

## Eugen Bleuler: Centennial Anniversary of His 1911 Publication of *Dementia Praecox* or the Group of Schizophrenias

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**In 1911, a book was published in Europe by Eugen Bleuler describing in detail asylum patients under his care who met clinical criteria for the psychotic disorder named *Dementia Praecox* by Emil Kraepelin. Bleuler's voluminous publication, now a classic to world psychiatry, validated Kraepelin's observations and extended them in ways that remain familiar to us a full century later in how we describe, diagnose, treat, and understand psychosis.**

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### Introduction

Emil Kraepelin introduced psychotic disorders to neurology, medicine, and the world on the eve of the 20th century with his description of *Dementia Praecox*.<sup>1</sup> He defined it as a dementing neurologic disorder, which, unlike dementing disorders in the elderly, had an “early” onset in the adolescent period of human development (*dementia praecox*). The disorder was characterized by psychotic symptoms (hallucinations, delusions, and disordered thinking), intellectual decline, functional paralysis, and early demise.

Eugen Bleuler followed Kraepelin and became the major figure to describe the characteristics of this syndrome in young adults, taking issue with Kraepelin on 2 points. He felt that cases of *dementia praecox* did not always arise in adolescence (*praecox*) nor did they always progress to intellectual dullness (*dementia*).

Bleuler regrouped the *mélange* of signs and symptoms of the disorder in ways that have changed to this day how we describe, diagnose, understand, and name this disorder. He started where Kraepelin left off and brought *dementia praecox* into the next century as schizophrenia.

Bleuler's magnum opus “*Dementia Praecox or the Group of Schizophrenias*” is a large monograph (book, p548) on this disorder which appeared in 1911

but which was not translated into English until 1950 by Joseph Ziukin, M.D. for the International Universities Press.<sup>2</sup> It was, and remains, second only to Emil Kraepelin's writing in the depth and breadth of initial descriptions of madness around the turn of the 20th century.

### Diagnostic Contributions

Bleuler identified mental functions, both simple and compound, and described how they became distorted and disorganized in schizophrenia. The altered mental functions that he regarded as fundamental to the disorder have come to be known as the 4 A's: association, affectivity, ambivalence, and autism. By fundamental Bleuler meant they were particularly characteristic of schizophrenia.<sup>3</sup> They are described in his book as follows

#### *Association*

In this malady, the associations lose their continuity. Of the thousands of associative threads, which guide our thinking, this disease seems to interrupt, quite haphazardly, sometimes such single threads, sometimes a whole group, and sometimes even large segments of them. In this way, thinking becomes illogical and often bizarre. Furthermore, the associations tend to proceed along new lines, of which so far the following are known to us: 2 ideas, fortuitously encountered, are combined into one thought, the logical form being determined by incidental circumstances. Clang-associations receive unusual significance, as do indirect associations. Two or more ideas are condensed into a single one. The tendency to stereotype produces the inclination to cling to one idea to which the patient returns again and again. Generally, there is a marked dearth of ideas to the point of monoidism. Frequently, some idea will dominate the train of thought in the form of blocking, “naming”, or echopraxia. In the various types of schizophrenia, distractibility does not seem to be disturbed in a uniform manner.

A high degree of associational disturbance usually results in states of confusion.

### *Affectivity*

In the outspoken forms of schizophrenia, the “emotional deterioration” stands in the forefront of the clinical picture. It has been known since the early years of modern psychiatry that an “acute curable” psychosis became “chronic” when the affects began to disappear. Many schizophrenics in the later stages cease to show any affect for years and even decades at a time. They sit about the institutions to which they are confined with expressionless faces, hunched-up, the image of indifference. They permit themselves to be dressed and undressed like automatons, to be led from their customary place of inactivity to the mess hall, and back again without expressing any sign of satisfaction or dissatisfaction. They do not even seem to react to injuries inflicted on them by other patients.

### *Ambivalence*

The tendency of the schizophrenic psyche to endow the most diverse psychisms with both a positive and negative indicator at one and the same time is not always quite explicit. Yet, after sufficiently long observation, one will find it to be present even in the mild cases. It is such an immediate consequence of the schizophrenic association disturbance that its complete absence appears highly improbable. It is for this reason that we include it among the fundamental symptoms.

The very same concept can be accompanied simultaneously by pleasant and unpleasant feelings (affective ambivalence): the husband both loves and hates his wife. The patient’s hallucinations reveal to the mother the “longed-for” death of the child by the unloved husband. She breaks out in endless sobbing and moaning. She suffers the most intense anxiety that they are going to shoot her and yet she constantly begs the attendant to shoot her. She claims there is a black man outside her room. Then she breaks into a startling confusion of tearful demands, complaints, and violence, demanding that she be kept in the hospital and permitted to join the black man. She verbigerates, “You devil, you angel, you devil, you angel.” (She is referring here to her lover.)

