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Review Article

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Psychosis: From the Classical Era to the Present

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ABSTRACT

This work explores the dialogue between various disciplines—philosophy, painting, psychoanalysis, and psychiatry—regarding the different ways in which psychosis has been interpreted across historical periods. The observational value in our praxis stems from a uniquely inferential mode, with privileged moments of insight that enable us to discern how structure evolves and undergoes its own modulation or transformation.

The classical era brought deviations, reformulations, comprehensive theories, and comparisons. This entire legacy was transformed with the arrival of the psychopharmaceutical. Thus, we are left to ask: What has become of the names of psychiatry? And what characterizes the post-classical era? Today's clinical practice finds itself embedded in a complex discussion that also impacts the training of future professionals.

Grounded in Foucault's analysis of the classical era, this study aims to examine the clinical insights that reveal how illness was conceptualized in a particular time, and how such insights still guide scientific approaches to pathology. Historical processes of recognition continue to offer vital suggestions for understanding and continuity. Therefore, painting, philosophy, and the work of numerous psychiatrists serve as avenues for exploring and studying psychosis. This work seeks to analyze the observations and relationships articulated by these thinkers

Keywords: Dialogue, Disciplines, ERA, Scientific Field

Psychosis: From the Classical Era to the Present

I will begin with a brief reference to Michel Foucault who, in the first volume of Madness and Civilization, identifies among the defining elements of the classical period the unsettling powers embedded in the visual arts—such as in the works of Hieronymus Bosch, the 15th-century Flemish painter. Everyone recalls his famous Ship of Fools, where men considered threatening to the community sail from shore to shore, eating, drinking, and singing. One can also observe The Extraction of the Stone of Madness, which illustrates how medicine, religion, and philosophy once suspected the existence of a literal stone in the human head—believed to be the source of madness and thus needing removal to restore reason. Similarly, The Garden of Earthly Delights, with its enigmatic brushstrokes, reflects an era that had already shed much of the violence of previous centuries [1].

No longer is madness confined to a ship—it is now enclosed within the hospital. Confinement has replaced embarkation. A century later, large asylums would be constructed, and it was within these walls that Pinel and 19th-century psychiatry would once again encounter the mad. It is evident that, during this time, the General Hospital was not a medical institution per se. It is unsurprising, then, that madness and criminality were not mutually exclusive, but rather implicated one another—whether through imprisonment or hospitalization.

For centuries, madness and passion remained closely intertwined. The most classical and straightforward definition of madness in that era was delusion: "This word derives from lira, a furrow; thus, delirium means to stray from the furrow, from the straight path of reason." It is only later that observational psychiatry would emerge, along with hospital-based internment and the dialogue between the mad and the physician—a dialogue

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that, from Pinel to Leuret, Charcot, and Freud, would adopt increasingly complex vocabularies [2].

Pinel maintained that the physician should not act based on classificatory diagnoses. His view can be extended to those moments in which reason and unreason were replaced by binaries such as truth and error, world and illusion, being and non-being, day and night—modes by which madness and its truth named themselves. Freud, in turn, re-situated madness at the level of language, effectively restoring the possibility of dialogue. From this perspective, the gaze becomes implicated in psychoanalysis as a field of study.

The Freudian field we wish to outline today is rooted in what was once called clinical observation: pure moments of inferential insight, which differ significantly from statistical aggregates or accumulated experiences across multiple cases. When Freud writes, for instance, "I observed five cases of women…," he was not conducting a statistical analysis nor quantifying his observations—he was offering a concrete, explicit reference. Just as Schreber is one single subject whose writings gave rise to a comprehensive understanding of paranoid psychosis, Freud did not require five, ten, or fifteen Schrebers. The value of observation lies in this specific inferential mode that characterizes our clinical praxis.

Distinguishing between obsessive psychosis and obsessive neurosis, or identifying how a subject's paranoid state may be nothing more than a crystallized trace of an obsessive fixation at a given moment—this is no small task. Clinical structure evolves, modulates, and transforms. The emergence of a psychotic episode in someone previously considered neurotic is discussed by Freud both in the case of the Rat Man and the Wolf Man. In the former, delusions concerning the captain—the "Raten"—and in the latter, hallucinations like the severed finger, serve as observable phenomena. Thus, the goal is no longer to diagnose illness, but to restore the domain of speech.

Paul Bercherie, in his book The Foundations of the Clinic, refers to Pinel as the one who first began to distinguish between symptomatic madness and idiopathic madness— terms that persisted throughout the 19th century in the works of Georget, Baillarger, Magnan, and ultimately Kraepelin [3]. Pinel, however, saw madness as a process of alienation, one that manifested as a form of the organism's reaction. Esquirol, who is often considered the founder of psychiatric clinical practice, further developed this view. His nosology advanced beyond that of his teacher Pinel, marking a divergence between psychiatry and neuropsychiatry.

