Kandinsky-Clérambault Syndrome: Narration and Psychosis

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Abstract

Interpretation by means of retelling a story is an ordinary event in human life. However, under abnormal circumstances, e.g. delusions of the narrator, this process is altered and even distorted to various degrees in both qualitative and quantitative aspects. In such cases, the assumption of misrepresentation of the actual story emerges as most striking as it is in contradiction with the objective reality. In the current paper, I will focus on the discourse features in the narratives of patients with the Kandinsky-Clérambault syndrome since it provides some of the best cases that serve to support the main focus of my search, i.e. establishing to what degree we can believe the subjective interpretative narratives of mentally ill patients. This perspective, on its own, has given rise to some doubts in psychiatry as objective science. Our hypothesis is that there are clear-cut features of delusion, which can be outlined by linguistic analysis irrespective of the cultural belonging of the patient and described following the method of the omnipotence of language as a tool of semiotics. For our purpose, additional aspects of the problem will be developed in detail, such as the semantic levels in narration in general and outlined concepts of schizophrenia and delusion transparent in discourse carried out in any language.

Keywords: Victor Kandinsky, Kandinsky-Clérambault syndrome, narration, philosophy of psychiatry, philosophy of science.

1. Introduction

Human beings are one of the living species on Earth. They are very similar genetically to the other species, but evolutionarily they are quite different, i.e. they have some unique abilities and characteristics that make the enormous distinction between them and the rest living species. The main and the most important of those characteristics are: (1) language usage, and (2) logical thought – represented by the understanding (Verstand or the capacity for simple judging) and the reason (Vernunft or the capacity for generalization and conclusion).

In order to survive during the day, the human being has to adapt to the constantly changing environment. Except for all animal modes of behavior and adaptation, human beings also use language capacity and logical thought. The first, those that we share with other animals, are characteristics to the natural (psychosomatic) survivor, the latter – to the social (psychosocial) survival.

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In psychiatry, diagnosing still remains subjective to a large degree, which questions its objective status as a science.

The Kandinsky-Clérambault syndrome (KCS) represents one of the most debilitating syndromes in psychiatry.

Analyzing the discourse features in the narratives of patients manifesting this syndrome can, in general, shed an additional light on the degree of truth reliability of the psychiatric patients’ subjective accounts.

Dr. med. Victor Kandinsky is a unique figure that combined both the roles of a patient with a manifested KCS and a medical doctor – a psychiatrist.

The analysis of the personal experience of Dr. med. Kandinsky reveals that KCS remains exclusively a subjective experience, which rises many methodological difficulties and doubts undermining the acceptance of psychiatry as an objective science.

However, it is necessary to mention that unique human abilities can sometimes err, especially under abnormal circumstances, e.g. during a mental illness period. One of the most famous and notorious errors that the Verstand and the Vernunft can make are the delusions (false beliefs based on false judgments) mostly founded on distortions in the representation-sensorial synthesis.

In the current paper, the main focuses will be on the concepts of delusional manifestations in schizophrenia, narration in psychiatric illnesses, the account of Dr. med. Victor Kandinsky and the concept of Kandinsky-Clérambault syndrome. We will also provide additional information on narration in general, on the conception of schizophrenia and also to what extent the narration has ecological validity in the mental illnesses.

Our main goal here is to develop in detail the narrative role of the self via the prism of the Kandinsky-Clérambault syndrome in the face of Kandinsky’s personal accounts of his delusions as a reliable source of subjective information on the topic.

2. Narration in general

We will now concentrate on the human linguo-logical idiosyncratic characteristics and, more specifically, on the derivative linguistic faculty of narration and its role in mental illnesses as such.

The phenomenon of narration implies, in an apodictic fashion, the co-occurrence and co-availability of interpretative processes. That is to say, that narration without a (linguistic, but not perceptual) interpretation, and vice versa, is impossible. Narration is realizable only via the linguistic apparatus, but the latter’s main function is, above all, an interpretative process; therefore, narration cannot be separated from it; it is some of the functions of language.

