The tool of diagnosis and operation of the mathème

To know, to do, know-how, to construct knowledge

What can I do? The freedom to intervene.

What should I not do? The deontology of intervention.

What can I fail to do? The right to intervene.

What ought I do? The ethics of intervention.

All that in function of a knowledge and a know-how.

An informed knowledge to act competently. Knowing what to do.

On the usefulness of diagnosis.

Diagnostikos in Greek means one who is capable of discerning, of recognising. He must first know the thing, the sickness of the living being or of the machine, in order to subsequently recognise it in one or other particular indivIdual, in the clinic or in the garage.

Am I capable of discerning, of recognising? Am I a diagnostician?

In order to diagnose, I must have a clear, obvious (*évIdente*) Idea of the thing to be recognised, for example neurosis, psychosis, perversion. And then be able to discern, make the distinction: I recognise neurosis in such an indivIdual, psychosis in another, perversion in a third.

To be a diagnostician one must have Ideas that are clear (know what one is talking about) and distinct (know to what they are specifically to be applied).

This is Descartes, approach. Clear and distinct Ideas involve first of all conviction, then a plan of action, finally the realisation of an action adequate to these Ideas.

Clear and distinct Ideas allow one to behave properly in life.

This approach based on evIdence is the very model of the medical science that is

evIdence-based; it follows exactly this Cartesian schema. The therapeutic schema follows the Cartesian order: clear and distinct Ideas and diagnosis, conviction and the practitioner's and the concomitantly the patient's adherence to the diagnosis, the action-plan and the therapeutic schema, the realisation and the application of the treatment.

In this sense, clear and differential diagnoses are very useful.

Treatment is not the only use of diagnosis, one must also communicate, there must be a consensus; further, one must take precautions about the difficulties that may arise.

Communicate, treat, do no harm.

First: by means of diagnosis, I am going to be able to communicate in a univocal language with my colleagues. Someone came up with the Idea that in order to have clear and distinct Ideas in psychiatry, it would be better to put to one sIde all interpretations and theories and to hold onto nothing but observable symptoms. This is the DSM which aims at communication between different practitioners in psychiatry. This works more or less well. By it one gains in terms of communication, it is even saId that a certain consensus can be reached; but the trouble is that one is no longer speaking about the same thing: there is no question now of talking about the human, the agreement now is to talk about the symptom that has gone through the mill of statistics.

Second: I am going to be able to treat the problem; to someone who is allergic, I will give an antihistamine, to someone anxious, an anxiolytic, to someone depressed an anti-depressant. Or again I will send the addict to a centre of detoxification. In certain conditions, I will propose one or other type of psychotherapy for the neurotic. Without forgetting the treatment made available by social security which offer specific subsIdies for one or other particular pathology.

Third, which ought to come first (*primum non nocere*): I am going to have to be prudent. Honour must be paId to every master. Care for myself (the gloomy despot), I will not accept to see anyone who could harm me in one way or another. Care for

society: cf. dangerous psychopaths, recIdivists. But also a common-sense prudence for the patient himself: I will be very careful not to pretend to be someone who knows everything with a paranoiac for example.

These useful services (to communicate, to treat, not to harm) serve as a justification for the operation of diagnosis. Once diagnosis as a preliminary approach to any treatment is put in question, objections rush in: it is useful, it is useful for communication, for treatment and for avoIding harmful effects. And we all stick together around this usefulness,' it is useful', it is very useful.

Let us loosen a little the vice, the diagnostic vice.
Not for one or other patient: is he going to be ranked in the drawers that contain things, the drawers of psychosis, of neurosis, of perversion or whatever? Let us loosen the vice not in the sense of putting one or other diagnosis in question.
'Let us loosen the vice' in a much stronger sense: where does this knowledge come from, from where do these supposedly clear Ideas come which are supposed in principle to distinguish my patient?

From where does this knowledge come to us?
From where is the consistency of this knowledge, of these clear and distinct Ideas, supposed to come?

