Anales de Salud Mental (1985) *1* : 17 - 23

A HISTORICAL REVIEW ABOUT THE CONCEPT OF SCHIZOPHRENIA

HIDEO HOSAKI *

KEY WORDS: *Schizophrenia — History of Psychiatry — Nosology.*
PALABRAS CLAVE: *Esquizofrenia — Historia de la psiquiatría — Nosología.*

Una revisión histórica sobre el concepto de esquizofrenia

El significado de esquizofrenia *ha variado según la época, los países y los estudiosos. Luego de mencionarse a los protopsiquiatras de la antigüedad que intentaron definirla y clasificarla, se examinan las contribuciones de Pinel, Esquirol, Morel, y luego las de los psiquiatras alemanes modernos, quienes en la búsqueda de un mayor conocimiento elaboraron la aproximación nosológica que nos rige actualmente, con discretas modificaciones. Kraepelin acuñó el término "Demencia precoz" e incluyó las formas hebefrénica, catatónica y paranoide. Bleuler inventó el nombre actual de la enfermedad y señaló que los síntomas fundamentales eran: trastorno asociativo, autismo y trastorno afectivo. La última parte del artículo trata de algunos psiquiatras contemporáneos que estudiaron la esquizofrenia (Meyer, Sullivan, Jaspers, Schneider y Conrad, entre otros) y menciona la influencia de las escuelas francesa, alemana y norteamericana en la psiquiatría japonesa.*

The paper begins with the assertion that the history of schizophrenia is the history of psychiatry. It is established, however, that the meaning of schizophrenia *has changed according to times, countries and researchers. After having mentioned the proto-psychiatrists from old times and their attempts to define and classify schizophrenia, the author reviews the contributions of Pinel, Esquirol and Morel. Then, the modern German psychiatrists, who in their search for a better knowledge of schizophrenia built the currently used, with sligth modifications, nosological approach. We learn, too, of those 19th century psychiatrists who coined psychopathological terms so familiar to us nowadays. This was the time when the two most prominent alienists who studied schizophrenia made their still valid contributions: Kraepelin and Bleuler. Both lived and worked around the turn of our century. Kraepelin coined the term* Dementia praecox *and as a subgroup of his brand new nosological category, he subordinated hebephrenic, catatonic and paranoid forms. Bleuler invented the current name of the disease* (split mind) *and pointed out association disorder, autism and affect disorder as the fundamental symptoms. In the latter part of the paper we learn of some contemporary psychiatrists who studied schizophrenia (Meyer, Sullivan, Jaspers, Schneider and Conrad, among others) and the author tells us about the French, German and American influences upon Japanese psychiatry.*

* Chairman of Domestic Committee of JICA Project for Peru; Director of Keio University Hospital; Professor and Chairman of the Department of Neuropsychiatry, School of Medicine, Keio University.

The history of schizophrenia is at the same time the history of psychiatry. So we can trace it back to Hippocratic era. When we want to study the vicissitudes on the concept of schizophrenia, it is very important to notice that the same term has been used in different meaning according to ages, countries and researchers. Consequently it is difficult to compare the meaning of the theories in different ages and countries and by different researchers. In the following pages, I would like to mention the vicissitudes on the concept of schizophrenia in historical sequence.

1) Before Kraepelin, the discussion was centered about the symptoms and psychopathological state of the illness.

Hippocrates, Plato, Aristoteles, Asclépiades, Cicero, Celsus, Aretaitos, Galenos, Sorenos, Paracelsus *et al* also discussed the psychopathological state including schizophrenia.

Plater, F. (1536-1614) is said to have made the distinct nosological classification in psychiatry for the first time: 1) *mentis imbecillitas* (means mainly both inborn and acquired mental subnormalities); 2) *mentis consternatio* (means mainly the disorder of consciousness); 3) *mentis alienatio* (includes mania, melancholia, hallucinatio paraphrosyne — similar to schizophrenia ?) and so on; 4) *mentis defatigatio* (includes insomnia and what originates from the supernatural).

Sacchias, P. (1584-1659) called whole mental disorders "amentia" or "dementia", in which he classified *fatuitas* (inborn mental subnormality), *insania* (afebrile delirium including mania, melancholia and epilepsy), and *delirium*.

In addition, there were classifications by de Sauvage, F.B., Cullen, W., Weickard, M.A., and by Arnold, T. It is a well known fact that Kant, the philosopher, was interested in mental illness and made his own classification of mental disorders.

