

Regarding hallucination and reality: the psychosis in ICD-10, DSM-IV-TR, and DSM-V and the psychoanalytic counterpoint¹

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Abstract: Psychosis is one of the few terms in classical psychopathology and psychoanalysis that remain in the current classification systems, such as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases), which allows to investigate the various ways of thinking about psychological distress. We discuss how the DSM-IV-TR, its current edition (DSM-V), and the ICD-10 define and use the term psychosis. The appropriation of this concept is based on a merely descriptive definition, as a refusal strategy towards etiological discussion. Hallucination, one of the criteria for the classification of “psychotic disorders”, is defined with a naive realism in which reality is taken as an objective construction. We present the psychoanalytic counterpoint to such appropriation: psychoanalysis points to the relevance of the symbolic structuring of perceptual phenomena and reality as a subjective construction.

Keywords: psychoanalysis, psychosis, hallucination, reality, DSM.

Introduction

The Diagnostic Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) are diagnostic guidelines – or their logic, at least – used by the Brazilian Unified Health System (SUS) for carrying out epidemiological studies and establishing funding for the mental health network. Thus, analyzing them is of epistemic and political importance. The diagnostic reduction to a description of signs and symptoms operated by these manuals sets aside the clinical method and results in diagnostic errors, which especially damages the organization of the mental health network treatments.

In addition to psychotic people being the majority served by the mental health network (Teixeira, 2007), psychosis is one of the few terms from classic psychopathology and psychoanalysis that remain in these manuals; thus, it allows one to better establish the network of comparisons between these different ways of thinking regarding the psychological suffering.

Supported in these propositions, we performed a critical analysis of the term psychosis in the DSM-IV-TR, DSM-V, and ICD-10, subsidized by the theoretical

framework of psychoanalysis. The appropriation of this concept supports itself on a purely descriptive definition, as a refusal strategy to the etiological discussion. As the presence of hallucinations and delusions is the criterion for diagnosing a psychotic disorder, they are defined from a concept of reality taken as evidence. Hallucination is defined as an error of perception and delusion as a false belief of reality. Both present the criterion for impairment regarding sociability, which is determined in relation to the impaired reality.

Moreover, we took hallucination as our guiding principle of analysis because it is still a paradox of definition in psychopathological history: the whole problem of hallucination seems to be linked to the fact that it is defined, almost solely, as perceptions without object (Álvarez, 2008). The uniformity that has defined hallucination since Esquirol, in his *Tratado completo de las enajenaciones mentales consideradas bajo su aspecto médico, higienico y medico-legal*, from 1838, until the *Tratado das Alucinações* of Henri Ey, published in 1937, is critically examined by Álvarez (2008): the first paragraph that Esquirol dedicates to hallucination became a classic quote, a definition that continues to resonate even today: “un hombre que tiene la convicción íntima de una sensación actualmente percibida, aun cuando ningún objeto hiera sus sentidos, se encuentra en un estado de alucinación; es un visionario” (Esquirol apud Álvarez, 2008, p. 131).

Colina (2001) points out that this is not exactly a perception without object, as the conventional definition

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assumes, but a “perception without subject”: without a subject of the word that is able to channel the perception to its capacity and natural expression. If the classification manuals of mental disorders define both hallucination and delusion from an objectifying and assumed definition of this reality, it is precisely at this point that we propose tightening the concept of reality supported by such definitions and the psychoanalytic elucidation regarding this issue. Nevertheless, psychoanalysis has always had to deal with the question of reality. Estevão (2009) reminds us of the importance of this concept to Freud since the beginning of his work, precisely because it did not seem like just an assumption. Some crucial Freudian texts to the design of this concept are *On Aphasia*, from 1891, the *Project for a Scientific Psychology*, *Formulations on the Two Principles of Mental Functioning*, *Negation*, *Neurosis and Psychosis*, and *The Loss of Reality in Neurosis and Psychosis* (Estevão, 2009). Thus, in Freud (1891/1979), we have already seen that reality is given through assigning meaning as opposed to an objectively given reality.

Lacan, starting from the Freudian premise, emphasizes the importance of the subject’s relationship with the Other and the significant organization in this subjective construction of reality. It is from these coordinates that hallucination is thought of by the symbolic order, settling that the “perceptual relationship with reality is not as natural as one could imagine, but a function of the significant phenomena” (Soler, 2007, p. 26).

To the conception of univocality of a reality previously assumed, explicitly supported by the characterization of hallucination as a criterion for defining a psychotic disorder in the DSM, psychoanalysis emphasizes a preceding questioning that we propose developing here: the lack of unity in the very subject to which reality is supposed to be true.

