Section of Psychiatry

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Paper

Conception of Schizophrenia Within the Last Fifty Years and Today [*Abridged*]

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The young generation of psychiatrists cannot understand that half a century ago their grandfathers were already proud of their knowledge of dementia præcox or schizophrenia. The young psychiatrist realizes that today we do not know much regarding the nature of schizophrenia and he must suppose that some decades ago even less or nothing was known. However, those who were young in 1900 looked back with compassion to the undeveloped and chaotic state of psychiatry in the middle of the nineteenth century. They too were conscious that they did not know very much, but they believed that at least in one way progress had been achieved. It consisted in the first reasonable classification of the formerly diffuse and disordered mass of psychopathological conditions. The former inability to classify reasonably the various psychopathological phenomena had suggested the existence of one single psychopathological process called degeneration. It was supposed that various kinds of pathogenic influences on the personality would cause various kinds of psychopathological symptomatology. Apart from all types of physical disease, damage by civilization was considered the main cause of psychoses: unfaithfulness to the old customs, luxury, passions, money-hunting and so on. These errors were corrected seventy years ago. It had been discovered that specific psychoses due to definite brain diseases existed; and on the other hand, hysteric behaviour had been recognized as a psychogenic disturbance and many psychopathic developments had been attributed to inborn deficiency. However, the majority of hospitalized psychotics still suffered from diseases of a quite enigmatic nature. Later on, Kraepelin succeeded in dividing them naturally into two large groups: the manic-depressive psychoses with their specific symptomatology and a phasic-benign course on the one hand, and dementia præcox with another specific symptomatology and an unfavourable outcome on the other.

It was believed fifty years ago that such a classification had opened the way for far-reaching new discoveries: it was believed that by the conception of dementia præcox a disease entity had been found, characterized by its definite symptomatology and its unfavourable outcome, and that such a disease entity must have one single and definite cause. The appearance of the conception of dementia præcox seemed to be the clue to the discovery of its ætiology. Psychiatrists became very eager to discover this ætiology and hoped to become pioneers in medical science just as had the bacteriologists shortly before them.

Today, we can look back to the great work of two or three generations of psychiatrists all over the world, who wished to discover the specific cause of schizophrenia and did not find it. This failure has been called the scandal of psychiatry. It is rather the tragedy of psychiatry of the first half of the twentieth century. This disappointment was so discouraging that many clinicians stopped all their research work, and others lost interest in schizophrenia and turned their attention to other problems. Kraepelin had asked his pupils to discover the cerebral anatomy of schizophrenia. He had assigned this task to one of his most capable collaborators, Alzheimer. When Alzheimer failed to solve this problem, he left the research position at Kraepelin's clinic in order to accept a clinical position in Breslau; neither could other neuro-anatomists find a brain disease explaining schizophrenic psychoses as Alfred Meyer showed so impressively here in London. At the same time as Alzheimer, Adolf Meyer in the United States was disappointed by his unsuccessful neuropathological research for a cause of schizophrenia and dropped it. He afterwards fought with great bitterness against the idea that any specific brain process existed as a cause of

schizophrenia. Between the two world wars it was maintained, particularly in Germany, that the schizophrenic psychosis was the symptom of a somatic disease, called schizophrenic somatosis. Nowadays we look back with astonishment and disapproval to the main arguments which were then used to support such a statement: these were fever, eosinophilia, a high sedimentation rate, weight changes, acrocyanosis and other somatic signs which were observed in some schizophrenics. But these are uncharacteristic symptoms, also seen in many other diseases, some of them even being due to emotional stress or to bad hygiene. It is not a proof for the existence of a specific schizophrenic somatosis if they are occasionally found in schizophrenics. Within the last few years, much research work has been done in order to discover endocrine derangements in schizophrenics. The main interest was devoted at first to the gonads, later to the thyroid, to the metabolism of carbohydrates, to the catecholamines and their descendants, to neurohumoral agents such as 5-hydroxytryptamine and the polypeptides such as neurokinine and substance P. For many years I have studied the endocrine functions in schizophrenics and have summarized the findings reported in the literature. I can summarize the result of this work as follows: The tremendous research work to discover an endocrine cause of schizophrenia has not been successful. We do not know of specific endocrine troubles which are the cause of schizophrenic psychoses. The arguments of those who state that schizophrenia may only be a symptom of an endocrine disease must be countered by the presentation of fundamental facts. The large majority of endocrinologic patients are not schizophrenic and the large majority of schizophrenic patients have no endocrine disease as far as we are able to determine with present techniques. Endocrine influences may improve or aggravate the course of schizophrenic psychoses; however, a specific endocrine cause for all schizophrenic psychoses has not been discovered.

