Anthology of German Psychiatric Texts

Edited by
Henning Sass

JOHN WILEY & SONS

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Previously published

in 1999

Anthology of French Language Psychiatric Texts

Edited by François-Régis Cousin, Jean Garrabé, Denis Morozov

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Anthology of Spanish Psychiatric Texts

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Anthology of Italian Psychiatric Texts

Edited by Mario Maj, Filipo M. Ferro

Series Director: Driss Moussaoui

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Preface

Driss Moussaoui
Mario Maj
Helen Herrman

The World Psychiatric Association (WPA) is the largest association of psychiatrists regrouped through their 130 national associations in 115 different countries. Among the tasks of the WPA, publishing activities represent a major component with its journal *World Psychiatry*, distributed to more than 32,000 psychiatrists worldwide, as well as a number of series of books.

The WPA is pleased to present the 4th volume of the series "International Anthologies of Psychiatry", which was made possible thanks to an unrestricted educational grant of Sanofi-Aventis.

The previous books of the series were:

- the *Anthology of French Language Psychiatric Texts* edited by François-Régis Cousin, Jean Garrabé, and Denis Morozov, published in 1999;
- the *Anthology of Spanish Psychiatric Texts* edited by Juan-José Lopez Ibor, Carlos Carbonell, and Jean Garrabé, issued in 2001;
- the *Anthology of Italian Psychiatric Texts* edited by Mario Maj and Filipo Ferro, published in 2002.

Two other anthologies are planned in the coming years: a Greek and an Arab one.

In a more and more globalized and monolithic world, it is essential to highlight the diversity of psychiatric traditions which prevailed for centuries in various parts of the world, through texts written during hundreds of years, until the mid XXth century. The aim of such initiative is not merely to value historical arte-

facts and to make them available to the psychiatric community. These classic texts may represent also a source of inspiration for psychiatric research nowadays, because of the complete difference in ideologies, perceptions, and historical environments. It is a way of looking with a modern knowledge at psychiatric phenomena through historical spectacles. For instance, it might be of interest to know that music therapy was used during Middle Ages in North Africa and the Middle East for mental patients, with various kinds of music for various kinds of patients. It might be of interest to know that Kraepelin hesitated for decades to classify his patients in the dementia praecox or manic depressive illness categories. It might be of interest to know that Gaëtan de Clérambault clearly stated the necessity of a developmental approach to mental disorders. The texts written by "doctors of the soul" during centuries are full of remarkable clinical observations, but also of etiopathogenic explanations, some of them relevant to the current research undertaken in various parts of the world. As a matter of fact, there is no interesting knowledge which does not induce in the reader new questions to answer, and some historical texts are excellent in that function.

We would like to thank Professor Henning Sass, past-president of the German Society of Psychiatry (DGPPN) and president of the Association of European Psychiatrists (AEP) who accepted to collect a number of important German language psychiatric texts.

This tradition has been indeed a major player in the psychiatric scene during the 19th and the 20th centuries. It did not include only psychiatrists from various *länder* of Germany, including Prussia and parts of the current Poland and Czech Republic, but also from countries such as Switzerland, Austria, or Holland. Heinroth, Griesinger, Kahlbaum, Jaspers, Schneider, or Kretschmer, to mention a few authors chosen for this anthology, impacted decisively on the psychiatric field during their time, and continue, to some extent, to do so nowadays. Some other authors, such as Kraepelin, a giant in psychiatric history, Bleuler, Kleist or Leonhard are not included in this anthology, because their work has been widely translated and disseminated, or because of the limited scope of

this book. We could almost have produced a second volume of this anthology with a number of important texts which could have been included, and which were left aside.

Our hope is that the reading of this book will benefit some psychiatrists to find fertile links between past and present preoccupations of our specialty.

We would like to thank very warmly Sanofi-Aventis company for its continuing support of the educational programmes of the WPA, namely the "WPA programme for libraries in developing countries" (1997–2001) and the "Series of International Anthologies in Psychiatry". Our thanks go especially to Mireille Cayreyre, Marie-Christine Bouri, and Hervé de Cidrac. We do appreciate the recent decision of Sanofi-Aventis to pursue the publication of volumes of this important series in the coming years. An electronic version of the four books we have so far in the series will be made available soon, making its dissemination even more efficient.

Presentation

Henning Sass

What is the purpose of an anthology of psychiatric texts? An intimate knowledge of the concepts, traditions and developments in the past is essential for understanding the present and predicting the future. This holds true for all medical disciplines, but especially for psychiatry with its close connections to philosophy, anthropology and even religion. Therefore, the study of the conceptual history is of special importance in our field.

In Europe, many German-speaking psychiatrists have made important contributions to the overall structure of modern psychiatric thought and knowledge, particularly in the areas of general and special psychopathology and also of nosology. For these reasons it is a particular pleasure to now present an anthology of German psychiatric texts, following the publication of anthologies of French, Spanish and Italian psychiatry. These anthologies make important sources available and form the historical foundation of current psychiatric knowledge together with English-language psychiatry, which is read throughout the world today.

In the selection of texts, only a few examples of the writings of some of the most important authors in the German language could be included. The selection was guided not only by the importance of the various positions from today's point of view but also by their impact in contemporary discussions. It begins with representatives of romantic medicine such as Johan Christian August Heinroth and Carl Wilhelm Ideler. The most important aspect of the work of Ernst Freiherr von Feuchtersleben is that he was the first to

discuss the concept of psychoses in its later meaning. The work of Wilhelm Griesinger, who became one of the founders of modern-day psychiatry during the waning days of romantic medicine, shines like a beacon. Even if his dictum that "mental diseases are brain diseases" represents only an abbreviated form of his very differentiated understanding of psychiatry, he made a significant contribution to the scientific foundations of psychiatry and won it a place in scientifically orientated medicine. Karl Kahlbaum's greatest contribution consists of his systematic description of a few important disease conditions such as catatonia or hebephrenia, but above all he is one of the founders of the 'clinical method' in psychiatry. This is based on the systematic description of abnormal phenomena, the ordering of symptoms into symptom complexes, the careful observation of the course and the search for pathoanatomical causes of disease. In Germany this clinical method was adopted and further developed by Emil Kraepelin, Karl Jaspers, Eugen Bleuler and Kurt Schneider.

If the names of Emil Kraepelin, Eugen Bleuler and Sigmund Freud were omitted in the further chronology of the authors in this anthology, this was only because most of their work has found its way into world literature through translations and secondary literature. The further selections for the anthology therefore concentrate on names that have received less attention but are nevertheless of particular importance in the history of ideas in psychiatry. One example is Paul Julius Möbius, who was one of the founders of the concept of hysteria in the German-speaking countries. Alfred Hoche was essentially a less prominent psychiatrist, but he made an important contribution to nosological discussion on the one hand in his article on the symptom complexes, which was directed against Kraepelin, and on the other hand, he is an example of the disastrous entanglement of some of the psychiatrists of his time with the perversions of medical activity in conjunction with racial theories and euthanasia. In contrast, Jaspers's work is a brilliant example of a philosophically based methodology of the greatest clarity and of a basic humanistic attitude, at the centre of which are the freedom and dignity of human existence. Josef Berze and

Hans Walter Gruhle, who dealt with the psychology of schizophrenia, are less well known but were quite important in conceptual discussion.

Kurt Schneider, like Emil Kraepelin, Karl Jaspers, Eugen Bleuler and Sigmund Freud, represents a beacon in the German literature of our subject in the last century. Building on the methodological foundation of Karl Jaspers, he created with his 'clinical psychopathology' a document of lucid clinical observation and analysis that contains important building blocks for today's diagnostic classification systems. In particular, his definition of the 'first rank symptoms' in schizophrenia represents one of the first and to date most influential examples of an operationalised diagnostic formulation. Ernst Kretschmer, who attempted to link constitution theory and psychology, along with Klaus Conrad with his differentiated gestalt analysis also made lasting contributions to the history of ideas in psychiatry. Henricus Cornelius Rümke is included as an outsider who described an interesting intuitive clinical observation for the diagnosis of schizophrenia with the 'praecox feeling'.

I hope that the book will find many interested readers and furthermore, that the continuing discussion of the intellectual foundations of our discipline, which contains elements of natural sciences and humanities in equal measure, will also include the contributions of this anthology as part of the history of European and world psychiatry.

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Johann Christian August Heinroth (1773–1843)

Johann Christian Heinroth was born in Leipzig on 17 January 1773 and died on 26 October 1843. Starting from 1811, he held the first German chair of psychiatric therapy in Leipzig. His book, "Textbook on Disturbances in Mental Life", appeared in 1818. This represented the 'romantic psychiatry' of the early 19th century, which opposed the purely rational views of the enlightenment and which saw "disturbances of the soul" as the consequence of an abnormal course of life which the patient had chosen for himself and which therefore was his own fault. The religious and metaphysical pathology of the 'psychists' regarded man as an organic part of the general or whole. Dissociation from the moral norms then current, perhaps in the form of dissolute behaviour, emotional excesses or ruthless pursuit of personal interests, led to psychiatric disease. Heinroth taught that mental disturbances were the consequences of the personified principle of evil, of the Devil; man was free and adrift in nature, so that his mental health was a question of strength of will. From the middle of the 19th century, the somatic theory came to be accepted, a positivistic and scientifically based view of psychiatry, analogous to physical medicine. This led subsequently to the radical rejection of all non-medical attempts to explain mental disturbances. Griesinger (1817–1868) expressed this as follows: "All non-medical, poetical or moral views of madness are of virtually no value in understanding these problems". Aside from his moralistic concepts of the aetiology of psychiatric diseases, we are indebted to Heinroth for his textbooks containing a fundamental survey of the clinical presentations of psychiatric disturbances and the therapies that were possible at that period (Textbook of Spiritual

Medicine, 1823) and for founding psychiatry as an independent academic discipline. His holistic position, which ascribes mental processes not only to somatic and biologically based causes, but also incorporates aspects of free will decisions and responsibility, has continued till today in anthropological and biographical approaches in psychiatry.

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On the Humour of the Soul, as the Internal Element of the Disturbance of the Soul*

§ 161

The essence of the soul is the feeling, the mind, the heart, in short, the internal being which is susceptive to joy and sorrow and which is also the site of the humour of the soul. As soon as man learns to feel, he desires and strives, and no sooner does he cease to desire and strive than he draws his last breath. This holds true with the exception of the internal motor of man's life, his spiritual life, being inhibited in its activity by a variety of pressures or impulses, or being forced away from the natural direction of these activities. If this happens, the consequence is disorder of the soul, albeit much has to happen before the mind is susceptible to such a pressure or impulse to an extent causing it or before a vulnerable state of soul is met that this is the consequence and that this humour of the soul is reached. We will pursue the humour of the soul up to this point, but first we will attempt to understand and to portray its concept and conditions as well as its character and related states which are necessarily linked to the humour of the soul.

§ 162

As has been said, the site of the humour of the soul is the spirit, the heart, the consciousness, or whatever one wishes to name the internal susceptibility of man for joy and sorrow. In his natural state, the feeling, desiring and striving man is never indifferent. Either he

*Reference: J. C. A. Heinroth. "Von der Seelenstimmung, als innerem Elemente der Seelenstörung". In: *Lehrbuch der Störungen des Seelenlebens, Zweite Abteilung.* Fr. Chr. Wilh. Vogel, Leipzig, 1818; chapter 2: 195–211.

has achieved the object of his desire, at least for a moment, or he is hoping for and expecting it, or he sees his aspirations shattered, or something he has attained, the joy of his heart, is wrested from him. In short, as regards his sentiment and the state of his mind, he is either always in a state of joy or sadness, hope and desire, or he is worried, fearful and anxious. These sometimes lasting, sometimes changing states make up the humour of his soul. In this vein, the nature of the humour of the soul is determined by the emotions of the spirit.

§ 163

Some men, despite being not completely indifferent and dull, are not particularly susceptible to joy or sorrow of any sort. In contrast, others exult or break into tears out of sorrow for the slightest reason. Others again are only moved by few things, but by these few very deeply and for a long time. This altogether indicates a special precondition of the humour of the soul, namely the degree of liveliness of the mind, as this determines whether the character and, as it were, the essence of the humour of the soul, becomes equanimous (but not indifferent) quietness or hot temper or deep and long lasting sentiment. However, that is not all! These grades of humour of the soul do neither fully account for the character of an even-minded – nor easily moved – nor deeply sensitive heart. Not every mind is touched by everything. Only those things, to which it is particularly susceptible, move the soul in a specific way. The even-minded man is neither particularly susceptible to those objects on the surface of life, nor to those in the depths of life. The short-tempered man is more touched by external matters and the contemplative man more by internal matters. Thus, a second condition for the humour of the soul is the susceptibility of the mind. We must then keep our eyes on both conditions of the humour of the soul, as these are of great importance for the origin of the disorders of the soul.

§ 164

Firstly, what is the source of the greater or lesser liveliness, the milder versus transitory, or the more difficult to excite versus longer

lasting affection of the spirit, or in short, what is the strength and weakness of the humour of the soul? Obviously, we can regard all this as influenced by the so-called temperament together with the (physical) organism. For it is unquestionable that the temperament depends on the constitution of the organic entity and on the relationship between its interacting components, although we cannot explain, but simply have to guess the many ways the organic basis determines the temperament. It is sufficient to note that the greater or lesser excitability and energy of the mind is exactly linked to the so-called phlegmatic, sanguine or choleric temperament, etc. The leisureliness of the phlegmatic man, the ebullience of the sanguine person, the burning passions of the choleric person, the deep internal life of the melancholic person, all these clearly point to the source of the different humours of the soul – the organic life. What if the origin of the essential and most internal life of the soul, the life of the heart, the mind, would be the physical life? This would be the vessel and the life of the nerves in their wide variety of interrelationships – as this must be the underlying foundation for the dispositions of the temperament to which the soul is so precisely linked – and would therefore be the essential and true basis of all human desire and striving. Anyone who has understood our previously outlined views on human life and who can clearly imagine how the life of the body and the life of the soul are formed by one and the same creative force which is only branched in its directions – as it were currents – either plastically and organically in space, or concentrated in feeling and consciousness in time – will not be surprised by the concept that the humour of the soul is based on the so-called temperament and its organic basis. Indeed the whole life of the soul draws the energy for its activity and strength, from one source, the physical organism. Thus, the livelier the organic life, the livelier is the humour of the soul and vice versa. This is confirmed by experience and cannot be disproved by any demonstration. Lack of food or sleep, exhaustion of physical energy by exertion of any sort or excesses, etc., and the resulting feeling of emptiness, weakness, dullness, pathological irritability, bad temper, poor mood and discomfort of the whole life of the soul, disgruntlement, melancholy, anxiety, despair, desperation even – to

be regarded as soullessness from loss of energy – all this is the clearest proof of the dependence of the life of the soul on the physical life. However, we must be reminded that this is no argument for materialism, as it is not simply the physical body which is formed there, which is active and which generates or withdraws energy, but the (individual) energy itself, which together form the organism and become aware of itself within and through the organism. Once it has reached self-consciousness, it knows that the organism is the necessary condition for its activity and its continued existence within a finite life-time, that it receives the nourishment and the impulse to continued activity and existence through the organism, and that the organism maintains it in mutual interaction with the external world. However, this energy also knows that the organism (the body) is nothing without it, that the organism is only its external manifestation – as the soul is its internal manifestation – and that this external manifestation would be inconceivable without it, the internal energy, which only senses itself as the soul as far as it exists as an organism. Thus, the organism is the precondition for the manifestation of the soul. Conversely, the precondition for the organism is the spiritual and creative energy born out of the soul. A different organism results in a different soul: a healthy organism gives a healthy soul; a diseased organism gives a diseased soul. If the parents were of a healthy constitution, a healthy soul will develop from the healthy body of the child. This soul is the peak and purpose of life and is also entrusted with watching over the organism, albeit without turning care for the organism into the principal aim of life, as the organism constitutes only the means to development and perfection. Despite this, the state of the organism corresponds to the state of the soul. Nevertheless, the soul is responsible for the maintenance of the right organic humour and no-one should blame the organism for a poor humour of the soul, as any matured human being can direct the maintenance of a good humour of the soul, by employing reason, which is nothing else than life regarding itself in its own pure lawfulness. Just as this lawfulness is manifested in the organisation of the organism, it is also apparent in feeling and in consciousness, in the voice of conscience, as it were, the compass of life. This is why the conscience is a focal point in the mani-

festation of human life and cannot be separated from its physical and spiritual essence. The humour of the soul is always related to conscience and thereby legitimised as something which, – although conditioned by the body –, is more than a mere reflection of the physical life. However, after having simply considered the basis for the degree of liveliness of the humour of the soul as one contributing element, we have to change the direction of our reflections in the following.

We have already identified this basis. It is the temperament, the humour of physical life.

§ 165

The second condition of the humour of the soul – the susceptibility of the spirit – remains to be discussed. There are two sources, which influence and nourish the human soul in a way that if the soul is open to one source, it cannot access the other. These two sources are reason and purpose with their contents namely God and the world. He whose mind lives for the world does not live for God and vice versa. The humour of the soul originating from the godly spiritual life is the most magnificent that man can attain. This is the true health of the soul, which has been described earlier as the normal state, in contrast to all abnormalities, which shall not be further considered here, as the origin of abnormalities of the soul is to be derived, by identifying these in its elements. We must therefore pay even more attention to the susceptibility of the spirit to the influence of the second source. There is a natural relationship between the temperament and the senses (sensuality), as both originate from the same root, the physical nature of man. Accordingly, it is not surprising that the susceptibility of the spirit is naturally biased towards the source of its natural liveliness of temperament – the physical, sensual and worldly life. In general, this is the reason for why man's whole spirit is totally immersed in the sensual and worldly life, even if his soul is engaged in apparently higher pursuits, like matters of science or art. Although the latter may appear paradoxical, it is evident that all science and art is in the service of the world. For neither science nor art seek sublime goals for the sake of the sublime, but with the intention of placing

it into the restricted context of the world, in order to take delight in its worldliness. Neither science nor art lead the mind to God and creates godly humour of the soul, but lead the spirit away from God by chaining it to reason and the senses. This not only explains the pride of academics and artists and why their life and existence is often so ungodly, accompanied by a totally ungodly humour of the soul during the most sublime scientific and artistic striving, but also the final lack of satisfaction of the mind, even in those who are seriously devoted to science and art attempting to satisfy their eternal thirst. Only exceptional characters reside in these high spheres; whereas the great majority of mankind lives in the lower regions of existences with their whole soul and mind depending on the objects of these spheres. This is why the necessity of being nourished by the world determines the character of their susceptibility and it is that dependence of the humour of their souls on external conditions which totally betrays their essential character. Because of this dependence, the susceptibility of the mind assumes the form of an inclination, tending as it were towards a focus. In this way, the humour of any soul, determined by this kind of susceptibility, appears to be enchained. The soul itself succumbs to the inclination and the resulting constitution is called selfishness. Thus, egoism is the second influence on the humour of the soul – the shape of the latter (in so far as the humour of the soul is related to the disturbances of the soul) – where the first influence and the underlying substance is the degree of liveliness of the temperament.

§ 166

It is thus usually the case that the humour of the soul of everyone whose spirit is not directed towards the godly will bear the character and the essence as it were of desire or sadness related to selfishness and the liveliness of temperament, depending on whether the mind has been satisfied or not. However, satisfaction in this sphere is neither complete nor long lasting. Therefore, it can be assumed that the character of this humour of the soul is usually negative on average, sometimes appearing as painful longing and striving, sometimes as restless expectation, sometimes as being violently dragged away, sometimes dissatisfied and disgruntled, or even anx-

ious and desperate. In general, as soon as the humour of the soul is not nourished by the source of the pure and the good, it features imbalance and uncertainty and an inability to maintain oneself alone or to withstand the storms and temptations of the worldly life. This is a general rule, with few exceptions in our experience.

§ 167

The humour of the soul is essentially associated with two types of individual states – the psychic and the somatic. This is not surprising, as the whole of man is influenced by the humour of the soul, which is why these aspects must be considered here. We will first consider the psychic side. Each sentiment, each feeling of the heart is naturally and closely coupled, on the one hand, with thoughts and imaginations, on the other hand, with the agitation and activity of some drive or a deliberate decision. It is impossible to feel one's desire or lack of desire, one's wishes or hopes, one's fear or disgust, without relating all these feelings to the idea of an object (be it a view or a concept) and without being stimulated by this object driving our attraction or repulsion. It is therefore justified to state that reasoning – our basic creative mental character – and will are directed by the feelings of the heart. Man lives (or thinks and acts) in the same way as he loves. This has very important consequences for the humour of the soul itself, as by now we have to regard it as the anchor of our whole life, the point from which our individual views and actions and the continuity of our expressions of life have to be considered and measured. An always even-tempered and mainly unmoved humour of the soul will produce nothing great, comprehensive or deep, either in good or in evil. An unstable humour of the soul will not establish a firm, energetic system of thoughts and actions. A deep and passionate humour of the soul will be capable of both, the greatest acts of heroism or infamy. It often happens that life, as a whole, will offer no opportunity to exploit one type of humour of the soul leading to a significant success. The humour of the soul in an instant is often the reason for the fate of a whole life, the source of a success deciding on the fortune or ruin of entire peoples or eras. In short, we recognise in the humour of the soul, the anchor point around which the thoughts

and deeds of mankind are centred and this is why the character and influence of the humour of the soul cannot be described too carefully or comprehensively.

§ 168

The second aspect of this influence is the somatic side. Everyone knows from personal experience that, on the one hand, the humour of the soul depends on the state of the body, but, on the other hand, the body depends on the soul. To be more precise, if the physical disposition influences the soul, it is only because the soul controls its harbouring organism. For, although we very often blame the poor humour of our soul on poor physical well-being, we should consider that the latter is usually entirely the result of our own work, as our physical well-being almost exclusively depends on our way of life, according to our own understanding or lack of it. However, it is long since known and recognised based on personal experience that the humour of the soul can directly affect the body. The effects of emotions, passions, fantasy, hard-thinking or even total spiritlessness on our whole somatic nature and on individual organs have been listed and fully described by many good observers. By avoiding all superfluous repetition, we would only like to comment on this: considering the influence of even slight and transitory humours of the soul on the physical life, this applies to a much greater extent to major and long lasting humours. For example, we can see how sufferings of the mind like enduring sorrow or misery are able to wear down the body. The vascular system, as well as the nervous system, the brain, the heart, the liver etc. respond to the effects of an unwise, self-consuming life full of desires and anxieties. Thus, after the end of such a life, it is unsurprising if pathological sections and organic abnormalities are found in those systems and organs and that one is tempted to list these under causes rather than effects. However, enough of this! We should neither repeat nor anticipate.

§ 169

From various starting points, from various directions of development, in various complexities, the spirit of man can develop a humour of the soul in which the seed of one or the other disturbance

of the soul lies already fully prepared, only in need to be fertilised by a stimulus in order to appear as a fully grown, specific form of disease after slow or quick development. The various starting points are determined by the different temperaments. One particular starting point is the indolence of the phlegmatic temperament, others the imbalance and fickleness of the sanguine temperament, the brooding contemplation of the melancholic temperament and finally, the impetuous vehemence of the choleric temperament. The variable susceptibility of the mind depends on these different points of origin in accordance with the temperaments. The indolent mind is most susceptible to rest and being disinclined to exercise the spirit and will, soul or body, its desire and striving only aims at preserving rest and existence. Two fruitful tendencies for disturbances of the soul originate from this frame of mind and humour of the soul: miserliness and cowardice. Once these two have taken over the whole mind, dominating the humour of the soul, only one violent stimulus is needed to unhinge the whole soul.

The imbalanced and fickle mind is most susceptible to sensual stimulation and change and indeed all external matters. It is directed towards life in the external world, leading to self-indulgence and vanity. As soon as these govern the humour of the soul, their additional external stimulation can cause various abnormalities of the soul.

The introverted brooding spirit is only susceptible to internal stimulation being directed towards the internal world of thoughts and feelings. If such a humour of the soul is well engrained, the tendencies of brooding and suspicion lay the foundations for important disturbances of the soul so that only some suitable stimulation is necessary to develop specific forms of abnormalities in the life of the soul from the readily available material.

The vigorous, impetuous spirit is only susceptible to intense external and internal influences. In total contrast to the phlegmatic temperament, the choleric temperament expresses itself in lively mental activity and a strong will. In accordance with the susceptibility of the lively humour of the soul, both are directed towards all aspects of life, but only take up important impulses. The vehemence and duration of hate, love, avarice or lust for power are frequently

merged or alternate at the height of this humour of the soul. They all contain the predispositions for the resulting disturbances of the soul requiring only the spark of a stimulus to grow rapidly from these powerful seeds into frightful forms of diseases, as fruits of the disturbed life of the soul.

Finally, we should consider the various complexities in which the human soul is entangled like in a labyrinth. This is why an existent humour of the soul – however simple it may appear at first glance – can only be explained based on interactions between the wide varieties of impulses in the course of a life. For in this case everything must be considered that can affect man and his mind, either directly or indirectly, and it is here where we find the manifold effects which can be classified as predisposing causes or as occasional causes. Although these may have little effect separately, they can have a major influence on the humour of the soul when taken together, acting focally. In this context, every somatic and psychic impulse, however remote, contributes and has its effect: climate, air and soil, time relationships, place of birth, environment, hereditary constitution, upbringing (i.e. natural or unnatural education or neglect of the spirit, the mind, the drives and the will), acquaintances, reading, idleness or inappropriate occupations, way of life, excesses of all sorts, cases of fortune or misfortune. To this have to be added diseases or pathological dispositions from a wrong way of life: syphilitic diseases, gout, haemorrhoids, wrecked digestion and disorders of the vascular and nervous systems. In addition, we must consider mental and physical exertion, night watches and various exalting or depressing emotions: love, anger, jealousy, pride, arrogance, vanity, ambition, failed speculations, vain hopes, resentment, worry, fear, anxiety and desperation. All of these are man's enemies; with each single one being dangerous on its own, only waiting for attacking us with brutal force either treacherously or openly, in order to rob mankind of its most valuable good: our rightful primacy over all animals, our entitlement to the free world of the spirit. We see how frequently they succeed when we look at the asylums, which can hardly be spacious enough to accommodate all the unfortunates. Regardless how manifold these impulses and their effects are and regardless how intertwined their influences can

be, they all converge at the humour of the soul. They merge with it, however great the differences in their own natures are, to form a single effect causing a gradually increasing exaltation or depression of the mind, so that only an additional stimulation of the will, the mind or the spirit, is sufficient to produce various forms of disturbances of the soul. Just as the shape of a tree is determined by the interaction of seed, earth, water, air and light and just as these different elements, attracted by the individual energy, create the life of each plant, the spirit, the site of the humour of the soul, gradually develops under the influences of a whole life: these influences are processed in accordance with life's internal nature and its own free will, thereby creating leaves, blossoms and fruits – either of prosperity or decay. Although unnoticed, everything in the world and in life helps either to refine man to pure spiritual beauty or to extinguish in him the traits of his origin. Some are near to take divine shape and only lack the courage to cut the last threads binding them to the earth. In contrast, there are others who are only bound by a weak thread to the anchor of reason and only a little pull is needed before this last thread snaps and man is drifting into the labyrinth of unreason – and often salvation is almost impossible. This pull, this impulse, the stimulus, the element, which fertilises and brings to life the seeds of the disease, is what we must now consider, now that we have devoted enough time to the place of birth of the disturbances of the soul and its internal element, the humour of the soul itself.

Concept of the Pathological Life of the Soul*

§ 33

Just as health manifests itself (§ 25) internally as well-being and externally as uninhibited and free activity in life of all types, sickness and the state of sickness manifest themselves internally by the feeling of illness and externally by restriction or inhibition of activity in life in a wide variety of manners. Thus, one can without hesitation regard freedom as the essence of health and restriction to life as the essence of illness. Just as complete freedom (§ 32) is the highest form of life, complete, general and irremediable restriction to all activities in life is death.[1]

§ 34

In any disease, any diseased state, life and its activities are more or less restricted and the feeling of illness arising from this restriction corresponds to the type and severity of the disease. However, a human is only a human, as a conscious being. Thus, a state of human illness is a state of more or less restricted consciousness. Consequently, as there is only one healthy state for man, that in which he lives and strives to live as a rational being (§ 27, 31) – gradually, from the first moment he follows his conscience, to the ultimate moment when his nature becomes one with his rational consciousness –, each consciousness which is not ruled by conscience

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*Reference: J. C. A. Heinroth. "Begriff des krankhaften Seelenlebens". In: *Lehrbuch der Störungen des Seelenlebens, Erste Abteilung, I. Vorbegriffe*. Fr. Chr. Wilh. Vogel, Leipzig, 1818; chapter 3: 23–31.

1. See also Beiträge zur Krankheitslehre. Gotha bei Perthes 1810.

or reason is a consciousness in a pathological state. A reliable proof of this is the lack of any feeling of freedom and bliss.

§ 35

The state of human illness is thus only possible in the areas of world- and self-consciousness and consequently not outside this area in merely physical life, if such an area may be conceived as separate from consciousness. Conversely, the physical life – since it is incorporated in consciousness and totally imperceptible without consciousness – is involved in every state of human illness, even if it is not immediately affected, but in danger of being affected, and may be genuinely pathological, depending on the type and degree of the state of illness. This is because the human being makes up an entity (§ 6), albeit differentially structured externally and internally and separated in different spheres, which, however, are endangered in their free activity, harmonic relationships and independent existence when a pathological state develops thereby becoming susceptible to the illness of other organic spheres.

§ 36

Consciousness is originally not in a pathological state, neither as world-consciousness nor as self-consciousness, as both of these are necessary steps in the development of consciousness towards the highest form of consciousness (§ 24). But just as soon as conscience is aroused, life becomes sinful, not in the world but for the world, not in the self (ego) but for the self, striving against human nature and providence, inhibiting the free development of the ultimate human character, and thus a state of human illness. This is why, in this state, the feeling of inner satisfaction or contentment is never found, but only a permanently futile striving towards it.

§ 37

The sinful human lives for the world or for himself, but basically for both. For whether he is obsessed by possession or by status, his pursuit of possession always aims at his existence or status and the one is not conceivable without the other. Striving for property or status, if not a mean for a higher purpose, but an

end in itself, is, therefore, sinful and a state of human illness, as it is a decline from the circle of freedom for which man is born, into the limited state of an animal or plant. Conscience may only stammer but the voice of reason greatly excites the feelings and the consciousness of the vigorous human and is destined to introduce him to the realm of freedom and blessedness for which he was created. If against his own better knowledge or at least exhortation, as a result of his own sustained idleness or free inclination – since free choice and will are man's most basic property – he adheres to what is not good or right and ignores the holy voice of his conscience, he disturbs his development and the revelation of life intended for him, in short, the order and lawfulness of existence and life itself. His offence against the highest life in relation to his own person is disturbance of life, inhibition and restriction, i.e. a state of human illness.

§ 38

Possession and status are loved by the world- and self-consciousness and the heart lives in love. Every state of human illness originates in the heart and both heaven and hell reside in the heart. The heart is the altar and shrine of life with love and loving happiness as its focus. However, the love of earthly status and possessions, even if satisfied, does not fulfil or satisfy human consciousness, but always leaves the thorn of vain desire in the mind. Indeed a mind of this sort, as it does not understand itself properly, only strives the more vigorously for external satisfaction, the less it receives of it. Therefore, it is truly caught in a state of suffering which is known as passion.

§ 39

All passion is indeed a state of human illness, which also affects physical life, which more or less succumbs to it, depending on the vigour of the passion. It is directed either towards possession or status (§ 37) and corresponds to a greedy or fearful state of mind depending on whether win or loss is seemingly imminent. Greed and fear are the scourge of the worldly and selfish man throughout his life.

§ 40

Depending on the directions they take and on the states which elicit them, passions can form a very complicated web within the human spirit, as they come in as great a variety as the objects of greed and fear and the properties of status and possession. However, they all share the characteristic of robbing the mind, which is subject to them of its calmness and freedom thereby removing it from the circle of higher consciousness. He who is the prisoner of passion is unfree and unhappy.[2]

§ 41

The prisoner of passion deceives himself about the objects and about himself. This deception and the resulting error are called delusion. Delusion is not a pathological state of the mind, but of reason, although the cause of delusion, namely passion, lies in the mind. We could deceive ourselves and commit errors without passion and still, any unaffected free spirit would easily recover from deception and error. However, delusion is a truly pathological state of the spirit, as it arises from a pathological state of the mind. No sooner is man free of delusion than he is free of passion. In delusion as in passion (which are both inseparable), the spirit is tied up and man feels unfree and unhappy.[3]

§ 42

We call a life that is painfully and vainly governed by passion and delusion, a foolish life, just as the whole activity of passion and delusion is foolishness. However, all action requires will and if the will only follows and indulges in the forces of passion and the deceptions of delusion, without paying heed to the voice of reason (i.e. conscience), which is either not yet developed or is mature and developed into the clear consciousness of the obligations for freedom and independence, the sin occurs, which continued as a habit will turn into vice.[4]

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2. See also Beiträge zur Krankheitslehre, pp. 239–260

3. Theorie des Wahnes. See also Beiträge zur Krankheitslehre pp. 260–268

4. Über die Natur und die Arten sowie die pathologischen Wirkungen des Lasters. See also Beitr. etc., pp. 268–280

§ 43

In that vice resides in the will, it is the most pathological of all the states considered here. This is because it opposes reason, while passion and delusion are beyond reason. They are admittedly all slavish states. However, whereas passion and delusion develop involuntarily, vice is the result of a voluntary decision, a free choice to depart from the law of virtue, declaring itself for the other side, in spite of all the objections from conscience. He who lives a life in passion and delusion does not pay homage to the principle of goodness (is godless) only, but he who lives in vice pays homage to evil (is a child of the devil). The two states are not at all the same, as a return to the state of human health is often easy in the former, or at least always possible, while in the latter it is always difficult and often impossible. It is a question of decrease in moral strength – the only way the fallen man can raise again – which makes recovery from vice so difficult. He who suffers from vice is near to spiritual death.

