

The Man Who Mistook His Wife for a Hat

Oliver Sacks

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HIS WIFE FOR A HAT

OLIVER
SACKS

PICADOR



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To talk of diseases is a sort of *Arabian Nights* entertainment.

WILLIAM OSIER

The physician is concerned (unlike the naturalist) . . . with a single organism, the human subject, striving to preserve its identity in adverse circumstances.

IVY MCKENZIE

Preface

‘The last thing one settles in writing a book,’ Pascal observes, ‘is what one should put in first.’ So, having written, collected and arranged these strange tales, having selected a title and two epigraphs, I must now examine what I have done – and why.

The doubleness of the epigraphs, and the contrast between them – indeed the contrast which Ivy McKenzie draws between the physician and the naturalist – corresponds to a certain doubleness in me: that I feel myself a naturalist and a physician both; and that I am equally interested in diseases and people; perhaps, too, that I am equally, if inadequately, a theorist and dramatist, am equally drawn to the scientific and the romantic, and continually see both in the human condition, not least in that quintessential human condition of sickness – animals get diseases, but only man falls radically into sickness.

My work, my life, is all with the sick – but the sick and their sickness drives me to thoughts which, perhaps, I might otherwise not have. So much so that I am compelled to ask, with Nietzsche: ‘As for sickness: are we not almost tempted to ask whether we could get along without it?’ – and to see the questions it raises as fundamental in nature. Constantly my patients drive me to question, and constantly my questions drive me to patients – thus in the stories or studies which follow there is a continual movement from one to the other.

Studies, yes; why stories, or cases? Hippocrates introduced the historical conception of disease, the idea that diseases have

a course, from their first intimations to their climax or crisis, and thence to their happy or fatal resolution. Hippocrates thus introduced the case history, a description, or depiction, of the natural history of disease – precisely expressed by the old word ‘pathography’. Such histories are a form of natural history – but they tell us nothing about the individual and *his* history; they convey nothing of the person, and the experience of the person, as he faces, and struggles to survive, his disease. There is no ‘subject’ in a narrow case history; modern case histories allude to the subject in a cursory phrase (‘a trisomic albino female of 21’), which could as well apply to a rat as a human being. To restore the human subject at the centre – the suffering, afflicted, fighting, human subject – we must deepen a case history to a narrative or tale: only then do we have a ‘who’ as well as a ‘what’, a real person, a patient, in relation to disease – in relation to the physical.

The patient’s essential being is very relevant in the higher reaches of neurology, and in psychology; for here the patient’s personhood is essentially involved, and the study of disease and of identity cannot be disjoined. Such disorders, and their depiction and study, indeed entail a new discipline, which we may call the ‘neurology of identity’, for it deals with the neural foundations of the self, the age-old problem of mind and brain. It is possible that there must, of necessity, be a gulf, a gulf of category, between the psychical and the physical; but studies and stories pertaining simultaneously and inseparably to both – and it is these which especially fascinate me, and which (on the whole) I present here – may none the less serve to bring them nearer, to bring us to the very intersection of mechanism and life, to the relation of physiological processes to biography.

The tradition of richly human clinical tales reached a high point in the nineteenth century, and then declined, with the advent of an impersonal neurological science. Luria wrote: ‘The power to describe, which was so common to the great nineteenth-century neurologists and psychiatrists, is almost gone now . . . It must be revived.’ His own late works, such as

The Mind of a Mnemonist and *The Man with a Shattered World*, are attempts to revive this lost tradition. Thus the case histories in this book hark back to an ancient tradition: to the nineteenth-century tradition of which Luria speaks; to the tradition of the first medical historian, Hippocrates; and to that universal and prehistorical tradition by which patients have always told their stories to doctors.