There have been very serious attempts to prove a gene mutation and a definite mendelian heredity as being essential factors of schizophrenic psychoses. However, the most varying mendelian types of heredity have been found to tally with the incidence of schizophrenia among the relatives of schizophrenics. The reason for this is the difficulties inherent in the diagnosis of schizophrenia. Is it possible, for instance, to distinguish clearly between a schizophrenic reaction and genuine schizophrenia or between a catatoniform involutional psychosis and schizophrenia? Since we are unable to determine the incidence of a manifested hereditary disposition, we are also unable to deduce a definite kind of heredity from this incidence. Another difficulty in research on the heredity of schizophrenics is seen in the impossibility of distinguishing between familial influences caused by heredity, and familial influences caused by an environment common to several members of a family. Schizophrenics of the older generation usually aggravate the environment in which the younger generation grows up. There are, however, many other arguments against the assumption that the answer to the question regarding the nature of schizophrenia may be a definite mendelian type of heredity. The study of the families of schizophrenics has certainly proved that there *are* familial influences on schizophrenic psychoses; however, it has not been possible clearly to separate familial influences due to heredity from familial influences due to common environmental factors. In so far as we recognize hereditary influences, they might rather be due to an incompatibility of different hereditary dispositions for the personal development than to one or two genes of specific morbidity.

Psychological research also attempted to determine specific influences as the cause of schizophrenia. They were not discovered. Misery and psychological stress of the most varied kinds are more frequent in the life history of schizophrenics than in an average life history. However, they are not more frequent or different in type from the stress situation in the past of alcoholics and other addicts, or of psychopathic and neurotic patients. Stress situations from childhood on are certainly a danger for the healthy development of the personality, but we do not know that there are unhappy life experiences of any particular kind which are decisive in the development of schizophrenia and only in the development of schizophrenia. Theoretically it was easy to give reasons for the hypothesis that a definite phase during childhood with disturbed interhuman relations was decisive for the later development of schizophrenia, for instance the phase of primary narcissism or the phase of separation and individuation or puberty. However, it has never been demonstrated that just at this particular phase disturbances occurred in the history of all schizophrenics, nor has it been shown that certain disturbances in these phases are always followed by schizophrenia. Nor has it been proved that a particular personality structure of the mother is the essential source for schizophrenic psychoses of her children. The descriptions of a mother-type responsible for a schizophrenic development of her children frequently apply only to a minority of mothers of schizophrenics or they are so vague and indefinite that they can be considered as applicable to any mother. Similar statements would be true of fathers and of interfamilial relationships.

We are forced to conclude that no single, specific cause for all schizophrenic psychoses has been found. I think that it does not exist.

One fact is certain: if no single essential cause for all schizophrenic psychoses has been found, many different types of damage do exist which show at times a schizophrenia-like symptomatology. In these cases we speak of a symptomatic schizophrenia. Of the chronic schizophrenia-like psychoses caused organically those with epilepsy have been studied by Slater *et al.* (1963). They are the most exhaustively studied, but not the only ones. Chronic symptomatic schizophrenias have also been observed in the course of Huntington's chorea, of progressive paresis (particularly after malaria treatment), of addiction to amphetamines, after traumatic brain lesions, and so on.