Narration consists of transformed (i.e. interpreted) internal and/or external perceptual material and hence it is observable and conceivable only in a particular form and shapes via the so-called linguistic interpreting process of the self and, subsequently, it could be shared and communicated to others. It is worth to mention that narration (as a part of the interpretative process) is playing the role of a limiting valve – it reduces (transforms, interprets) the real personal experience deriving from the so-called internal picture of the subjective experience to a formulated, fabricated and shaped generalized communicable entity, paying the price of some, in some cases even extreme, informational loss and also an addition of some noise.
3. Role of narration in psychiatry

After this brief introduction to language, narration and interpretation, we could directly jump to their implications and applications in mental illness. Narration plays a key role in mental illnesses. It is interrelated to the whole range from the abstract scientific terminology, to the mere pragmatics – the conversation between the patient and the physician, on the one hand, the inner self-conversation of the patient himself, on the other. It also is included in the so-called being-in-the-world or phenomenology of everyday life as the narrative interpretation that constitutes the self of the human being; here, the interpretation is regarded as representing the internal and external linguistically formulated descriptions of oneself.

The topic of the self is more than contradictory, but we believe that the self is a formation based on the personal autobiographical experience (linguistic and perceptual interpretation), linguistic self-interpretation and external interpretations of the other human beings. However, some authors, e.g. the Bulgarian psychiatrist Timen Timev, are in a different position – there is no self at all; the self is a stolen concept from others – “in order to reflect himself the individual is forced to take the place of the instance of the other psyches that he ontogenetically bears in himself and the name, from which he addresses himself to call it Self, is their name” (Timev, 1992: 333; my translation). Timev argues for a multiple self and the omnipotence of the psyche and the brain so that everyone is virtually a multitude of selves.

Narration in mental illnesses could play multiple roles, such as a simple act of inner and creative energetic transformation from one perceptual or psychological ontological state to another, which could be further externalized into an eventual communication; a communicative message to oneself and to others; an utterance, a judgment, a ratiocination or other linguistically represented experience. If we consider human life as a constant and never-ending interpretative process, then narration accompanies us during our whole conscious life.

In respect to the mental illnesses, there are narrations from both sides – from the physician’s point of view and from the patient’s point of view. We could say that the first narrations are structured in complex abstract formations, whereas the second – they are more “down-to-earth”, i.e. described by simpler words and structures, but both are generalizations, hence reductions (everything put in words automatically and apodictically limits the uniqueness, i.e. denies some part of the initial perception or state – *Omnis determinatio est negatio* – “the grand dictum of Spinoza” (Macherey & Ruddick, 2011: 7)). However, there are some unusual cases that involve a mixture between the two types – cases where the physician’s and the patient’s narrations are superimposed, integrated and interrelated one another, i.e. the narrator plays both roles of a patient and a physician. Our case here belongs to the last type – the mixed one, which we find and classify as the most intriguing one.

4. Schizophrenia, psychosis and delusion

Now we will give a brief outline of the nosological psychiatric concept of schizophrenia and more specifically of the concept of delusion as they are exposed by Piseva et al. (2005), Temkov and Kirov (1976) and Ivanov (1981). Schizophrenia is considered as an etalon of the psychotic phenomena; thus, not all schizophrenic psychoses are labeled as schizophrenia-form (or schizophrenia-like). It is necessary to mention that it is needed a distinction between the psychotic episode and the schizophrenia has to be made. Schizophrenia or schizotaxis (a pathological genetic predisposition) (Haralanov, Shkodrova & Haralanova, 2005) can be defined as severe cerebral atrophy (initially the coined term for it was dementia praecox (premature dementia), usually accompanied by psychotic phenomena and manifestations. Thus, as in the case of its simple form, schizophrenia can exist without a psychotic state/mood and it is not plausible to say that there is
any strong kind of conceptual similarity between them; they are both terms that refer to completely different nosological psychiatric units.

As such, schizophrenia virtually affects all processes in the organism and leads to various pathophysiological and psychopathological states. Unfortunately, nothing is left completely unaffected. However, some authors (e.g. the Bulgarian psychiatrist Prof. Dr. med. Svetlozar Haralanov) also do consider the possibility of mutual non-antagonistic existence of a psychotic picture and fully preserved intellectual and cognitive capacities – our case can be even classified into this category. There can be observed alternations and disorders to various different degrees in the architecture and functionality of psychomotor, somatosensory, cognitive, perceptual, conscious, linguistic, volitional and reasoning apparatuses. When we consider that most of those phenomena are expressed in extreme qualities and quantities, we come to a profoundly disturbing and sad picture of the illness, very similar to that of global dementia; suicidal ideations and tendencies are frequent. De facto schizophrenia could also be described as psychotic dementia, except for the pure and simple form, in which the psychotic features are non-dominant and often completely missing. The cerebral atrophy is more specific to it than the psychotic state, which is only an addition, but not an indispensable one.

