

English translation of **Freud's "Aphasie"**, an entry from the *A. Villaret Handwörterbuch der gesamten Medizin* {1888}

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Section Seven, pages 31-37 from

A Moment of Transition, Two Neuroscientific Articles by Sigmund Freud; Karnac Books, London, New York, 1990.

To historically situate this article, see the following (it is Freud's first article on aphasia):

1888 *Aphasie*, in Villaret, Albert: Handwörterbuch der gesamten Medizin, Bd. I, Stuttgart, 1888, S. 88-90. (This article)

1891 Zur Auffassung der Aphasien, Leipzig und Wien, Franz Deuticke, 1891.

1893-94 *Aphasie*, in Bum, Anton and Moritz T. Schnirer: Diagnostische Lexikon für praktische Ärzte, Bd. I, Wien und Leipzig, 1893. see <http://www.lacan.com/aphasiaf.htm>

Aphasia {ἀ priv[ative]-φάσις speech (φήμι) } (Fr. *aphasie f*; Engl. *Aphasia, Aphasy*; It. *afasia f, alalia f*); synonyms: *aphemia alalia*—word deafness, word blindness—agraphia. By [the term] aphasia, one understands the abolition or impairment of the ability to express one's thoughts through conventional signs, or to understand such signs, despite the continuance of a sufficient degree of intelligence and despite the integrity of the peripheral sensory, nervous, and muscular apparatuses that are involved in the expression or comprehension of speech. Deaf-mutism, the speechlessness of idiots, the loss of speech in coma as well through paralysis of the tongue and lips, therefore, do not fall under the concept of a[phasia]. A[phasia] is a psychical illness, but it must firmly grasped that it is not necessarily linked with intellectual disturbance; the latter is to be taken as a complication every time. One distinguishes between natural or emotional speech (gestural speech) and artificial or articulate speech, of which the latter succumbs to disturbances more frequently because it is acquired later—The manifold disturbances of articulate speech (true a[phasia] as opposed to *amimia*¹ only become comprehensible if one appreciates the following reflection on the normal course of speech. A 'word' is not a simple idea, but a complex that consists of four elements, two sensory and two motor.² The two sensory [elements] are: the mnemonic image for the heard word (the auditory presentation) and the optical image for the seen word (in script or print). The two motor [elements] are: the movement presentation (of the speech instruments) for the spoken [word] and the movement presentation (of the right hand) for the written word. The second and fourth of these components only play a role in the educated. Speech is learned by way of hearing. Besides this, the connections that link the four elements of the word representation with the idea of the object must be taken into consideration.—Accordingly, there are two principal types of a[phasia], motor and sensory, and four pure forms, namely, *word deafness, word blindness, motor a[phasia] (aphemia)*, and *agraphia*. These pure forms are encountered now and then in the clinic, but complex speech disturbances in which all four aspects of the speech function have suffered to

varying degrees are much more frequent.—The part of the brain in which the material of speech presentations is connected, and where disease therefore leads to speech disturbance, is the island of Reil, with its surrounding convolution, which stretches from the frontal to the temporal ends of the hemisphere as the first frontal convolution, base of the central convolutions, inferior parietal lobule, and first temporal convolution. The speech field is therefore partially situated in the depths, and partially in the borders of the Sylvian fissure.³ It is not developed in both hemispheres, however; in most (right handed) people it is the left, and in others (left handers) it is the right hemisphere, which contains the speech field. There are individual areas in the speech field of the left hemisphere, the injury of which produces a pure form of aphasia. These carry the— incidentally misleading—name of centres. Their precise circumspection is impossible at present. Thus the ‘centre’ for motor speech capability lies in the posterior part of the first frontal convolution (Broca’s area), the centre for writing capability in the posterior part of the second frontal convolution;⁴ the cortical region upon the integrity of which the understanding of heard speech depends is the first temporal convolution, and the corresponding cortical region for read speech signs is the inferior parietal lobule. Remarkably, these ‘centres’ for speech are the most outlying districts of the speech field and border directly on the centres of other functions (the tongue and lips, the arm, hearing and sight in general) whereas lesions lying between the centres of the speech field still seem to produce complex speech disturbances. The so-called centres for speech are therefore probably merely the radiation areas of association bundles that reach the speech field from other regions.⁵—The four pure forms of a[phasia] [present clinically in the following fashion:

