Historical Review of the Concept of Schizophrenia

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A critical review of the changing concepts of schizophrenia will be attempted in this chapter. This review will not be a complete one; it will not include the pre-Kraepelinian conceptions, which now have only a historical interest; and it will omit entirely all those theories which have received transient and inconsequential consideration. The contributions published since 1955 will be discussed in the subsequent chapters of this book, in relation to the various aspects of the disorder. The contributions examined in this chapter are those of six authors who, in my opinion, are responsible for the evolution of the concept of schizophrenia from 1896 to 1955. These innovators are Kraepelin, Bleuler, Meyer, Freud, Jung, and Sullivan. A host of contributions, some of them very valuable, have been stimulated directly or indirectly by the works of these six men; and the reader who is interested may find an account of them elsewhere (Lewis, 1936; Beliak, 1948, 1957; Benedetti, Kind, and Mielke, 1957; Beliak and Loeb, 1969; Cancro, 1971, 1972).

Although our purpose here is to discuss six different views of

schizophrenia, it is obvious that these views in respect to this condition reflect conceptions toward the entire field of psychiatry, or toward the human psyche, and therefore we cannot help in several instances to refer to other psychiatric areas. These six views have enlarged our understanding of schizophrenia almost exclusively in a psychological frame of reference. Some of the mentioned authors worked and theorized from an organic point of view also, but only their work in the psychological areas has retained significance. For instance, Kraepelin's hypothesis about metabolic-toxic disorders in schizophrenia did not produce the same repercussions that his clinical description of the psychological manifestations did.

In contrast with the relatively nonextensive work of these six authors is the immense amount of the work of countless researchers who have attacked the schizophrenic enigma from a predominantly organic point of view. These researchers have followed the assumption that in the study of schizophrenia, as in the study of other diseases in biology, one should follow Virchow's concept that any kind of pathology means organic or cellular pathology. Under the influence of this concept, which for a long time has dominated the whole field of medicine, researchers have examined every possible spot of the body

of the schizophrenic patient from top to bottom, from the hair to the sexual glands, in a relentless attempt to find clues that would reveal the organic nature of this condition.

Even at present the organic studies of schizophrenia outnumber by far the psychological ones. The most important of them, or those that at least promise to open constructive avenues of research, will be discussed in Part Six.

Emil Kraepelin

Emil Kraepelin (1855-1926) was the first psychiatrist to differentiate from the mass of intramural mental patients that pathological entity which he called *dementia praecox.* He did so in 1896, although the nam*t dementia praecox* had already been used by Morel in 1860 and by Pick in 1891. Morel described his first case in a 14-year-old boy, and for him the word *praecox* meant that the demential state started early, or precociously, in life, in contrast to senile dementia, which occurred in old age. Kraepelin, too, following the observation of Hecker, used the term *praecox* to refer to the fact that the condition "seemed to stand in near relation to the period of

youth." In Kraepelin's writings and in the Kraepelinian approach, however, the term *praecox* acquired, explicitly or by implication, an additional meaning: the state of dementia was supposed to follow precociously or soon after the onset of the illness. Thus even in the name of the disease, as used by Kraepelin, one recognizes his finalistic conception: the fundamental characteristic of the disease is its outcome, a prognostic characteristic.

The major contribution of Kraepelin was the inclusion, in the same syndrome, of catatonia, already described by Kahlbaum, hebephrenia, and "vesania typica," also described by Kahlbaum, characterized by auditory hallucinations and persecutory trends. After examining and observing thousands of patients, and seeing them panoramically in space and time, Kraepelin was able to discern the common characteristics in these apparently dissimilar cases. The characteristic that impressed him most was the progressive tendency toward a state of dementia. The other patients who did not have this tendency, like the manic-depressives, would be separated from the praecox group and subsequently would be recognized as having other differential symptoms also. Using this method of observation, Kraepelin could differentiate and define as dementia praecox a

symptomatology consisting of hallucinations, delusions, incongruous emotivity, impairment of attention, negativism, stereotyped behavior, and progressive dilapidation in the presence of relatively intact sensorium.

In England, Thomas Clouston, in an impressive address that he delivered in 1888 as president of the Medico-Psychological Association, spoke of "adolescent insanities" and offered a description in many respects comparable to Kraepelin's. However, he did not separate the praecox cases from the manic-depressive, which at that time occurred quite frequently. Thus there is no doubt that Kraepelin deserves to be considered the first author who differentiated the disorder.

Once he defined this syndrome, Kraepelin tried his best to give an accurate description of it. Like a man working at a microscope, he described as many minute details as possible. His monograph *Dementia Praecox and Paraphrenia* (1919) remains until today the most complete description of the symptoms of the schizophrenic from a phenomenological point of view. The symptom is described and accepted as it is, with no attempt being made to interpret it, either

physiologically or psychologically. Some symptoms (for instance, negativism) were described for the first time by Kraepelin.

Kraepelin also divided the patients into three groups: the hebephrenic, the catatonic, and the paranoid. Later, he accepted the differentiation of a fourth type, the simple, as suggested by other authors. He also separated from dementia praecox, a new nosological entity, "paraphrenia." In this syndrome, too, the outcome is the fundamental consideration: in spite of the progression of the illness, there is no decay of the personality. As to the etiology, Kraepelin considered dementia praecox an endogenous illness, that is, one not due to external causes. At first he thought it was due to organic pathology of the brain; later he felt that it might be due to a metabolic disorder.

The great merit of Kraepelin consists in his having been able to synthesize successfully the works of Kahlbaum, Morel, Wundt, and others, and to organize them in his own system. We cannot fully appreciate his influence until we read a book of psychiatry of the pre-Kraepelinian era and evaluate the confusing picture of psychiatry in those days. Today it is impossible, however, not to see the

shortcomings of Kraepelin's conceptions of dementia praecox. The acceptance of the prognostic characteristic as the fundamental one cannot be considered a sound principle. First, as Kraepelin himself came to recognize, not all cases of dementia praecox end in dementia; as a matter of fact, some of them seem to make a complete recovery. Secondly, this finalistic or teleologic point of view is incompatible with the scientific method, which searches for the causes and not for the effects.

Although Kraepelin himself was probably unaware of this influence, this overall prognostic concept reinforced the popular fatalistic attitude toward mental illnesses and discouraged therapeutic attempts. Reading his monograph on dementia praecox, one cannot help admiring the accurateness of his description; however, his description is remarkable for its extension and completeness, not for its depth. The patient appears as a collection of symptoms, not as a person; or, if he appears as a person, he looks as if he belongs to a special species and thus should be differentiated from the rest of humanity and put into the insane asylum. The psychiatric hospital is a zoological garden with many differentiated species.