In the symptomatology of acute organic psychoses, of Bonhoeffer's acute exogenous reaction type, quite frequently phenomena occur which in themselves can hardly be distinguished from schizophrenic symptoms. The symptomatology of the acute exogenous reaction type may be classified in three groups: The first group consists of a simple reduction of consciousness; it starts with tiredness, lethargy and somnolence and ends with coma. This group of phenomena has nothing in common with schizophrenia. A second group of phenomena in acute organic psychoses may be characterized by the catchword 'simplification and poverty of psychic life'. If this is the predominant feature of an acute psychosis we speak of an acute Korsakoff syndrome. This syndrome too has nothing in common with schizophrenia, but between the mere reduction of consciousness and the continuation of psychic life on a simplified and impoverished level a third group of symptoms may be interposed. They may be summarized as an alternation of consciousness, as disorder and confusion in the psychic life: confusion of thought, illusions, hallucinations, delusional thinking, raging and swaying emotionality such as we see in delirious states. Confusion with hallucinations, illusions and delusions with organic basis may be very similar to acute schizophrenic disturbances. It can be recognized as an organic disease only when it is combined with a reduction of consciousness or a Korsakoff syndrome, or physical symptoms of the underlying disease. In a word: acute somatic catastrophes may arouse a hidden psychic life, not to be distinguished from schizophrenic life.

Do psychoses with schizophrenic symptomatology as reactions to psychological stress exist? Certainly psychoses in close temporal coincidence with psychological stress do exist, and their symptomatology cannot always be distinguished from real schizophrenic psychoses. They are seen for instance in prisoners, or in somebody whose negligence was to blame for the death of a parent, or after sexual trauma in a young girl; we have seen it for instance in a woman surprised by her daughter during an adulterous act. In many of these psychoses the contents of the dissociated and delusional thinking and of the hallucinations centre round the psychological trauma. Some of these psychoses disappear without leaving schizophrenia-like residues or any other traces. These psychoses have long been described in the literature as schizophrenic reactions or reactive schizophrenias or psychogenic psychoses. We have been studying the families of such patients for a long time; some of these studies have been published (e.g. Bleuler 1941*a*,*b*, Ernst 1956, Rohr 1961). Others are still continuing. Among the relatives of patients with reactive schizophrenia we found more schizophrenics than in the average population, but less than among the relatives of schizophrenics. It seems as if psychological reactions may awaken psychic derangements of schizophrenic symptomatology partly alone, and partly in connexion with a particular disposition to schizophrenia. The homosexual panic of Kempf and the 'sensitiver Beziehungswahn' of Kretschmer have to be classified between these schizophrenic reactions and real schizophrenias: in both psychoses the psychogenesis is more easily found than in the majority of other schizophrenic psychoses, but both are hardly to be distinguished from real schizophrenias.

Chronic schizophrenic psychoses also exist in which the direct correlation with human suffering is more manifest than in the majority of schizophrenic psychoses: for instance, they have been seen to arise under the stress of impending execution. To the chronic schizophrenia-like psychoses with manifest psychogenetic backgrounds also belong the induced psychoses. We have studied these *folies à deux* with great interest. According to the older conception it should be easy to distinguish the real schizophrenia in the inducing partner of the pair from the pseudoschizophrenia (the psychogenic psychosis) of the induced partner, and the psychogenic psychoses should clear up after the separation of the partners and the schizophrenic psychoses should not. In our experience these assumptions do not all hold true in many cases. Neither of the partners is only the actively inducing and neither is only the passively induced. On the contrary, inductions go from one to the other, both psychoses are developed and maintained by the relationship of two closely sympathizing individuals in hostile surroundings. There are intermediate cases between schizophrenic developments with and without manifest psychogenesis.