§ 44

These are the states of human disease, which make impossible the feelings of real human health, the peace of mind, inner clarity and cheerfulness and pure sympathy thereby impeding any thriving activity and work. They overcome man gradually, for vice is preceded by delusion and delusion by passion. The first stage of human illness is never vice; the will is only affected by the disease after the mind and spirit have been seized. It is an open question whether the pathological state rises according to the degree of which the deepest layer of life, the strength of self-determination, the will, is affected. Nevertheless, no distinction can be made between all these pathological states, in so far as they are all unfree (§ 40). However, by sharing this lack of freedom, they also all share the possibility of recovering the healthy human state, as no human lost in these states has been robbed of the ability to abandon the state of enslavement and return to the state of freedom: he is still able to perceive both the weight of his chains and the warning voice of his saviour.

§ 45

When gripped by these states of human illness – passion, delusion and vice – man denies, often without knowing it, his true nature, in which everything strives towards the highest development of consciousness. Man is not at peace when he is not free. The satisfaction of all his earthly wishes does not make him happy. He continues to strive and remains a plaything and slave of his own inclinations, unrecognised by himself, as long as his striving is trapped in the circle of world- and self-consciousness. All his aptitudes should lead a man upwards. This is in accordance with his natural disposition. Unbeknown to himself, freedom and independence remain his goal, even though both only reside in the sphere of the highest consciousness, which hardly anyone can reach and of which most people have not the least idea. For conscience is and remains something foreign to them – is indeed to many an enemy – as it should become their deepest character, their innermost and best possession, their real self and ego. In this way, most people wander blindly and foolishly through life and once it is nearing the end wonder about its meaning. Many find no significance or content at all in life and destroy it, because it is worthless to them, or complain bitterly about an existence in which they cannot recognise any purpose or aim, filled with worry and misery, and which finally passes by like a breeze and vanishes like a shadow. Yet they are still happy enough in pursuing these fruitless but vigorous goings, as long as they unreel the thread of life with a certain moderation. Indeed, such people are regarded by most as wise men amongst idiots, worthy of imitation. However, these apparently wise men are not happy within themselves and repeatedly thirst for something better in vain. The saying "the kingdom of heaven is within you" is unknown to them. However, those to whom even this kind of moderation is foreign and who have themselves in no way under control approach a series of crises, which may not always overcome them, but against which they have no defences and for which they lack any protective internal stability. These are states of total lack of freedom, related to the aforementioned like death to sleep. Just as sleep is only a temporary confinement of the free forces, which have the possibility,

indeed the silent urge, to reappear with their normal day time energy, death is a rigid paralysis of these forces which can never be released. In the same way, these mentioned states of human illness with their temporary abandonment of freedom – which can be regained at any moment or restored to itself – are only a form of sleeping freedom. However, those states of human illnesses which are to be considered as the actual subject of this textbook represent the decay and death of true freedom and all genuine human life.

On the Stimulus, the External Element of the Disturbances of the Life of the Soul*

§ 170

Everything which incites man's reaction to the external world is a stimulus, either from the external world or triggered from within. For example, fantasies, thoughts, feelings and drives are all such stimuli which develop inside man and cause him to react. However, if disturbances of the soul are provoked without any noticeable external causes, one should be careful not to conclude that they have originated without stimulus or external element, for this is certain in every case of the formation of disturbances of the soul. There is indeed a contrast between the 'external' stimuli, the images, thoughts, feelings, etc., and the reactions of the soul they elicit. However, in most cases the stimulus causing disturbances of the soul is indeed external and easily recognisable with a little effort. It is only necessary to know the living conditions of those individuals who were subject to the effect of such a stimulus. Thus, objects of fright, fear, love, hate, pride, vanity or interest of any sort, like property, political convictions, religion, etc., are all stimuli which can have a determining effect by triggering reactions of a mind, which is susceptible to disturbances of the soul. The faithlessness of a beloved object, the loss of a fortune, even the sudden and unexpected acquisition of a fortune, the insult of a deeply hated enemy etc. – all these can act on the adequately prepared and ready mind like a spark igniting a powder keg and

*Reference: J. C. A. Heinroth. "Vom Reiz, als äußerem Elemente der Störungen des Seelenlebens". In: *Lehrbuch der Störungen des Seelenlebens, Zweite Abteilung.* Fr. Chr. Wilh. Vogel, Leipzig, 1818; chapter 3: 211–221.

thus can be regarded as the stimulus, the external element of disturbances of the soul.

§ 171

However, as argued previously, whatever the type of stimulus and its precise impact (see the first chapter), it has always a moral effect, where 'moral' here simply refers to freedom of choice or the free will of man, roughly as one uses the expressions 'chemical', 'mechanical' or 'organic' for certain types of effects or phenomena. We can even include the effects of simple physical stimuli in this category, in so far as they act as moral agents, inducing a moral reaction. For example, bad weather, or a great feast, or the twilight of a spring evening filled with the fragrance of flowers and the song of the nightingale, is a moral stimulus to many people in many respects, even though the stimulating elements are purely physical. There exists a mysterious relationship between the world and man, in a way that all that is finite, all that is specific, reinforces man's tendency to live in the finite and specific. Thereby, he forgets his higher destiny or does not even start to think about it, devoting himself to the enthralling limitations of the finite world. Once gripped by the power of the finite world, it is as if all his being degenerates, as if the wings of his free existence were broken transforming his entire life into a sin. Thus, we find all men living like under some sort of a natural spell, often without their knowledge and against their will. What has been described above (§§ 156, 160) as evil, idleness, the matter, the physical world or darkness, sensuality, in contrast to the good, the pure activity, the spirit, light and reason, this contrast is the magic and the spell which lies on the world when man enters it. The earth forces him into its service, binding him like the natural force of gravity. If the counterbalancing force of reason does not predominate or does not even have a voice, man succumbs to the earthly powers and everything that touches him is transformed into a stimulus and enticement to evil. The catalyst of it lies in himself – right at the end or better from the very beginning, according to the Holy Script. Thereby, he cannot free himself of his self-centredness and his penchant for becoming someone extraordinary if he does not pay homage to reason, the

godly principle of light. Thus, if the life of man is spent in the service of the worldly and if life's force has turned into gravity, so that all his feelings, thoughts and decisions belong to the earth, making him only susceptible to worldly matters, the decisive force of the finite world can dominate him enough to ban him forever from freedom and leave him in a state of slavery. Everything and every process is subject to laws, as is this a fact of the life of man. We will now pursue the manner in which the stimulus becomes the external element of the disturbances of the soul.

§172

We have compared the origin of the disturbances of the soul with their causes, or rather with their causal character, which consists of the combination of two factors or elements giving one unified product. The first element, as it was, the female or maternal component, containing the substance of the humour of the soul, is the basis. It is only lacking the fertilising effect of stimulation. Thus, the stimulus is the fertilising principle. How this happens will be determined later. Firstly, we have to consider its nature. To put it briefly, this is not only similar, but also closely related to the miasma. It is nothing new that the development of diseases by the miasma equals the actual process of illnesses. The miasma corresponds to the concept of illness, which can be transmitted from one individual to another or transferred from the cosmos to the individual. There is nothing isolated in nature as everything is related in a polarised and counterbalanced way. All the general and specific aspects of nature and all elementary and organic conditions interact with each other. The world and man are related to each other spiritually as well as physically. This is perfectly evident for the sphere created by man himself namely the earth, in so far as it has become the expression of human conditions. It is therefore justified that the kingdom of mankind has been given the special name 'world', as the traces of human thoughts, feelings and drives are evident everywhere on earth. The conveyor of these traces is always man himself. Man is affected everywhere by man, either directly or indirectly. This effect is the essential characteristic of all the stimuli leading to disturbances of the soul. Since the beginning of time,

degeneration has been widespread amongst man. One infects the other and passes on the original degeneration to the other. There is original sin. However, nobody has to be seized by corruption, or fully enslaved by the force of unreason. However, the atmosphere of the human realm is poisoned and the name of this miasma is the enticement to evil. What is its structure?

§ 173

It crosses the countries attaching itself to objects and their conditions, in the form of ideas, which have been formerly known – in blind but true belief – as ghosts or demons and which have been rightly thought of as having the power to cause evil. This is not a metaphor and even less a hyperbole: these spirits usurped the world and each disturbed soul is the result of their influence. The main unifying point of origin to which all these ideas are subordinate is egoism. This most evil idea is part of both the most and least common human conditions. Its poison is imbibed from one's infancy and finds the human heart a ready organ to process it. This poison contaminates the air we breath and we – unknowingly and unadmittedly – take it in with each breath. It infects our senses, our understanding, our fantasy and our feelings and it transforms itself assuming manifold shapes in order to rejoin the human being. The ideas of money, dominance, possession, pleasure etc. are all manifestations of the devil. They all resist the good spirit and attempt to destroy its influence upon man, in which they seem to be predominantly successful. We will demonstrate this considering only one example, the idea of money. Money in itself is a useful invention for regulating inter-human relations. However, the associated idea animating it has ruined a large proportion of mankind. This idea places money on the very basis of human existence, the support and medium for survival thereby replacing God. He whose self-fulfilment relies on money neither looks for nor needs anything else and has no other goal in his life because it is his God. Nobody can deny this. The idea of money has replaced the idea of God as the former has usurped the throne of the latter and rules over the kingdom of mankind. He who worships the idea of money has abandoned the Holy Ghost and sacrifices to the impure

spirit, which leads to man's ruin by its apparent favour. How many have gone mad by acquiring or losing possessions! How many will still succumb to this influence together with all the other demons surrounding mankind and building traps.

§ 174

The principle and the stimulus of evil act in two different ways on man – just as all poison acts in contrasting manners, either positive or negative, stimulating or paralysing. When life is seized by this stimulus, the effects can either be observed in the form of exaltation or depression. We cannot discuss these effects further, and they are only mentioned in so far as they relate to the force of nature. The stimulus, in order to be effective, always needs to be real and actively powerful, and only the manner in which it is spiritualised differs or is even polarised – if one can say that. We observe the antagonising principle of expansion and contraction everywhere in nature and all natural psychic and physical stimuli acting on life on behalf of nature are composed in this way. This also applies to those stimuli which induce disease. Leaving aside the stimuli which cause purely somatic diseases, we must however consider the double nature of the psychic factors. We then note that the character of positive stimuli always stands for something binding, lasting and apparently accomplished in its structure, expressing beauty or freedom, like, for example, the imaginations of gaining a fortune or possessions which can ensure life or the real or potentially winning lottery ticket. In contrast, the character of the negative stimulus is somewhat loose or disintegrating being prone to destruction, such as the death of a beloved person, a wrecked ship with our capital on board, an insult to our honour or our good reputation by slander or the revelations of a long concealed misdeed, etc. The negative force of all these conditions or objects acts like vitriol on life by incorporating the principle of destruction in itself.

§ 175

It may be objected that these and similar positive and negative stimuli are based on imaginations and consequently do not reside in extrapersonal objects or conditions. It could be argued that it

depends on our imagination only whether a win in the lottery becomes a positive stimulus and the loss of a friend a negative stimulus. However, this imagination is due to the structure of the external conditions and concepts linked to them which pre-exist already our imagination. For example, the idea associated with the lottery win was already there before we thought of it. It influenced us and we absorbed it to create, as it were, its afterimage. In a similar vein, we did not produce our friend's way of thinking and his character on our own. They were generated by our fantasy; but we have only assimilated what was already present and recreated an image corresponding to what was already present outside ourselves, stimulating our imagination. The loss of a friend, the extinction of what was there, is then also something real outside ourselves, but with a negative effect. This supports the reality of the positive and negative stimuli. Now, we should investigate whether every external stimulus is evil and if this is not the case, how the evil character of the stimulus, the stimulus to evil, can be recognised.

§ 176

John Brown was certainly right to say that there is no life without excitability and no excitation without stimulation. It would thus be foolish to assume that all stimuli including external stimuli are evil. Is man not just as much externally stimulated to do good as to do evil? Furthermore, the stimulus to do evil often lies not in objects, but rather in man. For example, somebody with a tendency to steal will sense the incitement to commit theft as soon as he sees a roll of money in someone else's room. However, a beguiling prostitute, a lascivious painting or novel, in short, anything inherently seductive bears the character of evil and its effects are always stimulation to evil. Thus, these examples illustrate how the essence of evil is part of external stimuli, such that the character of sin or human fall from good is imprinted on these stimuli. The extent of the realm of evil now becomes clear to us: it is the realm of human activity. It is not as if human activity were inherently evil, but rather that evil can only occur within the sphere of human activity. Everything outside ourselves is either the realm of nature or the realm of man. Nature is not evil. Consequently, every external trace of evil must be the work

of human freedom, which is indeed the case. Since the beginning of time, man passed on the evil from one generation to another, with one generation transmitting the disease to the other. In the course of time, the word and the deed may create good but also evil, if the spirit of evil is in them. The forces of decay are stronger than those of salvation as man falls more easily than he rises. Air and light are filled with the evil, created by man himself. Accordingly it is not surprising that so much outside us is evil stimuli and stimulation to do evil. All passion, foolishness and vice, all prejudice, narrow mindedness, malice, badness, and distortion of the individuals and masses and all effects, consequences, products of wrong activities and a wrong life are the incitement for doing evil pushing the souls into the realm of gloom, darkness and slavery.

Ideas on a Direct Psychic Method*

§ 325

Even if all aspects of the indirect psychic method are combined, there is much left to be desired – as not only do most chronic disorders of the soul defy medical help, but many of these disturbances start also acutely and despite all attempts of physicians to treat them during the acute state, progress ineluctably to the chronic state. The cases, which are most likely to be cured are those in which the nature and dominant character of the condition are actually physical with psychic abnormalities as only accompanying symptoms, such as feverish delirium, which vanishes as soon as the storm in the organism has settled. Just as the fever, the somatic affliction, is the main impulse; there are feverless idiopathic somatic afflictions, which also symptomatically seize and disturb the psychic life. This includes all vigorous stimulations of the ganglion system, such as irritation by worms. Thus, the author has observed that delirium in a patient who showed clear symptoms of mania vanished after taking a single dose of an effective purgative, as the delirium was nothing but a reflex of the ganglion system in response to the irritation by the worms. However, the actual disturbances of the soul, the products of a pathologically led life of the soul, are not of this sort, even though they do affect the somatic organism. The evil sits deeper and therefore requires deeper intervention. Although the indirect psychic method acts on the somatic organism in the first place, the most decisive, most rapid and most reliable method, however,

*Reference: J. C. A. Heinroth. "Ideen zu einer direct psychischen Methode". In: *Lehrbuch der Störungen des Seelenlebens, Erste Abteilung.* Fr. Chr. Wilh. Vogel, Leipzig, 1818; chapter 8: 63–80.

would be a direct psychic method targeting the diseased soul itself if it were possible. Such a method would be a heuristic masterpiece. In his previously mentioned thesis "de voluntate medici medicamento insaniae", the author dared to present a hypothesis which is only apparently paradoxical, as it postulates a force in man which he usually loses during his normal daily life, which is why the existence of this force is commonly denied. This is the place to communicate the essence of that hypothesis so that it may be subject to both theoretical and, more importantly, practical and experimental evaluation, as only experimental evidence is decisive here.

§ 326

We have to imagine that we as humans, with all our art and science, are degenerated and crippled beings. Our highest artistic and scientific ability is nothing in comparison with the fullness of vital strength, insight and effectiveness which we would be able to share in if we only discarded the shackles of our sinful character and life and breathed the air of the "magnificent freedom of the children of God". This is neither fashionable bigotry, subservient pietism, pathological mysticism, fanciful zealousness nor blind superstition which is being expressed here, but the result of a settled, considered, clear insight into human nature as the ideal before our eyes of purity and integrity. If considered properly, the word 'ideal' may condemn our enterprise, as this implies something which cannot be realised or achieved. We deny this. The purity and integrity of the human character and everything associated with it and originating from it is not at all something unattainable, but is only attainable from the religious viewpoint. However, we know no other truly religious standpoint than the liberating faith brought into the world by Christ and disseminated by the apostles. – As this is neither the right place nor our task to preach or to dogmatise, we will just have to accept the reaction of anyone who shrugs his shoulders, shakes his head or decides to stop reading this book. In this case, we would only like to cite Goethe[1]:

1. Lehrbuch der Seelenstörungen II

"Everything does not fit everyone.
Everyone should watch out for what he does –
Or where he stays
And where he stands – so that he doesn't fall."

As regards the author, he admits before the entire world that he only stands upright by striving for this liberating faith that "leads from the power of Satan to God" and that he is one of those whose souls only find rest under this aegis. This faith is and has the force of God. It is the strength of adamant trust in the eternal power, wisdom and love in which we 'live, think and exist' and it possesses the strength to raise us above ourselves and our selfish nature, above a decadent world and the kingdom of darkness with its nightmares, to free us from the chains of death, from transitory concerns to which non-believers adhere and to lead us to the realm of the light, the love and the strength. Without this faith, we are powerless, with mere self confidence, only resting on and in ourselves, our ability, our insight or our love, in other words, our egocentric drives, as our strength is a fragile support, our insight an ignorant leader and our love a restless, unsatisfying and volatile striving. However, in and with this faith we are strong, in the pure and adamant attachment to the eternal holy being or the living truth, united with this truth, as this is what faith means. Faith is the complete devotion of our existence to this eternal and holy being, as brilliantly and clearly revealed in Christ, the word, the reflection, the source and the wealth of eternal life. This faith liberates, releases and purifies us from all stains and ashes of our earthly nature. Immersed in and filled by this faith, we are purified and sanctified, inspired by a new and higher life and enter the realm of life and love. The apostles lived and acted in this faith as this was the focal point of their lives. This is why, they, in their simplicity and humility, stand so much above other men. He who has gained this faith – and everyone should and can achieve it as only the voluntary lodging of evil in us prevents this – stands not only above all the changing fortunes of life, but can also achieve, using the strength given by this faith, what no-one else can: the healing of many illnesses by pure will force or contact, as all that is touched by the holy becomes holy and healthy itself. The apostles were able to do this by the strength of the Holy Ghost given to them

and this Ghost is that of faith and love, as love is the life of the faith. No one can predict why different things happen to each of us under the same conditions. We therefore propose that everyone's strength corresponds to his faith. However, who possesses this faith and who is pervaded by it? Who acts through it? Admittedly, the author has never met anyone who genuinely believed in a way Christ and the apostles did. He is well aware of himself being far from this stage. He has not won the prize of this divine ability. We are immersed in the trivialities and weaknesses of a wicked time, from which the good spirit may hopefully liberate us in the near future. We really have nothing else to do but to combat the evil living in us as eagerly as we obey and pay homage to it, by using all the strength which is given to us, after we searched for it seriously: the strength of the faith that evil will be overcome and will no longer be part of us, as soon as we no longer freely submit to it. Christ himself as a condition for participating in all that is godly demanded this consent, this turning away from evil and towards the good, this love of God. He thus raised mankind to a higher level, by neither demanding nor forcing anything without man's free consent. This then is what we have to do and what we have to give – turn away from the evil and towards the love of the good. Each time we reject evil we are a step closer to the realm of integrity, of purity of heart, of faith, the kingdom of heaven, where Christ lives eternally and where we should live eternally as well. Therefore, if we were not often unfaithful and returned to evil in unguarded and incautious moments, mechanically attracted by overpowering habits, we would so much more often, more richly, and more powerfully experience the purity, clarity and holiness of the kingdom of heaven, than now in clear but transitory moments, shining on our life like a flashlight. The hatred of evil is part of the love of the good, which is again the element of faith. However, faith is a necessary condition, for allowing us to participate in the nature of the divine, the spirit and strength of which as well as the power of healing by will, sight and touch lies hidden.

§ 327

I wish to repeat that all this can only appear to be a fable to the irreligious spirit and only an impossibility to an entire worldly

mind set. "The natural man perceives nought of the spirit of God": this is admittedly an old saying, but it is still true. However it is also said: "Let us work and not become tired", and "Pursue holiness, for without it no-one can see the Lord". We can mock it, demonstrate it, and work it out of existence even enjoy it out of existence, – whatever we wish. Nevertheless, this truth remains the aim of life, which we must be familiar enough with to see it in every situation in life and which we should regard as the precondition for all successful activities. Therefore, it does not come as a surprise that this should also be the foundation of all medical work and namely the work of curing the disorders of the soul. The soul is the force most closely related to another soul. If an impure soul can corrupt a pure soul, a healthy, godly-invigorated soul should be able to cure a sick soul. However, the medium of all creative activity – the spiritually active and creative original force – is the will. Still, at first, the will has to be present in force, before it can act as a force. Thus, everyone who desires virtuousness in life should strive to invigorate, purify and sanctify his own will and necessarily acquire a strength that allows him to achieve what are otherwise called wonders due to the will born out of the faith. However, as a holy man once said, faith is not to everyone's taste. This is why only few possess the kind of will which can bring redemption and cure life. It is nevertheless amazing that a wild branch of faith, i.e. the natural faith or self-confidence and the resulting increase in will force (what has been called the 'croyez et veuillez' by Count Punsegur) in the form of the so-called magnetic agent, can already achieve so much – as we can see from all the properly recorded treatments. Nowadays, it is almost generally accepted that the will of the magnetiser is a 'sine qua non' condition for the action of all genuine animal magnetism. From this, it has to be concluded that the will contains an absolute force, the ability to conceive, reproduce or transfer energy. This is part of its basic character or indeed is its essence. It appears in its full purity as creative energy, but is suppressed in various ways in most men and only manifests itself in some individuals – those that are most lively and intact – in its true strength and efficacy. Although initially discovered by chance, it can be deliberately evoked if there is enough self-confidence. This acquired strength is never as power-

ful as that which is a natural gift, talent or instinct. Persons with this curative gift enjoy no advantages with respect to other abilities and mostly live much unrecognised in contrast to people with other gifts. This is why the healing power of many of low standing may frequently become the object of official investigation, after this power has already been faded away, weakened and exhausted by use and where it is then concluded that these people are capable of nothing being either deceivers or self-deceivers. However, this strength is like money: it will be lost by everyone who doesn't have the ability of keeping it. No: vox populi, vox dei. If many thousands are attracted to a healing power manifesting itself by chance, there is some underlying truth here, as they are not all simpletons, fanatics, superstitious people or swindlers – although some certainly are. However, the gifted individual exhausts himself, not during the use of his power – as this, being a gift, does not need the least effort, much like water gushing out of a mineral spring – but by being surrounded every day from morning to evening for weeks and months with patients of all sorts, to all of whom he is meant to be helpful. Thus, his fate is like that of the good magnet which is given more to bear than it can carry: it lets the load fall and loses its strength due to exhaustion. In a similar way, the mind of these gifted individuals is influenced by gradual changes. The increasing crowd of people, the growing reputation, the admiration, respect, esteem (almost extending to worship), the numerous financial demonstrations of gratitude, these all deafen, intoxicate, entrance, bewitch and corrupt people of this sort and pollute the spring which finally dries up. This is why the career of individuals with healing power normally declines over time and finally, to their own amazement, after realising of being no longer capable of anything while forced and driven to maintain their reputation and income, they seek their refuge in deceit. The latter is usually uncovered and the poor wretch is then condemned.

§ 328

We have deliberately spent some time on the question of the healing power of the will and to what extent it may be a gift, as the will in some people possesses this strength, but in others not, just as

some rocks contain veins of noble metals and others not. However, as already said, it is also an acquired skill, based on the practice of self-confidence, similar to the art of swimming. No one can swim when he enters the water for the first time. However, those who have learnt to swim remember that their skills improved as much as they were able to ignore their fear of drowning. However, the opposite of fear or doubt is confidence, trust and faith. The deeper the faith, the more one can build on it. The belief in our own abilities depends on this faith, i.e. it can be subject to decline and total destruction. However, the faith based on which we initiated this description and which is part of the force of God according to the Holy Scriptures is not subject to the fate of all things transitory. He who drinks from this source need never be thirsty. However, this enriching and sanctifying occupation is only granted to those who fulfil the above conditions. This is no easy occupation – as nobody readily renounces his own ego, his own selfish nature. However, these goods and powers cannot be obtained at any other price.

"If you do not bet your life,
You will never win it."

§ 329

So we postulate, just as Punsegur did, the existence of the devout will, but only as a higher power than assumed by the French magnetiser, namely as a healing strength which can act directly on disturbances of the soul. It is very difficult for everyone to regard this effect and its successful activity as a possibility, firstly because we cannot imagine the strength of the devout will given our low position in life. This will means nothing to us; it does not exist as it is not part of us. This is because we experience only what is real to us, and we only have the experience of our own egocentric will, which could itself show us this kind of deep energy lying dormant. Anyone who has achieved something out of nothing – the industrious farmer, the craftsman, the energetic businessman, the artist, the scientist, the hero or the statesman – any of these different owners of the multifarious goods of life – fields and land, skills, money and property, arts and science, regency in war and peace – would anyone of these possess the least

thing if he had not made every effort in working persistently and continuously? What power is responsible for all this if not the human will? If that will were removed from man, his life would come to a standstill, like a machine deprived of its energy. However, we use our will instinctively without being aware of it, and often we do not even permit ourselves to use it because of inherent or habitual idleness. How then should one be capable of imagining the power of a will based on faith? Secondly, we are unable to understand how disturbances of the soul can be cured by the will. However, do we understand at all any sort of cure? Despite describing natural processes by using comprehensible concepts, we neither understand nor speak the language of nature. However, if we wish to link causes to effects, we are obliged to conclude that there is a combined activity of forces in a way that the stronger forces determine the weaker ones. We notice that individuals or personalities influence each other already under normal conditions of life: One gaze, the word of a powerful impressive individual – be it loving, commanding or threatening – if directed towards someone else who is less powerful, may immediately cause fondness, obedience or fear. We have to admit that the mutual influence of souls or of wills exists under normal circumstances of daily life. Why then should we not assume that a healthy and energetic personality – with enormously enhanced spiritual vitality, inspired by the divine being – could influence an individual with psychic illness? It is only a matter of evidence revealing favourable changes in disorders of the soul by effects of this sort, similar to physical incidents caused by magnetism. In this case, we were obliged to recognise the spiritual agent and its direct psychic effect based on spiritual contact. However, until nowadays there is still no such evidence and we have already stated the reasons: the strength of our will is chained and can only be liberated by the higher faith of the pure soul. Thus, the opponents of our hypothesis will have an advantage until some individual succeeds in reaching those heights of pure existence in the face of which, the worldly spirit feels dizzy and shudders and which everyone to whom the divine is neither a matter of joke nor a fable has to strive for – if only by the simple saying: 'seek sanctity'.

§ 330

Everyone who has made the devout will his own finds himself at a stage where he needs no further instruction on how to apply this will, for it is clear to him, and he observes the limited, restricted earthly conditions of existence from the viewpoint of his free spirit. All his existence is immersed in the pure ether of life, revealing the most profound sense of existence. He is in the healthy, alert and conscious state of a true clairvoyant, in as much as the so-called clairvoyants are in a sick and comatose state. In short, he needs no instructions and indeed no one who reached this stage can profit from any instruction. The author admittedly indicated some rules for treating patients with disturbances of the soul in his frequently cited dissertation. However, if the will is to act in its genuine strength, it has to be completely liberated from any slavish state. However, this can only be achieved in a pure state of belief and in absolutely clear spirits. Accordingly, we consider it unnecessary to repeat these remarks, as the main issue is to create the agent, which once established, knows how to help itself.

§ 331

Without question, this agent, which appears to be helpful for one group of disturbances of the soul would also act on those of the opposite type, as the will inspired by faith and love (as the element of faith) should be just as effective in soothing cases of exaltation as in uplifting cases of depression. The whole area of disturbances of the soul would thus be open to this agent. Whether an individual who has gained faith will consequently experience the healing power of the will and whether he will enjoy its use as voluntarily as, for example, the ability of memory or understanding, is a question which, although it cannot be satisfactorily answered, renders our suggestion not just paradoxical, but even chimerical. One may say that the pure will "is absorbed by God's will or identifies itself with God's will. However, what can man do if it is God's will that disturbances of the soul should be cured through the strength of the devout will, i.e. through the strength of God?" On the other hand, one may also say that "each healing will is a divine gift, distributed according to God's wisdom, as he sees fit and not to those

who desire it." However, the truth, which can be found by everyone who strives seriously for it, never leaves us in uncertainty. It is a contradiction to think that man, inspired by the divine spirit once liberated from the slavery of sin and immersed in the life of faith, would remain as faint and feeble a creature, as he was in his natural, i.e. corrupt and fallen, state. No, he is only a tool of God because God acts through him and manifests himself through him. How can this be otherwise than through deeds of spirit and strength? This is how God manifested himself in his apostles because they believed, and this is how he will manifest himself time and again in everyone who believes and to whom it is promised: "as long as your belief is as little as a grain of mustard", etc. Otherwise, we would have to doubt God's promises and honesty and God himself. Once man becomes 'a new creature' through faith, he also becomes a strong nature, a strong nature in God, as before he was faint. Then let us all believe and we will all help. Whether in all cases and to the same degree will depend on the quality of our faith and our perfection. We cannot expect a greater degree of perfection than the extent to which we have been liberated from the slavery of evil and we only enter the realm of faith to the extent of which we can abandon the realms of sin and ungodliness. Man blessed by God has admittedly a totally different guiding principle from the ungodly and his path is at all times that of benevolence and love. If those who have lost reason are the unfortunate, what greater good work can be performed for them than regaining the highest good? Who else can do this apart from he who possesses it? The only ones in possession of this good are those with faith, as they have, as the apostle says, incorporated Christ, and in him lives the wholeness of the divine. It is then quite clear to them how to show the way of the truth to the lost souls, how to liberate those fallen victims to the spirit of evil, possessed in manifold ways.

§ 332

Here then is the nucleus of a practical hypothesis, rather than an enthusiastic theory. It will be presented to the reader and his judgement. For it is indeed daring, in a time in which gloomy, slavish mysticism is threatening to devour the fruits of three centuries of

enlightened effort, which however will at the most be only successful for a short time and will only serve its final annihilation. It is daring in a time, where in a science such as medicine which has always enjoyed the greatest freedom of research, opinions are proposed which seem to support this monster of the times and almost end this way of conducting research. It may be said that all the work of doctors over so many centuries, to clarify the laws of healthy and sick life, of the healing powers and of cure itself, is destroyed in this way. Is that correct? Is that responsible? Is that reasonable at all? This will push open the doors to the old barbaric ideas, the old superstitions and all that nonsense. In the face of it, the author prefers to write this himself, before a reviewer does it for him. However, he should be allowed some words of justification. We do not wish to examine how far the work of medicine has gone or can go to achieve its goals; this should be done elsewhere. If however medicine is the science which enjoys the greatest freedom, it must be allowed to propose suggestions for testing, however odd they may seem, if there is the slightest evidence that they have any foundation. This is all the author has done. He has recommended a new agent against the most powerful evils and outlined the conditions to acquire it. These are admittedly difficult enough and of such a nature that everyone who attempts to acquire them has to recreate himself as a new human being. However, this is no reason to reject this suggestion, as it is our old human nature, which we admittedly love above anything else, but which is really nothing special and can be abandoned without much loss. The only question is whether what has been suggested is possible or profitable. It is certainly not profitable in a sense, of losing our old individual characteristics. But, as we have shown, nothing would be really lost. As regards the potentials, only the experiment can decide. However, what is the purpose of such an experiment? The purpose is 'to free yourself'. However, true freedom is impossible without recognition of the truth and without rejecting sin, evil and the ungodly. Now comes the final and serious question. Is this something obscure, mystical, fanatical, does it kill or enslave the spirit? To make a suggestion, which originally and purely came from God, as was said: "If you follow my teaching (as you love God and not the

world), you will recognise the truth and the truth will make you free." You can say: "Very fine, very pious but what does this have to do with medicine?" Our answer is: a great deal, as "he who is blessed by God is good for all things". Please do not regard this as an old woman's saying, but as something powerful and relevant to the whole of life and thus also for what is known as knowledge and ability or science and art. Enough is said for now as there will always be something which "the Jews consider a nuisance and the Greeks foolishness". Moreover:

Si quid nosti rectius istis.
Candidus imperti; si non: his utere mecum.