The International Classification of Diseases (ICD-10) and the descriptive status of psychosis

Unlike neurosis, which has suffered a purging process from the DSM, the term psychosis suffered a fragmentation, being reduced to a category within a group of disorders known as “Schizophrenia and other Psychotic Disorders”. The DSM-IV (revised in 2000, therefore DSM-IV-TR) was developed along with the chapter on mental disorders of the International Classification of Diseases (ICD-10) in a collaborative work between the American Psychiatric Association (APA) and the World Health Organization (WHO). Due to the fact that these revisions have been made in parallel, the definition of psychosis in both manuals is very similar.

Chapter V of ICD-10 refers to the classification of Mental and Behavior Disorders, whose version Clinical descriptions and diagnostic guidelines (WHO, 1993) is intended for clinical, educational, and health-care use in general. The clinical descriptions of each disorder are

provided from a description of signs and symptoms that are considered “major” along with other “less important associated aspects”; and the diagnostic guidelines are described indicating the number of symptoms required for a reliable diagnosis to be made.

According to the revisers of this version, the clinical descriptions contain a certain degree of flexibility that allows a provisional diagnosis to be made when a clinical picture is not entirely clear. However, the existence of clinical implications is undeniable, specifically regarding treatment orientation, when establishing an early diagnosis or one based on insufficient clinical traits. Freud, in his text “Wild psychoanalysis” (1910/1996), already spoke of the caution that must be taken for diagnosis.

In this text, he made a criticism of a misdiagnosis based on a standardization of the theory, in this case, of the psychoanalytic concepts. He presents the case of a woman who complained of anxious states while she and her husband were getting divorced. After being diagnosed by a young doctor inspired by a trivial reading of psychoanalysis (who said that her anxiety was due to lack of sexual satisfaction), the treatment was then imposed: she should choose between returning to the husband, having an affair, or resorting to masturbation. The case is analyzed by Freud in a double perspective: in relation to the practitioner’s notion of sexuality, reduced to the sexual act and genitality; and in relation to the establishment of the diagnosis and treatment that will depend on this.

Freud argues that the practitioner probably assumed a clinical diagnosis of anxiety neurosis due to the woman’s complaint of anxiety and that, therefore, the treatment would involve some modification of the somatic sexual activity of the patient. However,

A person suffering from anxiety is not necessarily suffering from anxiety neurosis; thus, this diagnosis cannot be based on the description [of the symptom]; one has to know which signs constitute anxiety neurosis and be able to distinguish it from other pathological states that are also manifested by anxiety. (Freud, 1910/1996, p. 139)

This warning is both relevant and current: there is no direct correlation between symptom and diagnosis. For Freud, the woman suffered from anxiety hysteria, which would imply a different etiology and treatment. The result of a diagnosis based solely on the phenomenic aspect of the pathology is conducting a treatment that is not relevant for the pain of the subject. This is, or should be, the most deficitary implication for the clinic.

With this clinical implication, would the preparation of a diagnosis not be even more harmful – to the subject – when the clinical picture still does not allow a clear understanding of the articulation of signs and symptoms, as the clinical guidelines of the ICD-10 propose? As Dor (1991) reminds us, “the analyst should be able to lean on certain stable elements, both in preparing the diagnosis

and in choosing the best path to cure, from which there depends” (p. 15).

In the introductory part of this version, the writers previously warn about “the lasting and notoriously difficult problems associated with the description and classification” (WHO, 1993, p. 1) of acute and transient psychotic disorders. Nevertheless, they claim that the proposed descriptions and guidelines do not contain theoretical implications. For this, they resume psychopathological terms, only emphasizing their descriptive aspect. Psychosis was maintained for being a “simple and familiar” term (WHO, 1993, p. 99), and reduced, for convenience, to its semiological aspect:

Psychotic was kept as a convenient descriptive term Its use does not involve assumptions about psychodynamic mechanisms, but simply indicates the presence of hallucinations, delusions or of a limited number of multiple behavioral abnormalities. (WHO, 1993, p. 3)

Chapter V of ICD-10 provides a separation between what was named as ‘acute and transient psychotic disorders’ and schizophrenia, stating that schizophrenia is not the same as the “very acute psychoses that abruptly begin, have a short course of a few weeks or even days and a favorable evolution” (WHO, 1993, p. 10). This separation, however, is not intelligible and seems to be obscure to the revisers themselves: “The criteria proposed for its differentiation (schizophrenia) highlights the problems for defining the mutual limits of this entire group of disorders (acute and transient psychotic disorders) in practical terms” (WHO, 1993, p. 12).

The diagnosis of schizophrenia is established when there is a presence of delusions, hallucinations, and other typical symptoms for at least a month. However, when these same symptoms do not satisfy the minimum duration of time, a diagnosis should be made firstly in the category of acute and transient psychotic disorders, or, more specifically, in the diagnosis of acute schizophreniform psychotic disorder. Finally, if the symptoms persist for a longer time, the reclassification for the diagnosis of schizophrenia is recommended.