However, there is another pole of the illness – the mind-blowing idiosyncratic psychotic (in some cases even eidetic) experience. Today, according to neuropsychiatry (the biomedical model in medicine; see D’Haenen, den Boer & Willner, 2002), organic alternations in various brain areas (centers) represent the physical and physiological substrate, basis and cause of the psychotic phenomena, which on their own could furthermore additionally influence the impairment and atrophy of different cerebral loci. There are two main bio-psychiatric hypotheses about the neural correlates of psychosis, namely the dopamine-hypothesis and the glutamate-hypothesis of schizophrenia, but various other important neurotransmitters (serotonin, norepinephrine, acetylcholine, GABA, endorphins) and their brain pathways are also suspected to be involved.

As finalization of the analysis of the concept of schizophrenia, we wish to refer to one more idiosyncratic and authentic conception of psychosis (in order to show that there are different points of view, hence different interpretations, about the psychotic experience among the clinicians themselves) offered by the Bulgarian psychiatrist Timen Timev, who considers the psychotic episode as compulsive self-cognition, compulsive gift and negative significance: “Psychosis as opposition against the power of the human and the power of knowledge over the soul and as a reduction of these two powers. Psychosis as the fear of reason from the unreason, the fear of logic from the illogical, the fear of human from the inhuman, the fear of the planetary from the cosmic, the fear of the social from the individual, the fear of the social from the natural, the fear of prose from poetry. Psychosis as an indispensable distance, which separates one from another the paradigms, as a compulsive abyss of the unknown, which accompanies the alternation of one paradigm with another, of one self with another, and of one world with another” (Timev, 1992: 331; my translation). Timev regards the psychotic experience not negatively as most of the clinicians do, but, on the contrary, positively. He focuses on the fact that this most unpleasant experience actually is for the good of the individual and is caused by some major alternations and transformations of the multiple psyche and the “self”.

He further supports the idea that psychosis and creativity are somehow similar and that art as a whole could be used in the curing process of this mental disorder where narration as interpretation and self-expression takes one of leading roles – the individual should focus on something external to him in order to escape the dead circle of the psychotic chains. Delusion and delusional mood are some of the most interesting phenomena of mental illness as a whole. During our everyday perceptual and linguistic interpretation of the world, we understand the world, i.e. we make judgments about it. But as we mentioned already in the
introductory part – we could make false judgments. They sometimes can constitute what is called delusions (delusional judgments and beliefs). Delusion represents “a morbid disorder of the thought process […] in result of which emerges such a wrong logical reflection of reality that is in rough contradiction with it and is not subjected in any way to correction by a rational, nor a suggestive way” (Ivanov, 1981: 7; my translation).

It is far easier to notice that something is wrong during the observations of the patient than to find out the specific pathology and its causes. It is even harder to try to solve the puzzle by influencing these causal processes in a direction that aims at improving the current (and future) condition and complaints of the patient.

False beliefs leading to false judgments (and vice versa) are the main constituents of delusion. Delusion is defined as a particular state when someone has the firm hypothetical belief(s) that something exists or just is in a given way but not in another, but a way that is in conflict with the objective reality, i.e. the patient’s interpretation of the reality is based on false premises; therefore, it is said that from an objective point of view the whole belief is false. It is widely accepted that the delusional beliefs cannot be influenced or changed by any logical means – the patient’s conviction is so strong and so invulnerable and, additionally, it is often loaded with a large to extreme emotional charge. Although they are regarded as false (i.e. in severe contradiction with the objective reality), sometimes the false beliefs constituting delusion can be very picturesque and saturated with a richness of details, connections and relations (Ivanov, 1981).

There are many different types of delusions, such as grandomania (delusion of grandeur), delusions of influence and delusions of reference. Of importance for us are the delusions of influence that are part of the Schneider’s first-rank symptoms of schizophrenia that are incorporated into and constitute the so-called syndrome of psychic (or mental) automatism or the Kandinsky-Clérambault syndrome.