Kraepelin seems to see the patient as detached or to be detached from society. It never enters his mind that the schizophrenic may have been influenced by social forces, or may even be a product of society. Although his fundamental concept was the final outcome, that is, a temporal concept, he does not give a longitudinal picture of the patient. Except for the repeated mention of the fact that the patient decays progressively until he reaches a state of idiocy, we do not see in the Kraepelinian description different stages or any real movement, even toward regression. The patient is always seen in cross section.

It is often said that Kraepelin was more concerned with the structure of the psychic phenomena than with the content, that he was more concerned with how the patient thinks than with what he thinks. Undoubtedly he was not concerned with the psychological importance of the content of thought, but it seems to me that he was also not concerned with the real structure of patients' thoughts. A mere description of the symptoms is not a structural understanding.

When we examine the negative qualities of Kraepelin's conceptions, we are bound to be too harsh with him. It is really too easy for us to see what he did not see. Nobody would criticize Galileo

for not knowing the principles of electricity. If we concentrate on what Kraepelin did not give us, in comparison to others like Freud or Bleuler, we are bound to minimize his accomplishments, which are immense.

Kraepelin may be viewed as the Linnaeus of psychiatry, in comparison to Freud, who may be viewed as the Darwin. But as Linnaeus and Darwin were necessary in the development of biology, so both Kraepelin and Freud were necessary in the development of psychiatry. A great deal of resentment toward Kraepelinian psychiatry, which may be noted in some psychiatric circles, is due, actually, not to an attempt to minimize Kraepelin's accomplishments, but rather to a displeasure with the tenacity with which his concepts have been retained, even long after more penetrating ones have been formulated. Zilboorg (1941) wrote that "the system of Kraepelin appears to have become a thing of the past as soon as it announced its own birth in 1896." In a certain way this is true, because Sigmund Freud published his first outstanding book in the same year. On the other hand, one may say that even today Kraepelinian psychiatry is the best known in the world. Thousands and thousands of patients are still viewed and classified as Kraepelin taught, and until the middle 1940s, in the

United States, too, they were still labeled with the name *dementia praecox.* [1]

Eugen Bleuler

Kraepelin's contributions were not accepted without objections. Among the well-known psychiatrists who opposed most of his views were Ernest Meyer, Korsakov, Bianchi, Serbsky, and Marandon de Montyel.

Eugen Bleuler (1857-1930), a Swiss psychiatrist whose role in the history of psychiatry will remain an important one, accepted much of Kraepelin but revitalized the Kraepelinian concepts and revised them, making a strong attempt, though not a thoroughly successful one, to go beyond a purely descriptive approach.

In 1911 Bleuler published a monograph on dementia praecox that was the result of many years of study and research.[2] He renamed the syndrome "schizophrenia," implying that a splitting of the various psychic functions, rather than a progression toward a demential state, was one of the outstanding characteristics. He delivered a blow to the Kraepelinian concept of dementia praecox as a disease entity,

inasmuch as he included in the schizophrenic group many syndromes that at that time no one was prepared to consider as being related to schizophrenia. He included in the schizophrenic group psychoses that arise in psychopathic personalities, alcoholic hallucinoses, prison psychoses, and cases of symptomatic manic-depressive psychoses. Furthermore, he thought that the largest number of cases of schizophrenia are latent cases; these patients are never hospitalized because the symptoms are not severe enough, but still they show oddities of behavior that are attributable to an insidious schizophrenic process. As several authors have remarked (Morselli, 1955; Stierlin, 1965, 1967), Bleuler also considered and humanized the concept of schizophrenia by pointing out that even normal persons, when preoccupied or distracted, show a number of schizophrenic symptoms, such as "peculiar associations, incomplete concepts and ideas, displacements, logical blunders, and stereotypes." He added that "the individual symptom in itself is less important than its intensity and extensiveness, and above all its relation to the psychological setting."

Bleuler classified the symptoms of schizophrenia in two sets of groups: the groups of fundamental and accessory symptoms and the groups of primary and secondary symptoms. The fundamental

symptoms are not necessarily the primary ones; they are the symptoms that are present to an extent in every case of schizophrenia, whether latent or manifest. The accessory symptoms are those that may or may not occur. Among the fundamental symptoms Bleuler included the disorder of the process of association, which he considered the most important characteristic of schizophrenia, and also a particular type of thinking and behavior that he called autism. Among the accessory symptoms he included the acute manifestations of the psychosis, like delusions, hallucinations, catatonic postures, and so forth. Primary symptoms are directly related to the disease process; they are the necessary phenomena of the disease. The most important of them is again the association disorder. Secondary symptoms are caused by a combination of the action of the primary ones and the action of psychogenic factors.

The most important contributions of Bleuler were those related to his study of the process of association and disturbances of the affective life, the concepts of autism and ambivalence, and his interpretation of negativism.

The disorder of the process of association, according to Bleuler,

involves every aspect of schizophrenia. Whereas, on the one hand, Bleuler enlarged the concept of schizophrenia by making the Kraepelinian nosological entity less rigid and less specific, he tried, on the other hand, to individualize the essential mechanism of the schizophrenic process. He thought that it consisted of a loosening of the associations of ideas. This mechanism may range from a maximum, which corresponds to complete incoherence, to a minimum, which is hardly perceptible. He writes: ". . . single images or whole combinations may be rendered ineffective, in an apparently haphazard fashion. Instead, thinking operates with ideas and concepts which have no, or a completely insufficient, connection with the main idea and therefore should be excluded from the thought process. The result is that thinking becomes confused, bizarre, incorrect, abrupt. . . Bleuler described accurately the various degrees of this associative disorder and related symptoms such as blocking, elisions, logical errors, and so on, but he was not able to infer any underlying basic formal mechanism. He limited himself to the formulation that these symptoms were the result of a loosening of associations. As far as their motivation was concerned, Bleuler accepted Freudian mechanisms quite often. Blocking was seen by him as an exaggeration of

repression. He felt that psychological complexes might explain the combinations of ideas in a condensed or bizarre pattern. He accepted the Freudian concept of unconscious motivation and of symbolism, especially in explaining hallucinations and delusions. He thought that delusions result, not from a defect in logic, but from an inner need. At the same time, he expressed the opinion that it was not enough to explain everything with dynamic processes.