Such an assumption was confirmed when we started to examine some relatives of schizo-

phrenics more carefully than in routine practice. The schizophrenic regularly influences the thought of those members of his family with whom he is in close contact. In these relatives peculiar autistic conceptions arise and peculiar behaviour-patterns. One can find many intermediate conditions between peculiarities which are still normal and those which might be labelled as psychopathic or neurotic developments, and mild schizophrenic developments. This was also shown by systematic examination of the relatives with the Rorschach test. It has long been known that schizoid personality structure is common among the relatives of schizophrenics. Recent experience shows a close correlation of temporal development and of thought content of the peculiar and schizoid traits of the relatives, and of the schizophrenia of the patient. In such a case does the schizophrenic patient infect his healthy relatives? Or does the schizoid stigmatization of the relatives help the development of the schizophrenic psychosis? It seems that both occur together. In the light of these studies schizophrenic and psychogenic derangements seem very closely interwoven.

Psychoses of schizophrenic symptomatology developing in close temporal and thematic correlation with trauma of all kinds, and from which the patients recover entirely, are much more frequent in Africa than in Europe. The trauma is sometimes a somatic disease, but even more frequently a psychological catastrophe by which the whole family is affected. These psychoses are always connected with magic fears and magic defence reactions against these fears. The course is often favourable, despite the lack of modern therapy. The patients recover without traces of the psychosis. Frequently, however, such a psychosis ends with death. The outcome as a chronic schizophrenic psychosis is seen sometimes, but is not the rule. Some of our physicians at Burghölzli were able to collect rich material regarding these problems in Africa, and similar observations are described in the literature, particularly the French (Ey 1958).

If our present psychiatric ideas had been developed on the basis of our experience in Africa and not in Europe, it would hardly have been possible to speak of schizophrenia as an endogenous psychosis without manifest somatic or psychological background. In the light of psychiatric experience in Africa one would be forced to conclude that schizophrenic psychoses have as a rule somatic or psychological causes. In this connexion it is well to remember that the conception of schizophrenic psychoses as being endogenous and independent of manifest exterior influences is not yet two hundred years old. Earlier observers believed in various stresses as the cause of psychoses, which today we label as schizophrenias. Might it be possible that the civilization of the last few centuries in Europe conceals the interrelationship between exterior trauma and schizophrenic psychoses?

The psychology of the healthy has disclosed another important aspect of the problem of schizophrenia: a life similar to schizophrenic life appears in many people not only as a result of an organic process or a tragic life experience; furthermore, behind the everyday attitude of any healthy subject are hidden living possibilities that cannot be separated in principle from schizophrenic life. As early as the beginning of the century this was found by Eugen Bleuler and C G Jung when studying the early teaching of Freud at the Burghölzli Clinic. The day-and-night-dreaming and the thinking revealed in free associations of the healthy proved to be identical in nature with schizophrenic thinking. At this time Jung sketched the picture of a healthy dreamer who would be able to speak and to act. Jung thought that nobody could distinguish such a healthy dreamer from a schizophrenic patient. Eugen Bleuler saw in the wishful thinking, the autistic thinking, of the healthy the same principles as in schizophrenic dissociation. Jung pointed out how similar the transformation and symbolism of the libido were during the history of mankind and in schizophrenics. Storch demonstrated the identity of archaic thinking in foreign cultures, and schizophrenic thinking. Ever since then it has been demonstrated by many authors that there is nothing in schizophrenic phenomenology which would be quite strange to the healthy. The schizophrenic, however, is different from the healthy, because he lives mainly in a world which, in the everyday life of the healthy, is concealed. Freud stated that in schizophrenia things become conscious which should remain unconscious. (Moreau de Tours made a similar statement fifty years before Freud.)

Recently Henry Ey has brilliantly presented the conception that the schizophrenic openly demonstrates what is hidden in the healthy. A man is psychotic if he has no longer an unconscious life to be concealed, but if he has surrendered to his unconscious. Ey has also pointed out that opposites are the nature of the unconscious, where love and hate, wish and fear are always linked together. Schizophrenic and unconscious life have not only symbols and symbolic thinking in common, but there is also in both splitting, ambitendence and ambivalence.