Karl Wilhelm Ideler (1795–1860)

Karl Wilhelm Ideler was born in 1795 as the son of a pastor in Bentwisch (Brandenburg). In 1811, he started to study medicine at the so-called Pépinière in Berlin, but later moved to Paris. He worked with Langermann at the Charité in Berlin and was head of the Department of Psychiatry there for 32 years beginning 1828. He qualified as university lecturer in 1831 and later became faculty member, professor of medicine and member of the medical privy council. On the basis of the work of his teacher Langermann and in the tradition of romantic medicine, he published his "Foundation of Psychological Medicine" in two volumes (1835 and 1838). This work introduced psychology into medical science in the sense of 'spiritual pathology' (Stahl). Other works were "Biographies of the Psychiatric Patients in their Psychological Development" (1841), the widely read 'General Dietetics for Patients' (1846) and "The Relationship of Psychiatry to its Supporting Sciences" (1846). In 1847, he published the much respected monograph 'Religious Delusion'. He focussed especially on the emotional state or 'frame of mind' and ascribed an important role in the origin of psychiatric diseases to exaggerated passion.

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The Passions*

§ 73 Concept of the Passions

To understand to what extent the study of the mind is lacking a scientific basis, we only need to look at the fluctuating and inconsistent definitions of the concept of passions, which was so little understood that it was impossible to derive the various forms of madness from it. There was indeed not even a systematic scheme for the passions, no clear demarcation from the emotions was possible and the relationship between the passions and understanding or mind could only be very sketchily described. There were people who looked for the origins of the passions in physical anomalies, which are said to cloud consciousness and to imbalance the soul. There are other people who regarded the passions as corresponding to insanity, in other words, fully identical with madness, which only arises from the passions under specific conditions. In short, the concepts overlap to such an extent that any sort of accommodation is inconceivable.

Kant suggested the definition that passion is the drive (tendency) which hinders reason when confronted with a specific choice from comparing this with the sum of all tendencies.[1] Even though this is generally correct, it does not express how passion achieves its frightful power on the mind, not even in the context of the previous sentence, which states that a tendency is a sensory desire which has become a habit to the subject. The absolutely first point to make

*Reference: K. W. Ideler. "Von den Leidenschaften". In: *Grundriss der Seelenheilkunde, Erster Teil*. Verlag von Theod. Chr. Friedr. Enslin. Berlin, 1835; section 8: 539–548, 638–643.

1. Anthropologie p. 224.

is that the latter stipulation is far too restrictive, as tendencies derived from noble drives should by no means be equated with sensory drives, which does not preclude that these tendencies can only degenerate into passions. This is because we can only designate something as sensory in a practical sense, if it is directly related to physical relationships – so that most drives to achieve spiritual goals are excluded from this. It is also true that custom provides no sort of explanation for the power of passionate tendencies, even though it can be an important part of them. For many passions seize the soul suddenly and in many cases the customs of a long life are in no way suited to be augmented into passions. We are always forced to return to external characteristics. The reason that most definitions given are so deficient is that people were so gripped by the violent appearance of the passions that they failed to recognise their origin in the higher laws of the mind. It was then impossible, from a logical point of view (§ 7) or from the assumption of the inseparable unity of the desires, to explain the competition between the passions and the other interests of the mind, or to use this relationship to throw any light on these dark feelings.

It must be our all-dominant interest to create an organic[2] view of the passions, explaining what is seen on the basis of internal events. This should help us to understand how the passions originate in the soul's deepest needs, how they start in the deepest levels of the mind, from where they penetrate and master the whole soul, absorbing and appropriating all its strengths as it were, so that the subject and his whole existence lives and operates within them, abandoning every other effort at thought, feeling or acting. Each instinct attempts to maintain its independence in competition with the others and, as a result of its inborn drive to unrestricted development (§ 70), attempts to expand its field of activity at the cost of the others. If this instinct was the dominant one in the mind (§ 48), it was favoured by the external conditions (§ 49), and if it

2. It is hardly worth mentioning that the word organic is used here and elsewhere not in the physiological sense, but in the general scientific sense, to mean the harmonic development of the multiplicity from the unity, as this can also be applied to psychological relationships.

was not compelled to moderate itself by moral discipline, it will, in accordance with the law of antagonism (§ 72) become the ruler of the soul, and the soul's powers will according to the law of consensus (ibidem) be at its service and the soul will not be capable of asserting its essential interests against it. Moreover, its long-term action abrogates the law of the change of the activity of the mind (§ 69), it maintains the mind in unbalanced tension in this way and establishes this as a matter of custom (§ 71). This contains all conditions for passion, so that there cannot be more or fewer of these than there are detectable independent instincts, each of which gives rise to the corresponding passion of the same name. This means that we now have a complete systematic classification, which will greatly facilitate additional research. We then only need to amplify the concept of each interest of the mind and pursue its exaggerations and then we will be able to explain the characteristics of the resulting passion and the contradictions to which it necessarily forces the soul.

If we understand that every instinct is the effort to fulfil its purpose, it becomes clear that if an instinct totally dominates the soul, it will force the soul to sacrifice all other interests. Only its purpose dominates consciousness. In this way, it compels the mind to employ all means to satisfy it, which it demands, whatever the price, and to remove all obstructions. If any objection is raised on reflection, this is eliminated. If doubts awaken, the most they can achieve is to increase the impetuousness and the obstinacy of the passion, until thought is deformed into sophistry biased in its favour. Moral objections from internal reflection are most easily eliminated – as these arise from instincts which the passionate desire has already totally weakened and drained. The rational mind, whose sole intention it is to assert the logical sequence of ideas, has therefore no interest in protecting those moral objections. The situation is different with the concepts based on experience, which form external prudence from which the mind cannot free itself. For passion urgently needs the assistance of the mind to achieve its purpose, so that it encourages the mind to think acutely and carefully about how to fulfil its purpose, assuming that it has not exploded into senselessness. This is why highly intelligent pas-

sionate individuals, of all people, who are very well aware of their own will, are normally marked by the virtuousity with which they use their minds and can astonish us by the correctness or even brilliant combination of their conclusions, and by their deep knowledge of the human nature, which they may acquire if this serves their purposes. It is only when reality is absolutely opposed to their intentions so that they have no other choice than either to abandon their intentions or to deceive themselves about the means to their end, that they almost always decide for the latter, just because they have no real choice. They then adopt the most unlikely assumptions, fail to recognise the simplest truths which are unfavourable to them, ignore all earlier experience, or take a direct risk, as they are more prepared to trust blind chance, which often leads to the most improbable result, than to be restrained by the natural order of the matter. Or finally they ruin themselves, as they are incapable of resisting the passion which draws them over the precipice. For the subject can only suppress the first stages of passion of his own free will, although this does not happen so often, as its silently increasing power is closed to reflection. But no-one can resist its destructive force, once it has increased to this level.

This is an essential difference between passion and emotion, which is only a temporary increase in activity of the mind and is also only a fraction of passion. Also, as a result of the law according to which the instincts mutually exchange the role of dominant activity, emotions then go into rest. Conversely, the fact that emotions often meet an unprepared mind, means that their effect is often violent and can much more easily eliminate prudence, as is discussed in detail in the section on feelings. Passion only confuses thought to such an extent when it is transformed into lively emotions, which happens, either when they suddenly break out, or when there are important obstacles to their goals, which must be met with great impetuousness. In contrast, in most passion usually only develops gradually up to the highest stage. It, therefore, leaves the understanding time to consider the situation into which it has been forced and to connect the practical concepts with the desired purposes. Admittedly, the lack of balance with which passion competes with other essential purposes means that this is not

possible without multiple distortions and confusions of the simplest and most natural ideas and the coarsest violations of healthy logic. This is why unemotional persons wrongly believe that they can overcome the passions of others by revealing their inconsistencies and illogicalities. They have not understood that the ideas of passion are not linked by the laws of thought, but that the laws of thought are under the control of the dominant interest and that the validity of this is only clear to the person in the throes of passion and to his understanding – which has been misled to mutilate and distort the concepts.

While the emotion is more powerful in interrupting the natural connection between ideas and stops the subject from considering the consequences of his actions, and it much more easily excludes responsibility, as it often robs the unprepared understanding of its prudence as a result of arbitrary surprise, without fault. In contrast, passion cannot employ this excuse, as it does not exclude alertness to avoid illegal consequences.

In addition, emotion is open and honest, as it displaces the mind suddenly into another condition, without leaving time for consideration or pretence. It is much more the case that it produces the natural urge to announce publicly what is happening internally. In contrast, passion leaves enough time for consideration and instructs the understanding to keep secret purposes which could inspire resistance from others. It is accordingly cunning, sly, treacherous and hypocritical, secretly to undermine the foundations on which the enemy is standing and then to explode it with a mine. For he who has decided for a purpose must also approve the means, must remove the opponent without harming himself. The moral judgement, that rejects the purpose if its means are in contradiction to other, more essential purposes, cannot arise in the consciousness of passion.

The emotion heals itself, as once the subject comes to his senses, he is repelled by a situation which divorced him from his other interests. In contrast, passion has already suppressed all other interests and has made the subject indifferent to their violation. This long-term reforming of the state of the mind is what makes passion so pernicious. Man is created to fulfil all

duties prescribed by the nature of his mental life, but is alienated from these duties by the passions when all other interests are eliminated, thereby inevitably destroying the conditions of his own spiritual well-being, as will be shown all too clearly in a detailed discussion.

One more misunderstanding must be clarified which is often connected with the word passionate, in so far as this is thought of as a violent, impetuous, two-phased, changeable state of mind. Precisely, complete passion is characterised by decisiveness, steadiness and consistency, which is contrary to the description in the last sentence where competition foreign to real passion is suggested. As passion has collected all the strength of the will in itself, it does not allow contradictory interests even to arise. To put it pictorially, it fills every artery in the soul and fully penetrates its constitution, as a faulty blood mixture perfuses the whole organism. It is just the gradual emergence of the dominant instinct which deceives the consciousness, which is not aware of its increasing power and which is no longer capable of resisting this once it has fully appropriated the power of thought. This is why only acute attention can annihilate the initial seeds of passion. As a phrase which is part of our common knowledge says: every vice sneaks up to us and there is great danger of being ruined by it, if man yields to the desire which adopts a pleasant form to endear itself to us.

This is why the criminal does not understand how he could stray so far and is indeed indifferent to this in the worst case. If a warning voice had held him back from the first step on the path of vice, which finally would lead him to the court or to another dreadful fate, how he would have shrunk back with repulsion, because he might otherwise wake up with horror from his delusion, but then it would be too late.

As complete passion is characterised by cold prudence, this explains why it more rarely leads to madness, which frequently breaks out in its immature period. As long as the other instincts are not fully suppressed, they fight the evolution of the passion, setting the mind in uproar, as is recognisable in the derangement of the intellect. In contrast, once the competitive instincts have been suffocated,

they no longer disturb the peace of the mind, do not impair the intellect. One might take the fact that vicious men rarely succumb to madness (this statement excludes physical desires, whose frightful power to devastate the soul by deranging the nerves, cannot be denied), whereas more benevolent men often do, as evidence against the psychological theory which claims that insanity arises directly from passions. But in reality it is the opposite: a proper understanding of this fact confirms this theory. As it is more benevolent souls which cannot abandon themselves to the passions without a violent internal resistance from the other instincts, and thus inevitably disintegrate. Although this conflict might be totally unconscious and not be noted by the subject. This is why mad people who are totally full of their interests, and completely deluded regarding the fulfilment of those interests, do not feel any satisfaction but suffer from a vague feeling of disquiet. In contrast, the crude criminal is not presented with obstacles from his consciousness or from more any other noble motive and can abandon himself to his desires without being disturbed. The perpetual danger of being punished by the attentive law only awakens and sharpens his understanding, which has no time for idle dreaming, but must avoid tumbling towards a frightful fate. He behaves a bit like a body fighting against the penetration of a poison with violent reactions, as long as its internal tissues remain undamaged, but which does not react against pernicious cachexia when this insidiously enters and gradually converts the structure of his tissue.

Passions rarely occur in a pure form, as their complete development is too greatly in contradiction to the natural constitution of the soul and will therefore mostly meet a major obstacle in the opposition of other instincts. The passionate instinct is only successful in subduing other instincts when almost all external and internal conditions are favourable. However, if this is not the case, the interests of the subject are in permanent competition and the contradictions in consciousness become even more complicated and distorted. It also makes a great difference that amongst those other instincts, it will be sometimes this and sometimes another instinct which is most suppressed. This must all be considered if the depiction of the individual passions is not to be exaggerated.

§ 86 Every Passion is a Mental Disease

I will discuss the sentence in the title in the context of the teaching of the stoics, as described above, and will keep the controversy which this has triggered in studies of afflictions of the soul to the second part, where it will find its natural place in the investigation of the nature of the mental diseases. I will only deal here with some psychological inferences, which result so directly from the above discussion of the individual passions that they can make an essential contribution to complete their definition and significance. The future controversy really only runs down to a quarrel about the meaning of the word illness, which was initially related to physical states and was intended to express the self-destructive competition between the forces. As even the least significant disease can become potentially fatal and end in death, they are all regarded as being direct attacks on the principle of life. It was thought that the term mental disease would then be inappropriate, as this would directly deny the belief in immortality. This designation appeared to be even more false for the passions, as they often enhance the vigour of the soul for the fulfilment of purposes which could not have been attained by a cold-blooded and prudent decision, as most great deeds had been the result of the power of passions which overcame all obstacles.

With respect to the first objection, I already commented in the introduction that the conventional concept of disease vanishes in the light of Stahl's strictly scientific pathology and is replaced by its direct opposite, the curative power of nature in the fight against the obstacles of life. This effort at self-help is exactly what is missing in the passions without exception, as these cause increasing imbalance between the forces in the mind. Healthy opposition from the oppressed interests of the mind only occurs with the emotions and attempts to restore the imbalance. There is admittedly a weak hint of this still in the passions, where the fight of the suppressed instincts against the dominant instinct causes the feelings of restlessness, anxiety, fear, pressure and cramped tension. Although they are greatly oppressed, so that they are not clearly conscious or clearly felt, they are nevertheless not inactive and deprive the

subject of the peace of mind. This is why the subject cannot rejoice over or be comfortable with what he has intensely desired, but finally despises what he has made every effort to achieve. However, experience shows all too clearly how faint this self-help from the opposition of the instincts is, that it almost always is defeated and is suffocated without external help which wakes it and raises obstacles to the dominant passion. For the positive drive from the dominant instinct for unlimited development is only spurred on by imagining the obstacles and easily overcomes the other instincts and puts them at its service. This property of unrestricted ability to develop as basic predisposition is so totally lacking from the factors of organic life, that when the activity of any one of them predominates as a result of external stimulation and would assimilate or even annihilate the others, life itself would necessarily stop. As a consequence, we come once again to a contrast between mental and organic life; even in extreme passion, there still exists the condition for continuous activity, which is only stopped by the resistance from all external conditions. This is then an adequate argument that passion as a mental disease does not abolish the belief in immortality at all; passion only kills the spirit in a relative sense, in so far as it suppresses all other instincts only apparently without leading to their total destruction and the impossibility of their revival.

It is just in the last context that no objection can be made to declaring them for mental diseases, as the term disease in the most general sense means the state of restricted or even regressive development and can be used in this way in Stahl's concept. We are presumably all in agreement that life in its original meaning is progressive development of structures and the expression of forces, an extension of the active existence to larger and larger extents, in contrast to the unchanging nature of inorganic bodies. If we couple to mental life the essential concept of the moral as a progression to unending development, the basis of the belief in immortality, namely the progressive striving to similarity to God, then everything which contravenes this basic direction must be in contravention to the spiritual nature, must be regarded as pathological. I can presumably take it as proven that from this point of view all the characteristics which I have developed when discussing the passions

attain their essential significance, as they designate without exception mutilation, devastation and inhibition of the forces for thought and mind, and even the nobler passions force the mind into imbalance and can only assert themselves at the cost of other interests, the impairment of which is inevitably pernicious for themselves.

This then automatically disproves the assertion that the passions often have a healthy influence on human concerns, justifiable from the moral position. Firstly we must counter an important confusion in the terms, as enthusiasm is often confused with passion, as the mind is imbued in both with quite unusual energy. The two are essentially opposed, as real enthusiasm transfers all the energies of the soul into a higher sphere of action. He who is really endowed with enthusiasm will never deny an essential human interest if he notes it at all and this is why we admire in all human heroes the wonderful concordance of all excellent properties of the spirit and heart, which we otherwise meet in isolation and in occasional contradiction. Passion is only capable of dazzling by the glimmer of some individual strengths of the mind, behind which only too many defects and weaknesses are hidden. These defects vitiate the moral value of the actions and their favourable results for mankind. The application of this differentiation for the correct evaluation of exceptional historical characters seems to me to be so obvious, that it is superfluous to discuss individual examples. I do not wish to deny that the difference between enthusiasm and passion can be merged by a variety of gradations. On the other hand, there is no problem in assessing these mixed characters. It is much more the case that it is clear on precise observation how the noble and base, the moral and immoral characteristics are intertwined and how they limit each other.

The frequent confusion of a person's character with the success of his actions must be criticised, as the two are often in direct contradiction. Almost all passion damages the interests of others and can thereby prompt the reaction of those. This can cause moral forces to be unleashed, which although otherwise not released cannot be credited to the passion. Napoleon's regime of force in Europe evoked general enthusiasm for the fatherland and moral freedom and it is uncontroversial that he greatly advanced the true spiritual culture

of all those people who fought him, but who would take this for the immediate result of his absolute megalomania, so that the human race would be obliged to thank him? His claim to this is so slight, that if it had only been his decision, Rome would have been revived as ruler of the world and the European people would once again have been subject to moral death. This is indeed the highest proof of the moral world order, as even the passions have to serve it, as their final development is to evoke the effects which are opposite to their intentions. In contrast, goodness continues through all races, bringing salutary knowledge, prosperous institutions and wise laws, enhancing human well-being in the coming centuries.

It is unmistakable that the false view of the natural character of passion has come from the wrongly understood concept of freedom, the erroneous liberalism, which seeks all salvation in the unrestricted arbitrariness of the individual, and is thus in direct contradiction to moral discipline and legal order, the annihilation of which lets the pressure of so many degenerate into mob rule. It is not possible to explain this further without tiring the reader by repeating what I have already said above.

Finally, the pathological character of the passions is betrayed by the enormous violence of the emotions in which the victims of the passions are caught, which can destroy all prudence. Just compare the conscience troubles of a passionate pietist with the regrets of genuinely pious people, the insulted ambitious man who is snorting for revenge, the desperation of the miser who has lost his fortune, the love sick who has lost his idol through death, with the emotions of reasonable people in the same situations! To understand the difference between the two, you only have to remember that the violent emotion of passion can directly pass over into madness, from which the reasonable subject is spared, even if his spirit is shaken by his intense experiences.

Aetiology of the Psychiatric Diseases*

§ 116 General remarks

It is customary to classify the remote causes of insanity into those which affect the mind directly and those which initially affect the body, though usually the remark is interpolated that no sharp boundary can be drawn between the two classes because some psychological causes appear more to alter organic life and some physical influences chiefly alter mental activity. A few people think, therefore, that a precise distinction is not at all important because all the causative conditions of insanity lead to the common result of engendering a certain anomaly of vital activity, which must be regarded as the sufficient reason for the disorders of consciousness. If this assertion were correct and if the mind accordingly remained excluded from constant participation in the manifestations of insanity, psychology, at any rate, would make only small contributions to its aetiology, which would be limited to the fact that the passions constitute the most numerous causes. Indeed, not even this statement could be strictly proven and, in fact, it is often enough challenged with the assertion that precedence should be given to the physical causes. I need only recall the fallacy that was disproved above, namely, that the passions could not be regarded as crucial elements because in the opposite case, if they were generally widespread, insanity would have to be manifested more often. Consequently, as no particular value was attributed to them but nothing

*Reference: K. W. Ideler. "Aetiologie der Seelenkrankheiten". In: *Grundriss der Seelenheilkunde, Zweiter Teil.* Verlag von Theod. Chr. Friedr. Enslin, Berlin, 1838; 11th section, § 116–117: 273–289.

can come and arise from nothing, it was seen to be necessary to take refuge in the usual aetiological tenets of general pathology, where sun and moon, cosmic and telluric influences, the atmosphere with its mechanical, chemical and dynamic relationships and the thousand things whose action every person is exposed to daily were taken into consideration. Naturally, we respond with the question of why what affects everyone causes mental illness so rarely? And when we are answered with a mysterious expression that, at any rate, a peculiar diathesis or disposition must prevail in insanity also as it does in every disease, without which the strongest influences would be incapable of bringing it forth, this idle excuse should show us that the comfortable routine of rebuffing every explanation with a shallow word, thus cutting off deeper enquiry, is to blame for the innumerable contradictions that we encounter here. Most assert that strenuous thinking shatters the intellect; a few dispute this and with justification. The violent ravages, which sensual excess brings about in the mind and in the body, allow of no doubt that they are a fruitful source of the shattering of the intellect; nevertheless, there is no lack of those who deduce far worse consequences from the non-satisfaction of the mating instinct. How would these contradictions, of which I could list hundreds, even be possible, if people had been clear about the pathogenetic development of the mental diseases in vivid contemplation of the variety of disease progressions and the causative conditions characterised by them? But precisely because they did not penetrate into the inner connection of the essential phenomena, but contemplated them only as they stood out stridently, the essential thing was overlooked, that is, the processes hidden in the mind, and they subscribed to arbitrary hypotheses according to which the corresponding physical causes were concluded from this or that group of physical manifestations.

These only too well-founded remarks cannot be at all inviting in inducing us to follow the previous path, but we must rather look around for a completely different method if we wish to make room for the hope of penetrating somewhat deeper into the darkness of the aetiology of insanity. According to the essential agreement between the passions and idiopathic insanity expounded in the previous section, we can have no doubt about how we have to solve

the first part of our task: we must first become clear about the origin of the passions, because they constitute the taproot of idiopathic insanity, which cannot be conceived as even possible without preceding passion; we must then seek the peculiar conditions through which the passionate mind is robbed of outer composure to such a degree that its state must be regarded as a real disorder of the mind according to the prevailing concepts. According to the linguistic usage common in pathology, the passions are, therefore, the predisposing causes, whereas the above mentioned peculiar conditions are the situational or chance causes of insanity; however, we do not wish to place any special value on this terminology because it could easily lead us astray to vexing secondary concepts. When we have explained these two main sections on the aetiology, we shall still have a few supplementary conditions to add about the causes producing sympathetic insanity.

§ 117 The origin of the passions in general

Through the development of the concept of the passions given in the previous part, we are led back to the ultimate fundamental conditions of mental activity that we can recognise; this provides us with the advantage of being able to trace the pathogenesis of insanity back to the original elements of psychology and contemplating its development in the entire series of steps of successive mental states. This is all the more necessary as the first seeds of insanity were all too often sown in earliest childhood and, as they developed, they were intimately fused with the entire life as it evolved so that they gave that life the wrong direction right from the start and the earlier states can be regarded as a consistent preparation for the mental disease.

In order to begin our consideration with a general statement, we must first refer to the fact that the equilibrium of the emotional instincts is not innate in human beings, but is always a product of culture in the broadest sense of the word. It is only by stipulating for himself the law guiding his actions that the human being can arrive at autonomous and free self-determination, his endlessly mul-

tifarious development. But because the equilibrium of forces, which in the rest of nature is preserved by laws in an unconscious manner, can, in humans, only be brought forth by self-conscious reflection, it is only the external reins of the intellect which are able to keep the emotional instincts within the bounds of consistent effect, which otherwise, if not informed of their own interest, unerringly become wild and mock every discipline with blind force. Indeed, a certain symmetry in the emotional forces is innate in most people, which, therefore, stir fairly uniformly in childhood and youth, especially as life makes demands on them from all sides. If this were not the case and if children brought a discrepancy of instincts into the world so that their dispositions exhibited no aptness for the necessary conditions of life, the storm of the passions would break out with the first development of the mind, which would then exclude even the possibility of any moral culture. Meanwhile, in spite of the fact that nature provides human beings, her favourites, with the most wonderful gifts and has given them a conscience to act as a guardian throughout life, which calls them to reckoning about every misuse of it and although she has planted in them an ineradicable need for harmony with themselves because when it is lacking a restlessly tormenting disquiet will drive them to seek the lost contentment, yet we easily convince ourselves that all of these arrangements of nature only offer the intellect the means to achieve the consistent development of mental life and that, because it all too often neglects its task, the passions have, therefore, laid waste the entire domain of humanity through all time and space.

Just because the emotions awaken much earlier in childhood before the intellect has freed itself from the power of the senses and has become enlightened about the endless variety of things and its relationship to them in considered reflection and because youth's fullness of life shines through those instincts with the feeling of boundless striving to which it gives a magic with the boldest pictures of the imagination, soon outdistancing quiet thought, it is evident from this that the emotional disposition gets far ahead of the intellect in the usual course of life so that the instincts can thus degenerate all the more easily into passions, the more completely their constant growth evades consciousness and is almost always

noticed only when it has already ascended to a significant height and that the intellect can catch up with the emotional disposition only in later years and place the reins on it when mature experience has given the appropriate emphasis to its lessons.

If we understand here by experience the objective recognition of what is of benefit and what is harmful, it is clear that it will ultimately force itself on everybody because they must purchase it all too dearly with the sacrifices which their unconsidered actions in early years imposed on them. Unfortunately, this salutary lesson often comes much too late when irreplaceable losses in the noblest goods have already largely destroyed the actual value of life and passions have so laid waste the organisation of the mind that its former splendour can be identified only from ruins. Indeed, in the continuing conflict with themselves, many so forfeit composure that they do not learn even from the sufferings that are their own fault, they are not enlightened about their foolishness by any strokes of fate, that no warning from experience gains admittance to them, but rather that they blindly fall deeper and deeper into misery.

If some instinct in the original disposition now takes precedence and if it is encouraged preferentially by external stimulation, particularly through the spirit of the reigning opinions and morals, it will find a broad scope for free development in the personal circumstances; according to the laws of emotional activity it must of necessity become dominant at the expense of the other interests and when it develops consistently it will get more and more of the totality of mental vigour into its power and, consequently, grow into the highest power of passion. Under such conditions, man can never attain to the far-reaching reflection and to the self-control, which is based on this because he is unable to be enlightened by the suppressed interests of his disposition, which should counteract his passion. The objective circumstances of life never present themselves to the intellect in immediate and simple contemplation, but it discovers them only after tedious searching if it is not blinded by a predominant inclination. However, if man has learned to regard his ruling interest as an inalienable right, which happens every time in passion, he does not hesitate to assert it against the whole world and if he is really serious about it, he prefers to perish in the strug-

gle with the world than deny the demands, without which life has no further meaning for him. It goes without saying that all moral and religious motives and, ultimately, the most common rules of prudence no longer make the least impression but that his destiny must of necessity be fulfilled.

If we summarise all of these observations, we shall easily convince ourselves that the human race could not become other than it has appeared in history without our therefore blaming evil spirits for all the mischief that human beings have prepared for themselves in ill-fated blindness. Yet in the midst of all the horror of the ravaging passions, the comforting truth is revealed to us that the moral instincts are ineradicably planted in mankind as a whole and that only the highest degree of egoistic desires in individuals can entirely destroy feelings for justice, honour, duty, love, religion and human morality and can engender that wickedness in which arrogance and shamelessness, despotic and servile cowardly attitudes are united in a strange contradiction. Since the most selfish maxims, which destroy all morality completely, are constantly proclaimed and are supported by pernicious examples, and since even the concepts of duty, when distorted by reigning prejudices, often confuse more than they enlighten, mankind would long ago have been changed into a pack of wild beasts if the passions did not find a counterbalance in the disposition of the majority. The French Revolution made a good start in this direction and people would have liked to repeat its satanic crimes in recent times in order to introduce a republic of cannibals on the ruins of civilised behaviour, but the result in both cases taught us that man's moral nature cannot be destroyed but again attains the necessary development out of all the destruction through periods of the most enormous turmoil and that public morality has made significant progress in the last 40 years because the scenes of Robespierre's Reign of Terror would otherwise have been repeated in recent times. Böttiger remarks quite correctly that time always takes two steps forward and only one step backward.

If we now inquire into the conditions which make possible a well-ordered relation of human beings to one another and, through it, a generally progressive development of the single individual regardless of the fact that the entire race appears to chafe one

another in the constant disagreements of the passions, the answer lies in the nature of the social state itself. Since all act and suffer with and through one another, consequently, each is obliged to concern himself with the behaviour of others, to help him or hinder him according as his own interest demands; only the powers directed toward the common good can exist in lasting concord, while, in contrast, the passions of individuals incessantly arouse hostility and the bond of their mutual advantage is soon loosed. Consequently, all who do not dare to challenge the whole world to fight in absurd blindness, indeed, in blindly raging passion, are imbued with the necessity of a prevailing law and we actually see, as far back as history reaches, a positive law prevailing which was able to hold the passions of most in check unless the elements of immorality had become all too powerful under temporarily unfavourable circumstances.

Sooner or later the wave of passion break on the rocks of necessity, which brings the masses to their senses again and imposes obedience on them because the majority does not want to perish but wants to live at any price, under any condition, and, therefore, carries out the ruler's orders with weapon in hand to restore order and the law against the uncontrollable rebels. Thus, even despotism itself must be active in the service of humanity, which has to suffer much less from the tyrannical whims of individuals than from the raving cruelty of unrestrained peoples. For as soon as man has learned to obey someone else's law, he is thereby prepared for self-control. Therefore, for maybe ten excellent men in despotic states, we encounter scarcely a single truly high-minded and generous character among rebellious masses, which feel an instinctive repugnance for every outstanding merit.

Thus, the more the passions all hold one another in check so that each has to defend itself more than it can attack others, the more the possibility is offered to the intellect to place a limit to its blind forces and found a higher order of life in union with the moral strengths. This is also why consciousness of the necessity of criminal laws has imprinted itself in all peoples, because the simplest reflection is sufficient for the conviction that it is only through them that a stop can be put to the passions. Everyone sees

the enforcement of these laws on the malefactor with gratification because he then becomes aware that he is protected by a far-reaching order. If false liberalism strives to produce an opposing feeling through a total confusion of the concepts in order to entice others through demagogic arts to promote its inordinate ambition and domineering purposes, its hypocritical precepts can gain admittance only in a mob that lacks true enlightenment and is beguiled by passions, which in its political stupidity does not perceive how it acts against its own interest. Every wretched fellow calls for the assistance of the law when he has been insulted or robbed or when his life has been endangered and demands the firm punishment of the wrongdoer; how angry would he become against the agitators if he possessed sufficient understanding to see that they are burying a mine underneath his house, which will blow him up with all his loved ones. Thus, only an absolute lack of judgement can fail to recognise that the consistent dominion of positive law is the necessary condition of freedom and that the disadvantages for individuals, which grow out of its inadequacy, are worth nothing at all against the peace of civil harmony that is founded on it. He must be impoverished through his own fault to a high degree in all vital interests who, when an erroneous or falsely designed law demands an unjust sacrifice from him, could not replace this loss plentifully by the innumerable advantages of public order; on the other hand, where this has perished, even the wisest and best are irredeemably lost and, at most, can force from themselves a painful self-satisfaction in the heroic endurance of the bitterest misery. As long, therefore, as positive law finds the justification of its necessity in the deepest feeling of the majority, which entrusts its holiest interests to its protection, the passions can assume a truly destructive character only in single individuals. In most people, in contrast, they will only achieve a moderate power, which indeed produces various conflicts in the disposition, thereby inhibiting the general development of its strength, but this does not fully eradicate the necessary objective reflection so that it is not impossible to steer onto a better path.

Thus, most are moved by the various passions but these become silent when the evening of life approaches and the fire of the instincts

cools down; indeed, the instincts exchange roles several times in life to prove that while they have indeed taken control of the entire mind for some time, they nevertheless were unable to eradicate the emotional powers that were striving against them, which rather assert their precedence at another time. The mind is too mobile to be able to be bound for ever in a one-sided interest; newer and newer impulses impose themselves, which spoil its monotony for him and through a refreshing change in feelings provide him with a pleasant rest from rigid and painful strain in restless passions. For the latter provide a deceptive satisfaction only when they first commence, but as soon as they have reached their culmination, they leave behind indifference, repugnance and disgust against their interest, as they cannot suppress the consciousness of the sacrifices which they demanded. In reality, a passion that penetrates the entire life until its end and, thus, reaches the highest development has such roughness and devastation of the mind as its necessary consequence that it appears in the most repulsive form even to those who are given over to it to a moderate degree; how much more it must be an object of abhorrence to those who think differently. Even the originally better passions, namely the religious ones, as soon as they reach a certain degree, assume a repulsive character and inevitably extirpate human feelings so that even pious enthusiasm only too often displays the most glaring features of unkindness and even cruelty.

To this it should be added that the passions often signify less in themselves to the measure that they cause a sensation through noisy and forward behaviour; they are conscious of their own weakness and can only deceive the inexperienced through poltroonery and continue playing their part only until a vigorous authority opposes them. Thus, the loudest tumult of a rebellion is often subdued instantly by a mere demonstration of armed might and those who bawl the loudest in an asylum are often the easiest to quieten; on the other hand, the enduring passion often steps into the consciousness of a decided resolve with outer coldness and calm in order to arm itself composedly against external attacks. However noisy the drama may be, which the passions stage in daily life, its significance is not quite as bad as it appears to the ignorant. Those who appear

publicly with the greatest pretensions and who also adopt violent affections in order to give them more emphasis come to their senses again in the quiet of their own room, especially in the still of night, and, therefore, become more reasonable at the right time.