Rush, B. (1745-1813) is recognized as the father of American psychiatry. His classification is a list of symptoms that contains 13 items, and perhaps the symptoms of schizophrenia might be included in several of the items.

The well known classification of Pinel, P. (1745-1826), is as follows: 1) *manie;* 2) *mélancolie;* 3) *démence;* 4) *idiotisme*. Pinel's *démence* seems to include *incohérence* (*Zerfahrenheit*), and *idiotisme* appears to be closely related to stupor (*Stupor*).

Esquirol, J.E.D. (1772-1840), a pupil of Pinel, divided *mélancolie* into *lypémanie* and *monomanie*. Bayle, A. L.J. (1799-1858) described that ge-

	PINEL	ESQUIROL	GEORGET
manie	*en général* / *sans délire*	*manie*	*manie*
mélancolie	*partiel euphorique* / *partiel triste*	*monomanie* / *lypémanie*	*monomanie* / *lypémanie*
	démence	*démence chronique*	*démence*
idiotisme	*i. aquis* / *i. congénital*	*démence aigue* / *idiotie*	*stupidité* / *idiotie*

neral paresis is really a diffuse encephalomeningitis.

The classifications of Pinel, Esquirol and their pupil Georget, E.J. (1795-1828) are compared as follows (by Giraud, P.) (See p. 18).

Lauret, F. (1797-1851) described *démence incohérent.* Baillarger, J.G.F. (1809-1890) mentioned that *démence vesanique* means *démence incohérent. Démence vésanique* is equivalent to *démence organique* and it is a proper expression to French psychiatry.

Heinroth, J.C.A. (1773-1843) and Ideler, K.W., are representatives of Romantic Psychiatry. Heinroth explained mental disorders as related to religious and moral deficiency. But, his theory is refuted furiously by somatologists.

Morel, B.A. (1809-1873) proposed *démence precoce,* which was characterized by juvenile onset and rapid progressing dementia. Morel attached importance to degeneration and heredity. Morel's way of thinking was developed by Magnan, V.

Zeller, E.A. (1804-1877) is known as an advocate of *Einheitspsychose* (monopsychosis). Zeller considered that *melancholie, manie, paranoia* (*Verrücktheit)* and *amentia (Blödsinn)* were all solely pathological pictures belonging to the same disease process. It means that all mental disorders belong to only one disease process. This way of thinking is succeeded to Griesinger, W. (1817-1868). Meanwhile, Snell, L. (1817-1892) objected against monopsychosis theory and he regarded *Monomanie* and *Wahnsinn* as primary mental disorders.

Lasègue, C. (1816-1883) referred to *le délire de pérsécution.* Falret, J.P. (1794-1870) discussed about *persécuté-persécuteur.* At that time, the nosological classification of French School was as follows.

Further, Serieux and Capgras advocated *le délire d'interpretation* in 1909. Dupré and Logre advocated *délire d'imagination* in 1910. Magnan divided *délire chronique* into four stages and it led to Gilbert-Ballet's *délire hallucinatoire chronique* (1911).

2) From *dementia praecox* (Kraepelin, E.) to schizophrenia (Bleuler, E).

Manie
Mélancolie
Folie intermittent
Délire de pérsecution { *type Lasègue*, *persécuté-persécuteur*

Démence { *vesanique*, *sénile*, *paralytique*, *organique*

Débilite
Imbecillité
Idiotie

Kahlbaum, K.L. (1828-1899) divided mental illnesses into *Vesania, Vecordia* and *Dysphrenia. Vesania* takes the course of monopsychosis, namely, *Melancholie, Wahnsinn mit psychischer Aktivität (Manie), Verrückheit,* and *Blödsinn. Vecordia* shows partial mental disorders such as *Dysthymia, Paranoia, Dystrephia.* In 1872, Kahlbaum advocated *Katatonie (Spannungsirresein)*,which was contrasted with paralysis that was included in *Vesania.* Hecker, E. (1843-1907), Kahlbaum's pupil, advocated *Hebephrenie* in 1873. Pick, A. (1891) wrote a thesis titled *Primäre chronische Demenz* and he regarded it as a form of *dementia praecox.*

Under the influence of Morel, Kahlbaum, Hecker and Pick, Kraepelin, E. (1856-1926)) settled and advocated the concept of *dementia praecox.* It is well known fact that Kraepelin changed his opinion variously in each revision of his textbook.

