for his clarification of French terms from psychiatry.

References

[1] Originally published as "La presentation des malades". *Littoral* 17 (1985): 24-49.

[2] Freud, Sigmund. "Jokes and their Relation to the Unconscious" (1905). *The Standard Edition of the Complete Psychological Works of Sigmund Freud.* VIII. Tr. James Strachey et al. London: The Hogarth Press, 1961.114. *Bild* is the image; *vermitteln* in its intransitive form signifies 'to serve as a mediator'.

[3] Here I have taken up particularly those presentations that took place between 17/1/1975 and 14/1/1977.

[4] Translator's Note: In French, the study of clinical symptoms and signs is referred to as a 'semiology' (*sémiologie*).

[5] Intervention of Lacan at Henri Rousselle Hospital prior to the Neurology and Psychiatry Conference of Milan in 1970 on the theme "Contributions of psychoanalysis to psychiatry". Unpublished notes.

[6] Lacan, Jacques. *Écrits*. Paris: Seuil, 1966. 534.

[7] Here is the list of what has been published on the presentation of patients from Lacan's teaching: Miller, Jacques-Alain. "Enseignements de la présentation de malades". *Ornicar?* 10 (July 1977) Paris: Lyse; Melman, Charles. "Notes sur la Section Clinique". *Ornicar?* 9 (April 1977), Paris: Lyse; de Neuter-Stryckman, N. "Réflexions à partir des 'présentations de malades' de J. Lacan à Sainte-Anne". *Le discours psychanalytique* 10 (March 1984); Clastres, G. Gorog, F. Gorog, J.J. Laurent, E. Schreiber, F. "Les présentations de malades: bon usage et faux problèmes, Table ronde". *Analytica* 37 (1984).

[8] "Enseignements de la présentation de malades". *Ornicar?* 10 (July 1977) Paris: Lyse.

[9] "Les présentations de malades: bon usage et faux problèmes, Table ronde." *Analytica* 37 (1984).

[10] T.N.: In the original *pensées devinées* is a term from French psychiatry that describes the experience of having one's thoughts read or 'divined' by others. It is here rendered by its closest equivalent in the English psychiatric lexicon.

[11] Lacan, Jacques. *Écrits*. Paris: Seuil, 1966. 534-535.

[12] Lacan, Jacques. Seminar: *The Sinthome.* Lesson of 13th January 1976. Unpublished. This presentation was translated and published in English by Schneiderman, Stewart. *Returning to Freud.* New Haven and London: Yale University Press, 1980.

[13] Lacan, Jacques. Seminar: *The Sinthome*. Lesson of 17th February 1976. Unpublished.

[14] Lacan, Jacques. Seminar: *Encore*. Paris: Le Seuil, 1975. 115.

[15] Lacan, Jacques. Seminar: *The Sinthome*. Lesson of 16th December 1975. Unpublished.

[16] Lacan, Jacques. Seminar: *The Sinthome*. Lesson of 11th May 1976. Unpublished

[17] Lacan, Jacques. *Écrits*. Paris: Seuil, 1966. 176.

[18] Lacan, Jacques. Seminar: *Les non dupes errent*. Lesson of the 11th December 1973. Unpublished.

[19] Lacan, Jacques. Seminar: *RSI*. Lesson of 11th March 1975. Unpublished.

[20] Lacan, Jacques. Seminar: *RSI*. Lesson of 18th February 1975. Unpublished.

[21] Lacan, Jacques. Seminar: *The Sinthome*. Lesson of 13th January 1976. Unpublished.

[22] Dupré, F. *La "solution" du passage à l'acte. Le double crime des sœurs Papin*. Toulouse: Érès, 1984.

[23] Lacan, Jacques. Seminar: *Anguish*. Lesson of 23rd January 1963. Unpublished.

[24] T.N.: *L'Automatisme mental* is a syndrome defined by de Clérambault. It includes most hallucinations (psycho-sensory) and pseudo-hallucinations (psychical) of the psychoses. It is comprised of four elements: 1. parasitic sensations (visual, tactile and cenesthetic hallucinations) which are an ideational phenomena, in other words, purely sensory; 2. the triple mental automatism: phenomena of speech, of ideas and combined; 3. phenomena of mechanical splitting of thought (triple echo of thought, of reading and of actions) as well as thought broadcasting and repetition phenomena; 4. small mental automatism (*petit automatisme mental*) described as the 'shadow of an undefinable thought'.

[25] Ubersfeld, A. Cited by Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17e siècle*. Geneva: Droz, 1981. 22.

[26] Lacan, Jacques. *Télévision*. Paris: Seuil, 1974. 10.

[27] T.N.: The term *phenomènes élémentaires* is one that derives from de Clérambault. It describes isolated unelaborated and minimal hallucinations, interpretations and other phenomena that indicate the beginnings of a psychotic state.

[28] Vernant, J.P. Vidal-Naquet, P. *Mythe et tragédie en Grèce ancienne*. Paris: François Maspero, 1972.

[29] de Romilly, J. *Le temps dans la tragédie grecque*. Paris: Vrin, 1971, 11.

[30] de Romilly, J. *Le temps dans la tragédie grecque*. Paris: Vrin, 1971, 12.

[31] de Romilly, J. *Le temps dans la tragédie grecque*. Paris: Vrin, 1971, 30.

[32] de Romilly, J. *Patience, mon cœur !...* Paris: Les Belles Lettres, 1984.

[33] Vernant, J.P. Vidal-Naquet, P. *Mythe et tragédie en Grèce ancienne*. Paris: François Maspero, 1972. 39.

[34] Freud Sigmund. "Jokes and their Relation to the Unconscious" (1905). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, VIII, 140.

[35] Lacan, Jacques. Seminar: *Desire and its interpretation.* Lessons from March to April 1959. Unpublished. Lacan, Jacques. Seminar: *Anguish.* Lesson of 28 November 1962. Unpublished.

[36] Lacan, Jacques. Seminar: *Anguish.* Lesson of 28 November 1962. Unpublished.

[37] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 280.

[38] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 62 and 183. Pridament, in Corneille's *Illusion comique*, plays the role of a chorus.

[39] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 25.

[40] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 95.

[41] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 153.

[42] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz, 1981. 16.

[43] Forestier, G. *Le théâtre dans le théâtre sur la scène française du 17^e^ siècle*. Geneva: Droz. 1981, 139.

[44] Mannoni, O. *Clefs pour l'imaginaire*. Paris: Le Seuil, 1969. 304.

[45] Freud, Sigmund. "The Interpretation of Dreams" (1900). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, IV,(First Part), 337. The comparison with the dream within the dream is even better justified by virtue of the fact that his analysis of Freud is situated at the end of the chapter entitled *Die Darstellungsmittel des Traums* in which the correct translation of *Darstellung* is *presentation*.

[46] T.N.: Schizophasia (*schizophasie*) is a term used in French psychiatry derived from Kraepelin, describing profound disturbances of language. In English psychiatric terminology the closest equivalent is 'disorder of the form of thought'.