Thus the struggle of opposing conditions, by which every individual is stimulated partially to the passions and partially to control them and himself, can be traced throughout the history of the entire human race. Of the causes of the passions, we can only hint at a few particularly striking ones, for who would dare to find through objective criticism of historical documents all the hidden threads by which the destinies of the entire human race have been set in motion? The entire tissue is revealed only to the eye of the Omniscient and the greatest part will always remain hidden from the restricted view of mortals. Here, too, I must recall that the intellect, by breaking down into their elements the everywhere intertwined relations of the powers that act in combination, is led all too easily to a one-sided consideration which turns its attention to the details and, therefore, leaves the most important thing unheeded, namely, the intimate concatenation of all the elements that act in combination. Passion is never the product of a single source, but all the outer and inner circumstances of life are its parent; they, therefore, give it its overall character and give it such a peculiar individual stamp that a passion of the same name never manifests itself in the same form in two concrete cases.

Ernst Freiherr von Feuchtersleben (1806–1849)

Ernst Freiherr von Feuchtersleben, born on 29 April 1806 in Vienna, was a physician and poet and played an outstanding role in the cultural life of his home city. Aside from his psychological and psychopathological studies, von Feuchtersleben was a much read author in the Biedermeier period, as a disciple of Goethe and supporter of a theory of moral perfection. He was also active in educational politics and worked for some time as a senior official in the Ministry of Education. His work on the 'Diaethetics of the Soul' was published in 1838 in Vienna and in 1892 in England. This reached 50 editions and was particularly influential. His "Textbook of Medical Psychology" was the first Austrian textbook on psychiatry. This was published in Vienna in 1845. It was translated into English in 1847 and later into French, Dutch and Russian. A reprint was published in Graz in 1976. Von Feuchterleben's writings were of considerable significance in the development of psychiatric terminology, because in his textbook he was one of the first authors to introduce the concept of psychosis. At that time, this area of psychiatric disturbance was even less precisely defined than today. Von Feuchtersleben used the term psychopathic in this context, which was then intended as a comprehensive expression. The restriction of the term psychopathic to so-called psychopathic states (now known as personality disorders) came later. Von Feuchtersleben died in Vienna in 1849.

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General Pathological Aspects of the Psychoses*

§ 126.

However, before we approach the natural history of the psychoses, i.e. their specific pathology, we will first consider their most common features by outlining the main characteristics of their general pathology. These features are known to concern the spatial and temporal circumstances of the diseases.[1]

With respect to their spatial aspect, diseases are 1. either local or general. There is no doubt that the psychopathies, as compound states which take possession of the entire personality (§ 122), belong to the latter.

2. Idiopathic or sympathetic. The psychopathies belong probably always to the latter for the same reason, as their development can hardly be conceived without some disordered interaction[2] regardless of whether its causes are considered to be psychological in nature (disordered relation of mental activities) or psychological-physical (disordered relationship between the psychological function and the body) or physical (disordered brain function due to abdominal complaints etc.).

3. Varying according to the subjectivity of the patient, according to the already cited modifications constituting the personality (§ 53) and to be mentioned further.

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*Reference: E. v. Feuchtersleben. "Allgemein Pathologisches über Psychosen". In: *Lehrbuch der ärztlichen Seelenkunde.* Verlag von Carl Gerold, Wien, 1845; § 126–130: 271–286.

1. Töltenyi, Path. L. II. C. 4. S. Hartm. Nosogr.

2. Hartm. p. 294.

4. According to their relation to human society (epidemic, endemic, contagious). The epidemic occurrence of psychopathies, where the urge to imitate forms serves as some kind of miasmic vehicle (which is why they are very correctly designated 'imitatory epidemics') is beyond doubt.[3] Of course, the oldest examples are somewhat uncertain. Herodotus (IX 33) tells of such an epidemic among the Argive women, which originated from Proteus's daughters. They ran into the woods, murdered their own children, and were cured by Melampos by means of Veratrum album. Sprengel regarded this malady as leprosy.[4] Plutarch[5] reports on an outbreak of monomania in Milesian girls hanging themselves, which was cured psychologically by the law that all the bodies of those hanged were to be exposed naked. Whether the frenzy of the Abderites following the performance of *Andromache* belongs here, because Lucian says that it had been associated with fever, I leave undecided. The most remarkable epidemic of this kind was probably the dancing frenzy in the Middle Ages, described so well by Heckter[6], to which the tarantella (so-called after a dance customary in the Taranto region[7]) is perhaps related. Webster refers to an epidemic madness ravaging England around 1354.[8] Also, the St. Anthony's fire, which often manifested itself as mania and ended in imbecility, occurred epidemically.[9] In 1841 and 1842, the newspapers reported on religious ecstasy, which was epidemic in Sweden at that time, and recently there was another account of a similar epidemic among the Buryates on the Lena, the description of which is reminiscent of the convulsionaries of the Middle Ages (see Berl. Med. Centralzeitung 1844, no. 68). Dr. Maffei also describes a similar epidemic (in the Austrian State Medical Yearbook, issue VI. 20). It was named

3. L'esprit est sujet aux maladies épidémiques tout comme le corps; il n'y a qu'à commencer sous de favourables auspices, et lorsque la matière est bien préparée. M. Bayle, Dict. h. et cr. I. p. 12.

4. Gesch. I. §56. p. 118.

5. De virt. mulier.

6. Zimmermann, v.d. Erf. p. 647

7. Goethe, 38, 211.

8. See above, p. 40.

9. See above, p. 50.

'Pöschlianism' after a religious fixed delusion, which originated with a certain Pöschl. It usually commenced with melancholy, progressed into convulsive and raging attacks and ended in one case with suicide. I leave the account of the simultaneous movements in the soul of entire peoples, when they are swept away until they misunderstand reality, as a deceased excellent clinical teacher did, to those who hope to be able to calm these movements in a medical way.

The so-called lycanthropy was endemical in antiquity. In Arcadia, a country full of woods, marshes and pastures, the fixed delusion of being a wolf, which was accompanied by wolfish behaviour, developed frequently among the shepherds.[10] A similar disease occurs among the indigenous people of Brazil. A while after the Indian has walked around, pale, monosyllabic, reticent and with a confused and staring look, he suddenly breaks away one evening after sunset, storms through the village, howls, digs up graves and disappears into the woods. The disease ends with exhaustion or passes over into fever.[11] The Scythians often suffered from the delusion of being women, which has already been discussed.[12] The endemic occurrence of the spleen, of pellagra (insofar as it can be referred to here as pellagra mania[13]) and of cretinism is well known.

Contagion in its psychological sense can mean nothing else than pathological sympathy (§ 36). It is agreed that lunatic ideas in this sense are contagious, particularly among uneducated, nervous persons (with much receptivity and little spontaneity). The lunatic idea, incited by sympathy, becomes a movement through the imitative instinct (§ 46) and interferes with all aspects of life. Examples are found in the panicky fear, in the epilepsy among the orphanage children in Haarlem, which Boerhaave cured by using a threat etc.[14]

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10. Sprengels Beit. z. Ges. d. M. I. 2. St.

11. Das Naturell, die Krankheiten, das Arztthum etc. of Brazil by K. F. Ph. von Martius, Munich, 1844.

12. History section p. 22.

13. Brière de Boismont, sur le Pell, Journ. compl. 1832.

14. Zimmermann, von den Erfahr., p. 647.

This would be the occasion to say something about the geography of the psychopathies.[15] However, it is very difficult to discover anything reliable about this given the dubiousness of medical statistics in general and the extremely variable state of lunatic asylums in different countries. Indeed, one is led to the inverse fallacy through the latter since the number of those cases admitted, that is, listed in the reports, grows, as their numbers increase and they recover, while it perhaps diminishes overall as a result. Madness is rarer among non-European peoples, excluding perhaps Turkey and Egypt, than in Europe. According to Brigham, only in civilised America is it more numerous than in Europe, and among the savages[16] it is almost as rare as in children. It is very frequent in Russia, particularly in the form of mania, while the Finns suffer more from imbecility.[17] In France it became very widespread after the revolution but diminished again since 1830.[18] In Great Britain, the country of originality taken to its bizarre extreme, the number of lunatics in 1826 was 3000[19], in France it was 3000[20], and there was a relatively larger number in Holland. In Prussia the proportion is 1:666 and in Norway 1:551. The ratio in Italy is particularly favourable. A difference in the occurrence of the individual forms can also be noted. Manias are most common in the south, melancholy in the north, imbecility in valleys etc.; in England fixed delusion predominates, madness in France, imbecility in the Orient; Germany maintains a happier middle place. However, it should be remembered that the determining circumstances are not really geographical, i.e. the degrees of latitude etc. but ethnographical, i.e. the life of peoples. The observation that the nationalities are mirrored in specific cases of lunacy respectively – although in itself correct (as even with a broken leg, the genuine Frenchman will behave differently from

15. The most general aspects are found excellently treated in Töltenyi's Pathol. gen. p. 473.

16. Whether the ecstasies and visions that occur among them are psychopathic is debatable.

17. Leipziger Tagebl. 1842. 17. Dec. (d. Petersb. Irrh.).

18. Constit. 1838.

19. Gesundheitszeitung V. p. 62 (about 1:900?).

20. Thus, about 1:1000.

the genuine Englishman) – would nevertheless lead to useless mind games, if one were to develop it further.

§ 127

The psychopathies can be considered generally according to their time course (§ 126).

In general the psychoses belong more to the chronic than to the acute illnesses. Attacks of acute mania are usually part of a psychopathic state that is also present outside these attacks.[21]

The stages of growing intensity and waning with their nuances can also be distinguished in the psychopathies. In particular, the so-called precursor stage is usually clearly characterised, partly by a general more or less striking personality change in the individual (§§ 53, c, 54, 121) and partly by the transitional states referred to elsewhere (§79–188). This stage is characterised by uneasy sleep, frightening dreams, later followed by insomnia, confusion in the head, headache, sometimes alone, sometimes together with the transitional states referred to, variously alternating or linked with deviations in common feeling and sensory perceptions (illusions, hallucinations etc.). If completely absent, it is because of the rapid and violent causes of the madness. The assumption by Guislain and the highly observant and thoroughly thinking Zeller (Damerow's journal I. 1) that every mental disorder is preceded by a more or less obvious stage of melancholy, contains an insight but requires more precise and limiting diagnosis.

The type of the psychopathies is most rarely persistent, more often remitting (raptus), without regularity though sometimes with regularity, and it can of course be difficult enough to distinguish the intervals (lucid intervals) with certainty from convalescence and even from the illness itself. The objection that a maniac e.g. is healthy as long as he does not have the mania which is only expressed in attacks, that is, that intermittence cannot be assumed, is not accurate. If he always gets the attacks of the same kind again in certain periods, this reccurence is sustained by a diseased state of his personality. It is like intermittent fever. However, the proven

21. Tract. d. Vesan. sec. Lippich prop. Breit et Wieser 1842

occurrence of *furor transitorius* (§ 148) demonstrates in fact what could be concluded a priori: that the formerly customary definition of the psychopathies as permanent mental disorders, which was intended to distinguish them from the transitional states, would not suffice. The duration of a state can never be used to distinguish its nature.

A development into other diseases is unusual in the psychopathies; ending in health, sometimes through solemn crises, is rarer; ending in death, through apoplexy, phthisis, hydrops, is more frequent. What is peculiar to them, however, is the great tendency of recurrence, the ratio of which Esquirol sets at 1:10, which can be attributed to the circumstance that the psychopathies are based on the individual personality of each human being (§ 121), whose susceptibilities are always the same and whose impulses always recur. This peculiarity of the psychoses has not even eluded the general feeling: one usually has a certain fear in front of people who have been mad as if they could fall back into their malady again at any moment.

The critical processes in which one has psychoses sometimes seen resolving are: 1. the return of suppressed secretions and excretions, 2. previous pathologic deposits (psora, herpes, achores etc.) or pure neuroses (migraine, stomach cramp etc.). For the excretions (1), the skin and intestines are the most common routes, less frequently the kidneys, Schneider's membrane and the salivary glands the rarest routes. In pathological venosity, furuncles form often the sole but crucial balance (Zeller, loc. cit. p. 55).

The details of these conditions belong to the phenomenology of the individual psychoses.

§ 128.

Although the necroscopic details, as results of the process, will be cited in detail later, a prior general overview of the results of autopsies in disturbed persons will serve as a useful guide. Burdach[22] and

22. On the structure and life of the brain, § 378 ff.

Professor Lippich[23] have collected them zealously and critically, and we shall precede them only with a few introductory remarks.

A non-prejudiced consideration of the concept of 'psychopathy' has taught us (§ 123) that the individual organic metamorphoses do not constitute the disease itself. In such complicated circumstances they can neither be considered as the sole cause nor as the base nor as the product of the psychosis itself. Here, as ever, the *cum*, *post* and *propter* must be distinguished well and all necroscopy of patients with personality disorders is instructive only in that it draws our attention to what acts and is affected organically in these states of mind. It makes sense that not only the brain but all organic structures and not only the structure but also the chemistry need to be considered. Science, at its present standard of knowledge, still leaves the relationship between the functional disorders of the brain and its biology, that is, to its structure also, too unclear to be able to build upon it.[24] In addition, experience confirms that there is no part of the brain which when abnormal could not sometimes have caused (or accompanied?) a disorder of mental activity and also none where an abnormality would have left mental activity undisturbed.[25]

§ 129.

In order to avoid repeating details, something general can be said about the pathogenesis of the psychoses, as was already done regarding the spatial and temporal relationships of these conditions in general (§ 126–128). At this point we can be all the briefer since a recapitulation of what was previously stated will provide the central theme to everyone who is able to think for himself. The predisposing causes lie in the personality of the human being and in its conditions (§ 49–55), psychologically in the predominant fantasies (§ 36, 37), and physiologically in the weakness of the brain and nerves (§ 12–23) ('psychological vulnerability' in Canstatt). Occasional causes are found to

23. loc. cit. p. 29
24. Andral, path. An. Deutsch. Leipzig 1830, part II.
25. Burdach loc. cit. p. 644.

lie in the interplay between body and soul (§ 62–72) and in external influences of every kind, whereas the transitional states themselves (§ 79–118) can be named as the immediate causes of the psychopathies. That there can be no single specific cause of the mental illnesses, that it is in vain to seek for one, is amply evident from the concept of these states as compounded conditions (§ 122 I). Compounded effects can only be based on compounded causes. We must therefore consider that even among the elements that can be listed immediately, none can be regarded as conditioning on its own but only the interplay between several of these elements and the disposition in the concrete case.[26]

Heredity is undoubtedly the most common predisposing cause, as it conditions a certain type of personality forming the basis for its diseases. More than half of all cases have developed or at least been encouraged because of it. Marriages in the same family, therefore, help to propagate this seed. It often occurs without interruption from the father to the son, from the son to the grandson; it often passes interrupted from the grandfather to the grandson, often irregularly to the nephews and so on. The danger is less when the begetter became insane only after begetting (that is, only had a predisposition formerly[27]). The predisposition is expressed 1. from the psychological aspect by passivity in thinking, feeling and volition (Heinroth); 2. from the physical aspect by prevailing erethistic lack of vitality, the fundamental character of today's generation.[28] Such a constitution is typical of nervous individuals. However, certain constitutional diatheses should be considered here from the physical aspect in particular. These are: a) the scrofulous and rachitic habitus in which the above-mentioned constitution is

26. The untenable and useless aspect of the common numerical listing (particularly in England and France) of the causes of insanity is evident from this. To the uninformed they appear interesting; however, anyone who is familiar with the difficulties of medical statistics and in particular knows what matters in the genesis of the psychopathies, will also know how highly such information is to be estimated.

27. Lippich loc. cit. p. 38.

28. Hechenbergers Grundr. z. ein. Org.d. Seel.heilk, Vienna 1841, p. 30.

found again; b) the apoplectic, which predisposes to certain forms of insanity (especially maniacal), due to cerebral hyperaemia, c) the venous (otherwise atrabilious), which also predisposes to certain forms (with melancholic colouring) due to inhibited ganglionic conduction. The disposition of the individual forms through the temperament has already been mentioned (§ 125). With regard to the gender disposition, the statistical medical information is contradictory. No general law can be established and probably the psychological and physical character of a people, the status of the female sex and local conditions are the decisive factors.[29] The communicability of these states is greater in the female sex because of its livelier imitative instinct and Zimmermann therefore calls the contagious phantasms women's epidemics. The insane do not infect one another as each one is too occupied with his own mania to be susceptible to another one; even the raving mad are said to rather calm down each other through their shouting (?). Convalescents are also not infected (Jacobi) in contrast to those strikingly affected by the predisposition just described, particularly after more prolonged contact with the insane, e.g. as wardens and so forth (§ 126). Of the ages of life, the cycle from sex evolution to sex involution usually predisposes to mental disorders, childhood predisposes least, old age a little but more than childhood, and the phase of puberty the most. Hereditary psychopathies tend to develop in children at the same age as in their parents. While cases of development before puberty are rare, some have nevertheless been reported by credible observers.[30] Dr. Joh. Stoltz in Hall recently reported one case[31] and I also had the opportunity to observe a case of moria in a six-year old girl. Ideler reports cases of the rare psychoses occurring even after the involution period[32] on occasion of treating seventy-year old women with erotic delusions. Nobody doubts that education (§ 53a) forms an important element in the foundation of this unhappy

29. Ideler II. 371.

30. Friedrich, Diagnostik d. ps. Kr. p. 282.

31. Medizin. Jahrb. d. ö. St., March 1844.

32. II. 370. loc. cit. Esquirol hat in der Salpetrière zwei achzigjährige Weiber geheilt.

predisposition. Haslam rightly[33] identifies it as nearly the most important of all predisposing causes – rightly because, if accomplished correctly and energetically, it may check even the strongest of the hereditary predispositions (vide supra). In particular, it can play into its hands or work against it by unleashing or rationally controlling the fantasy associated with this unhappy predisposition. From this, it can be seen as well, how far back one has to go in recording the medical case history when investigating psychopathic states. However, if enhancement of this disposition is to be seen in an exaggerated education, this probably depends on the concept that one associates with it. Education can never be exaggerated as long as it is harmonious; and the higher it ascends in this sense, the more its psychological aspect will protect against the irruption of insanity. History tells of partially educated scholars and fanatic poets, but not of any wise man who became a fool.[34] With regard to occupations (§ 52c), both predisposing and occasional causes can be found in weavers, shoemakers and metal workers. If there exist national predispositions (§ 52), the data (§ 126) given on the geography of insanity should be referred to.

§ 130.

The occasional causes act psychologically and physical. The psychological ones are: 1., neglected spiritual culture and idleness (which is just as important pathogenetically as work is therapeutically); 2. one-sided education of the mind in one direction namely in that of fantasy; 3. affects and passions. It is obvious from all that has been said previously that these potencies must coincide with the psychological-physical disposition referred to (physical occasional causes usually contribute to it as well) in order to condition illness as such. How much more difficult it is for any mind kept down by early and all too hard constraints, which has never achieved a harmonious development and is therefore susceptible

33. Observat. II. ed. p. 236.

34. A dulling/blunting/deadening and weakness of memory produced finally by excessive intention of the thinking mechanism (Newton, Kant) cannot be referred to here.

only to depressing influences and low instincts, to withstand the effects of the affects and passions, all the more when it is part of a depressed physical life as is nearly always the case, probably requires no proof (Pinel). However, a practical proof of the pathological power of the affects and passions is the frequent occurrence of the psychopathies in times where all elements of social life are in upheaval: during and after revolutions, where sudden changes of fortune, loss of property, advancement and abasement fill the lunatic asylums and (if Pariset is otherwise correct) produce a thousand cases of mental disorder, which remain unrecognised and unmentioned in the overall chaos. Herein lies the answer to the question of why the number of mental diseases has increased with civilisation – a question whose truthfulness has been proved. Not civilisation itself but the needs, one-sided education, passions, affects etc. that grow with it, together set the temperament into passive movement; the resulting hothouse (§ 72), the pampering, are the facts behind this truth. Civilisation, as formal education, is only a transition to a culture of inner education and at this first stage, it stimulates maladies to which it holds the antidotes at the higher stages. It holds poison and antidote in the same hand.[35] Nowadays industrial hustle and bustle, belongs to the causative elements through the opportunities it offers to the owning class and is among the counteractive and curative aspects through the activity it stimulates and through the removal of isolation. If the savages show such a happy immunity to insanity (§ 126), they owe this not merely to the lack of civilisation but also probably to the non-mollycoddled energy of their physical vitality. Of all the passions, inordinate ambition in men and love (especially through jealousy) in women are the principle areas of insanity. As Goethe says very reasonably[36]: "Nothing brings us closer to madness than when we are distinguished from others and nothing preserves sanity so much as living together commonly with many people."

35. Weiglein, Diätet. Fragm., Graz 1842.
36. W. Meister, book V, chapter 16.

In Russia, the civil service, in which the greatest obsession with rank reigns, produces the highest number of lunatics.[37]

Love has a particularly strong impact due to the affects enmeshed in its transformations (§ 48). It is the frightful torments of jealousy, in particular, which produce innumerable victims. It is remarkable that unfounded jealousy leads far more often to insanity than founded jealousy, because the former creates objects for itself by fantasy and stimulates more affect through the inner struggle with itself.[38]

37. D. Petersb. Irrenh. Leipz. Tageb. 17th December 1842.

38. Ideler. Vol. II. 553. However, insanity occurs much more often in the celibate than in marriage. It is very common in prostitutes, according to Parent Duchatelet.

Wilhelm Griesinger (1817–1868)

Wilhelm Griesinger was born in Stuttgart on 29 July 1817 as son of the manager of the local hospital. After completing his final school examination at 17, he studied medicine at Tübingen University, which he completed at the age of 21.

In 1840, he started work as Zeller's assistant at the Winnenthal institution, where he had his first and formative experiences in psychiatric care. In 1843, he moved to Tübingen, where he worked as assistant physician and was also a lecturer in the university.

The first edition of his book "The Pathology and Therapy of Mental Diseases" appeared in 1845, followed by the second edition in 1861. In this work, Griesinger presented a concept of unitary psychosis, which was linked to Zeller's ideas. The disease process starts at a stage of primary and curable affective disturbance, progressing to secondary and incurable abnormalities in imagination, thinking and will. In other words, the condition starts with states of mental depression (melancholy) and mental exaltation (mania) and terminates in the pathological mental states of madness and idiocy.

In 1847, Griesinger became editor of the journal "Archiv für physiologische Heilkunde" [Archives of Physiological Medicine]. In this role, he was a strict proponent of empirical research and opposed the philosophical speculation of the romantics. In 1854, after a period as internal physician, which took him as far as Egypt, he became professor at Tübingen University. From 1860, he worked at the Zurich Canton Hospital and then moved to Berlin in 1868. In Berlin, he worked on the reorganisation of the psychiatric ward in the Charité Hospital and combated the teachings of romantic medicine, as represented by his predecessor, Ideler. Even in his

Tübingen years, Griesinger regarded psychiatric diseases as diseases of the brain, although he was also strongly influenced by psychopathological and anthropological ideas. He supported the collaboration between neurology and psychiatry by founding the journal "Archiv für Psychiatrie und Nervenheilkunde" [Archives of Psychiatry and Neurology] in 1867.

Wilhelm Griesinger died on 26 October 1868 at the age of 51 as a result of perityphlitis.

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On the Seat of Mental Diseases and the Method of their Study*

§ 1

This manuscript concerns the theory of the knowledge and healing of mental diseases or insanity. Insanity itself, an anomalous comportment of the imagination and volition, is a symptom; the establishment of the whole group of mental diseases is founded on a symptomatological method of observation and its existence can only be justified on this basis. The first step towards understanding the symptoms is their localisation. To which organ does the phenomenon of insanity belong? – Which organ must, therefore, be necessarily affected, universally and invariably, when insanity is present? – The response to this question is the first precondition for the whole of psychiatry.

If physiological and pathological facts show us that this organ can only be the brain, then particularly in mental diseases we must always recognise diseases of the brain.

§ 2

Physiology views mental life as a particular life form of the body; in mental acts it sees functions of certain organs and seeks to understand these specifically from their structure. Widely known experiments now show how the processes of mental activities in the broader sense are related to the whole nervous system, but

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*Reference: W. Griesinger. "Ueber den Sitz der psychischen Krankheiten und die Methode ihres Studiums". In: *Die Pathologie und Therapie der psychischen Krankheiten.* Verlag von Friedrich Wreden, Braunschweig, 1876; first book, general part: 1–12.

how the brain, and even then only in some of its parts, is the seat of the imagination and striving. Certainly, both the spinal marrow and the ganglionic systems of the sympathetic nervous system have not only conduction functions but also central activities of communication, association and stimulation (tone, reflexes, etc.). However, again they are merely peripheral to those higher central activities. Undoubtedly the states of the whole nervous system, by communicating directly with the brain, also provide aspects in the stimulation and maintenance of mental activities – impressions can arise from all peripheral nerve extensions that may give impulses for urges, for more obscure or more conscious imaginations and endeavours – but the collection and assimilation of these impressions, the influence they exert on large cohesive series of movements (on action), that imagination and striving itself which is influenced by them, occurs only in the brain.

The internal courses of events of the imagination and volition are as little to be understood in the organisation of the brain as those of feeling. Nevertheless, the processes that occur in mental activities can in general be readily associated with the structure of the parts concerned. The section of the central nervous system localised in the cranial cavity consists of neural masses which, on the one hand, receive the sensory chords of the spine and the central extensions of the higher sensory nerves and, on the other hand, send out the motor chords of the spine. Accordingly, we see how all the impressions that converge centripetally from the body and through the senses are combined, perceived and assimilated in the brain, stimulate and sustain mental activity, and how again from there stimuli arise for new, centrifugal acts, relationships of feeling and mental activities with the action of the organs of movement – strivings and motor stimuli for the muscle apparatuses.

We see in animal series how mental activities become more varied, richer and capable of finer development, the more the brain increases in size and the more complicated and the richer in structures its organisation, in other words, the more powerful the actual substance of the large hemispheres becomes. We see how in humans a highly defective development of the brain (in many cases of idiocy) is associated with weakness of the higher mental acts, of the imagi-

nation and volition, and experience in all humans shows us how these mental activities change substantially with the development and alteration of the brain in the various stages of life. It is precisely in these chronological metamorphoses, this progression from gradual growth to the peak of maturity and subsequent decline that the mental activity of the brain parallels all other organic functions and thus shows itself to be as subject to the laws of development of the body as they are.

It is well known that attempts have been made to transfer individual aspects of mental activity to other parts of the nervous system than the brain, for example mind to the sympathetic nerve. This hypothesis arose, from the psychological viewpoint, from the amply refuted assumption of separate mental capacities. On the pathophysiological side, it contradicts everything that can be said positively about the functions of the sympathetic nerve. – Equally unjustified is the theory, which by the way has also never been clearly stated, which assumed a direct effect of all parts of the body (hence also of the bones, glands, etc.) on mental activities and consequently also attempted to explain insanity directly from disorders of such peripheral organs.

In recent times – as a result of a highly interesting interpretation of experimental facts – actual mental functions, feeling and even licence have been ascribed to the spinal marrow (Pflüger, Auerbach). – Schiff (Physiologie des Nervensystemes I., pp. 211) has clearly and concisely elucidated these conceptions, both experimentally and psychologically. One has to admit that impressions are probably processed in the spinal marrow generally according to the same pattern as in the brain and it cannot be refuted absolutely definitely that feeling and even pain still arise in the spinal marrow in the decapitated frog; but there can be no question of 'will' here (in the common sense of the term); this includes conscious feelings with the concepts of purposeful movement, spatiality, one's own limited body, for which the involvement of the central sphere of the sense of vision (hence a cerebral process) is probably essential. – Very recently, moreover, Pflüger's view has also been disputed from the aspect of his experimental principles. Cf. Goltz: Königsb. med. Jahrbuch II., 1860: 189.

§ 3

The pathological facts show us just as well as the physiological that only the brain can be the seat of normal and pathological mental activities, that the integrity of the mental processes is linked to

the integrity of this organ, and also how in diseases both together are in turn dependent on the behaviour of other organs. In all severe diseases except for anomalies of feeling and movement, the constant and fundamental symptoms of brain diseases, whether they have arisen from internal causes or from external injuries, consist of just these mental disorders (exaltation or sluggishness of imagination, loss of consciousness, delusions, etc.), and the rarer observations in which, in the presence of severe disorganisation of the brain and loss of brain substance, no disorders of mental activity are displayed at all, do not invalidate those results of everyday observation.
[…]

The results of autopsies of the insane themselves provide a further and even more direct proof of our thesis that the brain is the organ that is affected in insanity. In many of these autopsies, actual anatomical changes are found in the brain itself or its lining, and where anatomical changes are present at all, those in the brain are at any rate the only ones that are constant. The fact that such changes are not always found does not invalidate this basis. Normally, we very often find no palpable changes in disorders of the central nervous system that predominantly take the form of irritation (e.g. in neuralgia, epilepsy), but much more so in states of weakness, paralysis; very many mental diseases, however, belong to the former category. This, therefore, is very similar to so many other nervous and brain diseases, epilepsy, tetany, etc., whose localisation in the brain or spinal marrow, even if not visibly demonstrated by pathological anatomy in many cases, is not doubted by anyone on grounds of physiology.

Apart from disorders of the imagining and volition, the majority of mental patients, however, also exhibit significant abnormalities of other functions that are equally unequivocally related to the brain. In particular, hallucinations, abnormalities of central sensory activity which are perceived to a large extent as peripheral but whose origin must necessarily be attributed to the brain, as the cases of persistent visual hallucinations in the presence of total blindness and atrophy of the optic nerve (Esquirol) for example demonstrate incontrovertibly. Likewise we see the central stimulation of voluntary muscles, an undoubted cerebral function that is

altered in very many mental patients, partly as increased activity and energy, partly as cataleptic rigidity and partly as paralysis that parallels the course of a certain form of insanity (dementia), and many other abnormalities of cerebral functions (reduced sensitivity to pain and temperature, insomnia, convulsions, congestion of the head, etc.) are observed in mental patients as more accessory phenomena, which may serve as further confirmation of an existing cerebral disorder.
[...]

§ 4

If the facts require that imagination and volition are attributed to the brain, that should not in any way prejudge the relationship of these mental acts to the brain, the relationship of the mind to matter. Admittedly from the empirical viewpoint the unity of body and soul can be maintained and it must be left to a priorism to study the mind without relation to the body, a disembodied mind, contenting oneself with abstract considerations about their immateriality and unity in contrast to the multiplicity of matter, etc. However, the hypotheses already advanced to make that inexplicable unity more amenable to reflection, from those fine fluids that are said to mediate between body and soul, those matters "thin enough to be able to pass occasionally for spirit", to the system of pre-established harmony whereby body and soul supposedly never act against one another but only ever in union with one another – these hypotheses are equally irrefutable and equally unacceptable for empirical consideration. How a material, physical process in the nerve fibres or ganglionic cells can become an imagination, an act of consciousness, is completely incomprehensible, indeed we have no idea even how to pose a question about the existence and nature of mediating processes between the two. Everything here is still possible. In this state of affairs, the simplest hypothesis is the best and certainly the materialistic one offers fewer difficulties, obscurities and contradictions (particularly also in relation to the first emergence of mental life) than any other. It is, therefore, scientifically justified, entirely irrespective of those possible but completely unknown mediating processes,

to comprehend the mental activities in that union with the body and in particular with the brain that exists between function and organ, to consider imagination and striving in the same way as the activity, the specific energy of the brain, just as one considers conduction in the nerves, reflex in the spinal marrow, etc., as the functions of these parts and to explain the mind first and foremost as the sum of all cerebral states.

Actual information about the process in the mind can be provided neither by materialism, which attempts to explain the mental processes from the physical, nor by spiritualism, which attempts to explain the body from the soul. If we also knew everything that happens in the brain in the course of its activity, we could investigate all chemical, electrical, etc., processes in their minutest detail – but to what purpose? All fluctuations and vibrations, everything electrical and mechanical, are still not a state of mind, an imagination. How that can come about – this puzzle will probably remain unresolved until the end of times and I believe that if an angel were to come down today from heaven and explain everything to us, our understanding would be totally incapable simply of comprehending it!

What should one then say to the trite and superficial materialism which would throw the most general and most valuable facts of human consciousness overboard because they cannot be grasped physically by hand in the brain? When the empirical approach ascribes the phenomena of feeling, imagination and volition to the brain as its activities, it not only leaves untouched the actual content of human mental life in its whole richness and emphatically maintains the fact of free self-determination in particular, it naturally also leaves open the metaphysical questions as to what it might perhaps be that enters into these relations of feeling, imagination and volition as a mental substance, that assumes the form of mental existence, etc. It must wait quietly for the time that the questions about the relationship of the content of human mental life to its form become instead of metaphysical – physiological problems. In the meanwhile, one should stop persecuting oneself about unanswerable questions, pelting with stones in science and demeaning oneself by incorporating totally heterogeneous viewpoints! The fanatics and pietists of materialism should consider one point which in the discussions of these questions to date seems to me not yet to have been properly raised. The elementary processes in the nerve masses, particularly if like many today one considers them to be essentially electrical, will probably be necessarily

extremely simple, consisting of plus and minus and always the same in everyone. How could the endless variousness of imagination, feelings, volitional orientations, not only of individuals but of whole centuries, arise from these alone and directly?