Bleuler went further than Kraepelin; he wanted to explain symptoms in respect to their psychological content as well as their structure. As to the content, he accepted Freud's explanations. He realized, however, that these were not enough; and although he was not able to formulate clearly what was missing in the Freudian approach, it is obvious that he searched for a structural or formal explanation of the symptoms, that is, he would have liked to have known why the symptoms have specific manifestations in schizophrenia. He tried to solve the problem by assuming that the structural defect involved always the loosening of associations; but he could not go beyond this point, and therefore his formal studies remained as descriptive as Kraepelin's. Although he might have been influenced by Wernicke's "concept of sejunction," Bleuler did not

attempt to give an anatomical interpretation of the symptoms. On the other hand, because he could not explain everything with Freudian mechanisms, he could not dismiss the idea that schizophrenia might be due to an underlying organic disease. In his book he mentions the possibility that mental causes produce the symptoms, but not the disease. He states that the disease process may be due to some kind of toxin, as is rheumatism. Thus, Bleuler himself is a good example of that ambivalent attitude which he was the first to describe; he expresses the feeling that schizophrenia is a psychogenic disorder, and yet he cannot dispel the idea that it may be organic in origin.

This concept of ambivalence, which Bleuler first described in psychotics, has since played an important role in psychiatric thinking, not only in reference to psychotics, but also in reference to neurotics and normal human beings. By ambivalence Bleuler meant the simultaneous occurrence of two opposite feelings for the same object, such as in the case of the husband who both loves and hates his wife. He found this symptom in every schizophrenic and thought that the most marked form of it was inherent in catatonic negativism. Shortly after the publication of his major book, Bleuler became less ambivalent and, as Stierlin (1967) put it, grew “defensive about his Freudian

leanings." He strongly reiterated that only symptoms may come about in the ways described by Freud and Jung, but the illness itself was probably the result of organic causes, as Kraepelin had postulated (Bleuler, 1913 *b).*

Bleuler thought that the affective disorders that occurred in schizophrenia were not primary but secondary. He was one of the first to note that when the patients' complexes were involved, the feelings of the patients were normal or even exaggerated. He also noticed that patients who appeared completely apathetic were capable of complete or partial recoveries. He saw the apparent loss of affect as due to repression.

The concept of autism is another of Bleuler's major contributions. He used this term to refer to a certain tendency to turn away from reality, accompanied by a certain type of thinking. Autistic thinking, according to Bleuler, as opposed to logical thinking, does not represent occurrences in the outer world and their associations; as a matter of fact, it excludes many external and internal facts. The autistic patient tends to live in a world of fantasy, where symbolization is used constantly. Autistic thinking is not bound by the laws of logic and

reality. “It is unlogical and permits the greatest contradictions with the outer world and in itself.” By failing to take into consideration the facts of reality it becomes “dereistic.” The autistic person identifies wishes or fears with reality. “The fear of having enemies is for his autistic thinking identical with the fixed conviction that they exist.” Autistic thinking flourishes particularly in schizophrenia, but it may occur even in normal situations: for instance, in children when they play; in subjects that are not sufficiently accessible to our knowledge and our logic, such as religion, love; or wherever the emotions “obtain too great a significance” (Bleuler, 1913a).

Undoubtedly it is to Bleuler’s credit that he defined and described this type of thinking, which is so different from what is generally called logical thinking. However, it must be remembered that fundamentally Bleuler has given us only a description of it. Here again it should be stated that he accepted Freudian interpretations in regard to the content; from a formal point of view, he limited himself to saying that this type of thinking was not logical. He felt that his concept of autism nearly coincided with Freud’s concept of autoerotism and with Janet’s “loss of the sense of reality.”

As far as negativism is concerned, Bleuler thought that it could not be explained solely as a motor phenomenon (1912a, 1950). He was inclined to consider it as a psychological attitude. The patient considers all stimuli coming from the environment as hostile and disturbing, and therefore he tries to block them off. This psychological interpretation allows for the explanation of negativism as being expressed only at times toward certain persons. As was mentioned before, Bleuler saw the negativistic attitude as being related to the ambivalent attitude. He also felt that intellectual negativism might be based on a general tendency of ideas to associate with their opposites.

Thus we may summarize the contribution of Bleuler as follows:

1. He saw the schizophrenic syndrome, not as a progression toward dementia, but as a particular condition characterized mainly by a disorder of association and by a splitting of the basic functions of the personality.

2. He enlarged the boundaries of what should be included under this syndrome.

3. He differentiated a new subtype, the simple (or simplex) type, using the name and some of the concepts already partially advanced by Weygandt (1902) and by Diem (1903).

4. He emphasized that affectivity is not absent in schizophrenia, and that it plays a more important role than it was then thought.

5. He attempted not only to describe the symptoms, but to explain them. As to their psychological content, he accepted Freud's contributions. From a formal point of view, his efforts have remained unfulfilled.

6. He gave psychiatry the concepts of autistic thinking and of ambivalence.

7. He enlarged the psychiatric terminology by coining the following well-accepted terms: schizophrenia, depth psychology, autism, ambivalence, and dereism.

Adolph Meyer

Adolph Meyer (1866-1950), a Swiss physician who came to the United States in 1892, was for several decades the leading American psychiatrist. Schizophrenia was one of his major interests from the beginning of his career (Lief, 1948; Meyer, 1906, 1910, 1912a, 1912b). Meyer was dissatisfied with the role given to heredity and autointoxication in the etiology and pathogenesis of dementia praecox. He felt that perhaps the psychological factors to which laymen and old

schools of psychiatry had given so much importance in the past should be reconsidered.

Kraepelin had given an accurate description of the disease after the onset. Meyer advocated that the patient be studied "longitudinally"; from the beginning of his life, all the factors that might have contributed to the mental condition should be searched and examined. Meyer thus became convinced that dementia praecox was the result of an accumulation of habit disorders or faulty habits of reaction. The individual who is not able to cope with the problems and difficulties of life, and who is confronted with failure after failure, may tend toward what Meyer called substitutive reactions. At first these new habits appear as "trivial and harmless subterfuges," such as day dreaming, rumination, decrease of interests, and so on, but later they become harmful, uncontrollable, and tend to assume definite mechanisms, like hallucinations, delusions, blocking, and so forth. These anomalous mechanisms, according to Meyer, are partially intelligible as substitutions for "efficient adjustment to concrete and actual difficulties." Meyer felt that it was possible to formulate the main facts appearing in the history of most cases as a "natural chain of cause and effect." He saw dementia praecox as "the usually inevitable

outcome of (1) conflicts of instincts, or conflicts of complexes of experience, and (2) incapacity for a harmless constructive adjustment."

Meyer called his concept "dynamic," inasmuch as it implied a longitudinal interaction of forces; he also called it "psychobiological," inasmuch as it considered the psychological as well as all the pertinent biological factors. He renamed the disorder *parergasia,* which etymologically means incongruity of behavior. This term, however, has not been accepted outside of his school.