From whom?

There are a crowd of those who are supposed to know, the responsible therapist, the psychiatrist, and especially all of those who feed, each one at his level, the theoretical corpus underlying every practice. One could thus explain the knowledge by a network, a network of transmission which extends infinitely and in which we can pick out certain highlighted figures.

What knowledge? In what does this knowledge consist?

Whatever may be the references of this knowledge, the very consistency of the knowledge depends on what I can form integrally by myself, from myself, without having to comfort myself by someone or other who is supposed to have sald it before me. Where find this force which gives consistency to the knowledge?

First of all in immediate observation, the clinical observation which has been collated into great morbId entities by our illustrious predecessors, for example. Let us point out that this knowledge of immediate observation (without theory and with interpretation if possible) is precisely the point of view radicalised by the DSM.

But the directly observable is never without a basis that escapes us. Let us take as foundation the evIdence or indeed the strangeness of the oddities of the unconscious. So we will question what radically escapes us, what is not directly observable, and people will speak about 'structure', as one talks about the framework or the chassis of a car. People therefore will have a psychotic, neurotic, perverse chassis and this chassis may be clothed, tuned according to the economic means of each one. By definition we do not see this chassis, we have to interpret it in function of a theory, which does not fail to involve the worst kinds of misunderstandings. Beyond the observable symptoms, there is supposed to be a profound structure (people talk about depth psychology), the background (at the level of Szondi), or again the unconscious, etc.

Contrary to and opposed to the DSM which systematically refuses theory and interpretation, the diagnosis of structure is always made in function of a theory of the psychical apparatus, and correlatively the indivIdual is always interpreted in function of a universal framework valId for the totality of humans. Examples: diagnosis in the framework of Szondi's instinctual system or diagnosis in the frame of the second Freudian topography. One must then clearly specify that the diagnosis of structure does not consist in differentiating several different structures, but indeed the putting to work of The Structure in order to situate the indivIdual in it, more particularly at one or other articulation of The Structure: there is no psychotic, neurotic, perverse structure, it is not the indivIdual that one is supposed to distinguish as being ranked in a specific structure; it is much more that the indivIdual is ranked in the general Structure and it is then a matter of specifying how, which is quite a different story.

Example.

Let us suppose the structure of the Freudian psychic apparatus, Id, ego, superego and outsIde external reality; insIde: the Id, this subterranean world of occult, violent, uncontrolled forces; in the mIddle the ego which limits and surrounds the Id; outsIde external reality, the world that can only interfere with the Id by means of the ego. The ego is therefore supposed to be the interface between the Id and the external world; in this regard it is supposed to be the structure itself (the ego *pontifex* as Szondi would say). Such an entity (Id\ego\external world), such a narcissistic monad, must take into account other monads, other people. The ego is thus joined to a superego which is supposed to regulate its external relations with its other fellows. The ego is then supposed to be confronted to three agencies: the Id, external reality and the superego. The ego (namely the structure in general) is thus supposed to be subject to three types of sufferings, to three pathologies: it can be in conflict with the Id, the ego is supposed to repress the Id and that is neurosis, it can be in conflict with external reality, a forclusive ego is supposed to lose the key giving access to reality and this is supposed to be psychosis, it can be in conflict with the superego, the ego is supposed to deny castration and that would be perversion[2].

I took this Freudian example because it offers the most frequent type of a diagnosis of structure (structure should be written in the singular) and because the underlying theory is easy: a ball with an insIde (the Id), and outsIde (reality) and a skin, a membrane that separates them (ego). After a little explanation which seems indeed to take up again the question of the diagnosis of a structure, Freud adds 'We do not know right away if we have acquired new views or simply enriched the treasury of our formulae'[3]. In other words, when we have constructed our framework of the diagnosis of structure the question is posed: is this not simply an enriching of our vocabulary, of our way of talking about different specific structures. All of that may serve to enrich polite conversation, the way of talking in clinical presentations; all of

[2] In 'Neurosis and psychosis' (1924), Freud speaks for this third type of pathology of 'narcissistic psychoneurosis' and calls it melancholy. The discussion of this point would require long developments that go outsIde the framework of this presentation.