Any dispute about materiality or immateriality of mental processes cannot, therefore, be decided on any account with our current concepts; it is associated in part, and even in its fundamental assumptions, with the question of internal changes in the activity of the nervous system. All comparisons with intangible factors that stand in a similar relationship to matter – they also appear as something immaterial but are brought about by material changes and modified in their effects and themselves in turn cause changes to matter – are of only limited help. The mental or nervous agent has nothing really analogous in the whole of the rest of the world; as Locke already has stated, the theory encounters the same difficulties, whether it allows matter to think or whether it wishes to understand the effect of an immaterial substance on matter. That mental activities, moreover, must always be accompanied by material acts is probably denied by nobody; this relationship is also very well developed in Stiedenroth (I. p. 52 and loco citato!); only the representation associated with that organic accompaniment is a true and conscious one to him and – a fertile phrase! – the more vivid the organic accompaniment, the more vivid the imagination. – Some aspects of the mental processes, moreover, are obviously more closely associated with so-called physical processes (with other acts of the organism) than others, e.g. pure, tranquil thinking. Memory and love, says Aristotle (On the Soul I. 4), relate not to the soul, but to the community of it and the body. In fact, the direct involvement of organic processes is most clear in memory and in 'love'; the same might also be said of phantasy.

§ 5

On the basis of all these premises, the question often and widely discussed by older German psychiatry, whether in insanity, in the abnormalities of the imagination and volition, the disease also actually affects the mind, will find its simple, affirmative response. However, one should not refer to diseases of the mind itself – just true pathology does not refer to diseases of life processes, of functions – but only to diseases of the brain by which those acts of imagination and volition are impaired.

§ 6

Even if all insanity is based on cerebral affliction, not all brain diseases, therefore, are mental diseases. What type of brain disease is it then that one has to deal with in the case of insanity? – From the anatomical standpoint, those diseases whose symptom complex is referred to as insanity are of the most varied nature. Mere irritation without appreciable tissue change, encephalitis of the cerebral cortex, atrophy, nutritional changes, circulatory abnormalities of the whole brain, intermeningeal apoplexy, simple cerebral hyperaemia, etc., – in all of these extremely varied states, there may be symptom complexes that result in patients being sent to mental institutions and which are described in psychiatric papers as mental diseases. Any attempt to distinguish insanity rigidly from acute or chronic cerebral diseases as conceived from an anatomical viewpoint, such as meningitis, encephalitis, etc., would be the most futile of undertakings since many cases of mental disease are themselves in fact meningitis, encephalitis, etc. The concept of mental diseases as purely symptomatological to a large extent falls entirely within those anatomical concepts and the objects of both cannot in any way be compared with one another. All that can be said in general with any certainty is that the brain diseases that underlie mental disorders are infinitely more often diffuse than focal diseases.[1]

Cerebral pathology nowadays still stands to a large extent at the point at which the pathology of the chest organs found itself prior to Lännec. Instead of starting universally from the structural changes of the organ and inferring the occurrence of symptoms specifically from the changes in tissue, cerebral pathology has to do often enough with symptom complexes of which the localisation is known only approximately and the mechanism of occurrence not at all. It has to limit itself to external phenomena and constitute disease groups according to something common and characteristic in the symptoms, initially separate from their anatomical foundation. Hence epilepsy, chorea, etc.; hence also the psychiatric or mental diseases, among which we must, therefore, include those cerebral

1. See the diagnostic comments of the author on cerebral diseases. Archiv der Heilkunde. Leipz, 1860; I: 51.

conditions in which abnormalities and disorders of the imagination and volition constitute the most predominant group of symptoms for observation.

The 'common brain diseases', the more circumscribed inflammations, abscesses, brain tumours, tubercular meningitis, etc., are not called mental diseases, even though with them mental activity commonly is also impaired to a greater or lesser extent, because other cerebral symptoms, the manifestations of impaired feeling and movement, as a rule are far more predominant: a potiori fit denominatio. In exceptional cases, however, such patients are also designated as mentally ill and end in mental institutions if, for example, the case assumes a chronic course from the outset, maniacal agitation develops at an early stage, etc. – On the other hand, in 'mental diseases', the sensory and motor functions of the brain are very usually also impaired, but this disorder is subordinate, the mental abnormality appears the main factor. – Further definitions of mental diseases can and need not be given; a general diagnosis of these can be found in section II, chapter 5 of this book.

§ 7

As insanity is merely a symptom complex of various anomalous states of the brain, the question might, therefore, arise as to whether its treatment distinctly and separately from other diseases of the brain can be justified at all, or whether instead psychiatry should be outwardly subsumed entirely within cerebral pathology? – However, if such is perhaps to be expected from a distant future, nowadays any attempt at such complete amalgamation would be premature and completely impracticable. As long as the fundamental inner relationship with the rest of cerebral pathology is borne constantly in mind, as long as one and the same correct and, as far as possible, physiological anatomy-based method is followed in both cases, cerebral pathology will be promoted rather than undermined in its internal classification by the outwardly distinct, monographic analysis of such symptomatically constituted diseases. Such an attempt at amalgamation, however, would be all the less permissible at present in that the position of psychiatry as a part of cerebral pathology at all would barely have to be acquired and in that many practical sides of psychiatry (the mental institution system, the relationship with forensic medicine, etc.) provide it with

its scope and specificity, which must also preserve substantial independence for it within cerebral pathology under all circumstances.

Previous attempts to include mental diseases entirely as diseases of the brain on the basis of corresponding anatomical changes proved to be premature and impossible as a result their failure (Sc. Pinel, Pathologie cérébrale. Par. 1844). When very recently one of the psychiatrists who has done greatest service to science made the attempt to analyse some of the mental diseases from a purely pathological standpoint (Calmeil, Traité des maladies inflammatoires du cerveau, Par. 1859, 2 vol.), by the nature of the matter this valuable attempt relates only to some of these conditions. – In this way, psychiatry will remain probably for a long time an independent branch of science within medicine; its separate treatment also gives the physician occasion to initiate himself at least to some extent into the sphere of the mental life, of which unfortunately otherwise so little news permeates the common circle of medical studies.

§ 8

As insanity is a disease,[2] and indeed a disease of the brain, there can be no other proper study of it than medical study. The anatomy, physiology and pathology of the nervous system and the whole special pathology and therapy constitute the indispensable previous knowledge for the psychiatrist. All non-medical, especially all poetic and moralistic, concepts of insanity are of the very slightest value to its understanding. Individual poetic representations of the insane are excellent in many features gleaned from nature (Ophelia, Lear, above all Don Quixote); but while the poet presents these conditions almost entirely in avoidance of their organic basis, conceiving them only from the mental perspective as outcomes of previous moral conflicts and only has to emphasize what serves this purpose, his description will at the least be one-sided. – A similar and more severe reproach because of the seriousness with which a few such attempts appeared, applies to the moralistic approaches. Nothing is more false, nothing is more refuted by daily observation

2. A disease from which one of cause can also die. When a recent psychiatrist (mental institution administrator?) says: Mental patients 'as a rule' die as little from mental disease as people do from common sense, this is an absurd antithesis. No-one dies of cause from health.

than every attempt to transpose the essence of mental diseases into the moral sphere. The facts speak loud enough for a very common mental aetiology of these diseases; how could it be otherwise since mental causes are also among the most important and most frequent of other cerebral and nervous diseases? – The respective state of the imagination and volition is essentially dependent on, indeed in part the necessary outcome of, the sum of all previous imagination and volition, and in this way a rich source of causal moments in mental life itself is opened up. However, although the sphere of morality is contained entirely within conscious, free thought, the starting points for the anomalous mental processes to which these diseases of the brain give rise lie in a totally different area. In insanity, affect-like mental states originally develop out of gloomy disturbances of mental common feeling, of self-feeling, and if a false representation and striving that overwhelm the patient has developed from these, he is already in a state in which the first preconditions for all morality – deliberation, the possibility of reflection and choice – are absent and none of his actions can be viewed from the moral viewpoint any longer at all.

The poetic and moralistic interpretations are not only unnecessary and theoretically wrong, but also of positive practical damage. As a result of them, lay people are filled with images of mental diseases that do not correspond to nature in the least; if these images do not then apply, they doubt whether mental disease is present. How naive is the astonishment of many visitors to mental institutions who had imagined their inhabitants to be so totally different! – Psychiatric theories which conceived of mental diseases as the maximum intensification of the 'passions' have contributed substantially to these misconceptions.

In the meantime – a real polemic against the moralistic interpretation of mental diseases is nowadays no longer necessary. Somewhat superfluously in refutation of this, one may be reminded of the many cases of the purely physical development of mental diseases – through head injuries, narcotics, etc., – of their inheritability – a family predisposition which often takes the form of a disposition in other relatives to other severe neuroses, epilepsy, hysteria, etc., – of the typical case, which not infrequently follows the same course as other nerve diseases, of the sometimes observed alternation with other diseases, of the possibility of more rapid recovery, of the analogy with dream states. The best rebuttal, however, is to provide insight into the actual processes themselves.

Karl-Ludwig Kahlbaum (1828–1899)

Karl-Ludwig Kahlbaum was born on 28 December 1828 in Driesen in der Neumark (now in Poland). After studying mathematics, natural sciences and medicine in Königsberg (now Kaliningrad), Würzburg and Leipzig, he was awarded a doctorate in Berlin in 1855. He initially worked as a doctor in the Provincial Lunatic Asylum in Hallenberg in Vehlau, near Königsberg in East Prussia. From 1866, he taught in Königsberg University. In 1867, he was appointed director of the Lunatic Asylum in Görlitz an der Neisse. Kahlbaum was one of the most important psychiatrists of the 19th century. He was stimulated by Griesinger and by Wunderlich's work in Leipzig. Kahlbaum created an epochal nosological work, which was of great importance for the development of psychiatric methods. His objective was to develop clinically based specific pathological concepts. In contrast to the concept of a single type of psychosis, which was popular at the time, he developed a differentiated concept of pathology with systematic consideration of the psychological cross-section, but with emphasis on the clinical course. This view became the established clinical method employed in psychiatry (cf. Hecker, 1871b) and was later employed and further developed by Jaspers, Kraepelin and Kurt Schneider. His monograph on "Catatonia or the Insanity of Tension" (1874) and his first description of hebephrenia (adolescent insanity) with his friend and colleague Hecker (1871a) are classics. Both clinical presentations became subforms of what was later called schizophrenia.

Kahlbaum died in 1899 at Görlitz an der Neisse, the city of his clinical activity.

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Catatonia or Tonic Insanity*

In these fascicles, I intend to publish a series of treatises which will digest into specifically defined subject areas the material from observations of patients, collected during my employment at two mental institutions, and resulting to some extent from clinical demonstrations which I have given at the East Prussian Provincial Mental Institute of Allenberg to students from the University of Königsberg. The fact that all previously published textbooks of psychiatry, despite deeming untenable the so far prevailing view of the division of this particular field of disease into the known forms of melancholiamelancholia, mania, etc., nevertheless continued to relate the specific pathological material to this framework, was a deciding factor for me in refraining entirely from referring specifically to a text book in my lectures and demonstrations at the patients' bedside and to develop to the audience symptom complexes by the clinical method in which all the signs and symptoms of the individual patient were utilised for the diagnosis and in which the whole course of the disease is paid attention to. These groups of diseases resulting from an association of the symptoms most frequently coinciding and from a purely empirical classification, which coincide only partially and indirectly with the previous diseases, were not only readily explained to the listeners, but the diagnostic based on them also provided the opportunity to establish with greater certainty from the patient's current state the previous course of the disease retrospectively and reveal the further development – not only very generally *quoad vitam et valetudinem*, but also

*Reference: K.-L. Kahlbaum. "Vorläufige Grenz-Bestimmungen und Krankengeschichten, Symptomatologie". In: *Die Katatonie oder das Spannungsirresein.* Verlag von August Hirschwald, Berlin, 1874; V–XIII, chapter 1: 3–6, chapter 2: 46–53.

individually in relation to the varied phases of the symptomatic picture – with greater probability than is possible from the standpoint of the earlier nosological framework. Although my observations were concluded to a large extent more than 7 years ago, it has not been possible for me to bring them to publication before now following the taking over of this private institution and its subsequent reorganisation. As the reliability of my earlier classifications and the resultant conclusions fully stood the test by the material in these observations gleaned from other social circles since then and as numerous conversations with colleagues have shown to me the extraordinary demonstrability of the new diseases, I no longer hesitate to proceed with the publication.

In the meanwhile, the direction of psychiatric studies has also changed not inconsiderably and has become clearer. There was a time when any specific psychiatric observation of a disease that did not conclude with extensive anatomical details was viewed askance. The anatomico-pathological work undertaken with such energy and with the greatest enthusiasm produced very extensive and valuable material, but contributed nothing to the basic views on the origin of mental illness and on the anatomical basis of its *intra vitam* so diverse and significant manifestations; and the view is now generally spreading that only comprehensive clinical observation of cases can bring order and clarity into the empirical material by using the method of clinical pathology and in this way prepare the psychiatric ground for further pervasion with anatomical detail. It has now been recognised that it is totally futile to search for an anatomy of melancholiamelancholia or mania, etc., because each of these forms occurs under the most varied relationships and combinations with other states and they are just as little the expression of an inner pathological process as for instance the complex of symptoms called fever or the collective manifestation of hydrops may be considered for certain somatic diseases to be the expression of their characteristic nature or their specific locus.

How wrong it was, and must of necessity have been, to expect pathological anatomy to reform the old obsolete psychiatric framework and more or less neglect all other paths is apparent from the way in which other pathological specialties have developed. What

reform and enrichment would the nerve-pathology not have experienced if there had been no concept of nervous histology, and how firmly established then became the distinctions and classifications acquired by physiological and clinical observation in neuropathology itself once pathological anatomy had taken a few definite steps in the field of neuropathology! I need only mention here by way of example Graves' disease, bulbar paralysis and aphasia. However, the clinical method offers much greater interest in that it successfully counters the increasingly overgrowing empty scepticism and inactive nihilism that has prevailed for a long time in psychiatry and offers a useful support for the practical requirements.

Psychiatry took the first step along the road of the clinical method with the definition of the so-called *"General Paralysis of the Insane"*. The fact that symptoms of paralysis occur in a series of mental diseases had been reported insistently enough in the observations by the older somatic school. However, it was only with the clinical definition of a specific syndrome in which paralytic manifestations constitute only one set of symptoms, albeit an essential one, that this subject, which until then had been relegated to a secondary position among the 'complications of insanity', assumed its extraordinary significance, to the extent that the main growth in psychiatric literature over many years has happened almost exclusively in articles on this subject. This single clinical disease also remained for an equally long time almost the sole fruitful subject of detailed anatomicopathological work in psychiatry, and thereby it seems to be proven how anatomicopathological research requires preparatory clinical work. However, even now this almost unique form of mental disease is still being discussed in current textbooks in terms of the clinical method only in relation to complications and one has not yet followed up the example of a clinical definition of disease that it offers in the new construction of other similar groups of clinical psychoses, but instead has again merely focussed observation on somatic complications. Only the French who discovered that first form have, almost alone until now, attempted to achieve further progress in the clinical direction *(folie circulaire)* without specifically being distracted by the somatic neurological symptom by which, though, this form is very specifically characterised. The

somatic symptoms of psychoses were enthusiastically observed and collected for decades by psychiatrists; yet it was not the existence of the somatic symptom that gave this disease its important scientific and practical significance, but the clinical method of its definition and description, and it is due to the fact that the customary method in general pathology was more proficient in somatic processes that this disease form first achieved such significance for the science of psychiatry. Somatic symptoms and somatic observation of mental diseases have also been used repeatedly elsewhere to discover and open up new paths to general psychopathology, or to establish new individual classifications for use in a general elucidation of the psychiatric material. However, mere pathological observation and statistical accumulation of the occurrence of individual somatic symptoms – however interesting it is in itself – as well as its intentional use for more general consideration and uniform presentation of the specific pathological material[1] also only results in rationalistic reform or a simple nominal alteration of the old psychiatric forms while their definitions remain unchanged, just as earlier psychiatry, which concerned itself primarily with changes of psychological designations, simply created a wealth of synonyms and ever greater incomprehensibility in the nomenclature. This does not produce a constant growth of valuable experiential material or a rational psychopathology.

Only the extensive and intensive use of the clinical method can provide assistance here and further stimulate the broad flow of psychiatric science to ever greater depth of insight into the psychopathic processes. Then the individual experiences of case-based

1. Thus, for example, the observation, entirely correct in itself, that tonic convulsive states occur frequently in cases involving a melancholic disorder gave rise to the idea that melancholy should be viewed as a form of tonic convulsion of the mind, in contrast to which the agitation of the maniac was compared with clonic convulsions, while for dementia the comparison that presented itself was with paralysis. A reform of the three old main forms of mental illness was then immediately derived from this neuropathological parallelism: melancholy was now called: mental tonism, mania: mental clonism and dementia: mental paralysis. Yet, what new and fundamental aspects did this provide for psychiatry other than a proliferation of the nomenclature without the slightest change in pathological content?

empiricism acquired in so many large hospitals for mental patients, now disappearing to a large extent with the holder of individual experience for the general science of psychiatry because of the variety and uncertainty of the nomenclature, will no longer be lost and an ever greater accumulation of material will be obtained that is usable for subsequent evaluation and an ever deeper understanding of individual and general phenomena in the mentally ill will be achieved on the basis of mutual understanding.

At the same time, with this promotion of the scientific analysis of mental and somatic manifestations, ever more ground will then be gained for anatomical research into psychopathic states and processes and for the anatomical rationale behind the individual disease forms, which in fact must, where possible, constitute the obligatory keystone and touchstone of pathological knowledge in all cases.

If I am to comment in greater detail on what I call the clinical method, I shall mention first of all somatic clinical medicine which has taught us how, in rational pathology, it is not the disease itself that is studied, but the patient in all his life functions, furthermore how no symptomatic phenomenon is considered too trivial, even if it does not initially appear to belong to the diseased organ or if normal physiology leaves us in the lurch as regards its explanation, to be studied carefully from the perspective of pathology and if necessary to be broken down into further individual phenomena and to have attention drawn to it through a new designation. Thus, in psychiatry as well, all life manifestations in the mentally ill patient must be the subject of pathological study, and it is quite rightly and urgently necessary that also the somatic processes should be studied and collected according to all the rules of clinical semiotic and diagnostic techniques and with all scientific facilities which, in contrast to moralistic theorists, the somatic psychiatric school referred to and strove after, decades ago. After all, however, the somatic, especially the non-neurological, phenomena are in the very great majority of cases of secondary interest to the main subject of psychiatric research, and mental phenomena in the narrower and broader sense – I say in the broader sense because in physiology and pathology no consistent distinction can be drawn at all between mental and neurological/somatic phenomena – remain the

main topic of psychiatric study. The basic clinical demand is then repeated for mental phenomena: the mentally ill human being as a whole, all mental and neurological processes, must be observed and studied individually, but not in the way of psychology in which the customary approach is to require all phenomena to be derived from one principle as parts of a similar whole, but in the way of natural science, i.e. as individual natural manifestations for which the pathologist, if he fails to find the analysis in physiology, must create the physiological analysis himself. The error of inferring all phenomena from one principle can, moreover, be committed just as much in the somatic and physiological (materialistic) as in the philosophical and psychological approach, and science is no further advanced, for example, if all mental manifestations are attributed to the one concept of the reflex process than when they were derived by the method of the philosophical schools from the principle of identity or of polarity, etc. Mental manifestations should initially be viewed and collected entirely without preconception, in the same way as individual manifestations in other sciences, and only when extensive material is acquired in at least a partially different form and with a greater wealth of detail than in current psychology can the causal or physiological and anatomical rationale be tackled – and only if a series of individual manifestations is analysed originally, so to speak, can an extensive comparison and simplification be justified. No other discipline can provide any basic assistance to psychiatry here. Psychiatry itself must make mental phenomena the subject of its most detailed study by the method of physiology and science and, just as many areas of somatic physiology found their first scientific, physiological analysis in pathology and through pathologists, therefore and to an even greater extent the original work of the psychiatrist is necessary to help collect and organise the material scientifically for a full, truly scientific psychology or psychophysiology. A major deficiency in our current psychopathology seems to me to appear here and the responsibility of the generally very unconducive discipline of psychiatry for the course of development becomes apparent. The wholly justified discrediting of previous psychopathological concepts and research coincided with the collapse of those excessive fantasy structures of natural philosophy

which were unable even to sustain their position in the realm of moral sciences, let alone have any justification as subjects of science. In this way, a disrespectful view developed among psychiatrists towards the mental aspect of the manifestations of the mentally ill and precisely the most immediate symptoms of the primarily diseased organ – for these are, in fact, the mental symptoms – were not thoroughly investigated in psychopathology. That must be changed before anything else because nothing fosters clinical observation as much as a detailed and exact symptomatology. However, for the time being one should not be put off by the quantity of totally necessary trivial and detailed work; one should not shy away from employing the simplest scientific operations, in the way of the first development phases of the sciences. Over and above the mental processes described in the register of our present psychology, there is an extensive world of individual mental manifestations which in psychological terms are still complete *terra incognita* and can only be discovered by meticulous investigation, although they are contained in the general mental phenomena and present to everyone's eyes and individual signs appear in writings where one least seeks them, in other words in dramatists and novelists. No-one is brought so near, or so often near, to these individual mental manifestations in their natural analysis than the psychiatrist who, in the cases of disease, has, so to speak, the experimental conditions presented by nature before him for observation. What is required here is to find a way through the excess and variability of manifestations, and for this there is no better means and indeed no other means than designation, terminology. This tool should not be despised, even if it provides only a temporary aid and in many disciplines is already an outdated viewpoint. Did not the blossoming of modern medicine, pathological anatomy, require the utmost assistance from this tool in recent times? How much more necessary will it be to have a rich nomenclature in the field of mental manifestations to permit deeper research!

More detailed consideration and more frequent analysis of the mental phenomena in the mentally ill human beings and the creation of a special scientific mental symptomatology is therefore a further urgent requirement of clinical psychopathology. However

paradoxical it might sound, it is nevertheless a fact that psychopathology, which for years was criticised because of its symptomatic nature, in fact had no symptomatology at all and that symptomatology took up by far the least space in psychiatric textbooks. Of course, if mental symptomatology had simply to consist, as a psychiatrist at the time once declared to me, in the fact that the individual objects of normal psychology needed only to be viewed negatively or pathologically altered and in that way we would have a mental symptomatology, then it would be better if it further remained unwritten. But with the symptomatology, the psychiatrist must create first of all the correct psychology that is usable for him and, in so doing, he must proceed totally without regard to whether the first manifestation that appears, whether practical or scientific, is important and does or does not provide any further benefit.

With so thorough a consideration of the vital phenomena in the patient, both somatic and mental – and among the mental phenomena, the intellectual as well as the affective and ethical, the conscious and voluntary as well as the unconscious and involuntary – it then becomes self-evident after just the first few steps that it is impossible to use the old disease names, even provisionally, for what they had previously always been applied to, even if they had been critically disregarded. However, as is not to be expected otherwise, new definitions very soon arise of their own accord since it cannot in fact be otherwise in the natural mental area than in other natural areas, where subsequent discoveries proceeded of their own accord once the path was opened up and levelled out with the first discovery. A first such discovery was the establishment of an entirely new type of mental disease according to a previously unused method of definition, which we may describe as the clinical, in contrast to the previous methods that operated according to uniform psychological or one-sided somatic principles, namely the establishment of the "General Paralysis of the Insane". Another such new type defined by the clinical method is the disease group that I have called juvenile insanity or hebephrenia, which Dr Hecker has specifically described in line with my classification and on the basis of my collection of pathological material, which to some extent

also supports his own observations (Virch. Arch. für path. Anat. Vol. 52.). A series of other such new definitions, the first of which is constituted by catatonia or tonic insanity, will be given in these fascicles in a specific clinical analysis.

I am very aware how far in my work I have remained behind what should and can be achieved with the method that I have followed – which is the method of all clinical medicine; but that we in psychiatry can only advance vigorously along this path as required by practice and science, of that I am certain, and for this reason also I believe that these somewhat fragmentary studies should be published as an encouragement in this direction.
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FIRST CHAPTER

Provisional outline definitions and case histories

Even at a very early stage in psychopathology, consideration was given to the fact that physical signs of disease were also present in most mental patients and that these physical signs were not without some significance for the mental illness. The interpretation of this relationship is known to have been a recurring point of conflict between the parties in that some viewed the somatic phenomena merely as random complications of the disease of insanity, while others sought to find essential elements of this disease in them. In the end, the so-called somatic school appears to have gained the upper hand in this dispute, but nevertheless the distinctions and classifications that have arisen from the mental approach continued to be influential and, despite the position of principle, the somatic signs of disease received only very cursory consideration insofar as they demanded attention for the prognosis and treatment and possibly even for the aetiology in individual cases. For the understanding of the nature of the disease or even for the definition of its conceptual scope, however, they remained almost entirely neglected and only the one disease of general progressive paralysis with delusions of grandeur constituted an exception to this.

As regards this disease, in which the paralytic manifestations were originally also viewed as a complication, the specific view gradually emerged that the particular mental symptoms in their characteristic configuration only occurred in association with the specific paralytic manifestations, that the progression of the mental disease state was closely related to the course of the somatic symptoms and that these somatic manifestations were also characteristic only of this disease. It did become apparent subsequently that paralysis of the insane also occurs without delusions of grandeur, just as it has been shown, on the other hand, that the paralytic manifestations are no different from those characteristic of tabes dorsalis and that, like them, they are due to grey degeneration of the dorsal spinal tracts. Finally, in recent times, attempts have been made to demonstrate how various heterogeneous disease processes have been thrown together in the classification of this disease form and in this way also the original view appears to be gaining more ground whereby the paralytic manifestations, at least for a series of cases, are only complications of the mental disease. But, however one ultimately conceives of this relationship, no-one can deny that in the classification of this disease, the paralytic symptoms assume a considerably greater significance for pathological understanding than the somatic manifestations in most other forms of mental disorders and that clinical investigation of this disease has become of considerably greater importance for scientific psychiatry precisely because of that somatic symptom.

I want to try now in this article to describe a symptom complex in which certain somatic, namely likewise muscular, symptoms accompany certain mental manifestations with the same frequency as in paralytic mental disease and, just as there, acquire substantial significance here for the form of the whole disease process.

This symptom complex is closely related to the mental states usually referred to as atonic melancholiamelancholia, which has previously been viewed as a specific disease, even though it occurs primarily only extremely rarely, resulting generally from a state of simple melancholiamelancholia or, as is quite often the case, from melancholiamelancholia with subsequent raving madness, so that the state of atonic melancholiamelancholia then represents

the third phase of the whole disease process. If the disease does not result in recovery, atonic melancholiamelancholia ultimately progresses to permanent dementia (terminal dementia), so that the mental picture of the disease process then has been constituted by four successive different states in the same case. This observation is consistent with the idea introduced by Guislain, Zeller and Griesinger whereby mental diseases proceed through various stages of a different general mental nature and that therefore, like simple melancholiamelancholia, raving madness, and dementia, atonic melancholiamelancholia is equally not to be viewed as a specific disease.

The so-called atonic melancholiamelancholia is known to be that state in which the patient sits there quietly or completely silent and motionless, with rigid faces, immobile gaze, focussed in the distance, devoid of movement and apparently of any volition, unresponsive to sensory stimuli, sometimes with the completely developed symptom of waxen flexibility as in catalepsy, sometimes only with a very slight but clearly recognisable degree of this striking phenomenon. The general impression conveyed by such a patient is one of profound mental anguish or immobility induced by severe shock, and has been classified in terms of disease either as a state of depression (hence the term atonic melancholiamelancholia) or as a state of feeble-mindedness (stupor or dementia stupida) or as a combination of the two (Baillarger's melancholie avec stupeur). This characteristic form of the general mental state, once it has developed, for the most part persists invariably in patients for a lengthy period, but sometimes it recurs repeatedly and then often in a very fleeting and transient way. Likewise, the intensity of its presentation is not always so very clearly apparent as in the description just given, and from both aspects of a somewhat defective development a correct interpretation of this condition is sometimes overlooked. However, the very fundamental relationship with other disease states and the constant association with certain somatic, namely muscular, symptoms have remained virtually ignored.

If all the cases which are associated with atonic melancholia – or as we might say more briefly atonicity – in the course of their development are subjected to precise clinical observation, it

will be found that at the start of the development of the disease epileptiform attacks or other convulsive states occur episodically in a large number of patients, but that these are soon succeeded by persistent convulsive states which assume their most extreme form in waxen flexibility in the stage of atonicity and may in individual cases persist even into the stage of terminal dementia. In addition to these interesting somatic symptoms which, in terms of their species forming significance, may be placed alongside the paralytic manifestations of general progressive paralysis with and without delusions of grandeur, these cases also stand out, however, through other somatic as well as specifically mental characteristics. In particular, there is a characteristic type of exaltation which may be described as bombastic ecstasy and, furthermore, an exquisite urge to talk in a manner of speech which is considered to be characteristic, in addition to the known aspects of atonicity and other more usual symptoms.

This disease therefore represents, so to speak, a clinical parallel to general progressive paralysis with and without delusions of grandeur. In some respects, as in its progression through the various forms of mental state and the fundamental relationship with muscular symptoms, it displays an entirely similar behaviour as those; in others, however, as initially in respect of the quality of the muscular and mental disorder and, as is highlighted later, specifically in respect of the prognosis, it represents its total opposite. And just as it is interesting from a general clinical viewpoint, so it is equally important because of its frequent occurrence and its anthropological associations.

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SECOND CHAPTER

Symptomatology

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As far as the symptoms in the sphere of activity and volition are concerned, the tendency to negation is striking at a very early stage and reaches its most pronounced character and its greatest peak in

the state of atonicity. Whereas the mania of other mental disease forms is characterised not only by the wealth of its declarations of intent and actions, but also by a very apparent weak-willedness and a marked volatility in volition and action, we find in catatonia a very remarkable monotony of the maniacal acting and the appearance through all the violence and the constant activity of negative declarations of intent and negative habits. The maniac, both in general progressive paralysis and in the simple form of typical general insanity, can be easily distracted from his activity if his urge for change and activity is simply nurtured sufficiently and at best, in some cases, consideration is still given to their individuality. The catatonic maniac, however, persists very consistently in his adopted mode of overproduction and stubbornly opposes attempts to encourage him in other forms of activity (e.g. to leave the room, go for a walk, etc.). Alongside these negations that arise in response to external stimuli, however, there are also others that are rooted in the individual consciousness and characteristic of this form of disease. The most incisive cases are provided by the symptoms of the urge to stay in bed and the refusal to eat which, however peculiar they appear in contradicting the character of mania in general, equally peculiarly distinguish catatonic mania from the manias of other diseases. Thus, the patient Adolphine M. (4th case), in whom the incremental stage lasted with minor fluctuations from August 1863 to August 1864 and the transition from mania to atonicity appears repeatedly blurred so to speak, was characterised right at the very beginning of the maniacal stage by her predilection for condemning criticism, a tendency to remain in bed and a refusal of food. These same symptoms, however, are very particularly pronounced in the stage following on from mania, both for completely developed atonicity and also for the transitional or intermediate forms from mania to atonicity.

There is probably no case in which this symptom of a tendency to negation is not present in some form, sometimes more actively, sometimes more passively. Thus, a disinclination to a change of location is particularly often present. Patients remain in bed, not out of any senseless and pathologically explicable need, but out of a disinclination to move or even out of a desire for contradic-

tion. If they do get out of bed, they do not want to get dressed or have themselves dressed. Out of bed, they stay firmly on one spot, refuse to sit down, refuse to leave from the often remote or hidden place. Or they do not want to change room, etc. (in respect of these symptomatic features, the 14th case reported [Benno von T.] is particularly interesting). – The phenomenon of the refusal to eat is extremely striking, particularly in this disease of catatonia. While in almost all other cases of mental disorder this is very clearly demonstrably the result of a motivated decision – whether the patient intends to starve to death in order to escape the misery of his life or whether he wants to protect himself from poisoning or whether he believes he can best revenge himself in this way on his enemies, or whatever else in the way of more or less pathological motives might be given – in catatonia there is very often a complete absence of motives and the refusal to eat is quite simply the result of the refusal to engage in any activity expected from the patient. If a bite to eat is placed in the patient's mouth, he starts to chew it a little and swallows it down. In some patients of this kind, for a long time it is simply necessary to place a spoon in their hand and possibly just place the first bite into their mouth and then they eat by themselves, or they only eat when no one is present, when no-one is looking, or like the patient Julius G. (second case) they leave a part of each meal uneaten – or whatever else may be said about such tics in patients with atonic melancholia. However, they would refuse to take food to the point even of starvation if their urge to negation were not satisfied. To some extent, there is a general negative tone that prevails in them, a tendency to negation to varying degrees, from the lowest level of pure indecision to a refusal to act, and the refusal to eat appears to be merely a point in this continuum of this general negative tendency. At times certain ideas of delusion or feelings of delusion also appear to provide a motive, in a similar way to that described previously. However, the obvious question might then suggest itself as to whether, in these rarer cases of catatonia in which a delusional motive may be proposed for the refusal to eat, the apparently motivating delusion is not in fact a secondary impulse to the original, so to speak, organic impulse, in the form of an attempted explanation or a reflex hallucination.