Within the German school, Wilhelm Griesinger incorporated Pinel's legacy. The "psychist" school and the somatic school took distinct positions regarding mental illness, and the nosological approach eventually gave rise to new parameters through the development of syndromatology. Griesinger proposed a nosology grounded in the concept of evolving clinical forms, which enabled the isolation of chronic delusions. It was Gaëtan Gatian de Clérambault, with his theory of mental automatism and his clinical description of the syndrome, who came to dominate the French school of thought.

Clérambault demonstrated that hallucinatory psychosis could be decomposed into two components: a core of automatism and a superstructure of delusion. His theory was based on the apparent structure of syndromes.

In the classical period, there were deviations, reformulations, exhaustive studies, and theoretical comparisons. Yet all this would be profoundly transformed by one decisive development: the psychopharmaceutical. This raises an important question: What has become of the names of psychiatry?

Today, protagonism belongs to substitution—namely, the commercial names of pharmaceuticals. The foundational names of psychiatry have been eclipsed by the rise of psychotropic medication. The elegant teachings of Clérambault or Henri Ey have faded from prominence, and the traditional lexicon of psychiatry has been all but erased [4].

This prompts us to ask: What is happening in the post-classical era? Those onceuniversal treatises and psychiatric studies are no longer what they were. They have been compressed and reduced to procedural manuals. When practitioners fail to adhere to these, they are deemed to have violated the legal framework governing psychiatric intervention. These manuals now carry the force of law, and any acute psychiatric episode may be attributed to a failure to follow their directives.

Continuing this critical inquiry: What does the term spectrum mean? Etymologically, it denotes something spectral, elusive. Its scientific definition refers to a distribution of intensity across a given magnitude—an all-encompassing reach. Thus, we now speak, for example, of the bipolar spectrum. Even a simple depressive state might be absorbed into this so-called spectrum of bipolarity.

This raises another important question: Is every depressive person potentially bipolar? Clinical observation suggests otherwise: we encounter hysterical psychoses that are not bipolar, and we also find obsessive psychoses marked by a profound loss of contact with reality.

So, here we are—at a point of broad and ongoing debate, one that also affects the training of future psychologists and psychiatrists, as they prepare to work with the next iteration of diagnostic manuals.

In the analytic experience, the patient speaks—at length—about their symptom. They speak in the singular, for analysis begins with the formalization of the symptom, and they speak to lament it. Symptom and fantasy are two distinct dimensions: one of displeasure (the symptom) and one of enjoyment (the fantasy). This is how the clinic operates: the patient finds in their fantasy a form of relief from their symptom. The analytic experience does not unfold in a unified field. Symptom and fantasy occupy different spaces, yet interpretation in analysis fundamentally targets the symptom.

The fundamental fantasy is not subject to interpretation by the analyst; it is an object of construction. What we see in Descartes' Passions of the Soul are names for passion itself—what he calls the passions of the soul, the passions of the psyche. Jealousy,

shame, ecstasy, rage—even hate and love—are passions, and in their expression, they become symptoms.

As such, given the narrowness and brevity of our ideas, we must ask: How can we situate discourse in a way that allows us to read the clinic? Can we imagine an analytic approach that does not exclude the psychiatrist's gaze? Freud and Lacan are exemplary in this regard: both were psychiatrists who managed to free themselves from classificatory systems and focus instead on discourse, finding more intimate examples than pure mentalism.

In this endeavor, neuroscience and cognitivism offer useful tools. Yet the field of speech presupposes that one can speak with a mad person. We are beings of language, and illness may arise within language itself. One might say that psychosis is, in the broadest sense, a pathology of language—a pathology of thought, of comprehension, of perceptual order. These are oneiric productions, projected into the world, as Maurice Merleau-Ponty said: "I give perceptual testimony to what I see."

Thus, with the classical era behind us—which, as we saw, revolved around the social rejection of madness as explored by Foucault—we confront our present. Even today, madness remains the family's secret. The mad are institutionalized, often only brought to consultation years after an episode has occurred. The reality described in The Ship of Fools persists. As the saying goes: "E la nave va."

To conclude: the pretensions of psychoanalysis, particularly the Freudian model, have been significantly transformed by the schools that followed. And yet, psychoanalysis still offers infinite suggestions. From this vantage point, it remains possible to speak of a viable form of treatment within psychotherapeutic action—as Lacan indicated in relation to psychoses [5].

Objectives First Objective

To establish a dialogue between the various scientific interpretations of psychosis, from classical authors to the present day.

Second Objective

To analyze, through a theoretical and philosophical corpus—and through artworks that thematize psychosis—the interdisciplinary nature of these perspectives.

Third Objective

To explore the ways in which psychosis is addressed in the observational accounts of key authors.

Conclusion

Although psychoanalytic theories—especially the Freudian model—have been significantly reinterpreted by subsequent schools of thought, they continue to offer important insights into the treatment of psychosis, as Lacan emphasized. In this regard, psychoanalytic work remains an open field, receptive to expansion and engagement with contemporary clinical and theoretical contexts.

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