### *Autism*

The most severe schizophrenics, who have no more contact with the outside world, live in a world of their own. They have encased themselves with their desires and wishes (which they consider fulfilled) or occupy themselves with the trials and tribulations of their persecutory ideas; they have cut themselves off as much as possible from any contact with the external world. This detachment from reality, together with the relative and absolute predominance of the inner life, we term autism.

### *Schizophrenia “Dementia”*

Interestingly, Bleuler did not regard patients with schizophrenia to be demented in the classical sense of memory distortions and losses.

“In no other disease is the disturbance of intelligence more inadequately designated by the terms “dementia” or “imbecility” than in schizophrenia. We see absolutely nothing in this disease of “definitive loss of memory images” or other memory disturbances, which properly belong to the concept of dementia. Thus some psychiatrists are able to maintain that even the severest schizophrenics are not demented (p71).

Bleuler’s diagnostic contributions to each iteration of our current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic systems are clear, all the way up to (and through) DSM-IV. He may also have been one of the first to articulate that diagnosis is a gestalt, ie, that the recognition and labeling of disorder resides in the collective data set of history, symptoms, functional aberrations, etc., not in any “pathogrammaric”: sign or symptom. If there is any “required” element it is disability, ie, decline and loss of vital functioning in the domains of work and interpersonal intercourse.

### **Therapeutic Contributions**

Bleuler was not just an astute diagnostician and scholar. His book chapter on “Therapy” suggests that he was also a very kind, dedicated, and levelheaded clinician. The following are selected observations and prescriptions from his vantage point in 1911.

1. Except for the treatment of purely psychogenic disorders, the therapy of schizophrenia is one of the most rewarding for the physician who does not ascribe the results of the natural healing processes of psychosis to his own intervention.
2. As yet, we do not know of any real prophylaxis for this disease. Hereditary factors give us some indications that members of a severely tainted family should not marry.
3. Once the diagnosis is established as probable or certain, no physician will neglect to take these general precautions: the best physical hygiene in which sufficient sleep and nourishment are especially important, avoidance of all toxic or psychic excitants. However, we can go a bit farther. Strong affects facilitate the outbreak of acute attacks; much opposition aggravates the disease. Idleness facilitates the predomination by the complexes over the personality, whereas regulated work maintains the activity of normal thinking.
4. All ambitious plans must be given up. On the other hand, one should induce the patients to perform lighter tasks. The occupations should be selected in such a way that an occasional interruption will not matter too much and we can avoid conflict with the patients if

a hebephrenic mood prevents them from working. Farm work and gardening are of course, most suitable, especially because these occupations which are generally regarded as “healthy” are more readily accepted as being of therapeutic value.

5. Routine mechanical office work can be helpful in some cases. However, we must caution against having the patients engage in independent intellectual work, which involves a certain degree of responsibility. Faultless performance can hardly be expected and the unavoidable rebukes can greatly endanger the entire pleasure that the patients take in their work.
6. Unfortunately, it is necessary to discuss the recommendation that the patient marry. The consequences, of course, are most regrettable because a second family and, in addition, also perhaps the children (the hereditary factor cannot be excluded) are made unhappy. Under all circumstances, if the disease is diagnosed or suspected, marriage must be discouraged with the greatest emphasis.
7. With equal emphasis, one must warn against all expensive therapies. Doctors and the laity constantly recommend all sorts of “nervous cures” for chronic patients. Close, and sometime even distant, relatives often sacrifice all they own for a totally incurable patient, only to fall, together with the patient, into the greatest poverty later on. A small farmer with some property ruined himself financially because, among other things, some doctor has prescribed 2 bottles of expensive champagne daily for his daughter. Even in wealthier families, the education and upbringing of the healthy children frequently suffers because everything is being sacrificed, quite uselessly, on the one sick member. Let us openly say to ourselves and to others that, “at present, we know of

no measures, which will cure the disease, as such, or even bring it to a halt.”

8. In general, it is preferable to treat these patients under their usual conditions and within their habitual surroundings. The patient should not be admitted to the hospital just because he suffers from schizophrenia but only when there is a definite indication for hospitalization. The indication is, of course, given when the patient becomes too disturbing or dangerous, when restraint is necessary, when he presents a threat to the well being of the healthy members of his family, or when it is not longer possible to influence him. In the latter event, the institution will attempt to educate the patient to act in a more acceptable manner, after which he will be released. The only, and often very practical, criterion is the patient’s capacity to react in a positive manner to changes in environment and treatment.
9. Treatment of schizophrenia by medication does not exist.

I would have been glad to have Dr Bleuler as the treating physician for my patients. After 100 years, how much farther along have we come?

## References

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