The motivational delusional idea would therefore emerge only as a consequence of the presence of that organic disorder underlying the negation. However, even in these cases in which a motive can be proposed for the refusal to eat in catatonia, in most cases it is far less obstinate than the refusal to eat in other forms of disease and can often be overcome following a few occasions of artificial feeding, in that the negative tendency is then satisfied by the other more minor aspects that have variously been described previously.

Finally, this symptom of a negative tendency is associated with the occurrence of characteristic, to a greater or lesser degree bizarre habits of movement and posture of the body and in particular the occurrence of marked habitual actions. The most striking are those bizarre stereotyped movements that are often found in all the larger institutions, one person grasping the tip of their nose every couple of minutes, another swinging their arm horizontally around their head from time to time and finishing the movement with a slinging motion of the hand. One lady when seated makes an arm and hand movement very similar to that when spinning on the spinning wheel. The patient Adolf L. in the 6th case had the habit of walking on the outer edges of his feet with the inner edges raised inwards, thus keeping his knees bent (cases from the East Prussian Provincial Institute of Allenberg). The patient Minna von B. (3rd case) had the habit at times of twisting a piece of cloth like a sausage and on the days concerned would sit for hours making this twisting movement. The frequent grimaces of many patients (14th case) also belong here. Compare also the 11th and 12th cases.

The catatonic patient is also very striking in his immobile posture, in the way in which the limbs and parts of the body are held at rest. A patient in Allenberg sat for many months in bed with her back curved and her head bent forward having previously lain apathetically in bed for a long time. The previously mentioned patient Adolf L. (6th case) had the habit when at rest of holding his right forearm in front of the middle of his chest, covering his face or part of his face with his right hand and holding his right elbow with his left hand, a position that is fairly often adopted for resting the arms and when thinking, but in this patient it became so stereotypical that the parts of the body concerned acquired deep

impressions at the points of contact. The convulsive protrusion of clenched lips ('Schnauzkrampf') which is very common in catatonia also belongs to this category. In most cases, these features of stereotypical posture and movement are reported only with cases that have already progressed to terminal dementia. However, they occur much earlier and, apart from the very well known rigid posture of the patients with fully developed atonicity, they also occur in the maniacal stage, particularly if manic states alternate with those of atonicity. In these early phases of the disease, or on the other hand during remissions and intermissions, when delusional thinking is not at all detectable, these patients are already, or still, characterised by the rigid posture of their whole body and by the habitual nature of their action and their whole nature. Thus, a patient for instance who was in a state of complete lucidity in the course of an intermission always took a particular alley during his walks in the garden, turned sharply around when he came to the end and was remarkable for his shuttling back and forth long after any trace of intellectual disorder in the narrower sense had disappeared. When asked occasionally for the reason, he said that the sun was shining in the other alleys, and yet it was not at all the case that this monotonous and in itself uncomfortable perseverance with the one short alley would happen in a healthy person and the change in sunlight in the garden with the progress of the seasons produced no change in his habit.

Let us now turn to the somatic symptoms. The manifestations of impaired volitional activity just described already suggest a pathological innervation of the motor nerves and this assumption becomes highly likely when we see that confirmed convulsive states are essential symptoms of this disease. However, it is in fact known that the convulsive form of waxen flexibility is a very common symptom of the state of atonicity and, as the reported cases show, other convulsive forms also occur often enough. Thus, the patient Adolf K. (first case) displays chorea-like convulsions of the face and extremities. In the second case history reported, the occurrence of an epileptiform attack is mentioned. In the third case history, it is said that hysterical incidents occurred, actual convulsions of the feet, then of the arms and jowls, in the course

of which a sound like the ticking of a clock in the mouth could be heard in the institute; at first, convulsibility of all muscles of the extremities (wavelike twitching of individual muscle parts in alternation), then tetany and trismus. In the 6th case, the convulsions were also observed in the institute and, as in the previous case, first a general convulsibility and then an actual epileptiform seizure. In the case of Paul M. (11th case), the convulsions occurred for several days in succession typically in association with maniacal attacks. Individual convulsions in the upper half of the body were observed in the hanging case. In two cases nothing was mentioned about convulsions in the medical case reports sent to the institution and I became aware of the convulsive attacks only subsequently on questioning the relatives. In the literature also, as mentioned previously, the frequent occurrence of convulsions is considered specifically in cases of atonic melancholia. As these convulsive states, in most cases, occur in the early development of the disease (only in the 5th, 6th, and 11th case are they observed in the subsequent course), it is therefore not unlikely that they occur even more often than appears to be the case in my observations to date and that their occurrence is simply not mentioned to the doctors concerned because it occurred at a time when the patient was not yet considered to be mentally ill or because these convulsive symptoms were not considered to be part to the mental disease. Some abnormality in the condition or in the functioning of the motor organs can be observed in the subsequent course in all cases; in most cases continuously throughout the whole disease, in other cases only temporarily. In part these motor disturbances might be regarded as a mental, and even voluntary, symptom comparable to the phenomena that have been discussed earlier under disturbances of volitional movement and activity. A part must be considered to be of cerebrospinal origin such as the condition of waxen flexibility and the crooked positions of the extremities resembling contractures. True paralysis is so rare in catatonia that it cannot be regarded as belonging to the symptom complex of this disease. However, decreased sensibility progressing to almost complete anaesthesia is common. It is especially mentioned in cases of atonic melancholia that deep needle pricks borne without any

outward signs of pain are in many cases attributable to the raising of the reaction threshold for motor reasons since later, after the mental disorder has diminished, the patients immediately exhibit complete sensibility and sometimes also retain the memory of the painful needle pricks from the time of atonicity.

Hyperaesthesia should also be mentioned as a very common symptom, and specifically a usually very violent and persistent occipital pain of which catatonic patients often complain. Whereas pain in the forehead region or in the temples or in the crown of the head occurs in other mental forms of disease, these are hardly ever observed in catatonics, while the characteristic occipital pain in catatonia occurs more rarely in the other forms.

The extremely frequent oedema that is observed in catatonic patients should be viewed as a disorder in the area of the trophic nervous system and therefore initially included here. This specifically involves oedema of the lower limbs, and not infrequently also of the eyelids. That of the upper extremities and trunk is much less common.

In terms of somatic disorders, severe oligaemia or chlorosis are observed almost constantly. Next to that are very common disorders of excrementation. The presence of abnormal states in the first part of the digestive tract and in the stomach may be inferred from the *foetor ex ore* that is sometimes present even with the greatest cleanliness, the abnormal sensations of taste and loss of appetite, although here again the difficulty arises of deciding how much relates to the result of the mental processes and the subsequent consequences of the processes that can be explained physically (such as *foetor ex ore* as a consequence of limited food intake). In terms of the skin, extensive epidermoidal desquamation and accumulation of epidermal crusts can frequently be observed. Othaematoma occurs in advanced stages, but much less often than in the terminal stages of other cases of mental illness.

Mention may be made here of the very common occurrence of pulmonary tuberculosis in catatonia as being of particular somatic or even diagnostic importance and at the same time it may be noted that a certain contradiction with the previously mentioned paralysis of the insane can also be observed in this respect. Whereas

pneumonia occurs more often in the latter and not infrequently causes a fatal outcome, while tuberculosis is observed only rarely in paralytics and specifically when the persons concerned have not already suffered from it prior to the mental disease, in catatonics tuberculosis frequently occurs in the subsequent course of the illness or even very early, often in cases where a congenital or otherwise acquired predisposition can be definitely excluded. Although the view is propounded that tuberculosis occurs very often in the mentally ill in general, I would concur with this observation only as regards the specific form of catatonia and limit it to this form, but otherwise assume only that the previous poor board and lodging within and outside the institutions was responsible for the frequent coincidence of tuberculosis and psychoses in general that was observed previously. Leaving aside cases of catatonia and cases in which tuberculosis was observed long before the mental illness, in the East Prussian Provincial Institute I observed, in fact, a remarkably small predisposition to pulmonary tuberculosis compared to the general human predisposition to tuberculosis and an extremely marked capacity in the presence of pulmonary tuberculosis for resistance to its effect on general behaviour and I can certainly report from my own practice in a private institute that no case of postpsychopathic tuberculosis has occurred except in catatonics. The proposition of a general predisposition to tuberculosis in all psychoses without distinction must therefore be modified and it may well be assumed that catatonia in itself, i.e. the anatomical conditions of catatonia and the life circumstances imposed by this form of disease, are accompanied by a certain predisposition to the tubercle process.

I have not observed a particular relationship with catatonia in other somatic diseases.

Paul Julius Möbius (1853–1907)

Paul Julius Möbius was born in Leipzig in 1853, where he attended the famous Thomas School. In 1870, he started studying theology and philosophy in Leipzig, Jena and Marburg, followed by medicine in 1873. He was awarded his Medical Doctor in 1877 in Leipzig, where he practised from 1879 as physician for neurology and electrotherapy. He also worked in the Neurological Outpatient Clinic under W. Erb and A. von Strümpel, where he qualified as university lecturer in 1883. Möbius was predominantly a neurologist, as is evident in his book "The Classification of Diseases" (1892). Several neurological symptoms and syndromes are named after him, such as Möbius' disease (ophthalmoplegic migraine). In the late 1880s, he withdrew into private practice and dealt more intensively with psychiatry. He worked on the question of genius and wrote pathological biographies of historical personalities. With his translation of Magnon, Möbius introduced the French concept of degeneration into German psychiatry. He also introduced the term 'endogenous' into psychiatric terminology. His studies of hysteria are still of importance today; these contain the first identification of the psychogenic causes of a disease. Möbius's views on female emancipation were highly controversial (cf. Möbius 1900 b). Möbius died in 1907 in Leipzig.

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On the Concept of Hysteria*

Every discussion should start by defining the terms related to the object of the discussion. This sounds old-fashioned, but is nevertheless correct. There are few subjects in which the lack of adequate definition of the terms has caused such a lack of clarity and so many contradictions and misunderstandings as has been the case with hysteria.

It was understood fairly early that the meaning of the word (roughly womb craving) did not correspond to the facts. One can ask whether it is even expedient to retain the unsuitable word. The answer must presumably be in the affirmative, if all hysterical symptoms really possess a shared characteristic. Old habits die hard and really no-one thinks of the uterus today when he mentions hysteria. With time, this word has simply become a sign and, eventually, any word which were to replace it would also have to be robbed of its actual meaning, as one cannot create new words. The situation is similar with melancholy, hypochondria and others, as no-one is misled any longer by the black bile or the belly.

It would not be advisable to name all attempts at definition which have been made over the years. It should be regarded as an important step forward that increasingly the idea is being brought out that hysteria is a psychosis, in other words, the essential and primary change is a pathological state of the soul. However, as it is accepted that there are cases of hysteria (particularly in men) in which there are no detectable abnormalities in mental activity in the strict sense, the essential characteristic must be sought not in

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*Reference: P. J. Möbius. "Über den Begriff der Hysterie". In: *Centralblatt für Nervenheilkunde, Psychatrie und gerichtliche Psychopathologie.* Febr. 1888; 11, no. 3: 66–71.

the type of psychiatric symptoms, but in the somatic symptoms. The mental peculiarities which we normally connect with hysteria – the moodiness, the craving to attract attention and similar – may be present or absent. On the other hand, if physical symptoms of a particular type are present, we diagnose hysteria, without asking further questions. What are these physical abnormalities then? I think the answer must be: *All these pathological changes in the body are hysterical which are caused by mental images.*[1] Every child knows that imaginations linked to lively feelings of desire or lack of desire can trigger all sorts of physical changes: crying, laughing, blushing, salivation in the mouth, vomiting from disgust, sweating for fright, diarrhoea from fear, rigidity from shock, lack of feeling in passion, etc., etc. The hysterical way is characterised both by the fact that these changes are triggered unusually easily and vigorously by imaginations and that imaginations trigger physical disturbances, such as hemianaesthesia, which cannot be observed at all in healthy subjects. In many cases, the form of the physical disturbance has no direct relationship to the causal imagination. It can however determine the content of the latter by drawing attention to specific parts of the body. Thus a light nudge on the shoulder can elicit the fear of severe injury to the arm: a hysterical paralysis of the arm is the effect. This type of connection is probably more frequent than is obvious from the start. It is however often difficult to investigate this, as it is comprehensible that the linkage of the imaginations can be really strange and the subject himself is often incapable of explaining the processes within him.

Two objections can be made to this view of hysteria. It may be said that, on the one hand, it does not explain all the symptoms of hysteria and, on the other hand, it includes symptoms which do not belong to hysteria.

The following response can be made to the first objection. It must be admitted that we can neither prove in general that all hysterical

1. Kraepelin's characterisation (Psychiatrie p. 390) is closest to this definition: "We may perhaps regard the extraordinary ease and rapidity with which psychological states manifest themselves in a variety of physical reactions as really being to some extent characteristic of all hysterical mental derangement."…

symptoms arise from imaginations, nor can we demonstrate in individual cases that a symptom which can be caused by imaginations really has been triggered in this manner. It is in fact an argument on the basis of analogies. Experience has shown that hysterical symptoms very often arise from imaginations, or the mental changes linked to these, and just as often vanish. This fact has not been discovered by experimental investigations in recent years, but has been demonstrated by these, so to say, *ad occulos*. Experiences with hypnotism in general, particularly however the results of suggestion or prompting, by means of which almost all hysterical symptoms can be elicited as desired, are of great scientific value for just this reason – that they throw a spotlight on the essential nature of hysteria. Thus, because imaginations are often the cause of hysterical symptoms, we believe that they always are. This belief endows our views with clarity and unity and is in particular of proven practical worth, as it provides a safe foundation for medical treatment.

I would like to emphasise that those who accept the above definition must then regard hysterical mental derangement as a complication. The reason that this very often accompanies hysteria is evidently that the mental change which is the essence of hysteria, through which imaginations can trigger the various physical abnormalities, is related to the mental change of which the manifestation is the so-called hysterical character or hysterical mental derangement.

The second objection is much less weighty than the first. Certainly, our definition does extend the area of hysteria; but this is precisely its value, as it brings together everything which has the same essential character. If the view which so far has been held of hysteria is too restricted to include all pathological symptoms triggered by imaginations, then this view must be extended, abandoning the inessential characteristics for the sake of the essential. Thus an attempt was made to disprove Charcot's argument that traumatic neurosis is a form of hysteria by arguing that the clinical course, i.e. the continuous character of the symptoms and their lack of improvement, would point against the assumption of hysteria. If however it is correct – as Charcot says – that fright (or the imaginations emerging in fright) is the cause of the disease, one

must then accept that the transitoriness of the symptoms is not the essence of hysteria and that there are forms of hysteria in which the symptoms are continuously exacerbated. Thus the disease designated by Friedreich as fright neurosis and called Paramyoclonus multiplex has been separated from hysteria, as the symmetrical twitches characteristic of P.m. are usually not otherwise observed in hysterical patients and hysterical mental derangement is lacking in P.m. As however the origin and clinical course allows hardly a doubt about its hysterical nature, the P.m. must be regarded as a subtype of hysteria.

The fear that our definition could weaken the concept of hysteria is totally baseless, as, on the contrary, it provides a clear demarcation. For example, it would simply be a misunderstanding to think that the physical symptoms accompanying some forms of insanity, such as muscular tension in ecstasy, the so-called catatonia in maniacs and similar, would fall under this definition. In these cases, the imagination is not the cause in a strict sense, but a motive. The patients remain in specific postures etc., because they believe that they must do so; for example, they intend to remain in this or that posture because a voice has ordered this. In hysteria, on the other hand, a motive is out of question; the process through which the imagination causes paralysis or whatever lies outside the range of consciousness, i.e. the patient does not know how his paralysis arises.

Neurasthenia is quite different from hysteria. That one too can arise through mental events, intellectual exhaustion, worry, etc., but is only fatigue from an excess of this activity, not an inhibition or enhancement of physical functions by action of an imagination. The essence of neurasthenia is exhaustion and hysteria has nothing to do with this. Hysteria occurs in people and in periods in which there is no question of nervous weakness and can by no means be seen as a consequence of over-civilisation like neurasthenia. However, it is quite obvious that a hysteric can become neurasthenic as much as anyone else.

A wide gulf separates epilepsy from hysteria. Epilepsy should really be counted as an organic brain disease. We know that focal lesions in the brain, chronic alcohol poisoning, lead poisoning,

uraemia etc. can cause epileptic attacks. Also, so-called idiopathic epilepsy must be due to some sort of physical cause in the wider sense; imaginations are out of question. The misleading expression hysteroepilepsy should be totally suppressed because if a patient suffers both epileptic and hysterical seizures then he simply has two diseases. If he has hysterical seizures, which only appear similar to epileptic seizures, then he suffers from hysteria and nothing else.

Finally, it might be suggested that the definition does not adequately demarcate hysteria from the phenomena of healthy life. However, a demarcation of this sort is neither necessary nor possible. This is because hysteria is simply a pathological enhancement of a tendency that exists in everyone. Everyone is, so to say, a little bit hysterical. The success of medical practice would be going badly if this were not the case.

From the practical point of view, the main thing is that all symptoms of hysteria are produced by imaginations and can thus only be removed by imaginations, in so far as this is possible at all. Putting it simply, this means that there is no other therapy for hysteria than a psychological – a sentence which probably is often spoken but often misunderstood. As the hysterical symptoms are not evoked by the patient intentionally, they cannot be removed by intention. If the cause of the origin is not a motive, the cause of the cessation cannot be a motive either. Psychological therapy, therefore, must not consist of appealing to the patient's insight or providing him with explanations, but must reach its goal indirectly.

We know that some physical abnormalities in normal life, such as hiccup, can be readily eliminated as soon as one succeeds in sharply captivating the attention. Experience has also shown that hysterical symptoms may be cured in a similar manner. As soon as the interest of the patient is held by something new, it is possible to magically remove the disease – admittedly only under certain circumstances, which we are mostly incapable of evaluating. In accordance with the average nature of man, it must usually be matters on which one's own weal and woe are dependent. One woman falls in love and is healthy; another hears a cry of fire and runs away with her previously paralysed legs, and so on. However, for the physician this is not the correct approach for most cases. Partly, the effec-

tive measures are not within his power, partly, these measures are ambiguous, in so far as the vigorous excitation may just as well do damage as they might help and one can seldom predict which will be the case.

The second approach is the one of suggestion. In a narrower sense, its pattern could be described as so-called suggestion: The physician says to the hypnotised patient: you can move your paralysed arm and the patient really can do it. However, suggestion was used before hypnotism was known, one does it daily and I think that one does not need hypnotism which is, after all, a questionable method. It is just only necessary to wake firm confidence in a cure. However, this means that the patient must surrender him- or herself to a state similar to hypnosis, in which he or she more or less deliberately decides to place firm confidence in the therapy, or, even better, in the physician. The benefit lies in the belief, namely to put it in theological terms, in the *fides*, *qua creditur* [how it is believed], and not in the *fides*, *quae creditur* [what is believed]. The essential is not the content, but the firmness of the belief. One can cure every hysterical symptom by any therapy – by distilled water as well as with static electricity. The physician can manage whose personal properties or fame enchant the patient. Aside from the physician's personality, a method is more active the more it affects the patient's imagination. I need not to explain this at greater detail. Usually, the physical or chemical remedy cannot totally be dispensed with, as the physician is mostly incapable of fulfilling and indeed may not fulfil the role of the wonder healer. However, the scientific physician must be aware that, whatever method he is using, he is carrying out a symbolic act, that it is not the chemicism, the magnetism, the galvanism or any other material manner, but only the imagination that is effective.

Hysteria does not only consist in the triggering of physical trouble by imaginations, but also in the fact that symptoms with physical causes in hysterics can, to some extent, be inhibited by imaginations. Thus belief in hysterics can more or less overcome pain from inflammation, cough from bronchitis and others. This is, so to speak, the useful side of hysteria. Now everyone is hysterical to some extent. I remind you of the vanishing of tooth-

ache when seeing the forceps. Depending on the extent to which the individual patient has a tendency to hysteria, belief during a disease can be helpful; to all patients it will be of some help. With regard to fact, the study of hysteria should be most urgently recommended to all physicians-to-be. I am sure that the ideas mentioned have not yet been adequately considered in therapeutic discussions.

In concluding this short article, the author would like to comment that he hopes that he is in essential agreement with the man to whom the theory of hysteria owes more than to anyone else, with Charcot.

Alfred Hoche (1865–1943)

Alfred Erich Hoche was born in a vicarage in Saxony. He not only published articles on psychiatry, but also poems under the pseudonym Alfred Erich. His scientific work has left few lasting impressions. His only significant contribution was his critical analysis of Kraepelin's nosological system, presented as a lecture on principles in 1912, under the title, "The Significance of System Complexes in Psychiatry". However, he never developed an independent psychiatric system himself. After qualifying as a doctor and working in the University Departments of Psychiatry in Heidelberg and Strassburg, he was appointed professor at the University of Freiburg im Breisgau, where he was director of the Department of Psychiatry. His work there included an extremely critical study of Sigmund Freud's psychoanalysis.

Hoche achieved enormous notoriety with a 17-page text which he wrote in collaboration with the Leipzig lawyer Karl Binding (1841–1920). This was part of a 62-page pamphlet, with the title, Approval of the Destruction of Undeserving Life. The text was influenced by the then current social Darwinism and also by the frightful events of the First World War. Binding and Hoche's article provided an important ideological background for the National Socialists' extermination campaigns and euthanasia of the sick and handicapped during the Third Reich. Hoche's wife was Jewish. In May 1933, shortly before his 68th birthday, Hoche submitted his resignation. He died in 1943.

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The Significance of Symptom Complexes in Psychiatry*

The division of labour between the two speakers has been so agreed that it falls to me to explain, on the one hand, the significance of the symptom complexes in their relationship to disease forms and elementary symptoms on the other hand. In other words, my task could be formulated as the current state of our classificatory efforts.

The history of psychiatry represents a very special chapter in the history of medicine. With its rapid course, development in its crucial periods has been compressed into a few decades and our discipline shows the traces of these special features of its past clearly enough. For a long time, the external difficulties of the field/or discipline and the need to struggle against them have absorbed the best workers. It was a battle with several fronts or, to use a metaphor, like the Jews building the Temple in Jerusalem, who held the trowel in one hand while they fought off their enemies with the other. Now that much has become better in external respects and the position of the overall discipline appears in a certain sense consolidated, a concentrated consideration of the foundations of our science has commenced, of the possibilities of knowledge, of the prospects and the aims – a very lively effort to approach from every possible facet the mass of experience, to which we provisionally give the collective name of mental illnesses.

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*Reference: A. Hoche. "Die Bedeutung der Symptomenkomplexe in der Psychiatrie". In: *Zeitschrift für die gesamte Neurologie und Psychiatrie.* 1912; 12: 540–551.

This development was by no means steady. It took place, if we look back over it, in phases, partially depending on individual outstanding minds, whose impulses acted like sourdough, partially through the natural gravity of things. Periods of standstill and resignation have always alternated with those of clinical optimism and greater activity. The actual progress was not always steady; apparent detours were revealed as actual advances; errors arose that unexpectedly brought truths to light.

The main changes that can be noted in the clinical sphere have taken place in the consciousness of the majority of those present here today.

The analysis of the enormous quantity of empirical material that had accumulated gradually into 'forms' was not only a logical but also an eminently practical need, especially because of the need to be able to predict as far as possible the later course of the individual cases. These efforts at analysis have been largely successful. The separation into organic psychoses and functional disorders has long been made (the double meaning of the word functional will be addressed later). The mental illnesses roughly of organic origin were again broken down into numerous sections, some of them in a final manner and some to the extent that there is justified hope of definitive boundaries. Here one could mention the breakdown of idiocy, senile and arteriosclerotic conditions, epilepsy etc. The main example of a happy final definition of disease conditions, which in all directions constantly prove to belong together, has been progressive paralysis. The success achieved here has perhaps been a misfortune in its side effects because it nourished the illusion that something similar might soon be repeated.

Marginal difficulties also arose even in the attempt to separate organic and functional disorders; these occur particularly in the group of the toxic psychoses which are uniform in aetiology but otherwise diverge in all directions.

From a particular point of view, an attempt was made to separate the endogenous from the exogenous diseases. The development of the concept of degeneration was indeed progress from the general biological aspect, but it created major new difficulties for classificatory efforts. The grouping of the clinical material from all of the

aspects mentioned results in circles, which coincide only in part and intersect in the most varied way.

With the functional psychoses, we enter the area of our most genuine problems daily in the clinic and also in today's lecture. For some time, 'functional' only meant that we are not yet able to demonstrate anatomical changes with today's aids but with the unspoken assumption that they would be present legitimately. Today, however, the adjective is also used in the sense that by it we understand such disorders that will never possess a pathological anatomy because they cannot possess one. In the clinical sense, we would essentially have to understand as functional psychoses those which are not destined to end with a mental deficiency.

Here, too, the wavelike movement which is usual in scientific discovery is not absent from the development of all the questions under consideration. Certain opinions arose, and the number of their adherents grew quickly only to diminish again quantitatively. Thus, for a long period, paranoia, then dementia praecox, and today manic-depression enjoyed favour in psychiatric opinion. Each time, the term then included for individuals such a large part of all the mental disorders that it was unimportant anyway for practical purposes whether they were called one thing or another. The scope, height and pace of these development waves were dependent on thinkers and schools. Today, the entire large area, which is not definitely grossly organic in origin or of uniform toxic aetiology or does not belong with epilepsy or hysteria, is, for certain ways of thinking, divided between dementia praecox and manic-depression. The magnitude of the concepts produced thus is in itself proof that the formula to provide the solution will not be found here. Nevertheless, in the clinical sphere we see a continuous regrouping, a pushing of cases backward and forward from one disease concept to another and extremely assiduous activity, albeit unsuccessful in its effect, for which in the past I used an image that was often taken amiss, of people who try to clarify a cloudy liquid by pouring it from one vessel into another. (For representatives of a logically operating psychiatry it does not require the hint that it only depends on the *tertium comparationis*, on the uselessness of the selected procedure.) Underlying all these assiduous efforts is

the indestructible belief that it should also be possible in the area of psychiatry to find particularly defined, pure, uniform forms of diseases, a belief that derives nourishment again and again from the analogy with somatic medicine without considering that the nature of the relationship between symptom and anatomical substrate, in the psychiatric and in the somatic area, cannot be compared with one another at all. Numerous mollifying elements have developed to counter the emerging fundamental doubts: the experience of the individual is insufficient; the observation of the disorders extending over 30 and 40 years is too short; there are abortive forms, mixed forms, borderline cases and transitional conditions; the purity of the diseases is clouded by the addition of feeble-mindedness or the influence of mental degeneration etc.

Overall, however, there is an increasing number of those who notice the large quantity of cases that cannot be accommodated according to our present system, and, which signifies very much more, they are inclined to admit this state of affairs but without giving up the belief in the existence of pure disease forms on that account.

I expressed these sceptical considerations for the first time 6 years ago in Munich. In the discussion of my lecture at that time, I was faced with an almost closed front of rejection. In the time that has elapsed since then, a slow rapprochement has occurred repeatedly to the at that time quite horrifying point of view, at least in oral explanations, but in part also expressed in the literature. Binswanger, in particular, has confessed to similar views. It is progress, in any case, that the subject I selected then has today become capable of being the topic of lectures and I have been happy to seize the opportunity to respond in a certain sense before this forum. The speaker, who can perhaps be suspected of being over-anxious to carry out reforms, has been assigned to a co-speaker who has undoubtedly the most solid scientific structure.

We ask initially: in the area of the functional psychoses as defined just now, what is the situation with such disease forms that we actually possess, which are generally recognised or else are sustained only by the individual in his inner forum when he examines himself honestly? I have already explained repeatedly in the past how we are continuously obliged to perform the act of ignoring disturbing

symptoms and reading what is absent into the disease conditions. The relative rarity of pure disease forms is hammered into the consciousness of every academic teacher in an importunate manner when it is a matter of finding suitable cases for elementary clinical demonstration or for the state examination. How far we are all constantly subject to the greatest self-deception in the clinical area is shown by even a glance, for instance, at the history of amentia or catatonia. We have all formerly, particularly under the influence of Maynert's lists etc., seen very many more cases of amentia than today where in Freiburg, for instance, a number of semesters can go by without the occurrence of demonstrable cases of amentia despite a not inconsiderable number of admissions. Where were the cases of catatonia in the past, which apparently today can no longer be mistaken, the traces of which we find only hinted at in old medical histories even if these were recorded entirely scientifically according to the ideas current at that time? Even if such extreme cases may be rare as I have experienced myself, when another assistant physician wrote in the journal as present status: "Patient presents the typical picture of amentia", yet everyone will have to agree with Alzheimer's judgement that our medical histories in general contain too many judgements and too little description. Every single one of us who knows how to maintain some objectivity towards himself recognises when he looks back over his life the changes in his capacity for illusion with regard to the purity of clinical conditions and also the undoubted influence to which we are exposed by the random transformations of the material with the absence or presence of increased numbers of convincing cases.

It would be superfluous in this assembly to illustrate in more detail the area of what is doubtful with individual proofs. Examples will occur to everyone. For instance, when we cast a glance at the present scope of manic-depression, we find there melancholy and mania, singly and in all variations of repetition; among these cases we find mixed states, cases with permanent changes occurring ultimately, cases without such, substitute phases of the most varied nature, acute and chronic paranoid states (including paranoia querulans), states of periodically recurring amentia, puerperal and climacteric psychoses and many more.

Totally vast is the chaos of what is generally or by individuals called paranoid. Under the collective label of dementia praecox, one finds curable, incurable, acute and chronic conditions, conditions that occur once and those that are recurrent and with symptoms in all conceivable shades, quite apart from the fact that it is today claimed repeatedly that there is a broad boundary between dementia praecox and manic-depression. We see states of confusion with delusions and excitation, fluctuations in mood and hallucinations, which neither have exhaustion as the cause nor belong to catatonia, and cannot be accommodated anywhere else in the present system. What has become of the concept of periodicity? Because of the fact that a single episode of disease in life can possibly be regarded as an expression of a periodic disorder, the concept has been diluted down to nothing or it is employed when quite heterogeneous conditions are repeated or when substitute phases of the most varied kind occur.

Truly, a considerable capacity for illusion is necessary if one wants to claim that clinical experience today of necessity or even only with a degree of probability leads to belief in the existence of pure disease forms. We have the most trenchant signal of this condition in our ordinary despairing helplessness in the prognosis of numerous disease states, which we encounter in a given individual case.

The purest representative of optimism in the clinical regard today is probably Kraepelin, who in the introduction to the second volume of his textbook in 1910 expressed the certain conviction "that the further development of clinical psychiatry is not opposed by any fundamental difficulties but only by such that can be gradually overcome by patient work and abundant experience". Kraepelin does indeed admit the increase in unclassifiable cases, but stands by his demand for monographs dealing with the entire area after conscientious fragmentation of the forms into their smallest variations, which would lead us to possession of the pure forms.

Alzheimer, too, who by and large recognises the actual plight, is of the opinion that it is not yet time to lay down our arms, that we have nowhere yet attempted the last suitable means right to the end.

If there are such extensive fundamental differences in the view of certain things, as expressed on the one hand in Kraepelin's foreword and in my Munich and Stuttgart disquisitions on the other, this tends to have to do with something that cannot be proven and established at a glance but is rather a question of belief. In fact it is essentially a matter of dogma.

This by no means releases us from the obligation to examine the scientific possibility or probability of one or the other view.

A precondition for the existence of pure disease forms in the psychiatric area must be that a certain cause produces certain material changes in certain locations of the brain, the direct expression of which should then be represented by the clinical symptoms. The belief in the existence of disease forms is, thus, inseparably linked to the belief in the existence of an anatomically tangible basis, regardless of whether this is a question of gross structural changes or microchemical or other types of functional changes, but in any case localised and possibly comprehensible processes.

An impartial examination of our actual knowledge in the area of the connection of mental phenomena to certain brain areas or systems shows straight away that we are all today still much too much under the spell or at least under the after-effect of localisation theory.

All that we actually possess in the main is the understanding that the spirit is not hovering over the waters, i.e. that mental life can legitimately be found only where highly differentiated nerve tissue exists. Most of our seemingly localising knowledge means only a tool required for neurological diagnosis. Mental functions are localisable only to the extent that their expressions when making for the periphery can be disturbed somewhere by an interruption of conduction. Only in this sense can we speak of centres of individual mental activities. Thus, sensory perceptions, speech functions, psychomotor processes of the most varied kind, individual accomplishments of memory function etc. are localisable in this sense, while otherwise the conviction must force itself on us with cogent force that for everything that we call feeling, mood, emotion, urge, will, judgement etc., extensive utilisation of the most varied parts of the brain is the precondition. We can probably also assume

it as a certainty that a sharp separation will be no more possible physiologically than when considered psychologically. They are only logical-dialectical fictions if we want to isolate, for instance, feeling and will or sensation and feeling from one another etc.

As soon as one adopts the today irrefutable idea that the most varied parts of the brain have a general function for all higher mental processes, very numerous possible targets open up for any disorder of any mental processes. Accordingly, hallucinations do not need to have their primary cause in the sensory cortex; what changes and is changed primarily in catatonic waxy flexibility does not need to be located in the psychomotor system at all in the narrower sense. Perhaps the strange psychological inaccessibility of some clinical disease conditions, such as catatonic obstruction in stupor, may be explained by the fact that the primary altering is not to be found in the adjacent area, that is, in the psychomotor area in the case of catatonia.