While the ICD-10 proposes the criterion of at least one month duration for the symptoms to diagnosis of schizophrenia, it indicates that some national classifications adopt the criterion of six months for the same diagnosis. However, as is justified by revisers, “in the current state of ignorance, there seems to be no benefit in restricting the diagnosis of schizophrenia in that way” (WHO, 1993, p. 11). And once again, they resort to the so-called atheorism and the descriptivist principle of avoiding commenting on the etiology:

Therefore, it seems better for the purposes of the ICD-10 to avoid any assumption about the chronicity required for schizophrenia and considering the

term as descriptive of a syndrome with a variety of causes (many of which are still unknown) and a variety of developments, depending on the balance of genetic, physical, social, and cultural influences. (WHO, 1993, p. 11)

Given this classification project, based on atheorism, the term mental illness presents itself as an impossibility for its realization. We know that the classification in mental illness implies, necessarily, obeying the criteria of the anatomopathological method: starting from the signs and symptoms observed, one searches for injuries and/or corresponding brain dysfunctions. Thus, according to Aguiar (2004), the specificity of a biological marker will allow for an etiological explanation of the disease.

However, etiology is still a dark continent for promoters of classification systems, not only from the ICD-10, but also from the DSM. The term “disorder” is used throughout the classification to avoid even greater problems inherent to the use of terms such as “disease” or “illness”. It is clear that “the problems inherent” to these terms refer to the etiological aspects involved. The refusal for the etiological discussion of the diseases is reinforced by the search for a term that is immune to theoretical and etiologic implications. Mental disorders are often associated with pain or disabilities that impair the sociability of the individual (APA, 2014).

Before the absence of this biological marker that allows one to confirm the etiology, the found solution was ignorance. It would be easier to ignore the etiological mechanisms of diseases rather than revive the historical debate in the field of psychopathology between those who defend organicism and those who defend psychism. The strategic abandonment of the term “mental illness” and the adoption of the term “disorder” is the focal point for grounding a classification system that aims to ensure a scientific status and, in turn, ensure the alleged universality.

It is noticed that some disorders have a temporary and transitory nature, i.e., a premeditated validity and that, depending on the duration of symptoms, are reclassified in other disorders. In many cases, the duration of signs and symptoms is the threshold for establishing the two different diagnoses.

In this perspective, the concept of comorbidity becomes a questionable point. Comorbidity is the simultaneous occurrence of two or more psychiatric disorders, and it may have the most variable diagnoses to a same case, often gathering categories of contradictory symptoms. The DSM III, published in 1980, was based on a hierarchy of diagnoses based on the identification of only one pathology to encompass all the symptoms that represent a patient’s condition. However, with the advent of DSM-III-R in 1987, this hierarchy of diagnostic axes was replaced regardless of the concept of comorbidity. (Kyrillos Neto, Silva, Pederzoli, & Hernandez, 2011).

As a result, we have the prevalence of two or more diagnostic categories of different axes in establishing one

diagnosis, that is, two or more diagnoses for the same subject. The concept of comorbidity was maintained in the revision of the fourth edition of the manual (DSM-IV-TR) and is widely used in the DSM-V. (Matos, E.; Matos, T., & Matos, G., 2005). For the revisers of the DSM-V, comorbidity, in cases of psychiatric disorders, is a rule, not an exception.

DSM-IV-TR and DSM-V: a naive realism in the definition of the criteria of psychosis

Let us now take a look at the definition of psychosis in the DSM-IV-TR, a multi-axis and category diagnosis system, which means it works with five axes, each one covering a area of information: Axis I comprises the clinical disorders and other conditions that may be a focus of clinical attention. Schizophrenia and other psychotic disorders are part of this axis. Axis II includes personality disorders and mental retardation. Axis III includes general medical conditions that are important to the diagnosis and treatment. Axis IV refers to the psychosocial and environmental problems that can equally affect the diagnosis and treatment of the disorder identified in Axis I. Lastly, Axis V presents the Global Assessment of Functioning.

As in its penultimate edition, the DSM-V no longer has an exclusively clinical use. Essentially, Laurent (2013) points out that few things will change between DSM-IV-TR and DSM-V, since “the DSM is still founded on a ‘consensus on the regroupings of clinical symptoms’, and not on an ‘objective’ measurement of anything” (p. 21). The category diagnosis model adopted in the last revised editions was replaced by the longitudinal model, providing a predictive character to the diagnoses. DSM-V revisers thusly justify such a change in the structure of the manual:

The results of numerous studies on comorbidity indicated that the boundaries between several “categories” of disorders are more fluid throughout the course of life . . . and many symptoms attributed to a single disorder can occur, at different levels of severity, in various other disorders. These findings indicate that the DSM . . . must seek ways to include dimensional approaches to mental disorders. (APA, 2014, p. 5)