While a schizophrenic-like life goes on in a concealed form in the healthy, a healthy life goes on in a concealed form in the schizophrenic. A modern confirmation of this old law was obtained from psychoanalytical work with schizophrenics. Psychoanalysis of schizophrenic patients has dis-

appointed us in many respects, but it has been very valuable in other ways. It has been clearly demonstrated that during each course of treatment phases occur in which the schizophrenic is like a healthy person with just the same intellectual capacity and just the same emotional life.

The following points seem to me important in the discussion of the nature of schizophrenia: (1) A single and specific cause of all schizophrenic psychoses has not been discovered. (2) Various somatic processes can arouse a psychic symptomatology which cannot be distinguished from schizophrenic symptomatology. (3) We often see schizophrenia-like psychoses arise under very severe psychological stress. (4) Definite limits between psychogenic psychoses and schizophrenic psychoses cannot be drawn. Modern studies have shown that many intermediate psychoses exist. (5) Psychic life very much resembling schizophrenic life exists in a concealed form in the healthy. (6) Healthy psychic life goes on in a concealed form in the schizophrenic.

Schizophrenic life is not foreign to human nature. No schizophrenic morbid process exists which would destroy healthy life for good and replace it by a new form of life. In the schizophrenic illness it is only the correct boundaries between two different forms that vanish. One of them is directed to the defence of the existence of individuals and society. It is rooted in experience and follows logical laws. It enables us to adapt ourselves to others and protects us from disaster. This life is ordered and deals successfully with ambitendence. The other form of life is experienced by the healthy in the mystic and magic, in the wishful and autistic thinking, and in dreams. It is directed not towards adaptation of our behaviour to reality but, on the contrary, to the adaptation of the fantasy world to our needs. This inner life creates a fantastic world according to our inner needs, it pays no heed to experience and logic or to the real world outside us. It creates symbols of our inner disharmony. There is no order in it and ambivalence belongs to its nature. This kind of life becomes manifest in schizophrenics, while it is concealed in the everyday life of the healthy. In the schizophrenic, it threatens existence, while it does no harm in the healthy.

Our pathogenic question has therefore changed: The former question was: What pathogenic force destroys the healthy and creates the schizophrenic? Today's question is: What changes the limits between the two forms of life? Such a doctrine was formulated long ago by the most outstanding psychiatrists like Moreau de Tours, Rümke, Ey, Binswanger, Wyrsch and others. It is very curious, however, that such a conception has been neglected in the research work on the ætiology of schizophrenia.

This modern question – What changes the boundaries between two forms of life? – no longer suggests that all schizophrenic psychoses must be ætiologically explained by a single and specific cause. Many types of trauma can destroy the dams keeping a chaotic form of life in its right place. For the symptomatic schizophrenias physical damage plays an important role, for schizophrenic reactions psychological stress.

As yet, however, we have not discussed the central question: What is the ætiology of the true schizophrenias, of the majority of schizophrenias, of those recurrent psychoses, the nature of which is still enigmatic? In order to answer the question, we have to take into account the following facts: (1) As a rule, schizophrenic patients are physically very healthy. (2) Familial factors in the ætiology are certain: schizophrenic psychoses are more frequent among the relatives of schizophrenics than among the general population. (3) Temporal correlations frequently exist between the course of a tragic life and the course of a schizophrenic psychosis. The contents of schizophrenic thinking are often in close relation with the psychological life stress.

If we take into account what we know and if we refrain from speculating on what is unknown, we must take heredity and psychogenesis into consideration.

Heredity alone is not a satisfactory answer to the problem of the nature of schizophrenia. The results of the studies on twins demonstrate clearly that other factors come into play. A schizophrenic psychosis may end in lifelong deterioration or in recovery – the factors determining the course are therefore of great importance; they are even more important than the hypothetical specific heredity which was supposed to be the cause of the disease. There are many outside influences which alter the picture and the course of schizophrenia, among others our therapeutic endeavours. Neither can the assumption of a pure and simple psychogenesis be supported. Such an assumption is disproved, since in the anamnesis of schizophrenics there are neither more nor other stressful situations than in the anamnesis of many other patients and even of many healthy people.