Evaluating a given mental state requires the knowledge of the normal functioning of mind and, on this basis, the physician makes a multilevel judgment, a multi-modal interpretation, about the extent of normality or abnormality of the mental state of the individual. Thus, the medical doctor plays the role of a judge who determines what subjective experiences and objectively observable behavior of the person, as an eventual patient, will be considered as normal or as alternations from the norm, basing his assumptions on the psychiatric and neurological data.

Berrios and Markova address the problem of the role language in describing mental and brain states and their different epistemic value: “crudely, language of mind is not equivalent to the language of the brain, and this carries implications for the hermeneutics of data” (Berrios & Markova, 2002: 6). They argue that the language of mind is used to describe psychological states and events (e.g. moods), the language of brain – cerebral ones (e.g. cerebral atrophy).

5. Dr. med. Victor Kandinsky

“Also as in our own time, psychiatrists then were vulnerable as they are today to mental disorders. Of the tragedies associated with mental illness, few are more ironic than the madness of a psychiatrist” (Agin, 2009) – a little bit harsh statement, but very close to the actual facts indeed.

Victor Khrisanfovich Kandinsky (1849-1889), an uncle of the famous artist Vassily Kandinsky, was born in Siberia into a family of successful businessmen, and later became one of the most famous and important figures in the Russian psychiatry by introducing the nosological entity of the syndrome of psychic automatism3 (Lerner, Margolin & Witztum, 2012). Kandinsky’s curriculum vitae is much more than just interesting, it is an unique example proving two hypotheses at the same time: (1) we do not know everything and even the best are not invulnerable
to errors and misperceptions, and (2) the psychotic madness can exist simultaneously with fully intact intellect, i.e. logical reasoning capacity, together with disordered cognition and perception.

Kandinsky is famous for his detailed description of his own subjective personal experiences during his psychotic states and his illness as a whole that he used as construction blocks for working out the concept of psychic automatism or KCS. It is known that he had some relatives affected by paranoid schizophrenia. He was a calm, conscientious and hard-working young man. He graduated from Moscow University Medical School in 1872 and started to work as a general physician in one of the hospitals in Moscow.

Kandinsky was not only interested in practicing medicine, but also in the theoretical speculations and abstract research. He published many journal papers in different languages (German, French and Russian) on various medical subjects; he was a prolific author: “for example, from 1874 to 1876 he published 31 papers on different topics including original contributions and literature reviews (there were three papers in psychiatry)” (Lerner & Witztum, 2003: 105). He elaborated a “system with 16 diagnostic categories of the mental illness in the domain of psychiatric classifications that was remarkably sophisticated for his time” (Lerner, Kaptsan & Witztum, 2003; Rokhlin, 1975). It seemed at that time that the young Kandinsky had marvelous perspectives in his hands. As a general principle, Kandinsky was arguing against “a general and undifferentiated approach, suggesting that every case should be examined individually according to the specific diagnosis and the person’s clinical state” (Lerner, Kaptsan & Witztum, 2003).

However, fate had different plans for him – in May 1877, he became ill (psychotic) and was sent to a psychiatric hospital as a patient where he spent 11 months; there was a suicide attempt as well (Lerner & Witztum, 2003: 106). During his stay at the hospital, he fell in love with one of the nurses and, after his recovery, they got married. Then, he started to work as a psychiatrist in St. Petersburg, at which position he remained for eight years until his suicide in 1889. To be noted and with reference to his lifetime mental condition, “Kandinsky also had depressive episodes without need for hospitalization [...] In transitional periods between illness and recovery, Kandinsky usually suffered from suicidal ideation” (Lerner & Witztum, 2003: 106). He committed suicide by taking a lethal overdose of morphine or opium. He continued to write as the effects of the drug become dominant and wrote his last words describing his condition: “I am not able to write anymore because I cannot see. Light! Light! Light!” (Agin, 2009). His wife arranged the publication of his scientific papers and two books then she commits suicide too. “At the time of his premature tragic death in 1889, he was still at the peak of his productivity” (Lerner & Witztum, 2003: 108).

Kandinsky’s physician diagnosed him as having melancholia, but his own diagnosis was Primäre Verrückheit or primary insanity, i.e. insanity not secondary to organic cause (Lerner, Kaptsan & Witztum, 2003) plus “paranoid hallucinatory-descriptive labels without biological content” (Agin, 2009) or simply a schizophrenia-like state; some authors even consider his illness as schizoaffective psychotic disorder (Ibid.). He published in German in 1885 a book on pseudohallucinations. KCS or the syndrome of mental automatism is described in a monograph in Russian published posthumously in 1890 by his wife, which is based largely on his own self-observations.