However, it is important to highlight a movement that has been called “a clash of titans in mental health” (APA, 2013) concerning the advent of the DSM-V. Laurent (2013) draws attention to the fact that weeks before the release of the fifth edition of the DSM, the United States National Institute of Mental Health (NIMH), when proposing a new project of diagnostic research of mental disorders, the Research Domain Criteria (RDoC), revealed that it will refrain from funding research based on the diagnostic categories of the DSM. Fajnwaks (2013) points out that the creation of a new classification from the RDoC, based on a biogenetic approach and use of neuroimaging,

represents a death sentence of the classification project for the diagnosis of mental illness in the DSM models. According to Laurent:

This is grouping, in a project titled Research Domain Criteria (RDoC), everything that has been isolated by science as objective signs in the field of psychopathology: neuroimaging, likely genetic markers, change of cognitive functions and their objectifiable circuits, in three key areas: cognition, emotion, and behaviors. The RDoC aims to establish a mapping of the set of these aspects through the continuum of the field, passing over the different tags and sub-groups of the DSM that divide endlessly. (Laurent, 2013, p. 21)

The DSM, which is responsible for the precipitation of a clinic with logical-positivist inspiration and that has been the main tool for the diagnosis and classification of mental disorders, may undergo changes in this status with the new RDoC project by NIMH, which incorporates behavioral and neuroscientific evidence.

Fajnwaks (2013) observes that this movement summarizes the current paradigm shift that guides the issue of psychiatric diagnoses. Judging from the reactions that preceded and followed the recent publication of the DSM-V, it is possible to conclude that we are witnessing the end of an era: the era of inconsistent classifications present in the DSM.

This paradigm shift regarding diagnosis is driven by what is called authority in the field of neuropsychiatry: the results of molecular biology (neuroscience and genetics). The use of neuroscience for diagnosis is defended by the promoters of RDoC as a secure, materialistic, and scientific means given the inconsistency of the DSM classifications and the hyperinflation of diagnoses resulting from the creation of this manual. On the other hand, there would be the establishment of a “clinical neuroscience” in the field of psychic suffering, specifically when building diagnoses.

Let us review. In the introductory section, regarding the uses and concepts of the DSM-IV-TR, there is the statement: “the sets of criteria have been simplified and clarified, when this could be justified by empirical data” (APA, 2004, p. 14). The strategy used to avoid calling upon explanatory systems – what would ensure the atheorism and scientificity of the manual – is supported, as we will see below, with the definition of the term psychotic, in an attempt to not extend the borders of the definitions, appealing to the description and pure visibility of the phenomenon.

The DSM-IV-TR justifies that the term psychotic has never had a widely accepted definition and, for purposes of this manual, psychotic was “conceptually defined as a loss of ego boundaries or a large impairment of the reality testing” (APA, 2004, p. 303), as opposed to the definition used in previous classifications that were too comprehensive. In the DSM-IV-TR, psychotic is reduced to

the presence of certain symptoms, which vary to a certain degree between the diagnostic categories.

The term “psychotic” was delimited from three meanings, ranging from a more restricted to a broader plan. In a more restricted definition, the term psychosis would specify the presence of delusions and hallucinations with no insight into their pathological nature. In an intermediate definition, psychosis would be characterized by the presence of hallucinations, but with the individual seeing them as pathological experiences. Finally, in a broader perspective, in addition to delusions and hallucinations, the positive symptoms of schizophrenia are considered, such as disorganized speech and catatonia. In the first case, we would have the Psychotic Disorder due to a General Medical Condition and Substance-Induced Psychotic Disorder; in the second case, Delusional Disorders and Induced Psychotic Disorders – and psychosis would almost be synonym of delusion; and in the third case, Schizophrenia, Schizophreniform Disorders, Schizoaffective Disorders, and Brief Psychotic Disorders (APA, 2004). Arguably, the manual justifies that the grouping, in more restricted and broader terms, is a facilitator of the differential diagnosis of disorders that include psychotic symptoms as a prominent aspect of their presentation, stating that the difference between them rests in their frequency and that there is no common etiology (Calazans & Bastos, 2013).

If the presence or absence of delusions and hallucinations is the criterion for categorizing a psychotic disorder, we must then pay attention to how the DSM-IV-TR defines them. Hallucination is defined as “a sensory perception that presents the sense of reality of a real perception, but that occurs without external stimulation from the relevant sensory organ” (APA, 2004, p. 766). Delusion is, in turn, taken as a

false belief based on an incorrect inference about the external reality, which is firmly maintained, despite what almost everybody else believes and despite incontestable proof or contrary evidence. This belief is not usually accepted by other members of the culture or sub-culture. (APA, 2004, p. 767)

Such definitions have remained in the current edition of the manual. In the DSM-V (APA, 2014), delusions are defined as “fixed beliefs that are not likely to change in the light of conflicting evidence” (p. 87). The degree of conviction with which the belief is held, “despite clear or reasonable contradictory evidence about their truth” (APA, 2014, p. 87), is the element that would distinguish the delusion from a firmly defended idea. The condition that hallucinations must occur in the context of an “unchanged sensory” remains as a definer of hallucinations: “they are experiences similar to perceptions that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, not being under voluntary control” (APA, 2014, p. 88).