We therefore revert to the obvious views that hereditary disposition and life history act together in the genesis of schizophrenia. Such a view is commonplace and was already adopted by the old hereditary theory as well as by the old psychoanalytical ones. The old hereditary theory assumed the existence of a specific gene for schizophrenia and considered that its manifestation might be checked or favoured by the varying destinies of the patients. On the other hand the old psychoanalytical theories assumed specific psychic traumata or any psychic trauma to

play a part in a specific phase of development, and supposed that its importance might be enhanced by dispositions hitherto not closely studied.

Our new conception, however, is clearly different from these theories. If we study the life history of a schizophrenic and of his family very carefully for many years, we always see an environment which is to a certain extent the reflected image of the patient's nature. We see on the other hand the manifestation of a hereditary disposition in close connexion only with the environment, particularly with the attitude of the patient towards his family. We never see what the older theories assumed to exist: an environment independent of the patient's nature, or the manifestation of the hereditary nature independent of the environment. The nature of the subsequent schizophrenic shapes and poisons his interhuman relations, which means just the environment so important in this connexion. On the other hand, the later patient is under increasing pressure due to his conflicts with others. Unfavourable nature and environment develop together and influence each other. They are interwoven from babyhood. The environment influencing the manifestation of the hereditary disposition is already a reflected image of this disposition.

One might ask: Does value X depend on factor A more than on factor B? This question, however, presumes that factors A and B are independent of each other. If A and B are dependent on each other, the question makes no sense. The older theories asked how much the morbid causes were due to the hereditary disposition and how much to environment, and they forgot that the effects of hereditary disposition and of environment always act together and are always interdependent. It is true, they are independent as regards many qualities in animals and plants and as regards many physical diseases. The world of the human relationship, which is the decisive environment for the genesis of schizophrenia however, is very much dependent on the personality of the patient; on the other hand, the manifestation of his personality is always seen in his attitude to his environment. Nature and nurture – as far as schizophrenia is concerned – are pathogenic forces which are closely interwoven and not to be artificially separated.

In the light of these considerations the genesis of schizophrenia is dominated by the personal and the unique. The assumption of an impersonal, specific damage is no longer necessary. Therefore, just what has never been found is no longer needed. According to such a conception the essential disposition for schizophrenia is the lack of harmony of the inborn tendencies of adaptation to others. These tendencies are contradictory in themselves and incompatible in their nature. A disrupted condition of the world of interhuman relations results. The disturbed environment acts back on the weak personality. The result is the splitting of the personality, of the whole inner life, which we encounter in the schizophrenic. Schizophrenia is to be understood as a faulty development of the personality; this faulty development would be dominated by just as many interwoven outside dispositions and influences as any development of personality. However, we can only accept such an interpretation since we know that schizophrenia does not create symptoms quite alien to human nature and does not destroy for ever what belongs to human nature.

This conception has to be distinguished sharply from the older hereditary theories of a morbid gene, the manifestation of which could be influenced by environment; we do not postulate a definite morbid gene, the existence of which has never been proved; we formulate what better corresponds to immediate observation: the disharmonic direction of personality-development, interfering with a harmonious attitude to life and poisoning human relations. We do not visualize environmental influences as independent of hereditary dispositions, but essentially as the consequence of these dispositions. Unlike the old psychoanalytical theories we cannot see a specific psychic trauma (such as a specific character of the mother) or a specifically sensitive phase of development during which a trauma operates. We believe that the whole life experience has its significance in the development of schizophrenia, though it may be possible that some experience and some phases of development can be more important than others.

This conception corresponds essentially to Adolf Meyer's teaching on common-sense psychiatry and on schizophrenic reaction types. On the strength of recent clinical observations his doctrine can be better demonstrated and better understood than ever.