In the first edition (1883), there is *Verrücktheit,* but no item for *dementia praecox.* In the second edition (1887), *Wahnsinn* appears. In the fourth edition (1893), we can find the name of *dementia praecox* for the first time, in the chapter of psychic degenerative process *(psychische Entartungsprozess)*, as *Dementia praecox, Katatonie* and *Dementia paranoides.* In the fifth edition (1896), *dementia praecox* is included in deteriorating process *(Verblödungsprozess)* in the chapter of metabolic disorders *(Stoffwechselstörungen),* and the item of *Whansinn* disappears. In the sixth edition (1899), the item of manic depressive psychosis *(manisch-depressives Irresein)* which formerly scattered in several parts, is arranged distinctly, and as the subgroup of *dementia praecox* there are *Hebephrenie, Kalatonie* and *paranoide Form.* In the most famous eighth edition (1905-1915), *dementia praecox* and *paraphrenia (paranoide Verblödungen)* are described in endogenous deterioration *(die endogene Verblödungen)*, while querulous delusion *(Querulantenwahn)* is moved from *Verrücktheit* to psychogenic illness *(die psychogene Erkrankungen)*.

It is said that Kraepelin for himselft advocated *dementia praecox* always contrasting it with manic-depressive psychosis. On the other hand, there may be the another standpoint of view that Kraepelin investigated *dementia praecox* in relation to *Wahnsinn* and *Verrücktheit,* especially to *Verrücktheit.* Moreover, Kraepelin for himself explained *dementia praecox* as a tentative concept, and he did not present it as a distinct disease entity.

Chaslin, Ph. (1811) described *folie discordante,* and Diem, O. (1903) described *dementia simplex.* Bleuler, E. (1857-1937) took into consideration the criticism against early onset and poor outcome of *dementia praecox.* Under the influence of Freud, S. (1856-1939), Bleuler wrote the book about *Group of Schizophrenias (Gruppe der Schizophrenien).* Bleuler's schizophrenia meant *Spaltungsirresein (split pscyhosis)*, and he pointed out association disorder, autism and affect disorder as the fundamental symptoms.

E. Bleuler's concept of schizophrenia is wider than Kraepelin's concept of *dementia praecox.* Especially the concept of latent schizophrenia that was introluced by Bleuler, E.,

made the borderline between normal and schizophrenia indistinct one.

3) After Bleuler, E. until today

Minkowski, E. (1885-1973) succeeded the Bleuler's concept, and regarded *autisme* as the loss of vital contact with reality (*le perte de contact vital avec la realite*). Clérambault, G.G. (1872-1934) advance the theory of *automatisme mental*, that is organic theory, and he opposed to St. Anne school. Claude, H. (1869-1945) divided Bleuler's schizophrenia into *démence précoce* of Morel type and *schizose* of constitutional etiology (*schizose* includes *schizoidie, schizomanie* and *schizophrénie*). Janet, P. discussed mental illness in relation to *tension psychologique* and *force psychologique*. Janet's standpoint is a kind of antinosological point of view. Guiraud, P. was a organicist and the tried to explain the fundamental symptoms of schizophrenia by the concept of *athymhormie*.

Wernicke, C. (1848-1905) and Kleist, K. (1879-1960) considered schizophrenia as heredo-degenerative illness (*heredodegenerative Erkrankungen*), and they also described minutely the sphere of atypical psychoses (*atypische Psychosen*). That concept was succeeded by Leonhard, K., who arranged cycloid psychoses (*zykloide Psychosen*) which consisted of motility psychosis (*Motilitätspsychose*), confusion psychosis (*Verwirrtheitspsychose*) and anxiety-elation (*ecstasy*) psychosis (*Angst-Glückspsychose*).

Bonhoeffer, K. advocated *Degenerationspsychosen* and Schröder, P. *degeneratives Irresein*. In Japan also, there are studies by Mitsuda *et al* about this sphere of atypical psychoses or degeneration psychoses. Still more in relation to this concept, there are Meduna's *Oneirophrenia*. Pauleikhoff, B. discussed about *Amentia, psychotische Primitivreaktion, episodischer Stupor, episodische Katatonie, vital bedrohliche Katatonie, Paranoid-halluzinatorische Psychose im 4. Lebensjahrezehnt, paranoischer Eifersuchtswahn* and *paranoischer Liebeswahn*.