Something else has to be added. After all, we all probably assume today that what we experience subjectively as mental processes represents the inward-facing facet of combined excitation processes in the nerve substance. In the process it is naturally very possible that very different psychological events can take place in the same structure systems with the same amount of chemical turnover and possibly very fine anatomically detectable alterations according to the form of the excitation process that is occurring so that even infinitely advanced microchemistry would not be able to provide a connection between tangible visible changes and certain mental phenomena. The mental represents a completely new category, which is closed in itself, obeys its own laws but is incommensurable compared to material processes. Though it would not otherwise coincide in all the directions with the processes I mean, I might use the analogy of using a certain expenditure of force on a given musical instrument with the same number of oscillations to be determined physically but only in a different order to produce musical forms with the most varied content, which, closed in themselves, also form a new category with its own laws, which is incommensurable with the material substrate.

If these ideas, against which there will not be too many actual objections, are accurate, any hope of anatomical differentiation of mental processes in the brain would have to be given up, not only in the area of the pathological but also for normal psychology.

In any case it seems to me that the prospects of being able to draw on the diversity or different localisation of this or that anatomically identifiable brain process as a principle for demarcating clinical disease forms are nil for the functional psychoses.

Nature daily provides us with very tangible negative proofs. I mean the fact, to which I referred previously, that precisely the gross anatomical disorders are the least regular in their individual symptomatology. This applies in the same way for progressive paralysis, arteriosclerotic and senile mental disorders and for those cases from the narrower and definite area of dementia praecox, which lead rapidly to severe and final deficiency manifestations. All cases share certain basic features of the disease condition, but in fact only the progressive disintegration of the mental personality in the named disorders is left in the end. However, this process, which we must apply to an additive effect of the quantitative reduction in the function-bearing nerve substance is accompanied by colourful symptom combinations of the most varied kind. We know that nearly all those disease conditions can occur in the named disease forms, sometimes episodically and sometimes of greater duration, which we find without deficiency manifestations as temporary and correctable disorders in the functional psychoses. Even if we are capable of making the diagnosis of progressive paralysis today with some certainty post mortem from the brain of a person unknown to us, we can, in general, state with regard to the clinical course that progressive dementia probably preceded death; regarding all the individual forms of the disease, whether with excitation or not, whether with manic, melancholic or delusional episodes etc., no one can state anything from the anatomical appearance.

Thus it is precisely those cases in which we partly identify and will partly learn to identify a regular pathological anatomy which will demonstrate the lack of success of our efforts to construct a legitimate bridge between anatomical alterations and mental phenomena.

The opinion I hold today on the basis of all these considerations, that we are on the wrong track in the constant searching for demarcated pure disease conditions of a mental nature is something new only in its extension to the entire field. To a certain extent, corresponding tendencies have already become obvious to us for a long time; I mean the partially preparatory and partially already concluded breakup of individual old historical disease concepts. In this connection, I only need to recall the history of hypochondria, nothing at all of which remains in the sense of a pure disease condition. Neurasthenia is following the same development path; if we regard it as an acquired exhaustion of the nervous system and subtract all of the cases deriving from the area of the periodic psychoses, constitutional ill-humour, alcohol, syphilis, dementia praecox, it is by no means as common a disease as was for a long time assumed. With regard to hysteria, the view is at least on the march that there is no disease *sui generis* of 'hysteria', that what we call a hysterical character is perhaps only a symptom of degeneration and that the cases in which the so-called hysterical character predominates have nothing at all in common with other cases except the name, especially, for instance, in cases of monosymptomatic hysteria.

The fact that the adjectives 'hysterical', 'hypochondriac', 'neurasthenic' to denote certain mental dispositions or reaction forms retain their full and generally accepted meaning remains untouched by these classificatory doubts.

Although we know far too little today of the numerous normal psychological types as such, yet we know more of such disposition and reaction types, for instance those which are collectively gathered together under the name of constitutional depression, the chronic manic, the distrustful-paranoid, the agile-litigating character, the particularly central disposition to disorders of consciousness, to delirium on occasions to which the normal person does not react etc.

The occurrence of these particular, lasting and largely accompanying reaction forms, each one of which is composed of a combination of elementary dispositions in the motor and sensory area etc., provides the compelling indication that certain symptom combinations are preformed in the normal just as in the constitutionally

degenerative psyche, which partially make up what we call the character of a person, and partially determine, in the case of particular pathological influences, how the pathologically deviant reaction form of the personality will turn out. We must assume exactly the same in the case of the pronounced mental disorders. There is no doubt among competent judges about what we describe using adjectives such as melancholic, manic, delirious, paranoiac. And that the psychoses in all places and at all times coincide in certain basic features is precisely because they possess such ever-recurring symptom complexes, from which the indications derived from the condition emerge for practical action.

We do not encounter such symptom complexes only in such mental disorders that give us the impression that they represent only an intensification of certain pathological dispositions, such as melancholy, mania, chronic paranoia, but these complexes are also supplied by organic processes in which they occur only episodically and as symptom groups of secondary importance, as in progressive paralysis.

The continued and regular recurrence of such symptom complexes undoubtedly arouses the impression that in a large number, perhaps in all psychological disorders, symptom combinations are produced which are already lying in readiness to a certain degree. A rough and only partially accurate example in another area would be the epileptic seizure, which is manifested immediately with the entire range of its individual components – aura, loss of consciousness, spasm, twitching etc. – as soon as certain requirements that we are unfamiliar with are present, without the central nervous system having somehow to prepare for this absolutely new process or learn it through practice. Quite diverse details, by no means predictable in their composition by someone who has not yet seen such a thing, of a pathological process always recur in the same manner, no different in the hundredth seizure than in the first, and must probably owe this grouping to some deeper, regular inner associations. In a similar fashion, *mutatis mutandis,* one would have to imagine that, for example, the combination of depressed mood, sensation of smallness and motor inhibition or of elevated mood, agitation and flight of ideas, or the intimate connection of hallucina-

tion and delusions or the coupling of attention disorders with the tendency to confabulation and much more is present preformed and it appears finished in the case of a psychiatric disease.

These symptom complexes have previously been called by me 'second-rank units'. The so-called disease forms in their present definition have proven to be too large, but on the other hand, the elementary symptoms are naturally even less suitable to be used to demarcate the different conditions as they represent individual manifestations. The symptom complexes would be located between these two series of manifestations; our present vision is still too little adjusted to them because we have always striven for realisation of our ideas from the content of the larger units, the pure disease forms.

It is not my intention to list here all the symptom complexes in detail which could be named at the moment in the sense of these remarks; however, looking for them appears to me the most urgent task of the immediate future.

Possibly the mental disorders will then be grouped into those whose symptomatology consists essentially in the breaking down of preformed complexes and those which create new symptom combinations haphazardly. Perhaps it will become apparent that this division coincides with the one that we make with the words functional and organic; perhaps it will also turn out that precisely those disorders which we call endogenous have a particular tendency to produce symptom complexes that lie in readiness.

This way of considering things will prove fruitful for normal psychology, too, but probably mostly for the borderline conditions.

I have no illusions about the sum of what can be achieved in a moment in this way and I also understand very well that this essentially negative point of view will be disapproved of as pessimistic and will be rejected as not progressive. Meanwhile it should be recalled that denial also has a positive value if it releases forces which otherwise exhaust themselves in a hopeless hunt for a phantom.

Karl Jaspers (1883–1969)

Karl Jaspers, born on 23 February 1883 in Oldenburg, was simultaneously one of the most important German philosophers, psychologists and psychopathologists of the last century. He went to the humanistic grammar school, then studied law for three terms, but transferred to medicine. He started work at the Heidelberg Department of Psychiatry in 1909, which was led by Franz Nissl at this time and stayed until 1915. He qualified as university lecturer in psychology in 1913 and was appointed professor in 1916. From 1921 to 1937 and 1945 to 1948 he was professor of philosophy in Heidelberg and after 1948 in Basle. The first edition of his book, "General Psychopathology", appeared in 1913. This represents the start of scientific psychopathology and is even today of decisive importance for the methodological foundation of this subject. He developed understanding by identifying mental processes as a subjective process of realisation and explanation by linking of repeated experiences to objective regularities as the essential modes of access for psychopathological research. Starting with Dilthey's work and Husserl's earlier studies, Jaspers developed a specific phenomenological method. However, he also took up Kahlbaum's clinical approach and attempted to surmount Kraepelin's rather elementary psychopathological views. In this manner, he created essential preconditions for the clinical psychopathology of Kurt Schneider, with whom he corresponded for decades on scientific matters. Jaspers was forbidden to teach or publish from 1937 to 1945. During this period, he revised his "General Psychopathology", although he had not performed clinical work for 25 years. The book was completed in 1942 and was longer than the first edition by 300 pages.

It first appeared only in 1946 and is still reprinted in this form. Karl Jaspers died on 26 February 1969 in Basle.

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Phenomenological Research in Psychopathology*

It is usual when examining mentally ill patients to distinguish between objective and subjective symptoms. *Objective* symptoms are all the processes that can be *perceived with the senses*: reflexes, visible movements, the photographable face, motor agitation, speech utterances, written products, actions, life-style etc. and the objective symptoms also include all *measurable performances* such as fitness for work, fitness for exercise, memory performance etc. Finally, it is customary to include to the objective symptoms the delusions, memory distortions etc., in short, the *rational contents* of speech-related manifestations, which we can only understand albeit not perceive with our senses, which we understand simply by *thinking*, i.e. rationally, and without the aid of somehow imagining mental processes.

All objective symptoms can be demonstrated directly to everyone who has the capacity of sensory perception and logical thought and their actual existence can be represented convincingly. The *subjective* symptoms however, if they are to be comprehended, have to rely on something which we tend to call subjective, in contrast to sensory perception and logical thought, they cannot be received by sensory organs but only by putting ourselves into the other's soul, by empathy. Thus, we can visualise them internally only by co-*experiencing*, not by *thinking*. Subjective symptoms are all the

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*Reference: K. Jaspers. "Die phänomenologische Forschungsrichtung in der Psychopathologie". In: *Zur Psychopathologie, Gesammelte Schriften.* Springer Verlag, Berlin, 1963: 314–328.

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emotions and inner processes, the sensory manifestations of which we believe to *grasp directly*, which in this way become an '*expression*', such as fear, grief and cheerfulness. Furthermore, subjective symptoms also include all the mental experiences and phenomena which the patients *describe* to us and make accessible to us only *indirectly* through their *interpretation* and their description. Finally, subjective symptoms are the mental processes, which are *interpreted* and deduced from fragments of the two preceding facts, from actions, life style etc.

A very definite *contrast in values* is usually associated with the distinction between the objective and subjective symptoms. Objective symptoms are the only definite ones, these alone are of scientific use, while subjective symptoms, albeit essential for provisional orientation are regarded as eminently uncertain to assess and unproductive with regard to further scientific investigations. There is a demand to build the theory of mental illnesses upon the objective symptoms alone and the ideal is to eliminate all subjective symptoms fully. Representatives of both psychology and psychiatry support this view more or less consistently. *Objective psychology* contrasts with *subjective psychology*. The former aims at working only with objective data and leads consequently to a *psychology excluding the mind.* The latter, which by the way, never tends to mistake the different kind of value of the former, values self-observation and subjective classification by establishing the way of existence of the mind and the characteristics of the phenomena and also is of value to such investigations when they are made without any objective lead. Examples of objective psychology include the large amount of work on the theory of sensory perception, measurements of memory and the investigation of the working curve including its components. We shall take the latter as an example in order to make ourselves aware that these investigations lead methodically to the elimination of the mental aspect. It is not *feelings* of tiredness (fatigue) but *objective* tiredness that is investigated. All concepts such as fatigability, recoverability, exercise capacity, exercise endurance, the effect of a break etc. refer to the objectively measurable performance, regardless of whether a machine, a soulless living organism or an ensouled human being is investigated. However,

such objective investigations tend then secondarily – completely justified of course – to draw on subjective mental phenomena for interpretation or for comparison with the objective performance. Subjective psychology, which will be discussed in this essay, is then employed. There is no doubt that objective psychology yields more visible and definite results that can be more easily grasped by everybody as compared to subjective psychology. However, the difference with regard to the *level* of certainty is only a gradual one whereas there is an essential difference regarding the nature of certainty. For subjective psychology *always leads to the ultimate achievement of concepts and opinions via the inner visualisation and consideration of the mind*, while objective psychology obtains its ultimate achievement in the sensory perceptions which are disputed by nobody, in numbers, graphs or rational contents.

So what is the aim of the much-scorned *subjective psychology?* While objective psychology seeks to become physiology almost or entirely by eliminating mental aspects as far as possible, subjective psychology intends to preserve the mental life itself as an object. Generally speaking, the latter asks about the bases of *mental experience*, its consequences and its inherent associations. Finding answers to such questions is the actual aim of subjective psychology. However, with each particular question, it faces the necessity of being clear about and making it clear to others just what is understood by a *specific* mental experience. It sees itself confronted with a countless variety of mental phenomena, which cannot be investigated as a whole but only separately. Thus, before it gets down to its actual work, it has to visualise and specify what mental phenomena are meant, which ones these must not be mistaken for and to which ones they are similar etc. The *phenomenology* arises during this preliminary work of independently visualising, clearly distinguishing and – ordering mental phenomena. This preliminary work is made temporarily into an end in itself based on the fact that it is difficult and comprehensive. As long as this independent methodical investigation has not been tackled, the preliminary phenomenological work always remained limited to unconnected, imaginative, ad hoc considerations including some good approaches but research could not stop at these.

Within psychological research, E. Husserl took the crucial step towards a methodical phenomenology following the preliminary work of Brentano and his school and of Th. Lipps. There is a range of phenomenological approaches[1] in psychopathology but they have not yet been developed into a generally recognised area of research, which could provide methodical preliminary work suitable for the tasks of actual psychopathology. As there really are many fruitful tasks here, allowing for everyone's collaboration, a programmatic exposition of the aims and methods appears appropriate to us.

In *daily life*, nobody thinks of the isolated mental phenomena being part of himself or others. Inside, we are always focussed on that *for the sake of which* we experience, not on our *currently* experienced mental processes. We understand others not by observing and analysing their mental life but by living with them in the context of events, destinies and actions. Even when we occasionally do consider the mental events themselves, we tend to do so only in the *context* of the events and their consequences as understood by us or we tend to classify personalities into character categories. On no occasion, we consider a mental phenomenon in isolation, as a unique perception, a feeling and describe its appearance, mode of existence and circumstances. The psychiatrist can behave *just in the same way* towards a patient. He can co-experience, whenever this occurs without the need to think about it. Thereby he can obtain a thoroughly personal, non-verbal and immediate understanding, which however remains his own pure experience without becoming conscious knowledge. He gains practice in understanding but not a collection of conscious experiences, which he could compare more clearly than in vague impressions

1. Kandinsky's book, *Kritische und klinische Betrachtungen im Gebiete der Sinnestäuschungen,* Berlin 1885, is almost entirely phenomenological, apart from the theoretical remarks, which can be neglected without detriment to the book. Oesterreich, *Die Phänomenologie des Ich in ihren Grundproblemen*, Leipzig 1910, and Hacker, "Systematische Traumbeobachtungen", Archiv f. Psych. 21, 1, 1911, pursue methodically the phenomenology of phenomena that are particularly important for psychopathology. In two works ("Zur Analyse der Trugwahrnehmungen", p. 191, and: "Die Trugwahrnehmungen", p. 252) I have made an effort into the same direction.

and 'feelings' which would allow him to be organised, defined and used for examination.

However, this attitude of merely co-experienced understanding, which is enormously satisfying for the individual personality and can indeed be, depending on disposition, the ultimate aim of one's entire profession, is subjective in a particular sense. When *individual assertions* are made or formulations are given from such overall understanding without further attribution, *without solid regular concepts*, they must be disapproved of as being 'merely' subjective. For they can neither be discussed nor verified. Even if we can value this understanding very highly due to the useful human talents apparent therein, we can never call it science, neither the understanding in its sublimated form, as practised for centuries among persons of cultivated circles, nor the conceptless empathy of the sympathetic psychiatrist.

In contrast, if psychology is to develop as a *science*, one must be aware from the outset that it takes as an ideal the completely conscious understanding of mental life that can be represented in solid forms, an understanding, which induces the above-described attitude unconsciously, vaguely and only personally and subjectively in persons with that talent. One must be aware of that it cannot remotely match this ideal as it is only at an early stage of development which only opens up some perspectives without being able to reach this ideal in the future. That is why many practise their personal understanding alone, to their own satisfaction and smile at the attempts at laying down conscious psychological concepts considering them as harmlessly shallow and trivial from the point of view of their comprehensive but vague knowledge.[2] The fact that knowledge relies only on conscious psychological frameworks constitutes their unique value from a scientific aspect but only from this point of view.

2. It cannot be denied that psychologists have committed masses of trivialities. It cannot be denied either that a pseudopsychology is sometimes established instead of a science based on methodical phenomenology; the content of that personal and, from the aspect of communicability, vague understanding is simply presented in *equally imprecise* though learned expressions instead of plain German.

This attitude, if it is not to remain merely an *experience* based on understanding but is to gain *knowledge* which can be communicated, verified and discussed, faces endless and extremely varied mental phenomena interacting in still unknown ways and which have effects and causes that remain yet to be established. Undoubtedly, the first step towards a scientific comprehension is to separate, demarcate, distinguish and describe specific mental phenomena, which are thereby *clearly conceptualised* and consistently denoted by a *certain expression*. For certain, visualising what is actually happening in the patient, what he is experiencing, how something is present in his consciousness, how he is feeling etc. is the starting point from which interrelationships, experience as a whole and additional thoughts about this and its causes as well as theoretical ideas must be disregarded initially. Only what is actually present in consciousness should be visualised, whereas everything else, being not really part of it is not present. We must leave aside all the conventional theories, psychological constructs or materialistic mythologies of brain processes, we must turn purely to what we can understand, grasp, distinguish and describe in its actual existence. Experience taught us that this is a very difficult task. Such lack of prejudice, which is inherent to phenomenology, does not exist *a priori* but has to be acquired strenuously after long critical work and often fruitless efforts in developing constructs and mythologies. As children, we first draw things not as we see them but as we think them. Likewise, as psychologists and psychopathologists, we pass a stage in which we somehow *think* the psychical to an unprejudiced immediate comprehension of the psychical as it *is*. This phenomenological attitude demands continuous effort and has to be acquired time and again by overcoming prejudices.

Now, how do we isolate and characterise mental phenomena and define them conceptually? We cannot materialise mental phenomena, we cannot visualise them by any sensory means. We can only guide others and ourselves in visualising their specific aspects from all sides. The genesis, the conditions and situations under which a phenomenon occurs, the context in which it tends to be present, its possible objective contents and also ostensive comparisons and symbolisation – a type of suggestive state, achieved most vividly by

artists – a demonstration of previously known phenomena, which play a part as elements of the present one etc. must lead from the outside to the mental phenomenon under investigation. It is an *appeal, reinforced by all of these deductions*, to the others and, when using our observations later, to ourselves, to visualise the phenomena of interest. The more numerous and specific the deductions are, the more certain we can be in dealing with one of the phenomena of interest here. This *independent* visualisation of psychological contents using the always-external signs is the sole condition under which *any psychological work* can be understood.

Just as the histologist describes the peculiar morphological elements in detail only to make it easier for everyone else to *see* them for themselves, and just as the histologist has to assume or effectuate this seeing for oneself in those who really want to understand him, the phenomenologist can indicate a variety of features, distinguishing characteristics and mistakes in order to describe the qualitatively peculiar psychological processes. However, he must be prepared for the others not *merely thinking* with him but *seeing* with him during contact and conversation with patients and by their own visualisations. *This* form of seeing is not sensory but intellectual. One has to practise this quite peculiar, irreducible ultimate, this 'bringing about', 'understanding', 'grasping', 'seeing', 'visualising' and one must have grasped it in order to advance even one step in phenomenology. This is the only way one can acquire productive criticism, which opposes both constructs and the unproductive, deadening denial of any possibility of progress. Someone who has no eyes to see with cannot practise histology; someone who resists or has no talent for visualising vividly the mind is unable to comprehend phenomenology.

This ultimate, irreducible quality of mental phenomena, which can be interpreted only by using various identical deductions as suggested by that former appeal, is already present in the simplest sensory qualities, such as blue, red, colour, sound, as well as in spatial dimensions, the consciousness of objects, perception, imagination, thought etc. We find these in the area of psychopathology, e.g. in pseudohallucinations, déjà-vu, in the alienation of the world of perception, experience of one's own duplication,

depersonalisation etc., though all of these terms only designate one sub-group of mental phenomena that differ among themselves in nuances.

In order to *visualise* all these ultimate phenomenological qualities, we have already repeatedly used expressions such as seeing, looking, feeling, understanding etc. All these expressions signify the same *ultimate experience*, which only shapes our concepts and which is the same in the psychological area as sensory perception is in the natural sciences. Just as sensory perception is evoked by the demonstration of an object, understanding and empathic visualisation are induced by the named, explicit deductions, the immediate comprehension of the expressive phenomena and the immersion in self-descriptions. From this mode of expression is derived the fact that empathy and understanding are not yet a simple ultimate phenomenon but still contain a series of distinguishable facts. Initially, like perception, this empathy assigns the first task to phenomenology, being its basis, and the second task to the investigation of its genesis.[3] Neither of these interests us at this point. We only have to state this fulfilment of our knowledge based on empathising and understanding experiences and to raise the question of whether this is a certain way of accessing facts. Once these experiences have been acknowledged as something ultimate, similarly to perceptual experiences, this question can be answered as follows: the technical aids allowing for storing former ideas for later comparison and many other things will always be so incomplete in the area of empathic experiences that it encounters far more difficulties than the area of sensory perception. However, in principle, certainty is achieved in the same way by comparison, repetition, re-examination of the empathised experiences and visualisation just as the scientific results found in sensory perception are compared, repeated and re-examined. Uncertainty reigns in both areas. Although it is undoubtedly higher on the psychological side, the difference is only gradual.

3. All the literature on empathy and understanding can easily be found in Geiger's clarifying lecture: "Über das Wesen und die Bedeutung der Einfühlung", report on the Fourth Conference of Experimental Psychology, 1910.

Whether we visualise our own mental experiences of the past or those of other people is much the same. There appears to be an important difference only between the observations[4] obtained with the *methodical experimental self-observation of persistent experiences* and the merely understanding visualisation. It is nearly only the latter that is considered for our investigations of psychopathological phenomena, as patients can only rarely and under particularly favourable conditions be led to such self-observation, namely if the disorders are simple (hallucinations during a calm, conscious state, agnosia etc.). However, this understanding visualisation of the phenomena shown in the mentally ill patient can always expect significant support from the concepts obtained by phenomenological investigation of the first kind.

The *means* of phenomenological analysis and discovery of what patients really experience are threefold: firstly, by immersion in gestures, behaviour, *expressive movements*; secondly, by *exploration* including questioning and the patient's information about himself as guided by us; thirdly, by written *self-descriptions*, which – if they are good – are always very valuable and possibly useful, even without personal knowledge of their authors. In all these cases, we are practising phenomenology in so far as we adjust to the aspects of the mind and not to the objective phenomena, which are only a transition point here, only a means, and are not themselves the object of investigation. However, good *self-descriptions* are of quite particular value.[5]

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4. The work of Külpe's school has been enormously fruitful for phenomenology. Not all of these highly intricate aspects will be presented in detail here, as the intention is only to outline phenomenological research. Cf. also on self-observation: Elias Müller, *Zur Analyse der Gedächtnistätigkeit und des Vorstellungsverlaufs*, Leipzig 1911: 161–176.

5. We cannot resist emphasising that it is of the greatest value for phenomenology if these are published. As educated and intelligent patients, in particular, provide good self-descriptions, doctors at private asylums, who could obtain these more easily than doctors at public asylums, who observe almost only patients from the lower social classes, would render a great service if they made these descriptions publicly accessible. Still, it is often regarded as insufficient and inferior to publish a single 'case' and it is necessary to point out the extraordinarily high value of self-descriptions, so that it becomes more usual

If we seek to approach the mental life of patients by these means, we are initially faced with an immense, constantly flowing chaos of ever-changing phenomena. Our first aim must be to restrict it to individual details, to visualise it from all sides for lasting use by ourselves and by others and to label it consistently with an identical name. The psychopathological phenomena strongly suggest such an isolating phenomenological consideration that abstracts from associations, which only aims at visualising the given but not at understanding its genesis, intending to see but not to explain. From a pathological point of view, numerous mental phenomena occur without understandable conditions; psychologically, they arise out of nothing and regards their causes, they are due to the disease process. Vivid memories of things, which were never experienced, thoughts with the consciousness of their correctness, without this consciousness being based on reasonable grounds (delusions), moods and emotions occurring completely spontaneously without underlying experiences or thoughts, amongst many other things, are frequent phenomena. All these are the object of phenomenological investigation, which establishes and visualises what they are really like. Three groups of phenomena can be found in this way. Everyone knows some of these, as they are part of *our own experience*. They share the same characteristics as the corresponding mental processes, which are normally based on reason. The otherwise completely identical phenomena shown in patients differ only in their origin, like e.g. many memory distortions. The second group can

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to collect and make use of these than hitherto. I would like to express the wish that those readers who are in possession of good self-descriptions – i.e. those that bring actually experienced mental phenomena visibly before our eyes – publish them or, if they decide against it, to allow me to view them for potential further use. For the interested reader I list a few of the best self-descriptions published to date. There are not many: Schreber: *Denkwürdigkeiten eines Nervenkranken*, Leipzig 1903; Thomas de Quincey: *Bekenntnisse eines Opiumessers*; Gerard de Nerval, *Aurelia*, German, Munich 1910 (though in literary form); J. J. David, "Halluzinationen", *Die neue Rundschau* 17: 874; Wollny: *Erklärungen der Tollheit von Haslam*, Leipzig 1889; Kandinsky: "Zur Lehre von den Halluzinationen", Archiv f. Psych. 11: 453; Forel: *Die Kranken*, Archiv f. Psych. 34: 960; Klinke, *Jahrb. f. Psych.* 9; Kaiser, Allgem. Zeitschr. F. Psych. 10: 423; Engelken, loc. cit. 6: 336; Meinert: *Alkoholwahnsinnig*, Dresden 1907.

be understood by us as *amplifications, reductions or mixtures of self-experienced phenomena*, like e.g. the blessedness during some acute psychoses, pseudo-hallucinations and perverse drives. How far our understanding visualisation goes, even independently of our own similar conscious experiences, is a question that cannot be answered conclusively. Sometimes it seems that our understanding reaches far beyond the possibility of even similar experiences of our own. The third group of pathological phenomena is characterised by their *complete inaccessibility to understanding visualisation*. We approach them only using analogies and metaphors, and in isolated cases, we notice them not by positive understanding but by the impulse, experienced during the process of understanding the incomprehensible. For instance, this may include all the 'made' thoughts, 'made' moods etc. which many patients undoubtedly report as experiences, but which we always identify only by these and similar expressions and by a series of identifications of what they are *not*. Some patients, whose consciousness of normal mental life is preserved during their psychosis, recognise on their own the impossibility of describing their experiences in normal language. A patient explained "that some of these things cannot be expressed at all in human language … to make myself somewhat understandable, I shall have to use a lot of metaphors and similes, which are perhaps only approximately correct; as this is the only way of comparison with known human experiences … (elsewhere) to this is added the consideration that these are mostly visions, whose *images* I have in my head but whose *verbal* description is immensely difficult and sometimes actually impossible." Some but not many of the patients' neologisms are based on such naming of their innermost experiences. A patient described a sensation in his hip more precisely answering the question of whether it was a twitching by saying: "No, it isn't twitching, it's twutching."

With respect to delimiting and naming individual forms of experience, psychiatry has worked hard from the beginning, and naturally, it could never have made even a single step forward without such phenomenological determination. Thus were described delusions, hallucinations, depressive and expansive emotions and more. All of this will remain the basis of further phenomenological

definitions but it often has to be freed of the ballast of theoretical considerations about physical foundations and constructs of mental interrelations. Numerous phenomenological approaches have been smothered straightaway by these theoretical efforts. We will now no longer be satisfied with a few meagre categories but will yield unconditionally to the phenomena and where we see one, we shall seek to visualise it fully without supposedly knowing what it is, based on our previous psychological knowledge. The current classification of the symptoms of madness into hallucinations and delusions is useful as a brief catchword but still these denotations incorporate an immense quantity of quite different phenomena. A few examples will illustrate the kind of established phenomena. a) Kandinsky described the *pseudohallucinations*, a certain type of pathological imaginations. They differ from normal imaginations in their great sensory certainty, their clearness, their amount of details, in their occurrence independent of and against the person's will, and thus in the experience of passivity and receptivity. However, they are different from hallucinations and normal perceptions, as they do not occur in the external space at the same time as the perceptions but in the internal space where we also see our imaginations. These pseudo-hallucinations have been criticised from a theoretical point of view. However, this is exclusively a problem of phenomenological description. The described cases can be visualised in a phenomenologically different and perhaps more evidentically way. Other cases (self-descriptions, results of explorations) can be referred to. However, Kandinsky can be disproved only by such illustrative visualisation but never by theoretical considerations. Being aware of the independence of the phenomenological task protects against complete misunderstanding and therefore unproductive criticism. b) Patients often experience a phenomenon in which they become vividly aware of somebody being behind them or above them. This somebody turns with them when they look around. They 'feel' that somebody is 'really' there. However, they feel no touch, they feel nothing at all, and cannot see his face either. Nevertheless, some patients judge that there is nobody, whereas others are convinced of the existence of this somebody of whose presence they are so intensely aware. These are obviously not hallucinations as the sen-

sory element is lacking and they are not delusions in that an experience is present that is dealt with correctly or delusionally only when it is judged.[6] c) A third example from the realm of feelings will illustrate that by mere immersion in single phenomena, by lacking any system and theory, one arrives at visualising and defining those phenomena that are initially simply strung together. One speaks of ecstatic feelings. Amongst these one can quickly distinguish different nuances albeit not different phenomena – of course, the correctness of the individual example does not matter here. Firstly, one finds general enthusiasm, emotion and feelings about all kinds of things, and secondly, a deep inner happiness, which now and then generates ideas of happiness, and thirdly, a feeling of blessed elevation and grace, sanctification and great significance. Each of these and similar distinctions, which can be made quickly, require, if they are to be of value, phenomenological expansion, adjustment and fixation.

Now, we know the *means* of psychopathological phenomenology (expressive movements, explorations, self-descriptions) and the *ways of deduction* for our own visualisation (genesis, conditions and combinations of the phenomena, their contents, their already established phenomenological elements, symbolic references etc.). Finally, we also know that there remains only the *appeal* to the others to visualise the phenomena themselves by taking into consideration everything listed. Therefore, any phenomenological work will include individual cases, general descriptions derived from them as well as the definition of concepts. It is not a reproach but only confirmation of a fact that phenomenology describes only the immediate obvious. It is only that the way leading towards a more general understanding is always difficult in the individual case as is the relative completeness of the phenomenological delimitation. It must be borne in mind that whereas the experience of a single patient is always infinite in variation, the phenomenology only derives something general from it. Although this may just be

6. I shall soon describe these and similar phenomena elsewhere using cases as 'corporal consciousness'.

the same experience of a different case, which we therefore label identically, the infinity of the individual changes constantly. Thus, the situation is that phenomenology, on the one hand, abstracts from an infinity of changing elements and on the other hand, is turned not towards something abstract but towards something entirely concrete. Only as far as something can be brought to real, immediate actuality, i.e. only if it is concrete, is it the object of phenomenology.

Let us make the case that a series of phenomena can be generally visualised in a conscious way by the described phenomenological delimitation. For the second time, we are now apparently faced with a new chaos of innumerable named phenomena, which by no means satisfy our scientific needs. In order to *delimit* individual phenomena, they have to be organised in order to bring to mind consciously in a methodical way the psychological variety and they have to be clarified up to the limit that has been reached in each case. The phenomena can be ordered quite differently according to one's particular purpose. For instance, they can be organised according to their genesis, possible physical conditions, contents and according to their significance to a specific aspect (for instance the logical, ethical and aesthetic aspect of psychological phenomena). All of these ordering principles are justified per se. However, they are not a very satisfying phenomenology. Here we seek an order that places the mental phenomena next to each other according to their *phenomenological relationship*, just as the infinitely numerous colours in the colour circle or the colour sphere are made satisfyingly clear phenomenologically. Given the current state of phenomenology, it appears that there is a series of phenomena, which seem to be completely unrelated: sensory perceptions and thoughts, hallucinations and delusions are *fundamentally* distinct phenomena and not linked at all by *transitions*. Such very distinct phenomena can only be placed next to each other, but not ordered in more detail. Yet, the degree to which these dissociations will finally be reduced to one or a few more basic psychological distinctions cannot be anticipated.