An unbiased critic may find great merits and great pitfalls in Meyer's concepts. The greatest merit lies in his having reaffirmed the importance of "mental" or psychological factors in the etiology of schizophrenia. The longitudinal aspect of the process of maladjustment, before it reaches psychotic proportions, had not been adequately stressed before by any other school, except the psychoanalytic. In other respects, however, Meyer's formulations remain vague and inadequate in explaining any specific characteristics of schizophrenia. Accumulation of faulty habits and of repeated failures may already indicate some preexisting abnormality, either

organic or environmental. Meyer explains the progression of the habit deterioration as caused by the gradual substitution of increasingly inferior and distorted material. Finally, the distortions are so great that they become full-fledged schizophrenic symptoms. The role that anxiety plays in this process is not clearly apparent from his writings. Furthermore, how and why these faulty habits lead necessarily to schizophrenia, and not to other psychopathological reactions, remains unexplained. Meyer seems to believe that there is only a gradual or quantitative difference between faulty habits and clear-cut schizophrenic symptoms. He seems to consider the faulty habits only as the expression of maladjustment at a realistic level; he does not stress enough the point that what he calls substitutive habits often have a symbolic or nonapparent meaning. Moreover he does not emphasize that schizophrenic symptoms have an archaic or primordial aspect that is lacking in prepsychotic faulty habits.

In addition, although some schizophrenic-like or symbolic manifestations may appear as faulty habits in everybody's life, a constellation of them, as is found in schizophrenia, seems typical or characteristic enough, even from a qualitative point of view. The faulty habits that we may find in human beings are innumerable, but the

schizophrenic symptoms, from a formal point of view, are strikingly similar in every patient. The patients do not appear only as caricatures or exaggerated expressions of their prepsychotic personality; the greatest number of their characteristics have undergone a drastic metamorphosis and have been channeled into few definite patterns. In other words, if a substitution of faulty habits occurs, it is because they are substituted by schizophrenic symptoms. Meyer's interpretation of schizophrenia as a substitution of faulty habits is therefore not an interpretation. In addition, those faulty habits found in the history of many schizophrenics are found also in the history of many psychoneurotics.

Meyer is correct in considering schizophrenia a progressive pathological adjustment; however, from his writings one does not learn when a patient with faulty habits is to be considered an overt schizophrenic. It may be asserted that the faulty habits of the schizophrenic disclose some kind of malignancy that is not present in the faulty habits of the neurotic. This concept had led many psychiatrists to make an accurate search for those latent schizophrenic symptoms that seem to be psychoneurotic traits. A pseudoneurotic type of schizophrenia has even been described (Hoch

and Polatin, 1949). Because many of these patients do not move toward either a more or less psychotic condition, it remains for the individual observer to classify them in one way or the other.

No doubt this search for latent schizophrenia in apparent psychoneurotics has resulted in the early diagnosis of many schizophrenics. However, this tendency is perhaps exaggerated in some sectors and for some time may have had a deterrent effect as far as therapy is concerned. In fact, until the early 1940s a diagnosis of schizophrenia discouraged a psychotherapeutic approach, which Meyer himself usually found "negative and rarely clearly positive" in these cases (Meyer, Jelliffe, and Hoch, 1911).

Summarizing, we may state that Meyer's major contribution was his emphasis on a longitudinal study of the patient and on the reaffirmation of the importance of the psychogenic factors. His approach must therefore be considered a partially dynamic one. Its dynamism is somehow stunted by the fact that the early environmental factors, acting during the childhood of the patient, do not receive the proper stress, and by the fact that its symptoms are more or less considered from a realistic, that is, nonsymbolic, point of

view. The dynamic psychoanalytic point of view not only is more complete, but actually preceded the psychobiological one historically.

Although Freud was born before Meyer, and some of the main psychoanalytic concepts preceded those of the psychobiological schools, we have disregarded chronological order and have discussed Meyer before the founder of psychoanalysis. Conceptually, in fact, Meyer does not go as far as Freud and seems to provide a bridge between the Kraepelinian-Bleulerian points of view and those which follow a fully psychodynamic approach. Moreover, in the first few decades of its existence, psychoanalysis devoted itself almost exclusively to the psychoneuroses, so that the psychobiological approach had an opportunity to gain a respectful place in the study of schizophrenia.

Sigmund Freud

Whereas the German schools of psychiatry had been interested mainly in the psychoses, the French schools centered their interest on the study of the psychoneuroses. Sigmund Freud (1855-1939), himself an Austrian, after spending one year in Paris at the school of Charcot,

felt the influence of the French school of psychiatry more than of any other. Thus we find that throughout his life he paid only secondary attention to the study of the psychoses. Freud's influence on psychiatry as a whole, however, is of such magnitude and of such a revolutionary nature that even the field of psychoses had to be totally reviewed in the light of his contributions.

Because of his special interest in the psychoneuroses, Freud was predisposed to see the psychoses, not as clinical entities completely unrelated psychologically and etiologically to the psychoneuroses, but, on the contrary, as having the same basic functions and mechanisms. This point of view was already a fundamental innovation in a psychiatry that insisted on individualizing nosological entities.

In one of his first psychoanalytic papers (1894), written nine years before the first dynamic interpretations of Adolph Meyer, Freud first described how unbearable ideas may give rise to hallucinatory psychoses. The unbearable idea is rejected by the ego, but the attempt to reject it is not successful. The idea comes back as a hallucinatory wish-fulfillment. The girl who could not accept the fact that she was not loved by a certain man, in her delusional system saw him and

heard him near her.

In another early paper (1896), Freud gave the dynamic interpretation of what seemed at first to be a case of chronic paranoia, but which later was recognized as a case of the paranoid type of dementia praecox. In this paper, for the first time in the history of psychiatry, the term *projection* was used, and this mental mechanism was explained. Freud found that in this case, too, as is common with neurotics, the nucleus of the psychical mechanism was repression. However, in this case repression of self-reproach is "projected" onto others who thus become the persecutors.

In another paper of paramount importance (1911) that reported Schreber's case, Freud described other projection mechanisms. He showed that the rejection of a homosexual wish accounted for the persecutory complex. The proposition "I (a man) love him (a man)" is not accepted by the patient, who wants to deny it with the contradictory proposition "I do not *love* him, I hate him." "I hate him," by projection, becomes transformed into "He hates me." Thus from a homosexual wish a delusional idea is formed.