Classical fables have archetypal figures – heroes, victims, martyrs, warriors. Neurological patients are all of these – and in the strange tales told here they are also something more. How, in these mythical or metaphorical terms, shall we categorise the ‘Lost Mariner’, or the other strange figures in this book? We may say they are travellers to unimaginable lands – lands of which otherwise we should have no idea or conception. This is why their lives and journeys seem to me to have a quality of the fabulous, why I have used Osier’s *Arabian Nights* image as an epigraph, and why I feel compelled to speak of tales and fables as well as cases. The scientific and the romantic in such realms cry out to come together – Luria liked to speak here of ‘romantic science’. They come together at the intersection of fact and fable, the intersection which characterises (as it did in my book *Awakenings*) the lives of the patients here narrated.

But what facts! What fables! To what shall we compare them? We may not have any existing models, metaphors or myths. Has the time perhaps come for new symbols, new myths?

*

Eight of the chapters in this book have already been published: ‘The Lost Mariner’, ‘Hands’, ‘The Twins’, and ‘The Autist Artist’ in the *New York Review of Books* (1984 and 1985), and ‘Witty Ticky Ray’, ‘The Man Who Mistook His Wife for a Hat’, and ‘Reminiscence’ in the *London Review of Books* (1981, 1983, 1984) – where the briefer version of the last was called ‘Musical Ears’. ‘On the Level’ was published in *The Sciences* (1985). A very early account of one of my patients –

the 'original' of Rose R. in *Awakenings* and of Harold Pinter's Deborah in *A Kind of Alaska*, inspired by that book – is to be found in 'Incontinent Nostalgia' (originally published as 'Incontinent Nostalgia induced by L-Dopa' in the *Lancet* of Spring 1970). Of my four 'Phantoms', the first two were published as 'clinical curios' in the *British Medical Journal* (1984). Two short pieces are taken from previous books: 'The Man Who Fell out of Bed' is excerpted from *A Leg to Stand On*, and 'The Visions of Hildegard' from *Migraine*. The remaining twelve pieces are unpublished and entirely new, and were all written during the autumn and winter of 1984.

I owe a very special debt to my editors: first to Robert Silver of the *New York Review of Books* and Mary-Kay Wilmers of the *London Review of Books*; then to Kate Edgar, Jim Silberman of Summit Books in New York, and Colin Haycraft of Duckworth's in London, who between them did so much to shape the final book.

Among my fellow neurologists I must express special gratitude to the late Dr James Purdon Martin, to whom I showed videotapes of 'Christina' and 'Mr MacGregor' and with whom I discussed these patients fully – 'The Disembodied Lady' and 'On the Level' express this indebtedness; to Dr Michael Kremer, my former 'chief' in London, who in response to *A Leg to Stand On* (1984) described a very similar case of his own – these are bracketed together now in 'The Man Who Fell out of Bed'; to Dr Donald Macrae, whose extraordinary case of visual agnosia, almost comically similar to my own, was only discovered, by accident, two years after I had written my own piece – it is excerpted in a postscript to 'The Man Who Mistook His Wife for a Hat'; and, most especially, to my close friend and colleague Dr Isabelle Rapin in New York, who discussed many cases with me; she introduced me to Christina (the 'disembodied lady'), and had known José, the 'autist artist', for many years when he was a child.

I wish to acknowledge the selfless help and generosity of the patients (and, in some cases, the relatives of the patients) whose tales I tell here – who, knowing (as they often did) that

they themselves might not be able to be helped directly, yet permitted, even encouraged, me to write of their lives, in the hope that others might learn and understand, and, one day, perhaps be able to cure. As in *Awakenings*, names and some circumstantial details have been changed for reasons of personal and professional confidence, but my aim has been to preserve the essential ‘feeling’ of their lives.

Finally, I wish to express my gratitude – more than gratitude – to my own mentor and physician, to whom I dedicate this book.

O.W.S.