I. *The sensory a[phasia]s*

- (a) *Word deafness*. The patients no longer understand what one says to them, despite the preservation of hearing and good intelligence. To them speech sounds like a confused noise, though the vocabulary that the patients make use of themselves is unrestricted. With word deafness, however, one does nearly always find motor speech disturbance, so-called paraphasia, which consists in the patient’s use of inappropriate words for expressing his thoughts without realizing it. This paraphasia can go so far that the patient’s speech becomes entirely senseless and that patients are perceived as mentally disturbed.
- (b) *Word blindness* ([or] preferably writing blindness). The patients are not able to recognize the meaning of written or printed speech signs that they see very well; otherwise they have good speech ability. Therefore they cannot read (alexia) or they read with the help of a trick whereby they trace single seen, but unrecognized letters.⁶ This ‘blindness’ sometimes applies only to syllables, while single letters are still recognized; at other times (it applies) to letters as well. Here it is not rare that numbers are still recognized. Word blindness is nearly always complicated by unilateral restriction of the visual field (hemianopsia).

II *The motor a[phasia]s*

(a) Actual motor aphasia (aphemia). This is by far the most common speech disturbance and is mostly encountered in (its) pure form. It is characterized by abolition or diminution of the vocabulary. In extreme cases the patient only has gestures, in others only individual syllables or words or even entire phrases, with which he answers everything.. He is, however, very well aware of the insufficient character of these expressions and is visibly hurt by his inability to say more than his remaining stereotypical phrases. The speech remnants of the a[phasi]c frequently have the character of an interjection—‘Yes’, ‘No’—or they consist of individual syllables, ‘tan-tan’, ⁷and senseless combinations of these, like ‘akoko’, ‘monomentive’, eventually [combined] into entire, simple constructed sentences. All this speech is correctly articulated, which strictly distinguishes a[phasia] from paralysis of the speech instruments (alalia). If the reduction of the vocabulary is not severe, it mainly affects nouns and expresses itself insofar as the patient tries to transcribe them by indicating the actions. So, e.g., instead of ‘Give me my hat’, he says, ‘Give me that which one puts on the—’. The speech capability of an a[phasi]c fluctuates with his general condition, however, and under the influence of excitement he can frequently experience a sudden deterioration. It is to be noted further that many a[phasi]cs who are unable to articulate a specific word themselves, i.e. through their own train of thought, can repeat it if it is said to the first. This depends upon which of the manifold association pathways for speech are destroyed or preserved and finds its analogy in other forms of speech disturbance.—Motor a[phasia] frequently, but not necessarily, coexists with paralysis of the right-sided extremities or with paralysis of the cerebral pathways that govern the tongue, lips, laryngeal, and pharyngeal muscles. It is common to find motor a[phasia] in the first days after a left-sided apoplectic insult [and] for as long as the entire hemisphere continues to suffer under the consequences of the insult. Usually the speech disturbance soon diminishes. In such cases it can be perceived as an indirect focal symptom.

b) *Agraphia* can be designated as ‘a[phasia] of the hand’ after a fortunate expression of Charcot’s. Agraphia is found comparatively rarely in pure form. If a right-sided paralysis is present, the question of the presence of agraphia is naturally left undecided. Otherwise agraphia accompanies motor a[phasia] as a rule but does not necessarily keep pace with it. It consists of the patients putting only senseless and disconnected strokes together when instructed to write. Now and then such patients can also still write properly to dictation or copy from a model, whereas they are unable to write without such a stimulus.—One must analyse the more complicated aphasic disturbances through careful investigation in such a way that one can ascertain which connections between the individual elements of the word presentation, and between these and the idea of the designated object, are preserved or interrupted.⁸ Because a[phasia] is an exquisite focal symptom, any lesion that affects the speech field can rise to it; thus, brain haemorrhages, softenings, tumours, traumatic influences, abscess, etiological factors like heart and vascular disease, syphilis, morbus Brightii, acute infectious diseases (typhus, variola), diabetes mellitus, etc., as with the other forms of brain disease, come into consideration here, without the one or the other contributing a