According to Freud, in erotomania the mechanism is the following. The patient, who does not want to admit attachment to a man, forces himself to think, “I do not love him—I love her” (that is, “I do not love a man, I love a woman”). By projection, “I love her” becomes “She loves me.” Delusions of jealousy in women have a similar mechanism. “It is not I who love women, but he (my husband) who loves them.” In every case the delusion is a defense or an attempt to deny the homosexual wish.

It is only with his paper on narcissism (1914) that Freud applied his libido theory to the interpretation of schizophrenia and could integrate the other psychoanalytic concepts in the interpretation of this psychosis. Contrary to Kraepelin, Bleuler, and Meyer, Freud felt that the essential characteristic of schizophrenia was the change in the patient’s relationship with people and “the other objects” in his environment. Other psychiatrists had already noticed that the schizophrenic is remote and disinterested in other people. Freud interpreted this withdrawal as withdrawal of libidinal cathexes. What other authors consider affective disposition for the various components of one’s life and environment was for Freud cathexis, that is, an investment of energy or libido. When the libido is withdrawn

from the environmental objects (or rather from the mental representations of these objects), we have a state of narcissism. Decathexis (or withdrawal of libido) in the schizophrenic psychosis has the role that repression has in psychoneurosis. Now the withdrawn libido is directed into the self. When the ego becomes hypercathected, the result is megalomania. When the body becomes hypercathected, the result is hypochondriasis. Freud believed that all cases of schizophrenia start with either megalomania or hypochondriasis. The libido, which in other conditions withdraws to less primitive points of fixation, in schizophrenia withdraws to a narcissistic level. A narcissistic regression that entails regression of ego functions ensues.

Most schizophrenic symptoms, including thought disorders, have to be interpreted as impairment of ego functions and expression of the resurgence of the primary process. The primary process is a way of functioning of the unconscious, as well as of mental life in early childhood, before the system preconscious comes into being (see Chapter 15). According to Freud, in schizophrenia there is an attempt at restitution; that is, an attempt to invest again with energy (or to recathect) the objects that have been decathected. Hallucinations and

delusions are interpreted by Freud as attempts to reestablish contact with the world, to reinvest energy in the environment. In other words, in psychosis there is not only loss of reality, but also remodeling of reality (1924b). Psychosis, whether in paranoia or dementia praecox, substitutes something for what it denies; the symptom is not only regressive, but also restitutional. Catastrophic delusions of cosmic magnitude, like the experience of the "end of the world," often found in these patients, are withdrawal of libido. Things become indifferent or irrelevant and may appear ruined or dissipated. The delusion formation is interpreted as an attempt at recovery, a process of reconstruction, inasmuch as it is a method used to recapture a relationship, though a distorted one, with the world.

At first Freud thought that the schizophrenic regression is the result of strong instinctual demands with which the ego is not capable of coping. Especially in his early theories, there is a neglect of the role played by the ego and superego in determining the disequilibrium that brings about the disorder. However, in his book *The Ego and the Id* (1923), Freud wrote that neurosis is the result of a conflict between the ego and its id, whereas psychosis is the analogous outcome of a similar disturbance in the relation between the ego and its

environment (the outer world). In the paper “Neurosis and Psychosis” (1924a), he wrote that whereas in neurosis the ego, in virtue of its allegiance to reality, suppresses a part of the id, in psychosis the ego, in the service of the id, withdraws itself from a part of reality. In other words, the ego accepts part of the id.

Freud also never fully evaluated the role of anxiety in schizophrenia. His second theory of anxiety, which would have helped him greatly in this attempt, was formulated in 1926, after he had already written his works on the psychoses.

Any attempt to give an adequate account of the importance of Freud’s contributions to the field of schizophrenia remains somewhat unfulfilled because the whole psychoanalytic theory would have to be repeated, each part of it having a direct or indirect relevance.

Many of Freud’s theories have to be discarded. It is not true that schizophrenic regression is caused only by instinctual demands. Even such orthodox Freudians as Arlow and Brenner (1964, 1969) recognize how little importance Freud gave to the ego and superego. The withdrawal of libido to the narcissistic level can hardly explain in

itself the specific characteristic of schizophrenia. On the other hand, the concept of regression as a return to earlier levels of integration is acceptable to many authors if it is separated from the concept of libido. The concept of regression has replaced that of deterioration in schizophrenia. The patient returns to infantile or archaic levels of integration because he is unable to function at a higher level. These levels, however, are not necessarily representative of earlier levels of sexual development, as Freud thought. The most prominent ego psychologist of the orthodox Freudian school, Hartmann (1953), added to Freud's concepts by postulating that schizophrenia is due to a failure to neutralize sexual and aggressive energy.

It is also not true that all schizophrenic psychoses start with megalomaniac or hypochondriacal syndromes. The thought disorders of the schizophrenic cannot just be labeled regressive aspects of ego functions without further analysis. On the other hand, the whole psychodynamic interpretation of schizophrenia can benefit immensely from concepts developed by Freud in reference to other subjects. Perhaps of all the contributions of the founder of psychoanalysis, the most important in relation to schizophrenia is the concept of symbolization. According to this concept, the symptoms are no longer

accepted at a phenomenological level, but as substitutes for something else that they symbolize. The repressive forces of the ego transform the symptoms in such a way that they are no longer recognizable to the patient as attempts to fulfill objectionable wishes. The study of symbols, which Freud made in his masterful book on dreams (1901), was later extended, especially by Jung, to the field of schizophrenia. Symbolization is possible in most cases through the use of the primary process.

Freud's important concepts such as those of the unconscious, repression, and transference have a great value when they are applied also to schizophrenia. Rather than to attempt in this book a too sketchy account of their significance, the reader is referred to the usual textbooks of psychoanalysis and especially to the writings of Fenichel (1945), Drellich (1974), Greenson (1974), and Freud himself (1938). It is important, however, to mention here that the significance of these concepts in schizophrenia is somewhat different from that derived from their application to neuroses. For instance, the unconscious decreases in extension in schizophrenia as a consequence of a partial return to consciousness of what is generally repressed in psychoneuroses and under normal conditions. The concept of

transference is applied by Freud to schizophrenia in a negative way. According to him, all the libido in the schizophrenic is withdrawn from external objects; and therefore no transference, no attachment for the analyst, is possible. The result is that the patient is scarcely accessible to analytic treatment. This idea of Freud's discouraged many therapists from attempts to treat schizophrenics, although, as Fromm-Reichmann wrote (1952), Freud hoped that future modifications of the analytic technique would make schizophrenics, too, amenable to treatment.