Nevertheless, these definitions have the inconvenience of sticking to phenomenonic descriptions from what Chalmers (1993) characterized as a naive realism. Reality taken as evidence, as a fact that is imposed in itself, promotes, in the words of Kyrillos Neto and Calazans (2012) “a new juror faith in the existence of indelible facts that are independent of a discourse” (p. 12). By favoring the observable and empirically accessible dimension of psychic disorders, we have the disregard of the structuring dimension of the look as a consequence (Kyrillos Neto & Calazans, 2012). In this sense:

any clinical perspective that considers having access to a objectifiable reality that can serve as a criterion of demarcation between reality and fantasy is nothing more than a positivist doctrine with devastating political consequences regarding the subjectivity. The empirical reality could not be the mainstay of the meaning, since the place of the object for psychoanalysis is empty. There is no extralinguistic reality able to support the signifier. (Cardoso & Lustoza, 2012, p. 119)

Almeida (2008) argues that the philosophical orientation of the DSM is not studied, only incorporated. We would therefore have a vulgar empiricism. And as the pretense of empiricism, in general, is to have access to reality with the minimal possible load of metaphysics, the most immediate effect of empiricism and metaphysical asepsis is the required correlation that the DSM extends between the definitions of delusion and hallucination and the so-called “reality testing”.

The exaggerated use of phenomenonic definitions, as proposed by DSM-IV and ICD-10, makes it impossible to distinguish psychosis from what it is not, i.e., to establish a differential diagnosis. Because, with these definitions and criteria, how could we consider, for example, the hysterical conversions, compulsive thoughts and acts, phobic behaviors? Do these not harm social conviviality? If we take seriously the question that, in schizophrenia, we have disorganized speech, are we not able to find the same speech disorganization in some disorders that are not psychotic? On the other hand, do we not have paranoid people with organized speech? Are not phobic ideas unacceptable to social conviviality and could they not be considered as “false beliefs?”. Thus, will we consider every phobic person as delusional – and, therefore, psychotic? – Could anorexic people who say they are fat not have their perception considered as true and without “external stimulation from the relevant sensory organ?”. These are some tributary issues of a purely descriptive definition that is supported based on an objective judgment of reality, which is imposed to the subject to the detriment of his/her orientation in the relationship with the Other and his/her modes of *jouissance*.

Psychosis and the subjective construction of reality in psychoanalysis

The idea of a merely given reality, objectively imposed to the subject, is criticized by psychoanalysis. By linking perception and representation, Freud (1891/1979) conceptualizes reality from an assignment of meaning. That is, the allocation of meaning mediates the subject-perception relationship, and it is this relation that constitutes the reality.

Reality was approached by Freud indirectly: the impossibility of defining an anatomical and physiological substrate for hysteria put in check, according to Estevão (2009), the meaning of reality in which Freud graduated as a doctor. Specifically regarding psychosis, "The loss of reality in neurosis and psychosis" (1924/1996) is a text of major importance on this theme.

Freud (1924/1996) demarcates the distinction between neurosis and psychosis in relation with loss of reality, noting some similarities and differences of this detachment from reality. In neurosis, the "I" obeys the demands of reality and represses the pulsional demands, whereas in psychosis, the "I" is under the domain of the "It" and turns away from reality. For Freud, this detachment from reality in psychoses occurs in a first stage, when the "I" rejects the external reality and, in a second stage, as the "I" tries to replace the external reality with the delirious reality: "also in psychosis, two steps could be discerned, the first of which would drag the 'I' away, this time far from reality, while the second would try to repair the damage caused and restore the individual's relationship with reality" (Freud, 1924/1996, p. 230).

The delusion would be the attempt to reconstruct a new reality. "The second step of psychosis, it is true, is intended to repair the loss of reality" from the "creation of a new reality" (Freud, 1924/1996, p. 230). While the neurosis only ignores reality, psychosis repudiates it and tries to replace it. It is important to point out that this relationship with reality is by no means static, one-sided, or "objective":

the transformation of reality is carried out on the psychic precipitates of old relationships with it – that is, on the traces of memory, ideas and judgments that were previously derived from reality and through which reality was represented in the mind. This relationship, however, has never been a closed relationship; it was continuously enriched and changed by new perceptions (Freud, 1924/1996, p. 231).