Why has such a conception not been widely accepted? Certainly because the conception of schizophrenia as a disease entity with a specific and single cause was dominant. As I have remarked, the hypothesis of a specific morbid cause has never been proved. It may be right despite the absence of proof, but we also have to consider the possibility that it is incorrect. For the older clinician schizophrenia appeared to be a tremendous catastrophe entirely contradictory and alien to human nature. He had to believe, therefore, that schizophrenia was created by some monstrous damage and so, logically, he could not accept that it was due to a multiplicity of factors similar to those that play a role in every man's development. But today we know that schizo-

phrenic life is not so absolutely alien to human nature as it might seem.

One argument for the concepts presented is based on our observations during the treatment of schizophrenics. I do not believe that a causal treatment of schizophrenia exists which is directed against one particular and single primary damage.

The technique in psychotherapy of schizophrenia has proved to be of little importance; it seems that the essential in the treatment of schizophrenics consists of three principles: The first is a steady, quiet appeal to the healthy within the morbid, to the patient's sense of human responsibility and dignity and to his membership of human society. In applying this principle, occupational therapy, organization of the patient's spare time and the way we talk to him, our way of being with him are the most important help. The second principle is surprise and shock, for instance in suddenly giving the patient an unexpected responsibility, or a sudden direct analytical interpretation, or discharging him unexpectedly from hospital and so on. The third (less important) principle is calming the patient if he is excited. All special techniques and all special methods of psychotherapy of the schizophrenic are efficacious if these principles are applied.

I should not like to maintain that every question regarding the mode of action of physical therapy in schizophrenia has been answered. I am inclined to think that the physical treatments fit in quite well with our psychotherapeutic work with schizophrenics: they create new natural and strong human relations; they mobilize vital forces by surprise and violent shock and they tranquillize, this frequently being a necessary condition for social readaptation.

We therefore see the therapy of the schizophrenic dominated by just the same forces which form and develop the personality of the healthy from childhood on. Active participation in society, the creation of close and happy contacts with others and mobilization of one's own energies in the face of danger are essential to both: essential in the development of everyone and essential in the therapy of schizophrenics.

It may be possible that these therapeutic observations are a hint that the development of schizophrenia can be understood as a perversion of the development of personality. Nevertheless we must continually study the objections against such a concept. It does not satisfy the clinician who seeks specific damage. It does not satisfy the psychoanalyst who wants psychoanalytical knowledge to be applied in a more detailed way. It does not satisfy the geneticist who would like to prove the importance of a mendelian heredity. The patho-physiologist will be particularly disappointed if the brilliant progress of our knowledge regarding phenylketonuria and other metabolic diseases has persuaded him that schizophrenia is to be explained as an inborn error of metabolism like many forms of feeble-mindedness. Last but not least the proposed concept does not satisfy us because it is too simple and banal and ends where it should begin: it should explain in detail the correlation between disharmony of hereditary dispositions and disharmony of life experience. Furthermore, it is quite possible that a great future discovery will disprove all that I have said.

It is an important aspect of present-day psychiatry that psychiatrists analyse their own attitude and emotions with regard to the patient and the patient's problems. This should be done not only during psychotherapy, but also with regard to our own scientific thinking. Contact with a schizophrenic patient is always a stressful experience. Something in us reacts to this experience as to a serious threat to our own existence. It is self-protection for the physician to draw clear limits between himself and the schizophrenic. The feeling of awe and anxiety in the presence of a schizophrenic is mitigated if we see in schizophrenia some obsession very alien to ourselves. Such an alien nature was considered in earlier centuries as something demoniac. Today it would be an emotional help for us to know that a morbid mutation, an inborn error of metabolism or a specific, tremendous exterior damage, anything not concerning ourselves, was the cause of schizophrenia. Our resistance to the concept of schizophrenia as something enclosed in our own mind can, of course, be quite rationally justified. It may perhaps also be welcome to irrational thinking.