New York

February 10, 1985

Part One

LOSSES

Neurology's favourite word is 'deficit', denoting an impairment or incapacity of neurological function: loss of speech, loss of language, loss of memory, loss of vision, loss of dexterity, loss of identity and myriad other lacks and losses of specific functions (or faculties). For all of these dysfunctions (another favourite term), we have privative words of every sort – Aphonia, Aphemia, Aphasia, Alexia, Apraxia, Agnosia, Amnesia, Ataxia – a word for every specific neural or mental function of which patients, through disease, or injury, or failure to develop, may find themselves partly or wholly deprived.

The scientific study of the relationship between brain and mind began in 1861, when Broca, in France, found that specific difficulties in the expressive use of speech, aphasia, consistently followed damage to a particular portion of the left hemisphere of the brain. This opened the way to a cerebral neurology, which made it possible, over the decades, to 'map' the human brain, ascribing specific powers – linguistic, intellectual, perceptual, etc. – to equally specific 'centres' in the brain. Towards the end of the century it became evident to more acute observers – above all to Freud, in his book *Aphasia* – that this sort of mapping was too simple, that all mental performances had an intricate internal structure, and must have an equally complex physiological basis. Freud felt this, especially, in regard to certain disorders of recognition and perception, for which he coined the term 'agnosia'. All

adequate understanding of aphasia or agnosia would, he believed, require a new, more sophisticated science.

The new science of brain/mind which Freud envisaged came into being in the Second World War, in Russia, as the joint creation of A. R. Luria (and his father R. A. Luria), Leontev, Anokhin, Bernstein and others, and was called by them 'neuropsychology'. The development of this immensely fruitful science was the life-work of A. R. Luria, and considering its revolutionary importance it was somewhat slow in reaching the West. It was set out, systematically, in a monumental book, *Higher Cortical Functions in Man* (Eng. tr. 1966), and, in a wholly different way, in a biography or 'pathography' – *The Man with a Shattered World* (Eng. tr. 1972). Although these books were almost perfect in their way, there was a whole realm which Luria had not touched. *Higher Cortical Functions in Man* treated only those functions which appertained to the left hemisphere of the brain; similarly, Zazetsky, subject of *The Man with a Shattered World*, had a huge lesion in the left hemisphere – the right was intact. Indeed, the entire history of neurology and neuropsychology can be seen as a history of the investigation of the left hemisphere.

One important reason for the neglect of the right, or 'minor', hemisphere, as it has always been called, is that while it is easy to demonstrate the effects of variously located lesions on the left side, the corresponding syndromes of the right hemisphere are much less distinct. It was presumed, usually contemptuously, to be more 'primitive' than the left, the latter being seen as the unique flower of human evolution. And in a sense this is correct: the left hemisphere is more sophisticated and specialised, a very late outgrowth of the primate, and especially hominid, brain. On the other hand, it is the right hemisphere which controls the crucial powers of recognising reality which every living creature must have in order to survive. The left hemisphere, like a computer tacked onto the basic creatural brain, is designed for programmes and schematics; and classical neurology was more concerned with schematics than with reality, so that when, at last, some of the

right-hemisphere syndromes emerged, they were considered bizarre.

There had been attempts in the past – for example, by Anton in the 1890s and Pötzl in 1928 – to explore right-hemisphere syndromes, but these attempts themselves had been bizarrely ignored. In *The Working Brain*, one of his last books, Luria devoted a short but tantalising section to right-hemisphere syndromes, ending:

These still completely unstudied defects lead us to one of the most fundamental problems – to the role of the right hemisphere in direct consciousness . . . The study of this highly important field has been so far neglected . . . It will receive a detailed analysis in a special series of papers . . . in preparation for publication.

Luria did, finally, write some of these papers, in the last months of his life, when mortally ill. He never saw their publication, nor were they published in Russia. He sent them to R. L. Gregory in England and they will appear in Gregory's forthcoming *Oxford Companion to the Mind*.