The way the DSM-IV-TR and the current edition of the manual (DSM-V) define hallucination is based on the idea of a perceptual error, more specifically, by correlating the idea of adequacy of perception to reality, which would take place by the sensory organs. Soler (2007) says that the perceptual phenomena demand a meticulous effort, since

from there one can establish formulations of what is called objectivity.

The issue of perception was introduced in psychoanalysis from the experience of Freud on neurosis and its relationship with reality, specifically from neurosis under transfer: "the very subject of the unconscious, insofar as it comes into play during the transfer, introduces the problem of perception in psychoanalysis" (Soler, 2007, p. 25). In this perspective, Nasio (1997) points out that there is only hallucination in the relationship with the other, applying the issue of hallucination in the practical and theoretical scope of the transferential relationship.

From the Freudian assumptions, the reality in Lacan is almost always marked by the symbolic as a subjectification of the significant dimension (Vieira, 2003). Lacan (1958/1998) held a relevant criticism regarding the determination of hallucination as a disturbance of reality, reissued and proclaimed by the classification manuals. In On a question preliminary to any possible treatment of psychosis (1958/1998), the alleged unity of a *percipiens* is questioned.

In this text, the formulations that will accompany all Lacanian schools in relation to psychosis are systematized (except the reformulation of the pillar concepts that emerged from the so-called "second clinic"): the foreclosure of the Name of the Father in place of the Other, the failure of the paternal metaphor, and the absence of a phallic signification. Lacan performs a semantic analysis of the phenomena of psychosis, based on the subject's relationship with the signifier.

The review undertaken on the notion of the subject of perception (*percipiens*) and perceived object (*perceptum*) and its articulation in the classical proposition advocated by most theoretical positions concerning the perceptual phenomena is that hallucination would be a *perceptum* with no object:

We dare, in effect, to put in the same bag, so to speak, all positions on the matter, whether mechanistic or dynamic, either from the organism or the psyche, and the structure, of disintegration or conflict, yes, all of them, no matter how ingenious they are deemed, to the extent that, in the name of the manifest fact that a hallucination is a *perceptum* with no object, these positions are satisfied in asking the *percipiens* a justification of this *perceptum*, with no one realizing that, in this question, one moment is skipped: that of asking whether the *perceptum* itself leaves a univocal meaning in the *percipiens* here requested to explain it. (Lacan, 1958/1998, p. 538)

Lacan gathers all these theories on the basis of the same inability to explain hallucination. The consequence of this shared proposition that hallucination is the *perceptum* with no object is asking the subject of the perception to justify this *perceptum*, without asking if this *perceptum* produces a meaning on this subject.

To think about the phenomenon of hallucination, as Quinet (2004) explains, Lacan resumes the phenomenology in which there is no phenomenon without the subject of perception: “the *percipiens*, far from being external, takes part in the *perceptum*, the subject of perception being included in the perceived” (p. 36). Husserl posits that the subject of perception is not out of the world, out of the phenomenon. The author introduces the subject and his immanence in the very phenomenon: “every position of a ‘non-immanent being’, of a being not contained in the phenomenon . . . is placed out of the circuit, that is, suspended” (Husserl apud Quinet, 2004, p. 36).

Despite sharing the enunciation of Husserl regarding the very subject of perception being part of the phenomenon, Lacan deals with a subject that is divided and determined by language, contradicting the fact that the “phenomenology of perception is organized from the concept of a unified subject (the subject that perceives) and of a predecessor unity of the object” (Sanábio, 2010, para.29). Thus, in psychoanalysis, the phenomenon must be previously analyzed, as structured by the significant relations: “the *perceptum* has a structure of language, as it is dependent on the *percipiens* that inhabits a universe of structuring discourse of its reality and perceptions” (Quinet, 2004, p. 38).

Due to the structure of language that determines both the subject of perception and the perceived, the *percipiens* is divided and the *perceptum* is equivocal. Thus, the perceived is also structured by the symbolic and organized by the signifiers, those that lend themselves to the meaning assignment task of naming the data of perception. These proposals reinforce the theory that reality, far from being an objective datum and taken as evidence in accordance with the definitions in the DSM, is rather mediated by the symbolic, which means pointing out that the organization of the perceptive reality is from the order of the signifier:

Dubiety belongs to the signifier [...]. If the signifier organizes the *perceptum*, one cannot think of unity, on the contrary, the object can be inserted in several meanings. Moreover, what is at stake in the mediation between the *percipiens* and the *perceptum* is the relationship with the Other, which Lacan describes in the L-scheme. (Estevão, 2009, p. 148)