Freud was the first author who really succeeded in explaining the content of this psychosis in psychological terms. He was also the first to disclose in a convincing manner the importance of psychological factors in the etiology of this condition. He did not limit himself, as Meyer did, to the interpretation of the symptoms as faulty patterns, but also uncovered their symbolic meaning.

Freud was also successful in explaining, at least partially, the formal aspects of several symptoms, such as projections. His concept of regression remains a fundamental one in the field of schizophrenia. However, the excessive importance that he gave to sexual frustrations

as the cause of the regressions did not permit him to give enough consideration to the patient's total interpersonal relations.

Carl G. Jung

Of the psychoanalysts who departed from Freud, Carl G. Jung (1875-1961) was the first to make outstanding contributions to the field of schizophrenia. His book *Psychology of Dementia Praecox* was written in 1903, nine years before his break with Freud (American edition, 1936). In this book Jung described the importance of the autonomous complex. Certain French authors, in particular Charcot and Janet, had already postulated that a series of ideas, removed from consciousness, maintain a more or less independent existence. Janet attributed the phenomenon to the so-called *abaissement du niveau mental.* Jung added that the dissociation of this autochthonous group of ideas was dynamically determined. Word association tests convinced him that the dissociated ideas were emotionally charged and that the defense mechanisms that isolated them were the same as those described by Freud in hysterical patients.

Jung felt that delusions, hallucinations, and other schizophrenic

symptoms were due to the activity of the complex, which could not be under the control or correction of consciousness. He criticized those theories that interpreted the apparent incongruity between the ideational and affective functions of the schizophrenic as due to psychic ataxia (Stransky, 1903). The *belle indifference* of hysterics is a reaction to oversensitiveness; why not accept the same mechanism in dementia praecox? He thought, however, that the hysterogenic complex causes manifestations that are reparable, whereas the effects of dementia praecox are not. He thought also that possibly the emotional disturbance in dementia praecox engenders an anomalous metabolism or toxin that injures the brain in a more or less irreparable manner, so that the highest psychic functions become paralyzed.

Jung is thus the first author to conceive of the possibility of a psychosomatic mechanism in schizophrenia. According to him, it is not an organic disorder that produces the psychic disorder; on the contrary, the emotional disorder produces an abnormal metabolism that causes physical damage to the brain. This fact is particularly interesting in that, for the first time, the nervous system itself is considered the victim of a psychosomatic disorder. Jung, however, considers this possibility as a mere hypothesis and does not exclude

the idea that a change of metabolism may be primary, as Kraepelin suggested. On account of this metabolic disorder, the last accidental complex may become “clotted” or “curdled” and thus determine the content of the symptoms.

Jung stated that the “essential basis of our personality is affectivity.” Thought and action are only “symptoms” of affectivity. Affectivity is the dynamic force of the complex, which may occupy the whole mental field and disturb many of the ideational processes. Jung referred to the disturbances as he noticed them in his experiments on associations, but he did not give a complete explanation of the formal mechanisms of schizophrenia. According to him, the autonomous complex disturbs the concentration of the patient and paralyzes all other psychic activities. Recognizing that the psychological mechanisms of dreams are closely related to those of dementia praecox, he wrote, “Let the dreamer walk about and act as though he were awake and we have at once the clinical picture of dementia praecox.”

In a paper originally published in 1908 he stated that some unknown factor of predisposition may produce a nonadaptable

psychological function that can develop into manifest mental disorder (1917). In its turn, the mental disorder may determine organic degeneration with its own progression of symptoms. In the same paper he wrote that there is overwhelming proof that a primary psychological fault in function exists from the time of childhood. He also added that borderline cases of dementia praecox had been restored to normal life with analytic treatment.

In a 1913 paper Jung differentiated his psychological types, formulating a concept that was to have great importance in psychiatric thinking (1920, 1933). His first thoughts about a psychological classification actually originated from his effort to compare hysteria and dementia praecox in every possible way. He felt that whereas in hysteria one always finds an "extrovert personality," as he called it, with an exaggerated emotivity and psychic energy directed centrifugally, that is, toward the environment, the opposite is true in dementia praecox. In dementia praecox the psychic energy is centripetal, that is, directed away from the environment and toward the self, the emotivity is decreased, the personality as a whole is what he called "introvert." These early studies of Jung stimulated a subsequent series of studies of the personality of the schizophrenic.

Others, like Kretschmer, added a physical counterpart to Jung's psychological description. According to Kretschmer the introvert has an asthenic and the extrovert a pyknic constitution (1934).

Another of Jung's concepts that was important in his interpretation of schizophrenia was his hypothesis of the collective unconscious (1921). Jung was very much impressed by the similarity of myths all over the world in spite of geographical, historical, and racial differences. He explained this similarity as the manifestation of a general or collective unconscious that stores the primordial images or *archetypes* that have been deposited there as a result of numerous recurrences of identical situations. Thus our personal psyche rests on a deep impersonal psyche. Jung thought that it was not enough to interpret the symptoms of the patient, as Freud did, from the information derived from the detailed personal history of the patient, but that it was necessary to go beyond. For instance, a person's image of parents cannot be attributed only to his childhood memories of his parents. The images of father and mother acquire a stronger value and intensity on account of the archetypical parental image stored in our collective unconscious.

Jung minimized the effect of culture and society on the individual psyche. Some of the patterns that he attributes to the collective unconscious are the effect of the impact of culture on the individual. The individual's image of his mother is not only the result of what he thinks and feels about his own mother on account of his memories of her, but also the result of what culture teaches him that mother is.[3] Certainly in pathological conditions, and especially in schizophrenia, archaic modes of thinking and feeling resurge. However, only the formal mechanisms, or rather the propensity for those formal mechanisms, may be attributed to nonacquired factors. We may call these factors functions of our nervous system or of our collective unconscious, as we wish. The content and the motivation of those emotions and thoughts, however, to a large extent originate in the environment of the individual, that is, in the family and in his culture. The explanations of symptoms go beyond the study of the personal history of the patient and the environment to which he was exposed. Jung is right in this respect; however, what is not explained by personal and environmental factors is the *formal* aspect of the symptom, or the psychological structure.

Jung's theoretical formulations force one to attribute more

importance to congenital or hereditary factors than to environmental ones. Nevertheless they have not led to major therapeutic errors. In certain cases, therapy may solve psychological problems no matter whether we think they are due to the collective unconscious or to social forces. Thus, the Jungian approach has helped many psychotics, and especially borderline cases (Baynes, 1949).