Resembling Claude's way of thinking, Langfeld, G. (1958) classified genuine *Schizophrenie* and *schizophreniforme Psychose;* Rümke, H.C. (1958) made distinction between *echte Schizophrenie* and *Pseudoschizophrenie;* Kisker, K.P. (1964) classified *Kernschizophrenie* and *situativ-bedingte Schizophrenie* (*Egopathie*).

Freud, S. had influenced upon Bleuler, S. Freud supposed organic disorder in the background of schizophrenia, and tried to explain from neurosis to schizophrenia through a unified point of view. As to hallucination and delusion, Freud considered projection. As to delusion of persecution, he considered repression of homosexual tendencies, regression of libido, fixation to narcissistic stage and so on. Meyer, A. (1866-1950) gave the name of *parergasia* to schizophrenia. He considered *parergasia* (schizophrenic state) as a result of the fault habit of reaction in past life history. Sullivan, H.S. stressed the disorder of interpersonal relationship. Arieti, S. considers about schizophrenia that the specific character fails to defense the extreme state of anxiety, and adopts the paleologic mental mechanisms belonging to lower levels of integration, and assumes the form of a progressive regression.

Jaspers, K. (1883-1964) and Gruhle, H. (1880-1958) approached schizophrenia by the concept of non-understandability (*Unverständlichkeit*) and of process (*Prozess*). Consequently, they were cuestioned by psychodynamic school, but their phenomenological school established a certain standpoint in psychiatry. Their successor, Schneider, K. (1887-1967) is well known by his specific classification system and also by the first rank and the second rank symptoms (brought forth empirically) about schizophrenia. His classification system has been used widely in these days.

Kretschmer. E. (1888-1964), as seen in his book about sensitive delusion of reference (*sensitiver Beziehungswahn*), indicated that delusion might be understandable from character, external factors and experience elements. He advocated multidimensional diagnostic (*mehrdimensionale Diagnostik*). According to his viewpoint, continuous shift is permitted between schizothymia, schizoid and schizophrenia.

In 1957, Huber, G. advocated *cenesthetische Schizophrenie* as the fourth type of schizophrenia.

Conrad, K. (1905-1961) introduced Gestalt-psychology to the study of the delusion of schizophrenia. He considered that at the beginning of the illness central problems are the disturbance to change *Bezug-system* (reference system) and the impossibility of *Uberstieg* (getting over).

From the standpoint of *Daseinsanalyse* (ontoanalysis or existential analysis), Binswanger, L. (1881-1966) tried to explain the abnormal experiences by the alternation of patient's situación in being-in-the-world (*In-Der-Welt-Sein*).

The family studies of schizophrenia have been widely performed today (Bateson, G., Litz, T. *et al*). Also influenced by that trends, the viewpoint of antipsychiatry appeared since about 1960 (Cooper, D., Laing R.D., Szasz, T., *et al*). From that standpoint, schizophrenia (including all mental disorders) is rejected, and it is said that "so-called schizophrenia" is no more than a label given arbitrarily by doctors, and that "schizophrenia" labelled by doctors is a forcedly selected way of life as a result of conflicts in the patient's families, and that no need exists for admission and restriction, and that patients should be freely permitted to go their own way.

Basically, Japanese psychiatry was strongly influenced by German psychiatry; however partly even in Japan there were some university-departments of psychiatry which were influenced also by French psychiatry and by American psychiatry, as our department of psychiatry of Keio University. After the World War II, Japanese psychiatry has been much influenced by American psychiatry.

As to schizophrenia, in accordance with the world trend, Japanese psychiatry has the trend to restrict schizophrenia narrowly. Also according to that trend, the diagnostic names of *Atypische Psychose* and borderline case, etc, were appeared. Here, *Atypische Psychose* means periodical schizo-affective psychosis, and that is

different from "atypical psychosis" of DMS-III.

Concerning DSM-III young doctors accept it relatively favorably. On the other hand, elder doctors express disagreement about the method to change diagnosis by duration of illness as in case of schizophrenia. Also elder doctors entertain a doubt about the broader interpretation of depressive illness to include hallucination and delusion.

At any rate, by introduction of DSM-III, the extent of schizophrenia is changing more or less, but general trend is surely going to restrict the concept of schizophrenia in narrow sense, and this trend is supposed to continue for some time.

Dirección postal
School of Medicine, Keio University
35, Shinanomachi, Shinjuku-Ku
Tokyo 160
JAPAN