The L-scheme represents the alienating relationship, crossed by the imaginary, between the subject and the Other and the wall of language. Highlighting three signifiers from the Oedipus complex (the mother, the child, and the phallus), Lacan constructs an imaginary triangle that will be superimposed on the L-scheme, thus formalizing the R-scheme and the field of reality. In this scheme, “we can seize how the homological imprisonment of the meaning of the S subject under the signifier of the phallus can resonate in the support of the field of reality” (Lacan, 1958/1998, p. 559). From the R-scheme, Lacan wonders whether it would be possible to situate

the geometrical points of this schema in a schema of the structure of the subject at the end of the psychotic process, thus articulating the I-scheme:

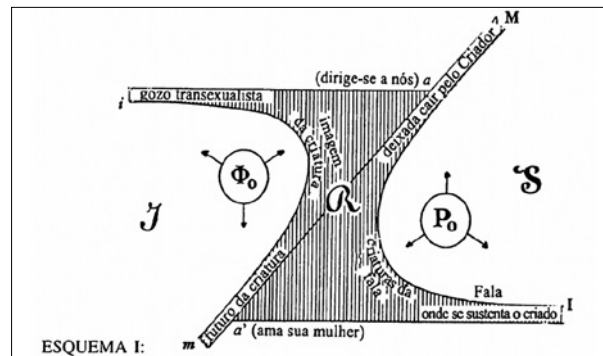


Figure 1. I-Scheme

Source: Lacan (1958/1998, p. 578)

Translation: (directed to us) – transsexual *jouissance* – future of the creature – image of the creature – (loves his wife) – creatures of the speech – dropped by the Creator – Speech – where what is created is sustained

Taking as reference Schreber and his “elegant solution”, the I-scheme is the topology used by Lacan related to the constitution of reality in psychosis, represented by a double absence in relation to the previously formulated scheme: the Name of the Father in the symbolic and the phallus in the imaginary. From what is presented in this schema, “it is possible to highlight the relationships by which the effects of the signifier induction, relapsing in the imaginary, determine this disorder of the subject that the clinic designates under the features of twilight of the world, demanding, to respond to it, new signifier effects” (Lacan, 1958/1998, p. 579). For the I-scheme, Lacan inscribes the importance of the “function of reality in this process, both in its causes and effects” (Lacan, 1958/1998, p. 580), synthesizing the subject’s relationship to the Other in the psychotic structure and revealing the effect of the Name of the Father’s foreclosure.

In this sense, there is nothing in hallucination in psychosis that would be out of the symbolic structure of language. This statement is illustrated by Lacan with analyses of the Schreber case that makes it possible to think of psychosis in terms of signifiers:

From this structure, the subject gives the following examples [Memoirs..., p. 176]: (1) Nun will ich mich... (now I’m going to...); (2) Sie sollen nämlich (You must in fact...); (3) Das will ich mir... (In this I want), so that we can stick to these, to which he has to respond with their significant supplement, which does not bring him any doubts, namely: (1) surrender to the fact that I am an idiot; (2) regarding you being expelled (key word) as a renegade of God and went to a voluptuous debauchery, not to mention the rest; (3) to think about it. (Lacan, 1958/1998, p. 546).

In this excerpt, Lacan illustrates, from Schreber's memoirs, the phenomena of message and code present in psychosis as effect of changes in the significant structuring and result of the "predominance of the signifier function in these two orders of phenomena" (Lacan, 1958/1998, p. 546). The phenomena of code refer to the neological phrases in which the "signifier itself is the object of communication" (Lacan, 1958/1998, p. 544), which shows the radical separation between signifier and signified. The message phenomena concerns the moment when the phrase is interrupted precisely at the point in which the meaning would emerge, revealing a significant chain breakage. To the phrases "Now I'm going to...", "You must in fact...", and "In this I want...", Schreber responds in an attempt to give them meaning: (1) "surrender to the fact that I am an idiot", (2) "be exposed as a renegade of God", (3) "to think about it". Thus, in the phenomena of psychosis, Lacan specifically searches, in the two orders of phenomena of code and message, to "represent the internal connections of the signifier to the extent that they structure the subject" (Lacan, 1958/1998, p. 547) and his reality.

Final considerations

In the classification manuals analyzed in this study, psychosis is referred to a conventional descriptive status as a strategy of denial from the etiological discussion. By favoring what they understand as signs of indisputable objectivity, the DSM is striving to circumvent any theoretical reflection (Álvarez, Esteban, & Sauvagnat, 2004).

The "sense of reality of a real perception, but with no external stimulation of the relevant sensory organ" (APA, 2004, p. 766) is the definition of hallucination created by the DSM as a criterion for classifying a psychotic disorder. This definition is more a reissue of a convenient

description that has been propagated throughout the history of psychopathology: hallucination is a perception with no object. In our view, another question arises in regards to this issue: what is the status of the reality used by the manual in defining hallucination as an error of perception? Could this not merely be a presumed reality, taken as evidence and, mainly, that is imposed as objectively given to the subject?