In a paper read in 1939 at the Psychiatric Section of the Royal Society of Medicine, Jung reiterated some of his previously expressed ideas and added a few others. He criticized the concept of latent psychosis. A latent psychosis is nothing else than the possibility that an individual may become temporarily mentally ill at some period in his life. The existence of unconscious material in his mind proves nothing. Such material is found in neurotics, artists, poets, and normal people. According to Jung, "The possibility of a future psychosis has nothing to do with the peculiar contents of the unconscious mind. But it has everything to do with the question whether the individual can stand a certain panic, or the constant strain of a psyche at war with itself. ' ' Jung states that the psychosis is generally interpreted from two points of view, either as a primary weakness of consciousness or as an "inordinate strength of the unconscious." He believes that the

second theory "cannot be easily dismissed, since it is not unthinkable that the abundant archaic material could be the expression of a still existing infantile, as well as primitive, mentality. It could be a question of atavism." He adds, "I seriously consider the possibility of a so-called *development arrete,* where a more than normal amount of primitive psychology remains intact and does not become adapted to modern conditions."

Jung's contributions to other fields are too extensive to be reported here. The reader is referred to the original works of Jung as well as to the writings of Jacobi (1943) and Henderson and Wheelwright (1974). Jung's major contributions to the study of schizophrenia can be summarized as follows:

1. He was the first to apply psychoanalytic concepts fully to schizophrenia. He described the existence of the autochthonous complex in this condition and felt that affectivity was the dynamic force of the complex.

2. He was the first to see the possibility of psychosomatic involvement of the central nervous system in schizophrenia, although he did not formulate his concept in these words.

3. He attempted a description of the basic personality of the schizophrenic, which he identified with the introvert type, and contrasted it with the personality of the hysteric, which he identified with the extrovert type.

4. He advanced the theory of the collective unconscious. According to him, many symptoms of schizophrenia were the reproductions of the archetypes deposited in our collective unconscious.

5. He thought that schizophrenia was due to unusual strength of the unconscious and that an abnormal number of atavic tendencies did not adjust to modern life. With this last point, Jung seemed to reaffirm the importance of congenital factors and to minimize greatly the role played by environmental or interpersonal forces.

Harry Stack Sullivan

Harry Stack Sullivan (1892-1949) is the American psychiatrist who has made the most valuable contribution to the understanding of schizophrenia in a psychological frame of reference.

The full evaluation and assessment of this man in the history of psychiatry have not yet been accomplished. Even in the short period since his death, his appreciation has undergone various changes. His

greatest merit consists of having added the interpersonal dimension to the field of psychiatry. More than any predecessor, he has shown that one becomes a person mainly by virtue of relations with other human beings and not by means of inborn instinctual drives. He is actually the first author to offer a deep and convincing *psychodynamic* interpretation of schizophrenia. Freud had already indicated that the essential characteristic of this psychosis is the change in the patient's relationship with the environment. But whereas Freud attributed this change to a withdrawal of libidinal energy, Sullivan attributed it to difficulties originating in interpersonal relations. According to him, the psychiatrist must be more concerned with what goes on between people than with the intrapsychic. As a matter of fact, according to him nothing that is psychodynamically or psychotherapeutically significant is intrapersonal or intrapsychic; everything evolves from the individual's relations with other people, especially people with whom he has lived in his childhood, his parents or parent-substitutes, whom Sullivan calls "the significant adults" in the individual's life. Everything is interpersonal; all our thoughts and fantasies deal with people, either real or imaginary.

One might say that every type of dynamic psychiatry is

interpersonal. Is not Freud, for instance, studying what goes on between parents and children when he describes and interprets the Oedipal situation? This is true only to a limited degree. Freud focused his attention, not on the interpersonal relations, but on the fight of the individual against his instincts. The parents are seen by Freud mostly as a source of sexual strivings that the child has to inhibit. In his early writings, Sullivan too, under the influence of Freud, gave considerable attention to these sexual strivings and stressed sexual maladjustment as the precipitating factor of neuroses and psychoses. Later, however, he came to recognize the importance of the parent-child relationship in its totality. Sexual difficulties may enter, under exceptional circumstances, as the cause of the abnormal interpersonal relations. Generally they are the effect, not the cause, of a poor parent-child relationship. The child has needs that require the cooperation of others, generally the significant adults, for their satisfaction. An interpersonal process that may bring about insecurity is thus necessary.

According to Sullivan, the attitudes of the parents determine the responses of the children. The personality, or the "self," of the child is built from "reflected appraisals," that is, appraisals coming from the

parents. The anxiety of the mother, or her anger or disapproval, brings about discomfort and anxiety also in the child. He may be badly hurt in the course of the development of his self-esteem; he may dissociate from consciousness what is unpleasant, and throughout his life may resort to "parataxic distortions." By parataxic distortion Sullivan meant distorted interpretation of an interpersonal situation. The distortion is due to the fact that the patient identifies the other person involved in the relation with somebody else, or with a person who exists only in his fantasy. If the parataxic thinking is not corrected, the patient will obtain less and less "consensual validation," that is, less and less recognition from others of the validity of his statements. This lack of recognition will increase the difficulty of the interpersonal relations.

A complete examination of Sullivan's contributions and theories will not be attempted here. Some of his concepts will be illustrated in Part Two of this book. For a more thorough understanding of his impact on modern psychiatry, the reader is referred to other works (Mullahy, 1948, 1949, 1952, 1967, 1968; Thompson, 1950, 1952a; Witenberg, 1974). The works of Sullivan himself have finally all been published, most of them posthumously (1953a, 1953*b,* 1956, 1962,

1964). In this section only some of Sullivan's contributions to the field of schizophrenia will be considered.

Unpleasant "uncanny" experiences, which occur in childhood because of poor maternal care, determine in the child a tension state that eventually changes into a state of great anxiety. The associations that are connected with disapproval and anxiety become connected in a conceptual construct and are personalized as the "bad-me." The child tries to dissociate these experiences from his consciousness; they become "not-me processes."

In the initial phase of schizophrenia there is a failure of the dissociative process, and a state of panic occurs. A disorganization of the personality takes place, and the early uncanny experiences come back to the surface. The patient perceives a terror, which reproduces the primitive formulation of the *bad* mother. According to Mullahy (1967), for Sullivan the bad mother is a "complexus of impressions" of the mothering one by the infant resulting from her interference with the satisfaction of needs and "her association with the induction of anxiety." For Sullivan schizophrenia is a disorder of living, disorder that may consist of one episode, a series of episodes, or a whole life.