“To my sadness, during two years I suffered from insane hallucinations [...] I felt various abundant hallucinations in all my senses except taste. The most frequent and vivid were visual, tactile, and common sensibility hallucinations” (Ibid.; see Lerner & Witztum, 2003: 106). However, he also reported that “in the first moths of my malady there were no hallucinations. This period was generally characterized by intense but chaotic intellectual activity [...] a lot of ideas that ran speeding but not in the right course, experienced as forced and false” (Ibid.; see Lerner & Witztum, 2003: 106).
The KCS is defined by Kandinsky himself with the following features (Ibid.; see Lavretsky, 1998: 545): imagined telepathy, reading and broadcasting of thoughts, enforced speaking, and enforced motor movements, disturbances in visual, auditory, olfactory and tactile perceptions, variations of mood from mania to depression, with depression predominant and often including thoughts of suicide. It also involves: alienation from or loss of one’s own mental processes (cognitive, sensory and motor), which are attributed to somebody else, combined with delusions of physical or mental influences, such as stealing or insertion of thoughts.

Kandinsky describes the phenomenon also as “subjective perceptions which in vividness and character resemble real hallucinations except that they do not have objective reality [...] my hallucinations are not just images generated by my imagination or memory, but sensory full and involuntary, and in addition to their vividness and involuntariness, they are “forced” in character” (quoted in Berrios, 1996: 56).

Gaëtan Gatian de Clérambault himself gave a little bit more sophisticated systematic definition of what he called “mental automatism” (Lerner, Kaptsan, & Witztum, 2001); he divided the automatisms in three subtypes that can occur separately in time or simultaneously as a “triple automatism”:

1. **Associative type (ideatoric or ideoverbal)** – disturbances in the form of thought, e.g. loosening of associations, derailment, blocking and flight of ideas, disturbances in the content of thought, e.g. delusions of influence on one’s own mental processes (e.g. thought broadcasting).
2. **Sensory type (senestopathic)** – unpleasant feelings in the internal organs thought to be caused by somebody else plus delusions of physical influence.
3. **Motor type (kinesthetic)** – delusional belief that somebody else performs one’s own movement and actions.

Clérambault introduced another syndrome known as Clérambault’s syndrome or erotomania that has to be distinguished from the KCS. Unlike erotomania, KCS is largely unknown in English-speaking countries, although it shares many similarities with some of the first-rang symptoms of schizophrenia of Schneider (Temkov & Kirov, 1976: 213). Some other conceptions have similarities with KCS such as the Gruhle’s term paralysis of the ego – discontinuation in the psychic life caused by a cessation in the flow of a sense of consciousness – “loss of mastering over the interior environment leading to the loss of a sentiment of one’s own activity and of the feeling of autonomy” and “thought or acts that happen spontaneously, independent of the will and which on occasions may even escape conscious registration” (Arboleda-Florez, 2002: 569).

Today we have a more detailed definition of the KCS. The appearance of the syndrome is accompanied usually by intense inquietude, feeling of inner tension, anxiety, fear, sometimes confusion and lack of clarity, also feelings of depersonalization and deregulation could occur. Some authors argue that “there is no automatism without amnesia” (Ibid.: 572), but this is not consistent with our data, because the person preserves his subjective observational capacity while loses his feeling of agency. Some of the most frequent symptoms are: feeling of uncovering, feeling of abduction and reading of thoughts, experiences of broadcasting and “implanting” of foreign thoughts into the head of the patient, feelings of hypnotic suggestion, senestopathic images. Distinct motor mechanisms are rare; more usual are the feeling of being possessed, experiencing movements like an automat, a robot, et cetera. There are some more complex influences that can be encountered such as controlling of the sleep, implanting and depriving of power, taking away of the sexual potency, magical influence, influencing by the action of electromagnetic waves, electrical current, rays, apparatuses, et cetera (Ivanov, 1981).

In some cases, delusions of being possessed have somehow modernized contents (Ivanov, 1981): the assumption of being controlled by a complex system of apparatuses by an artificial satellite on the Earth, the assumption that the brain of the patient is an aperture card on
which the others take in some information, the assumption that the verbal influence is being conducted via radio transmission and the receiver is installed in the gold replacement of one of the patient’s teeth.