[3] 'Neurosis and psychosis' (1924).

this may help to find the words which give the good conscience of having 'understood', namely caught the indivIdual in the vice of the proper category (and the supervisor can help with that).

The courage to know

But Freud immediately adds: Let us nevertheless not abandon the 'courage' of the construction of the structure in general, which is, for him in 1924, the articulation of the psychical apparatus in ego, superego and Id (psychic reality is outsIde the psychical apparatus).
The courage to pose the question of structure is not the facility of inscribing indivIduals in the aforesaId 'psychotic, neurotic or perverse' structures.
What is at stake is The Structure itself not as one can learn it from the mouth or from the writings of someone else, but only as I can find it by myself, starting from my own experience.
For that I cannot be content with reading and copying Freud, Szondi, Lacan or whoever. I must have the experience myself; otherwise I can learn strictly nothing. Undoubtedly I have to hand multiple theories, multiple structures: the unconscious-preconscious-consciousness, the ego-Id-superego, Szondi's instinctual system, the imaginary-symbolic-real, the four discourses, the formulae of sexuation, etc. But all of this is only an enriching of our vocabulary, of ways of talking that are useful for pigeon-holing patients, symptoms and everything we can get our hands on. [That forms part of the scaffolding that Freud always takes great care to distinguish from reality. The approach through knowledge will never touch the real of the Thing. There is no thing in itself of psychosis, of neurosis, of perversion. These are only modalities of approach depending on the Freudian psychical apparatus in 1924, of the psychical ball. It is certainly not the best way of tackling The Structure.]

The operation of the matheme

You can *know* nothing in the proper sense of the term, if you do not construct it yourself. What one can only know by constructing it oneself is called the matheme,

not as a reference to mathematics, but as a reference to Socrates or rather to Socrates' interlocutors who invented knowledge on the spot, 'extemporaneously'.
It can happen that the matheme concerns a mathematical property (for example the square root of 2 invented by Meno's slave), but it is not necessary.
I therefore propose to you the following little exercise.
Which constitutes the only thing which can be transmitted.
Because of the pressure of time, I will take an extremely simple matheme, which requires no knowledge of mathematics or of psychoanalysis, and you will see I hope that here transmission is integral.

Think of a dream that you had last night or in the distant past it doesn't matter. Because you are reasonable and because you have read *The interpretation of dreams*, and because you want to have clear and distinct Ideas, you have perhaps the conviction that it means this or that. It may even be moreover of use to you as a diagnosis, 'This is the dream of an obsessional, of a hysteric, of a psychotic or of a pervert'. You are quite naturally pushed towards the evIdence: 'That means such and such'. But the evIdence is nothing other than resistance to any questioning.
So then let us go on to the second part of the exercise. From all this dream material, remove pitilessly everything that does not correspond to the act of dreaming properly speaking in that it bears witness to your innermost core. Thus you make disappear the integrality of all the motives; even the most shameful motives still only bear witness to a relative discomfort about one or other episode of your life which has encumbered your inner life and that you find shameful. There remains to you only the pure kernel without a content: 'I dreamt, and I can put in parenthesis all the representative elements of the dream', 'I dreamt and I have forgotten everything'.
If you have done the exercise, you accepted what is offered in the first phase, you accepted a 'it is that', it is such dream: and then in the second phase, you refused, 'it is not that', I dreamed, but that is not reduced to such or such element, with such or such memory, with such or such interpretation. 'I ask you to refuse what is offered because it is not that'.

This exercise is an example of an experience of knowledge that is entirely

transmissible. If you wish you can experience it and develop it yourselves. This knowledge is matheme. It is the same thing as mathematics: you can develop by yourselves the properties of a triangle starting from the moment that you set about it. Here the matheme is the complete development of a separation starting from the evIdence, 'It is that' and then 'It is not that', the general formula of every differentiation.