An issue which is very important in Sullivan's theory and nevertheless was minimized until recently is the role of the adolescence period in the engendering of schizophrenia. Although the early Sullivanians stressed the importance of childhood, adolescence too was deeply studied by Sullivan and was given an important role in the psychodynamics of the disorder. The repeated blows to self-regard that occur in this period of life are just as important as the uncanny experiences of early childhood. The sequence of events that leads the patient from the state of panic to a full-fledged symptomatology was dynamically and very vividly illustrated by Sullivan in *Conceptions of Modern Psychiatry* (1953). In that book he described the resurgence of what was dissociated, more from the point of view of the subjective experience of the patient than from the point of view of the observer. In all the writings of Sullivan, even in those that deal with abstract conceptions, the patient is seen, not as a clinical specimen, but as a person who cannot relate to his fellow human beings without a hard struggle. When the patient is examined or treated by Sullivan, he is no longer alone in his subjective world; Sullivan shares his suffering and sees his frightening vision of "reality." In the therapeutic situation Sullivan was not predominantly an *observer* but, as he put it, a

participant.

Sullivan also pointed out that in the "paranoid solution" there is not only on the part of the patient an attempt to project, but also to *blame* the environment. Contrary to some extreme positions of later psychiatrists, who consider the blaming of the environment a completely justifiable act on the part of the patient, Sullivan deemed this tendency pathological and hoped to abate it with therapeutic intervention.

In his first paper on schizophrenia (1924), he stated that the foundations of his work and his concepts of this disorder are pluralistic, but that he accepted three conceptions particularly in the interpretation of his data. The first is the postulate of the unconscious, as formulated by Freud. The second is the teleological vitalist hypothesis of hormic energy. The third is "the genetic hypothesis of mental structure and functions, which implies a vital sequence of experience."

In this paper Sullivan wrote that "the disorder is one in which the total experience of the individual is recognized." He acknowledged the

eruptions of primitive functions of thinking, and, even in this first paper, he mentions the fact that there is a profound alteration of the sentiment of self-regard. He criticized Bleuler's formulation of the disorder as based on impairment of the association of ideas and reached the important conclusion that the primary disorder in this illness is one of *mental structure.* He wrote that the mental structure is dissociated in such a way that "the disintegrated portions regress in function to earlier levels of mental ontology."

Although in this important paper he expressed regard for the works of Levy-Bruhl, Jung, and Storch and referred more than once to the appearance of primordial or archaic concepts, Sullivan tried to explain the schizophrenic symptomatology as a return to infantile and fetal mental functions exclusively. In other words, according to him there is no necessity for accepting the notion of phyletic regression of mind structure. The phenomenology is subsumed in the "ontogenetic psychology." Although, to my knowledge, Sullivan was the first psychiatrist to speak of *mental structure* in a formal nonorganic sense, his predominant interest in the dynamics of schizophrenia prevented him from conceiving that some of the phenomena, even from a formal point of view, are determined by factors that transcend the history of

the patient. Thus, already in this first paper his conceptions were diametrically opposite to those of Jung.

Sullivan was not clear, however, in his understanding of the schizophrenic mental *structure* to which he referred. From a dynamic point of view, his first paper is a good forerunner of the great contributions he was to make later. We have already mentioned his realization of the alteration of the sentiment of self-regard in the schizophrenic. He also outlined in this paper simple therapeutic procedures: there should be no free associations; the patient should be asked simple questions; the psychotherapist should have recourse to primitive forms of thought exchange.

In a subsequent paper, Sullivan (1925) stated that according to his experience, the complex etiology of the disorder invariably culminated in a situation in which the sexual adequacy of the individual, according to his own ideals, was acutely unsatisfactory. In the same paper he wrote that there is no good reason for believing that all or most of that which is not fairly accessible to awareness is sexual. He felt, however, that many things, particularly undeveloped impulses that finally escape inhibition, may acquire a sexual coloring.

In another paper, Sullivan (1929) wrote that after thirteen years of study of schizophrenics, his conclusion was that the existing interpretations of this disorder were misleading. He felt that the current researches, such as genetic, organic, and psychoanalytic, had been inadequate. The schizophrenic has to be seen as a total person. Prenatal and childhood environmental factors are very important. He reminded the reader of the peculiarity of the parents of the schizophrenics and stated that psychiatrists have usually noted that they cannot secure a good history of a schizophrenic from his mother. He regarded schizophrenia as a condition characterized by (1) "regressive preponderance" in implicit fantasy life; (2) a "regressive preponderance" of overt irrational activity, like ritualistic and magical behavior; and (3) an extraordinary preponderance of motivations that normally receive only occasional expression. He stated that this concept of schizophrenia implies a genetic-evolutionary view and eliminates all considerations of duration of the process and of the outcome. The problem of motivation was the fundamental one. In the history of every case that he studied, he found a point at which there occurred "a disaster to self-esteem." This event often was experienced as a state of *panic.*

Sullivan's contributions to the field of schizophrenia can be summarized as follows:

1. He demonstrated that schizophrenia, as well as any other psychiatric condition, is engendered by poor interpersonal relations, especially parent-child relations. In doing so, he opened up new vistas and included psychiatry in the realm of social sciences. His achievement in this field has not been contrasted by two limitations that, for sake of objectivity, must be taken into consideration. First, even he, the creator of the theory of psychiatry as the field of interpersonal relations, felt that the chronic insidious cases of schizophrenia must be organic in nature. This idea, however, to my knowledge was never elaborated and was lost in the midst of Sullivan's great contributions. Secondly, although Sullivan made a social science of psychiatry, he did not study the overall sociological forces that derive from the structure of our society and that, by acting upon the individual, may predispose him to mental illness. Undoubtedly Sullivan had been exposed to the anthropological and sociological influences necessary for such a study (Sapir, George Mead, Benedict, and others); as a matter of fact, in the last few years of his life he devoted himself to the psychiatric study of international relations. It is to be assumed that if untimely death had not interrupted his

work, he would have expanded his interpersonal approach to include the impact of society as a whole on the engendering of psychiatric conditions and of schizophrenia in particular.

2. More than any of his contemporaries, Sullivan felt that schizophrenia could be treated psychotherapeutically. He made the psychotherapeutic treatment of the schizophrenic the primary work of his life.

Notes

[1] Beliak, who for many decades retained the role of reviewer of all the work done on schizophrenia, entitled his first work, published in 1948, *Dementia Praecox. The Past Decade's Work and Present Status: A Review and Evaluation*. In his subsequent books he used the word schizophrenia.

[2] This classic work was translated into English only in 1950.

[3] Jung has taken into consideration the effect of cultural factors, but only in the engendering of the *analogues*. The analogue is an equivalent of the archetype, after culture has modified its appearance. Jung's archetype, however, is not just a formal structure; it has also a content that is determined by the collective unconscious (1959).

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