particular causal relationship to the form of a[phasia]. The latter rather depends solely on the localization and extent of the established lesions in the speech field.—A[phasia] is not always the consequence of a material brain process; rather, neuroses like hysteria and neurasthenia may also produce aphasic disturbances. Hysterical a[phasia] is purely motor as far as it has been studied until now. However, it is characterized by its completeness or, rather, by its absolute character. It is not that the patients are restricted to the use of individual words, but that they are completely speechless, indeed voiceless; not a sound, not a cry comes about. Hysterical a[phasia] is therefore actually a ‘mutism’. Writing capability is always preserved and increased, however.⁹ When questioned, these patients point at their mouths, then put pen to paper and write their thoughts down with unusual rapidity and certainty.—The speech disturbance resulting from neurasthenic brain-fatigue is limited to the forgetting of individual concrete words and to the confusion of similar sounding words in speech and is thus similar to the paraphasia that occurs in healthy people.¹⁰—The prognosis and therapy for aphasia is the same as that for a paralysis and is directed to the basic complaint. Under favourable circumstances all forms of aphasic disturbance are capable of improvement or compensation. If a persistent defect of speech ability remains behind, then one can attempt to ameliorate it through the re-education of the patient. Thus the word blind [patient] learns, even if laboriously, to read again, and the agraphic learns to write again. The later can make use of the left hand to learn to write, either in mirror-writing or in normal characters.¹¹ Preserved intelligence is a precondition for such learning attempts.

Editors’ Annotations

¹ Loss of the power to communicate by means of gesture or non-speech signs

² This and the following three sentences are relevant to the determination of the authorship of this paper. They read as a précis of Freud (1891), pp. 73ff. Freud’s view that the word comprises a complex of four rudimentary ideational elements can undoubtedly be attributed to Charcot, under whom Freud studied in 1885-86; cf. Freud’s translation of Charcot’s *Leçons sur les maladies du système nerveux* (Charcot, 1886, p155).

³ Freud 1891b. p. 67) identifies this same *continuous cortical area* as the ‘speech field.

⁴ The localization of a unitary centre for this function was never ‘definitely established’, but Freud later (1891b. p.63) identified the same region in this context.

⁵ The important point made in the last two sentences is more fully stated in *On Aphasia* (Freud, 1891b, pp.62-64) and restated in Freud’s abstract of that work (1897b. p.240).

⁶ This pseudo-reasoning manoeuvre is known as ‘Willbrand’s sign’.

⁷ This was a recurrent utterance of Broca’s famous (1861) patient, Leborgue. He came to be known by the name of ‘Tan’ by the Bicêtre hospital staff.

⁸ Freud’s (1891b. p.77ff) psychology of language and classification of the aphasias followed this exact scheme.

⁹ This claim was also made in the ‘Dora’ case study (Freud, 1905e [1901], p. 39) and in the ‘Hysterie’ article in Villaret’s dictionary (Freud, 1888b3, p.47). The more general remarks on hysterical aphasia were also restated there and again later (Freud 1893c.ppp. 163,164,169).

¹⁰ Freud made a very similar point in *On Aphasia* (1891b. p.13) and again in *The Psychopathology of Everyday Life* (1901b. p.53); (cf. Stengel, 1953, p.xiii).

¹¹ This method was based on the traditional assumption, made in accordance with the teaching of others, that the intact right hemisphere can take over the speech function of the damaged left one in right-handed individuals. Freud did not question this teaching (see Freud & Rie, 1891a, p.126).