Inner difficulties and outer difficulties match each other here. It is not only difficult, it is impossible, for patients with certain right-hemisphere syndromes to know their own problems – a peculiar and specific 'anosagnosia', as Babinski called it. And it is singularly difficult, for even the most sensitive observer, to picture the inner state, the 'situation', of such patients, for this is almost unimaginably remote from anything he himself has ever known. Left-hemisphere syndromes, by contrast, are relatively easily imagined. Although right-hemisphere syndromes are as common as left-hemisphere syndromes – why should they not be? – we will find a thousand descriptions of left-hemisphere syndromes in the neurological and neuropsychological literature for every description of a right-hemisphere syndrome. It is as if such syndromes were somehow alien to the whole temper of neurology. And yet, as Luria says, they are of the most fundamental importance. So much so that they may demand a new sort of neurology, a

‘personalistic’, or (as Luria liked to call it) a ‘romantic’, science; for the physical foundations of the *persona*, the self, are here revealed for our study. Luria thought a science of this kind would be best introduced by a story – a detailed case history of a man with a profound right-hemisphere disturbance, a case history which would at once be the complement and opposite of ‘the man with a shattered world’. In one of his last letters to me he wrote: ‘Publish such histories, even if they are just sketches. It is a realm of great wonder.’ I must confess to being especially intrigued by these disorders, for they open realms, or promise realms, scarcely imagined before, pointing to an open and more spacious neurology and psychology, excitingly different from the rather rigid and mechanical neurology of the past.

It is, then, less deficits, in the traditional sense, which have engaged my interest than neurological disorders affecting the self. Such disorders may be of many kinds – and may arise from excesses, no less than impairments, of function – and it seems reasonable to consider these two categories separately. But it must be said from the outset that a disease is never a mere loss or excess – that there is always a reaction, on the part of the affected organism or individual, to restore, to replace, to compensate for and to preserve its identity, however strange the means may be: and to study or influence these means, no less than the primary insult to the nervous system, is an essential part of our role as physicians. This was powerfully stated by Ivy McKenzie:

For what is it that constitutes a ‘disease entity’ or a ‘new disease’? The physician is concerned not, like the naturalist, with a wide range of different organisms theoretically adapted in an average way to an average environment, but with a single organism, the human subject, striving to preserve its identity in adverse circumstances.

This dynamic, this ‘striving to preserve identity’, however strange the means or effects of such striving, was recognised in psychiatry long ago – and, like so much else, is especially

associated with the work of Freud. Thus the delusions of paranoia were seen by him, not as primary, but as attempts (however misguided) at restitution, at reconstructing a world reduced to complete chaos. In precisely the same way, Ivy McKenzie wrote:

The pathological physiology of the Parkinsonian syndrome is the study of *an organised chaos*, a chaos induced in the first instance by destruction of important integrations, and reorganised on an unstable basis in the process of rehabilitation.

As *Awakenings* was the study of ‘an organised chaos’ produced by a single if multiform disease, so what now follows is a series of similar studies of the organised chaoses produced by a great variety of diseases.

In this first section, ‘Losses’, the most important case, to my mind, is that of a special form of visual agnosia: ‘The Man Who Mistook His Wife for a Hat.’ I believe it to be of fundamental importance. Such cases constitute a radical challenge to one of the most entrenched axioms or assumptions of classical neurology – in particular, the notion that brain damage, *any* brain damage, reduces or removes the ‘abstract and categorical attitude’ (in Kurt Goldstein’s term), reducing the individual to the emotional and concrete. (A very similar thesis was made by Hughlings Jackson, in the 1860s.) Here, in the case of Dr P., we see the very *opposite* of this – a man who has (albeit only in the sphere of the visual) wholly lost the emotional, the concrete, the personal, the ‘real’ . . . and been reduced, as it were, to the abstract and the categorical, with consequences of a particularly preposterous kind. What would Hughlings Jackson and Goldstein have said of *this*? I have often, in imagination, asked them to examine Dr P., and then said, ‘Gentlemen! What do you say *now*?’