6. Subjectivity in mental illness diagnosis assessment: The role of the narrative

After having considered in details the concept of schizophrenia, and delusion in particular, the account of Victor Kandinsky and the Kandinsky-Clérambault syndrome, we can approach now the essence of our main goal – what are the advantages and the disadvantages of the mental illness narration, i.e. what is the importance of those narrations at all.

It is indispensable to mention that the very language of neurobiology is soaked in fundamental claims or, more precisely, theories, hypotheses and principles that, however, have been not all validated. Constructing a good and accurate diagnosis is a complex process.

We will consider both patient’s (as viewed from clinician’s perspective) and clinician’s point of view. First, the subjective complaints (interpretations of some sort of perceived dysfunction or change in the physical and/or psychic functioning) of the patient have to be taken into consideration and analyzed.

Even at this first step, we encounter one serious problem – it is possible to assume that the “same” internal state will result in its equivalent interpretation and equivalent description by different individuals? Probably this is so not completely, but only to some extent. Then, how could we know that the internal state, as described by the individual, is de facto the particular experienced state that is matched by the description, i.e. does the description match the experience accurately (assumption of validity)? Having in mind that people differ much in their education, value systems, worldviews, personal experiences, also in the capacity to describe and discriminate between different states, i.e. the sensitivity to changes in the internal states, et cetera, we could conclude that the changes in the internal states are going to be interpreted in different ways by different individuals and that this interpretation will be affected by various factors: “there will be a marked degree of formatting going on (noise from various sources) which will change and distort the original signal to variable extents” (Berrios & Markova, 2002: 10).

An important role also plays the language itself and the linguistic categories available to the individual for creating more or less adequate interpretation (description) of his complaints and his situation. It is interesting that we cannot say that interpretations themselves can be true or false, exact or apodictic; they can only be “fair, imaginative, beautiful, audacious, speculative or silly” (Ibid.: 20). For the complex symptom judgments the distortions will be greater, hence “the epistemological [epistemic – capacity to gain, construct, generate knowledge] justification for subjective data in terms of their validity and reliability remains poor” (Ibid.: 10).

The second step is the clinician’s interpretation of the speech and the behavior manifested by the individual. The clinician is in a better position: he relies on the clinical knowledge (the agreement on specific diagnostic categories between the clinicians themselves; however, “current groupings are determined by more arbitrary factors with face validity based on consensus of opinions, but not information concerning the disease states themselves” (Ibid.: 11)) that is more or less closer to the objective state of affairs in the world; thus, the determination of the phenomena is better in quality and therefore the chance of distortion is slighter, but still present. At the moment, the features are chosen in terms of criteria that are easy to measure, of availability, saliency, et cetera, but not in terms of their conceptual representations. However, here we see that, in general, the epistemological validity is also weak. Also, little is known about the structure of the concepts of mental disorder, disease, illness, malady, sickness.
Now we could conclude that, in principle, the psychiatric data (both from patient and clinician) is marked by weak epistemological support and, therefore, a poor epistemic validity. However, it seems that “there is little choice for the social collective but to accept and internalize as certain a worldview that has been choses for it” (Ibid.: 11), i.e. that patients’ complaints, interpretations and descriptions are neglected, because they are based usually on false premises. On the other hand, the clinician’s situation looks better, but here are still some controversies – some of the premises are based on consensuses.

Our current case is concerned with the personal narration of the psychotic experiences by the patient and its epistemological validity. We have seen that patients’ descriptions and interpretations are not a reliable source of information due to the above-mentioned big chance for distortion by different causes. However, our case is a little bit particular, because the roles of the patient and the clinician are played by one and the same individual, namely Dr. med. Victor Kandinsky: “a subjective description of such an internal experience by an expert psychiatrist may be particularly illuminating as to the nature of madness [...] much of his research in psychopathology was based upon his own experience, and his writings are significant sources in assessing his psychiatric condition [...] Kandinsky was an interesting patient, and he himself described his clinical picture with great detail, both in the acute phase and throughout his whole life” (Lerner & Witztum, 2003: 104).

As we have mentioned already, there could exist strange cases where the intellect is almost intact in contrast to the manifestations of psychosis. The case of Kandinsky seems to be such. This is the major reason (together with the fact that he was a medical doctor) why the theoretical writings of Kandinsky are more detailed, with greater quality and greater epistemic validity in comparison with the interpretations and descriptions of the psychotic phenomena by the “ordinary” patients.