Supplementary exercises: Starting from this matheme, reconstruct all the theories more complex than the elementary matheme; they finally take on a value, they are finally transmitted because you are capable of supporting them in their questioning power.

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But why all this trouble? We work in institutions and there are surely always some smart people to think in my place (is that not moreover what they are paId for?); I have only to follow the style of thinking, the directives which ought all the more easily therefore bring about a consensus. And these smart people may be flattered to have such an audience. Therefore that would suit everybody. Thus everything would remain ordered by a reasonableness as sane as possible, with clear and distinct Ideas, conviction and consensus, the therapeutic project, etc. And the know-how of those who intervene would only be the practical execution, the application of directives given from on high. The one who intervenes would therefore have no liberty and no right. His deontology and his ethics would consist in obeying. And still happy that between the orders there remain some gaps.

Knowing how to manage psychical symptoms?

But the aforesaId symptoms disturb reasonableness. He is disturbed as they say. Reasonableness, the good Cartesian reasonableness defends its territory. Diagnoses, whatever they may be, always present themselves in the name of a healthy reasonableness supposed to judge what is deviant with respect to a proper reasonableness. The proper reasonableness locked into its evIdence may well try to deviate, to caricature judgement; instead of producing the matheme and of getting one's own reflection going, the judgement becomes conclusive: 'This indivIdual is

definitively psychotic'; that is called a final judgement and it is always a condemnatory judgement: 'I am giving you another month to live' would say the doctor; the psychopathologist 'I can only leave you for the rest of your life with a semblance of truncated humanity'. It is always in the sense of an insult. All the diagnoses of psychopathology can moreover serve as insults: a sort of schizophrenic, of paranoiac, of hysteric, of obsessional, of pervert, of neurotic, etc. And quite justifiably the psychopathologist is a little embarrassed in delivering his verdict to the patient.

It would perhaps be a matter of putting him to work, to the work of an experience that he is the only one able to do and which would begin, for him, by remarking that he thought 'it was this' and that 'it was not that'. Open him up to the matheme rather than enclosing him in a diagnosis. Because there is indeed a certain obvious reason (yes 'that's it') for everyone even for the most 'unstructured' personality, but there is also not a deficiency of reasonableness, but a strangeness (a 'That's not it') which insists in a symptom, a dream, bizarre behaviour etc.

In any case diagnoses are presented: we can clearly see that he is psychotic, hysterical, perverse, etc. It is obvious. That's it.
Let us take up the exercise again. Think of the diagnosis that might be applied to you. Where does it come from? From your reading or from another imaginary or real. With a bit of distance everyone can have the experience that 'It's not that'; yes this does indeed express some features of behaviour or of response to aggression but 'that's not it'. Through this difference carried on in your reflection, a knowledge is produced. Anyone can do it. This distance is the true knowledge, the matheme which gives to judgement the possibilities of being infinitely flexible.

Diagnosis would therefore be useful on condition of introducing some flexibility into it, of bringing it into play moreover as well as putting some variation into it.
The trouble is that diagnosis is an *unequivocal systematisation* of a Cartesian behaviour entirely constructed because of the evIdence that goes from clear and distinct ideas towards adequate treatment. EvIdence-based medicine bears witness

to this.

Why not apply it to psychiatry? People are quite naturally tempted to stick to it with of course some modifications.

People that we see present, in opposition to this method completely polarised towards evIdence, the affirmation, sometimes at the price of their lives, of a quite different rationality; it is not the evIdence, but the strangeness of the symptom which contests reason.

Will be able to hear it?

Will we be able to produce its matheme for ourselves? And to have the matheme produced by the one who is no longer a patient, but an inventor, an 'analyser', if you wish?

To invent knowledge upon the work of a questioning of rationality itself, to make readable what offers itself literally in each of the symptoms that are offered to us.