As the organization of the perceptive reality is mediated by the symbolic order and structured by the significant ambiguity, we are compelled to ensure that the relationship of perception with reality is not as naive or as natural as the definition proposed by the DSM.

By formalizing the dependence of the symbolic order both in structuring the subject (which is not a unifying *percipiens*) and in the field of perception, Lacan innovates this not only by refuting the classical definition of hallucination as a *perceptum* with no object, but also by crediting the place of language in this articulation:

The thesis, therefore, is this: the field of perception is an ordered field, but ordered according to the subject's relationship with language, and is not ordered by the cognitive apparatus or the perceptive look. The thesis is radical. It implies that language is not an instrument of the subject, but rather an operator, in the sense that it produces the subject itself. It is also completely new and extreme, because Lacan highlights the entire field of perception, and not only that of language and speech perception. (Soler, 2007, p. 34)

We agree with Soler (2007, p. 35) in emphasizing that we cannot forget that the relationship with reality in general, specifically perception, is under the incidence of the unconscious. This is the Freudian discovery of another reality, the psychic reality, which, for Lacan, is not anti-predicative and does not fall short of language.

Sobre alucinação e realidade: a psicose na CID-10, DSM-IV-TR e DSM-V e o contraponto psicanalítico

Resumo: A psicose é um dos poucos termos da psicopatologia clássica e da psicanálise que permanece nos sistemas classificatórios atuais, como o DSM (Manual Diagnóstico Estatístico de Transtornos Mentais) e a CID (Classificação Internacional de Doenças), o que nos dá condições para investigarmos as diversas maneiras de pensar o sofrimento psíquico. Desse modo, analisamos criticamente como o DSM-IV-TR, a sua atual edição (DSM-V) e a CID-10 definem e utilizam o termo "psicose". A apropriação desse conceito ampara-se em definição meramente descritiva como estratégia de recusa ao debate etiológico. A alucinação, um dos critérios para a classificação dos "transtornos psicóticos", é definida partindo-se de realismo ingênuo em que a realidade é tomada objetivamente como um dado. Assim, apresentamos o contraponto psicanalítico para essa apropriação: a psicanálise aponta para a relevância da estruturação simbólica dos fenômenos perceptivos e para a realidade como construção subjetiva.

Palavras-chave: psicanálise, psicose, alucinação, realidade, DSM.

À propos de l'hallucination et la réalité: la psychose dans la CID-10, DSM-IV-TR et DSM-V et la et le contrepoint psychanalytique

Résumé: La psychose est l'un des rares termes de psychopathologie et de la psychanalyse classique qui restent dans les systèmes de classification actuels, tels que le DSM (Manuel diagnostique et statistique des troubles mentaux) et la CID (Classification internationale des maladies), qui nous donne les conditions pour enquêter sur les différents façons de penser la détresse psychologique. Ainsi, nous verrons comment le DSM-IV-TR, son numéro actuel (DSM-V) et la CID-10 définissent et utilisent le terme psychose. L'appropriation de ce concept se prend comme une définition purement descriptive de refus de stratégie de débat étiologique. L'hallucination, l'un des critères pour la classification des «troubles psychotiques» est définie à partir d'un réalisme naïf où la réalité est prise comme une donnée objective. Ainsi, nous présentons le contrepoint psychanalytique de cette appropriation: les points psychanalyse à la pertinence de la structuration symbolique des phénomènes de perception et la réalité comme une construction subjective.

Mots-clés: psychanalyse, psychose, hallucination, realite, DSM.

Acerca de la alucinación y la realidad: la psicosis en la CID-10, DSM-IV-TR y DSM-V y el contrapunto psicoanalítico

Resumen: La psicosis es uno de los pocos términos de la psicopatología clásica y el psicoanálisis que permanecen en los sistemas de clasificación actuales, tales como el DSM (Manual Diagnóstico y Estadístico de los Trastornos Mentales) y la CID (Clasificación Internacional de Enfermedades), que nos da las condiciones para investigar las distintas formas de pensar sobre la angustia psicológica. Por lo tanto, se discute cómo el DSM-IV-TR, su edición actual (DSM-V) y el CID-10 definen y utilizan el término psicosis. La apropiación de este concepto mantiene a sí misma como una definición puramente descriptiva de la negativa a la estrategia de debate etiológico. La alucinación, uno de los criterios para la clasificación de los "trastornos psicóticos" se define empezando con un realismo ingenuo donde la realidad se toma como un hecho objetivamente. Por lo tanto, presentamos el contrapunto psicoanalítica a esa apropiación: puntos psicoanálisis a la relevancia de la estructuración simbólica de los fenómenos de percepción y la realidad como una construcción subjetiva.

Palabras clave: psicoanálisis, psicosis, alucinación, realidad, DSM.

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