The considerations I have presented contain much of what we know of schizophrenia and they disregard what is not knowledge, but speculation. Secondly, they give definite aims to research: we should not only continue to look for a specific cause of schizophrenia, we should also look for the laws for the correlation of the most varying influences on development. What periods of development are more decisive than others? What types of poisoned human relationships do more harm than others and to what personalities? What somatic influences and conditions also have influence on the morbid development? Thirdly, I think the conceptions I have presented allow us to judge our present treatment in the right light: they are a protection against the discouraging idea that all our present treatments of schizophrenia are only symptomatic, that they are only a miserable expedient, and that the efficacious great causal therapy is still to be discovered. For the moment, as long as our formulations are not disproved, we

can better evaluate our therapy. Our patient endeavour to understand the schizophrenic, to feel with him, to accompany him, to let him be active, and sometimes to shake him, corresponds to our conception of nature and genesis of the schizophrenic psychoses. We ought not to be ashamed of such a therapy. It is right that we believe in its value and in its sense. It is right that we devote a good part of our life's work to it and develop it further and further. We may hope that steady progress in the present therapeutic approach will bring even more help to our schizophrenic patients than we can give them today.

Finally, the correct therapeutic attitude towards a schizophrenic patient is easier when we accept him as a brother whom we can judge according to our own nature, than if we watch him as a person who has become unintelligible in his thinking and feeling and in principle a creature different from ourselves.

Summary

At the beginning of the century it was considered that the separation of the schizophrenic psychoses from the tremendous number of the mentally sick was a great advance. For half a century the principal aim of students of schizophrenia was assured: they sought to discover the single cause of a disease whose symptomatology and course seemed to suggest one single entity. These studies, however, were not successful. They did not lead one step nearer to the discovery of a specific cause of the hypothetical disease entity, schizophrenia. Today, we have to ask ourselves why a specific cause of schizophrenia has not been found. The reason may be simple: perhaps none exists! There may be many different pathogenic factors together responsible for the outbreak of the disease. Just as we cannot explain the development of the healthy personality by considering a single normal influence, we cannot understand the development of schizophrenia by considering a single damaging influence. In either case we have to deal with an integration of many dispositions and of many influences.

One thing is certain: disturbances very similar to schizophrenia arise from most varied types of damage. Both somatic diseases and psychological stress may be responsible for the outbreak. We may imagine, therefore, that even in the healthy subject there is some disposition in the direction of schizophrenic psychic life and that such a disposition may perhaps be a normal part of human nature. This, indeed, has been proved by research into the psychology of the healthy: beneath the surface of healthy psychic life enabling us to adapt to others and to the real world, there is hidden in every man a chaotic inner life which goes on without consideration of reality. This chaotic and illogical inner life cannot be distinguished from the schizophrenic way of thinking, imagining and living. Perhaps we may conclude: the symptomatology of schizophrenic psychoses is not always the same resulting from a common cause, but it is always of the same type, because schizophrenic disease reveals the same human tendencies.

Just as schizophrenic-like forms of life exist in a hidden form in the healthy, a healthy psychic life is hidden behind the morbid mask of the schizophrenic. There is not, if this is correct, a disease-process of 'schizophrenia' which would create a new kind of life and would destroy the habitual life for ever. Rather, in the schizophrenic individual irrational thinking and the corresponding disordered and contradictory emotions overflow. These lie beneath the surface in the healthy.

Forces very different in nature may destroy the dams protecting the healthy from being overwhelmed by this chaotic life. When these forces consist in somatic or in apparent psychological stress we call the resulting psychoses symptomatic schizophrenias or schizophrenic reactions. For the 'genuine' schizophrenias we do not know of any other damage but inborn disharmonic personality traits interwoven with unhappy and disharmonic life experience. Development into schizophrenia may be started by a disharmonic personality which creates disharmonic and dissociated human relations. The split-up life experiences would make it impossible to continue life as a harmonious, unsplit personality. Among other observations it is our present experience with therapy which supports such a conception: we treat schizophrenics with influences similar to those dominating the healthy development of ego and the healthy adaptation to reality.

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After an introduction by Sir Philip Hendy (*Director of the National Gallery*), a paper entitled **The Grotesque Head and the Grimace from Leonardo to F X Messerschmidt** was read by Mr David Kunzle (*National Gallery, London*).