So, on the one hand, we have the internal states indicating some dysfunction or disorder in the physical or psychological domains. On the other, there are different individuals possessing different means of making different interpretations of the symptoms that, on their own, seem to be almost identical to all patients with small variations (clinician’s perspective), i.e. after removing the interpretations of the different individuals and their different means for that it remains clear that for the purpose of the easiness of giving the appropriate diagnosis, the clinician reduces all individual subjective states and their descriptions to categories that are universal.

However, in the case of psychosis, there are some important points that affect the capacity of interpreting the internal experiences of oneself. It is widely accepted that there is a disruption in the sense of the self and alternations in self-experience in the psychotic patients, some authors even speak of a “collapse of the ability to maintain ongoing dialogue within the self” (Lysaker & Lysaker, 2002: 207). There are observable disorders in the linguistic apparatus, i.e. the psychotics have troubles with following logical rules and meaning attribution and understanding. Thus, the patient preserves his capacities of an observer of his subjective phenomenal flow, but there is a marked confusion in determining and attributing the sense of agency to those phenomena, hence the possibility to consider some internal experience as alien to oneself, i.e. caused or imposed externally, thus involuntary and foreign. All this, according to J. Frosh (1983), is described as “the underlying danger the psychotic defends himself against is psychic and emotional death. It is this threat to survival that leads to their desperate means of creating an illogical reality” (quoted in Lysaker & Lysaker, 2002: 208).
7. Conclusion

It seems that the psychotic has severe disadvantages in conducting an adequate interpretation of the reality, which presupposes that his descriptions will be of little to no value due to his negative and positive psychotic symptoms. However, as we saw, there could be particular cases where the intellectual capacities are preserved, but the psychotic phenomena are full-blown. Then, for the individual, there is no other possible alternative than to just say that some of his experiences are alien to him. Intellectual capacities are essential for the interpretation itself, but it seems that what is more disturbing to the sound reason are the psychotic phenomena themselves and their paradoxes.

So, it seems that logic does not help much here – even if the patient knows that what he experiences is false and unreal, his personal beliefs and convictions seem to dominate. Even if we have the best and detailed interpretation of the psychotic phenomena, we must acknowledge that, after all, the real causes remain unknown and the descriptions and the interpretations remain nothing more than what they actually are – descriptions and interpretations. We should look for some more objective methods in finding the real causes, but not to disregard and neglect the mental illness narrations – they are indispensable and rich source of information.

Our conclusion, advanced in the previous two paragraphs, and augmented with the account of Dr. med. Victor Kandinsky and the symptoms of the syndrome he has developed, gives rise to many discussion points. On the one hand, it seems more than plausible a psychiatrist is in a better position to describe his psychotic states than the “normal” mentally ill patient with poor education and average intellectual skills. On the other hand, even taking into consideration this fact, the problem goes even further – it questions the whole psychiatry as an objective science – because of the criteria used in the diagnosis assessment of mental illnesses.

The account of Kandinsky is a good example providing insight into the triad patient-illness-interpretation. The important conclusion from our analysis is that the interpretation of the patient himself on his mental illness depends on many factors so that different people will give different accounts and descriptions to their psychic states. The latter, however, can be classified into categories such as symptoms and syndromes. However, the context should not be neglected, but on the contrary – it plays a more than an important role for the giving of a psychiatric diagnosis. In the end, as we already mentioned, psychiatry should seek more objective measurements and assessments of mental illnesses such as brain scans and blood tests measuring neurotransmitter levels that can be applied to all patients not only for the purposes of scientific research.

“We like to think we know so much, but we really do not know much at all. We remain children in the garden of knowledge. One hundred and twenty years after the death of Dr. med. Victor Kandinsky, mental illness still confounds us, a continuing and devastating plague. We are not alone in history” (Agin, 2009). “We believe that Kandinsky’s life and work exemplifies a fine model of coping with a debilitating mental disorder. For this, alongside his clinical and scientific contributions, he deserves to be remembered in the history of psychiatry” (Lerner & Witztum, 2003: 110).

Endnotes

1 The statement is derived from private communication with the author (2014).
2 The statement is derived from private communication with the author (2012).
3 Known and used in Europe as Kandinsky-Clérambault Syndrome (KCS).
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