Otherwise, these completely separated phenomena contrast with groups of clearly ordered, related phenomena. There are transitions between them just as they exist between colours. The pseudo-hal-

lucinations are an example[7] of how such related phenomena can be sorted in one overview. On closer consideration of individual cases, it is apparent that there are transitions between normal mental images and completely developed pseudo – hallucinations (which are never physical and always remain in the inner, imagined space). In order to make these clear, it is possible to find four main opposites between which these phenomena can oscillate in a series of transitions. If we describe, for instance, the location within each of these series, we shall have sufficiently characterised phenomenologically the particular phenomenon situated between mental image and pseudohallucination. These four opposites are:

Fully developed pseudo-hallucinations	*Normal imaginations*
1. Have a certain outline, standing before us complete with all details	Have an indistinct outline, appear before us incompletely and only in isolated details.
2. Have completely adequate perceptions with regard to the individual emotional elements.	Are only adequate in very few emotional elements or not at all, e.g. an imagined face appears to be entirely grey.
3. Are constant and can easily be maintained in the same way.	Melt, dissolve, and constantly have to be generated anew.
4. Are independent of the will, can neither be evoked at will nor changed. They are accepted with a feeling of passivity and receptiveness.	Are dependent on the will, can be evoked and changed at will. They are generated with a feeling of activity.

7. Again, it does not matter *here* whether the selected example is correct. It should only serve to visualise the aim.

This example, which we shall not discuss further at this point, shows how it is possible to group related phenomena purely phenomenologically in that *only truly experienced aspects of these phenomena* provide the basis for classification, while additional thoughts and theories remain still quite excluded. At the same time, it is apparent from these explanations how important it is, to use a catchphrase, to distinguish *phenomenological transitions* from *phenomenological abysses*. The former allow for phenomenological ordering, whereas the latter only allow for contrasting pairs or lists. Thus, it is natural to decide only with difficulty and clear visualisation whether a group of phenomena that is distinctively separated from the previous ones can be recognised as new. Nevertheless, given the present situation where many want to attribute everything mental to as few simple qualities as possible, it is better to accept a few, soon to be categorised phenomena too many, than to revert to the shallowness of psychological constructs based on a few elements.

While the ideal of phenomenology is a *clearly structured infinity of irreducible mental qualities*, the other ideal is that of *as few ultimate elements as possible*, such as in chemistry. All more complex mental phenomena should be deduced from their combinations, and every mental phenomenon should be represented sufficiently by analysing such elements. Finally, it can appear consistent with such a view to come down to a single ultimate mental atom, upon which everything mental is based in various combinations. This science-oriented ideal certainly incorporates a sense for the *genesis* of mental qualities. As the origin of the infinitely varied colours can be attributed to oscillations that differ merely quantitatively, one may wish to explain other mental qualities from their genesis and then perhaps order them differently according to this perspective. However, as regards phenomenology, such a demand appears quite meaningless. The aim of phenomenological analysis is to become aware of the mental phenomena through clear delimitation. *Among other things,* this can be achieved by demonstrating mental qualities that occur as a part of what has been previously mentioned. This breakdown of complex forms into such parts, which is *only one* way, is regarded as the *only* analysis from a point of view, which only seeks to account for the genesis. From this viewpoint, for instance,

perception would be explained by breaking it down into elements of feeling, spatial dimensions and intentional acts. In contrast, true phenomenology only arrives at a characterisation of perception as an irreducible mental quality by comparing the imagination with the assessment, which are both built of the same elements. Although the view of 'analysis *into ultimate elements*', just like the view of "analysis as the delimitation of ultimate qualities" at times succeeds in presenting itself as free from aspects of genesis and as purely phenomenological, it gets confounded again with developmental considerations at every opportunity. Thus, the complex forms *arise* again from the combined elements.

In contrast to these views, phenomenology does not even share the ideal of as few ultimate elements as possible. On the contrary, it does not intend to limit the infinity of mental phenomena but to make them, as far as possible – and that is naturally an infinite task – *clear*, obviously *conscious* and *recognisable* in their details.

We have pointed out, even though along very general lines, the aim and method of phenomenology, which was always practised, but never really flourished. As its mingling with other research tasks was always its main defect, we will once again list briefly what phenomenology does not aim at and what it must not be confused with.

Phenomenology deals only with what is really experienced and concrete, *not* with something *thought to underlie* mental life, i.e. *theoretical constructs*. In all its discoveries, it must ask itself: is this actually experienced? Also, is this really present in the consciousness? Its identifications derive their certainty from the fact that the visualisation of mental reality succeeds time and again. They can only be refuted by correctly visualising the hitherto incorrectly visualised facts and not by demonstrating their impossibility or difference with respect to some theorems. Phenomenology gains nothing from theory but only loses. The correctness of the individual visualisation cannot be verified according to general criteria. It must always provide its own benchmark.

Phenomenology deals with the truly experienced. It looks at the mental 'from within' by using immediate visualisation. It therefore does *not investigate externally emerging phenomena*, the motor phe-

nomena, the expressive movements as such, in short, any objective performance. The extent to which expressive movements and self-descriptions are not object but means of phenomenology has been explained above.

Phenomenology, in addition, is *not concerned* with the *genesis* of mental phenomena. It is only a precondition for such developmental investigation, leaving it quite aside and can neither be disproved nor advanced by it. Investigations like that of the origin of colours, perception etc. is foreign to phenomenology. Such actual developmental investigations have been far less dangerous to it than the 'brain mythologies', which interpreted and replaced phenomenology by constructs of physiological and pathological brain processes. Wernicke, distorted his important phenomenological discoveries with interpretations of association fibres, disconnections etc. These constructs tend not to allow complete phenomenological investigations. Out of necessity, they have to practise phenomenology at the beginning but when they eventually meet their theory, they feel that they are on secure ground and condemn all phenomenological aspects as 'subjective' in a strange misjudgement of their own sources.

Finally, phenomenological consideration must also be *separated from understanding the genesis of mental processes*, this unique understanding that is applicable only to the mental, for which the mental evidently 'emerges' from the mental, for which, as a matter of course, the attacked person becomes angry and the deceived lover becomes jealous. Both, phenomenological visualisation and the comprehension of the genesis of its elements are synonymous to understanding. To avoid confusion, we call the phenomenological understanding of mental states *static understanding.* This comprehends only the situations, experiences and modes of consciousness and is the basis of phenomenological delimitation and characterisation. In contrast, *understanding of the genesis* refers to the understanding of the associations of mental experiences, the development of the mental from the mental. Now, although phenomenology has nothing to do with understanding the genesis and rather has to be treated completely separately from this, its object may still be the *regular consequences* of the mental. These are experienced in reality and together with

it form a unique phenomenological entity. Perhaps the experience of the will is an example of this. This *phenomenological consequence* is something quite different from an *understanding of its constituent element*s. We limit phenomenology to what can be understood from a static viewpoint.

It is self-evident that, when we look at psychopathology as a whole, we find our actual interest in understandable aspects of genesis, in unconscious inter-dependencies, in the establishment of the physical causes of mental processes, in short, in the *interrelations*. Phenomenology only teaches us to recognise the form in which all experience, everything mentally real, manifests itself. It does not teach us to know the contents of the individual experience or the unconscious foundations on which the mental floats like foam on the surf. It will always be more tempting to penetrate the depths of this unconscious because of the recognised associations than merely making phenomenological discoveries, though completing them conscientiously is the precondition for all further investigations. Only in these phenomenological forms does the actual mental life that is accessible to our immediate comprehension take place. Ultimately, we investigate all the unconscious associations only in order to understand this mental life.

To conclude, let us denote briefly some *individual tasks* of phenomenology. There is no complete area of psychopathological phenomenology at all. Even if a phenomenon is clearly apparent, as in some kinds of hallucinations, good case histories, which can serve as proof of experience, are so rare that carefully described cases are still of great value. There is still much to do regarding the types of hallucinations, which can be successfully investigated, particularly with respect to the higher senses. One only needs to think of perceptions of face-illusions in objective space appearing together with real perceptions. The phenomenology of delusional experiences has hardly been addressed. Everything beyond is part of the work about feelings as the first symptom of paranoia. The phenomenology of pathological emotions is incredibly poor. The very best is to be found in Janet's outstanding articles, though careful delimitation and systematics are barely emphasised. The self-consciousness has been investigated systematically in Austria. In order to address

these problems, phenomenological descriptions by psychiatrists, who have the material in their hands, and self-descriptions that are more detailed than previous ones would be of the greatest value.

Histology demands an account of every given fibre, every grain when examining the cerebral cortex. In a quite similar way, phenomenology demands that *every mental phenomenon, every experience, that comes to light during the exploration of patients and in their self-descriptions, must be accounted for.* One should never be satisfied with an overall impression and a few ad hoc selected details but should know how each detail is to be comprehended and interpreted. Acting in this way for some time, allows on the one hand, for some things to become less strange after being seen often. These are the things, which the person who works only with an overall impression has not been aware of and finds astonishing and quite unprecedented according to his momentary receptiveness. On the other hand, however, one pays attention to what was formerly really unknown and becomes justifiably astonished. There is no danger that this astonishment will ever cease.

It is self-evident that many psychiatrists already proceed in this way and would correctly perceive it as a presumption if this were to be announced as something new. However, the phenomenological view is far from being so widespread as not to need continuous promotion. It may be hoped that a valuable enrichment of our knowledge of what patients truly experience will grow from it.

Causal and 'Understandable' Relationships between Events and Psychosis in Dementia praecox (Schizophrenia)*

Understandable relationships are something entirely different from *causal* relationships. For example, we *understand* an action from motives; we *explain* a movement causally by nerve stimuli. We *understand* how moods result from affects and certain hopes, fantasies and fears arise from moods; we *explain* the emergence and disappearance of memory dispositions, tiredness and recuperation, etc. The understanding of one psychic aspect through another psychic aspect is also known as *psychological explanation* and scientific researchers who are only concerned with what is accessible to the senses and with causal explanations express a comprehensible and justified aversion to psychological explanation if it should *replace* their work anywhere. The understandable relationships of the psychic have also been termed *internal causality* to indicate the unbridgeable chasm that exists between these relationships, which can only be referred to as causal in allegorical terms and the genuine causal relationships, *external causality*.

Understanding and *causal explanatory analysis* in human research are intertwined in a very complicated way, but one that on closer methodological examination is fairly straightforward and clear. In this article, we have not set ourselves the task of analysing these relationships in detail. Instead, we wish to attempt to tease out

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*Reference: K. Jaspers. "Kausale und 'verständliche' Zusammenhänge zwischen Schicksal und Psychose bei der Dementia praecox (Schizophrenie)". In: *Zur Psychopathologie, Gesammelte Schriften.* Springer Verlag, Berlin, 1963; 329–412. First published in: *Zeitschrift für die gesamte Neurologie und Psychiatrie.* 1913; 14: 391–408.

causal and *understandable* relationships on the basis of *concrete* cases. Whether and to what extent our insight is fostered by understanding, by what is known as psychological explanation, can only be demonstrated by the provision of concrete material. Our intention is to augment this material. However, we cannot avoid establishing, first of all in a very brief introduction, the methodological relationships of this line of research and, at the same time, associating the terms used with fixed concepts.[1]

Methodological overview

It is not our intention with our proposals here to win over researchers who follow totally different paths. Our aim is simply to make those who pursue similar aims to ourselves provisionally aware of the methodological preconditions under which we are working. In this sense, we ask for an understanding of the apodictic form, without which we could not achieve the necessary brevity.

1. *External and internal sense.* We compare – but it is *only* a comparison – the existence of the external world perceived through our sensory organs with the existence of the internal world that is not perceived in sensory terms. We can perceive in concrete terms and describe plants, animals and all other objects individually; we can also introduce *relationships* into the sensory facts through explanations, through causal thinking. Likewise, we can visualise and describe mental *states*, mental facts, experiences, modes of consciousness as such (e.g. concepts, thoughts, feelings, pseudohallucinations, delusional ideas, drives, etc.). Secondly, we can understand psychological *relationships*, understand how one psychic aspect arises from another, how actions stem from motives, how moods and aspects arise from situations and experiences. *Sensory perception* contrasts with *visualisation of the psychic*, *causal explanation* with *psychological understanding.* As both forms of acquainting ourselves with the psychic are designated 'understanding', we distinguish the under-

1. Particularly remarkable in the literature are Simmel, Probleme der Geschichtsphilosophie, chapter I, and Max Weber, Roscher and Knies et al. in Schmollers Jahrbüchern. 1903–1906; vol. 27, 29, 30.

standing of states as a *static* understanding from the understanding of relationships as a *genetic* understanding. Visualising, defining, describing and ordering mental states is the task of *phenomenology*[2]; comprehending psychological relationships convincingly is the entirely different task of the *understanding or empathetic psychology*.

2. *Genetic understanding*. The understanding of how one psychic aspect arises from another is very varied in its nature. The first important distinction was drawn by Simmel, who distinguished between the understanding of the *spoken* and the understanding of the *speaker*. If the contents of thoughts arise clearly from one another according to the rules of logic, then we understand these relationships *rationally*. If, however, we understand thought contents as having arisen from the moods, wishes and fears of the thinker, then we actually understand the relationships *psychologically* or *empathetically* first of all. While *rational understanding* will lead to the statement that a rational complex which was entirely comprehensible without any psychology was the content of a psyche, *empathetic understanding* leads us into psychological relationships themselves. Whereas rational understanding is only an *aid* to psychology, sympathetic understanding is *psychology itself*.

3. *Empathetic psychology and performance-oriented psychology*. Empathetic psychology has totally different tasks from performance-oriented psychology which developed out of physiology. The two do not impinge on one another and neither has the right to criticise the other since both pursue entirely different aims. Performance-oriented psychology, which can only achieve useable results experimentally, involves the test subjects being given *tasks* whose solutions are *measured* against various benchmarks. The dependence of the performances on different factors is studied systematically by changing the conditions and consequently the complex performance is slowly broken down into more elementary performances; causes for its origin are discovered and theories of causal links established. Studies on memory, perception, scope of consciousness, capacity for

2. Phenomenology was developed by Husserl (Logische Untersuchungen, 2nd vol.). For our purposes, cf. my paper on the phenomenological research approach in psychopathology, see p. 314.

work, etc., all proceed in principle in the same way and, over the course of the decades, have created the valuable structure of physiological psychology, which has only been undervalued by humanistic researchers who wrongly considered empathetic psychology to be the only form.[3] Performance-oriented psychology does *not* want to understand *anything*; it does not in any way delve into the psyche, but in principle it treats the entire psychophysical mechanism as a soulless life form whose functions are examined. As *objective psychology* (as opposed to empathetic psychology and phenomenology as *subjective psychology*), it can produce extraordinarily precise results. By its nature, however, it can *never* give a response to phenomenological questions and to questions of empathetic psychology. Just as it is wrong for many humanists to despise performance-oriented psychology *in itself*, so it is equally wrong for scientifically oriented scientists who accept only sensory-related experiences, experiments and statistics to despise empathetic psychology. These approaches to research pursue entirely different aims. The mistake first arises when they *replace* one another and mistakenly want to *transpose* something from one field to the other.

4. *The evidence of genetic understanding and its origin.* When Nietzsche made it convincingly understandable to us how moral principles, moral demands and redemptive religion arise from the awareness of weakness, poverty and suffering because the soul uses this detour to satisfy its desire for power in spite of its weakness, so we experience direct evidence which we cannot trace back further and which we cannot base on different evidence. All empathetic psychology is built on such evidential experiences of totally impersonal, detached, understandable relationships. Such evidence is obtained *on the occasion of* experience of human personalities, but not *proven by the method of induction based on* repeated experience. Its force of conviction lies *in itself*. The recognition of this evidence is the precondition for empathetic psychology, just as the recognition of perceptual

3. Experimental psychology adopted a completely new direction beyond performance-oriented psychology with Külpe's school in that experiments with planned self-observation promote phenomenology. Performance-oriented psychology requires experiments. But not *all* experiments serve only performance-oriented psychology, even though most do.

reality and causality is the precondition for natural sciences. The question as to the *psychological genesis* of this evidence lies outside the methodology of this article, just as the genesis of perception or evidence in the conviction that there is a causal relationship lies outside the study of the preconditions of science. The question of the genesis of evident understanding is tackled in the psychology of empathy. This, therefore, is of no interest to us in a methodological context. We should, however, like to point out that the opinion that evident understanding can be *based* on repeated experience and is not something final is equally false and equally to be refuted as the opinion that the evidence of the causal principle can be *derived from* experience. This opinion is wrong even when the psychological genesis of evidence points to repeated experience.

5. *Evidence of understanding and reality, understanding and interpretation.* When Nietzsche transposes the convincingly understandable relationship between consciousness of weakness and morality to the actual individual process of the emergence of Christianity, this transposition to the *individual case* can be wrong despite the correctness of the general (*ideal typical*) understanding of that relationship. The judgement of the *reality* of an understandable relationship in an individual case is based *not only* on its evidence, but above all on the *objective material of sensory, tangible reference points* (verbal content, intellectual creations of all kinds, actions, lifestyle, expressive gestures) which are understood individually, but always remain to some extent incomplete. All understanding of individual *actual* processes, therefore, remains to a greater or lesser extent an *interpretation,* which only in rare cases can achieve a relatively high degree of completeness. The relationships are most clearly apparent by comparing how *causal rules* and the *evidently understandable relationships* relate to reality. Causal rules are precisely *rules*, are obtained via the process of *induction* and culminate in theories which reflect something underlying the directly experienced reality. A case is *subsumed* in them. Genetically understandable relationships are *ideal typical*[4]

4. On the concept of the ideal type, cf. Max Weber: Die 'Objektivität' sozialwissenschaftlicher und sozialpolitischer Erkenntnis. Archiv. f. Sozialw. 1904; vol. 19.

relationships, are *evident in themselves* (not empirically obtained), *do not lead to theories*, but are a *benchmark* against which individual actual processes are measured and are recognised as being *more or less understandable*. Understandable relationships wrongly appear as rules when the *frequency* of occurrence of the understandable relationship is established. Its evidence is not, however, in any way increased as a result; it is not the relationship itself, but its frequency that is found empirically. For example, the frequency of the understandable relationship between the price of bread and theft is stated. The frequency of the understandable relationship between autumn weather and suicide is not confirmed at all by the curve of suicides, which reaches its peak during spring, but the understandable relationship is *not* thereby *incorrect*. *One* actual case can become the occasion for us to grasp an understandable relationship; its frequency then adds nothing in terms of increasing the evidence once it is obtained. Its observation serves different purposes. In principle, it is entirely conceivable that a poet, for example, should convincingly present understandable relationships that have never occurred. They are *unreal*, but possess *general evidence in the ideal typical sense*.

6. *Limits of understanding, limitlessness of explanation*. The obvious idea that the psychic is the area of understanding and the physical the area of causal explanation is wrong. There is *no* real process, whether physical or psychic, which is not in principle accessible to causal explanation; psychic processes *also* can be subjected to causal explanation. This causal explanation, for example, has already started to work successfully in the psychophysiological investigations of the occurrence of sensory perception, in the discoveries of the dependence of speech function on certain brain centres, etc. A *consequence* of psychic states, each of which in themselves must naturally be understood phenomenologically (statically), can in principle also be explained causally. It is not absurd to assume that the succession of understandably related thought processes could be explained causally according to certain rules *without* considering the understandable relationship. In this case, the comprehensibility of the relationship of those psychic processes would be just as immaterial and arbitrary for the causal explanation as the incomprehensibility in another case. It is, therefore, in principle not absurd both

to understand and to explain *the same* real psychic process. It is simply that the two relationships observed are of entirely different origin and of an entirely different sort of validity. They do not help one another mutually in the slightest. The explanation does not make the relationship any more understandable; understanding does not explain it any more. Each of them, understanding as well as explaining, means something new to the other.[5] In fact, there is in any case no known process which could be both understood and explained in this sense. The discovery of such a process is an infinite problem. The fact that in almost all psychological studies understanding and explanation go together is something quite different. This *combination* of methods is essential for psychology, but in no case provide understanding and explanation different angles on *the same* real part of the complex mental process.

Whereas, in principle, with causal explanation we are not confronted anywhere with limits, but continue to expand into infinity in all directions; in the case of understanding we come up against *limits* all the time. The existence of mental predispositions, the rules governing the acquisition and loss of memory dispositions, the sequence of mental constitutions in growth and age, and everything else that we can summarise as the foundation of the psychic is a limit to our understanding. In mythological times, man believed he saw Thor in thunder and lightning. There were researchers who still believed that *everything* psychic was understandable. We now know that only *certain aspects of the psychic* are accessible to our understanding. We will meet with the question of where those limits lie in the problem 'Understanding and unconscious', after the types of causal explanation in psychology have been briefly characterised.

7. *Types of causal explanation in psychology*. Causal investigation uses the inductive method to seek for relationship rules. In the primitive form, *mere rules* are established whereby one process is viewed as a cause and the other as an effect, e.g. a mood as the consequence of alcohol intake. In the completed form, causal *equations* are found on the basis of prevailing theories (e.g. the atomic theory in chemistry). In psychology, only the first step is involved. We possess *no prevail-*

5. These things are convincingly explained by Max Weber, loc. cit.

ing theory here, but use a wide variety of things as elements of causal thinking whether we view them as cause or effect. These elements are constructed given the relevant research *possibilities* according to the relevant research *aim*. The *types of causal thinking* in psychology change according to the *nature of these elements*. In order to help construct elements of causal explanations, the concepts within the domain of phenomenology and empathetic psychology become again relevant to the domain of causal thinking. Phenomenological units, e.g. a hallucination, a form of perception, are explained by physical processes, complicated understandable relationships are seen as a unit – for example, a manic symptom complex with all its content – which prove to be the effect of a cerebral process or the incomprehensible effect of an emotional upset, such as the death of a close person. Even the infinite set of understandable relationships which together make up what is called the personality can in a causal context be viewed as a unit (an element) and its causal genesis can, for example, be examined using the rules of genetics. With such *causal* investigations, we must always *think of something extraconscious underlying* the phenomenological units or the understandable relationship and must, therefore, use concepts of *extraconscious dispositions, predispositions, psychic constitutions and extraconscious mechanisms*. These concepts, however, *cannot* be developed in psychology to all-pervading theories but are only used for the investigational purposes concerned, insofar as they prove usable.

8. *Understanding and unconscious*. It is in the nature of all *causal* investigation that it delves into the *extraconscious* bases of the psychic. It appears initially that all phenomenology and all empathetic psychology remains *in the consciousness*. This contrast does indeed persist. However, for phenomenology and empathetic psychology, it is never absolutely clear where the *frontiers of consciousness* lie. Both continue to gain further ground. Phenomenology describes previously entirely *unnoticed* forms of psychic existence and empathetic psychology comprehends previously *unnoticed* psychic relationships, as when it comprehends certain moral perspectives as reactions to the awareness of weakness, impotence and poverty. Thus, each psychologist experiences in himself the fact that his psychic life is becoming increasingly elucidated, that what was unnoticed is

becoming known to him and that he never knows with certainty whether he has reached the final frontier.

It is entirely wrong for *this* unconscious, which phenomenology and empathetic psychology allow to become *known* when before it was *unnoticed*, to be lumped together with the genuine unconscious, with what in principle is *extraconscious* and never noticeable. The unconscious in the sense of unnoticed is actually experienced. The unconscious in the sense of extraconscious is not actually experienced. We are right to refer also to the unconscious in the former sense usually as *unnoticed* and the unconscious in the latter sense as *extraconscious*.[6]

It has always been the task of all psychology to raise the unnoticed into the consciousness. The evidence of such insights was always confirmed by the fact that everyone else was also able to notice more or less the same thing when actually experienced under favourable conditions. Now, there is a series of facts that we *cannot* understand from retrospectively noticed, *actually experienced* processes, but which we still think we understand. For example, Charcot and Möbius highlighted and as a result understood the association of the spread of hysterical sensory and motor disorders with the crude physiological and anatomical concepts of the patient concerned. However, such a concept could not actually be demonstrated as a starting point for the disorder – apart from the case of suggestion – but the disorder was understood *as if* it were occasioned by a conscious process. Whether in such cases, this description of the genesis is correct even if the unnoticed but actual psychic processes have not been elucidated or whether it is simply an apposite *characteristic* of certain symptoms through a *fiction*, remains uncertain. Freud, who has described such '*as-if understood*' phenomena in large numbers, compares his activity with that of an archaeologist who interprets human intellectual activity from a series of fragments from past ages. The main difference is simply that the archaeologist interprets what was once *actually* there, whereas in the case of the '*as-if understanding*' the actual existence of the object of understanding remains unclear.

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6. cf. Hellpach: Unbewußtes oder Wechselwirkung, in Zeitschr. f. Psychologie.

Thus, major possibilities for expansion are open to the empathetic psychology in that it raises the *unnoticed* to consciousness. Whether, however, it can also penetrate the *extraconscious* by an 'as-if understanding' must remain doubtful. Whether the *fiction* of the 'as-if understanding' proves usable for characterising certain phenomena is a question that cannot be decided generally, but only in individual cases.

9. *The tasks of empathetic psychology*. The formulation of the everyday understandable relationships known to everyone in common speech results in trivialities. The tasks of empathetic psychology are to extend understanding beyond the known into the *unnoticed* and also to extend it to *totally unusual* relationships (e.g. perverse sexual drives together with their relationships to other instinctual impulses) and finally to tease out the *understandable relationships from psychotic states* that initially appear simply to be confused. The material of this article will serve this last task.

10. *Understanding and judging*. It is a fact that we assess all genetically understandable relationships as positive or negative *in themselves*, whereas we assess everything incomprehensible, if at all, only as a *means* to something else. Thus, we view the emergence of moral demands from resentment *in itself* disparagingly and thus we value memory *only* as a tool. In the science of psychology, however, we must refrain very strictly from *all* such *value judgements*. We must simply record and identify understandable relationships as such. Obviously, sometimes it may be the case that we *appear* to judge when we recognise an understandable relationship in a specific case. This appearance occurs because the understandable relationship in itself is *immediately* judged negatively or positively by *everyone*. We cannot escape this *appearance* in any way. Moreover, correct value judgements *are based* on correct understanding and as a correct understanding is rare and is, therefore, difficult – in fact only with a particular predisposition and a conscious cognitive development is there a certain guarantee of aptness – any assessment by others is mostly false and dependent on chance and extra-experiential sources. As everyone wants to be viewed favourably, people mostly find themselves *correctly* understood if the outcome is a favourable assessment. For this reason the word 'understanding' in everyday

speech is frequently used synonymously with 'assessing favourably', with the consequence that people who are viewed negatively, particularly in situations where their negative value is clearly apparent, find their understanding so very especially difficult and themselves always misunderstood.

11. *The previous achievements of empathetic psychology*. In any analysis of an *individual* personality or a specific action, something can be achieved for empathetic psychology. What is achieved with the discovery of *general,* understandable relationships, rather than with such individual analyses, has never come about in a planned, systematic way, but in the form of essays, reflections and aphorisms. And what is acquired here for empathetic psychology is almost always riddled with judgements and with 'worldly wisdom'. The unique value of these achievements nevertheless remains: understandable relationships have only ever been discovered innovatively and convincingly through the intuition of unusual people. Most of our conscious knowledge of understandable human psychic life flows directly from them or indirectly through the mediation of secondary sources. Following certain predecessors in antiquity (Theophrastus's *Characters*), the Frenchmen Montaigne, Labruyère, Larochefoucauld, Vauvenargues and Chamfort are particularly pre-eminent. Totally unique and the greatest of all understanding psychologists is Nietzsche (particularly *Human, All Too Human; The Dawn; The Gay Science; On The Genealogy of Morals*).

Empathetic psychology has always been practised within psychiatry. On the one hand, it was much too widely applied in the earlier teachings of the 'psychological causes' of mental diseases and on the other hand – particularly in more recent times with the decline in the general level of humanistic training – it has been extended and simplified and finally the desire emerged to eliminate it entirely. It has almost always possessed a certain standing in France. Janet, in our times, is its most pre-eminent researcher. In Germany, empathetic psychology has been revived in psychiatry with the teaching of reactive psychoses (Bonhoeffer, Wilmanns, Birnbaum and others), which were studied particularly in the abnormal states of detention and imprisonment. It has also slowly developed in the teaching of *psychopathic personalities* (hysterical characters, etc.).

Overall, however, it has remained a poor relation.

At the same time as these endeavours in psychiatry, Freudian psychological teaching has developed as a certain reaction to earlier extremely somatic lines of research. Through the number of pupils and the quantity of publications, the school has had an unrivalled success. Not only because of this success, but particularly because of the extraordinarily interesting content of these teachings, no psychopathologist can avoid taking a view. Unfortunately it is the case at present that the majority are either *Freudians* or *anti-Freudians*. Instead of a critical examination of the details and the adoption of what is convincing, one side abandons itself unconditionally to the teachings, while the other rejects everything wholesale. Of the outstanding researchers who have associated themselves with substantial parts of Freudian teaching, Bleuler is one of the few to adopt a critical approach.[7] We also attempt to contribute to and to accept those aspects which we find convincing and to adopt a critical approach, which we outline here briefly on the basis of the previous methodological remarks:

a) Freud's psychology is, in fact, a form of *empathetic psychology* which does not provide causal explanations, contrary to what Freud believes. Causal explanations play a role in that the physical bases of a understandable relationship *in its entirety* are viewed as the cause of, for example, a paralysis of an arm, clouding of consciousness, etc.

b) Freud convincingly introduces us to many *individual,* understandable relationships. We understand how complexes suppressed into the unnoticed reappear in symbols. We understand the reaction formations to suppressed drives, the distinction between the primary, genuine psychological processes and the secondary processes present only as symbols or sublimations. Freud to some extent

7. Bleuler's Schizophrenie (Wien 1911), to which we will return in greater detail later in this article, is a psychiatric book on psychoses in the strict sense of the term. This is, at last, a book which makes use of empathetic psychology to analyse these psychoses. It is full of excellent remarks. Rich in superb details, as a whole, its drawbacks lie in the lack of methodological clarification, excessively numerous repetitions and false, or, at least, very disputable, excessively dogmatic, general psychological and philosophical views.

elaborates Nietzsche's teachings in detail. He delves far into the unnoticed inner life, which he raises to consciousness.

c) The fallacy of the Freudian demand that *everything* in the inner life, that *each* process, should be *understandable* (meaningfully determined) is based on the confusion of understandable relationships and causal relationships. Only the claim of unlimited causality, not the claim of unlimited understandability, rightly exists. There is another error associated with this one. Freud establishes *theories* on the causes of the whole psychological process out of *understandable* relationships, whereas understanding by its nature can *never* result in theories and causal explanations must *always* result in theories (the conjectured *interpretation* of an individual psychological process – and there can only be *individual* interpretations of this kind – is naturally *not* a theory).

d) In many cases with Freud, there is not an understanding and a raising into consciousness of *unnoticed* relationships, but an '*as-if understanding*' of *extraconscious* relationships. When one realises that in acute psychoses, the psychiatrist on initial examination observes nothing other than confusion, disorientation, defective performance or meaningless delusional ideas, it must, therefore, appear a step forward if it is possible by using 'as-if-understandable' relationships to provide a provisional characterisation and order in this chaos (for example, the delusional content of dementia praecox). Earlier a similar advance was achieved when the pattern of distribution of the hysterical sensory and motor disorders was characterised by referring to the understandable relationship with the crude anatomical concepts of the patients. In particular, Janet's investigations show that there actually are *splits* of psychological relationships in hysteria. In extreme cases there may, in fact, be two minds in the same individual which know nothing of one other. In such true splits, the '*as-if* understanding' has a *real* meaning. How far such splits occur (Janetian cases are very rare) and whether a split actually exists in dementia praecox as well (as for example Jung and Bleuler teach) is a question that cannot be answered conclusively. It would be as well to suspend one's final judgement here. Freudian researchers are, in any case, very incautious in their rapid assumption of splits and the 'as-if understandable' relationships which Jung, for example,

believed he had discovered in dementia praecox are to a large extent unconvincing.

e) An error in Freud's teachings lies in the *increasing simplicity* of his understanding, which is associated with the transformation of understandable relationships into *theory*. Theories impose *simplicity;* understanding finds infinite *variety*. Freud now believes almost *everything* psychological can be attributed understandably to sexuality in a broad sense, as it were the only primary force. Writings by many of his pupils, in particular, are unbearably tedious because of this simplicity. One always knows in advance that the same thing will be found in each article. Empathetic psychology is not making any more progress here.

Our remarks on methodology are not intended *to prove* anything, but rather *to define* our approach and the terminology which we will use below. We have set ourselves the particular task in this article of looking for understandable relationships between events and certain acute psychoses, the specific features of which among reactive psychoses we should like to define. In order to facilitate this task for us, we still require a second precondition, a terminological clarification of the concept of reactive psychoses.

The concept of reactive psychoses

Möbius separated the *exogenous* psychoses, which are determined conclusively by an external cause (e.g. syphilis, excessive alcohol consumption, etc.), from the *endogenous* psychoses, which arise predominantly from an inner disposition. *Among* endogenous psychoses, we share with Hellpach[8] the division into the *reactive* and the *productive* abnormality. In the first case, an unchanged abnormal constitution reacts abnormally to external stimuli before reverting to its previous state, while in the latter a process occurs without external stimuli that increasingly alters the mental constitution.

The concepts of exogenous, endogenous, reaction and process for a long time served to define so-called disease entities. In our time, there is an increasingly widely held view that a definition of

8. Grundlinien einer Psychologie der Hysterie. 1904: 71 et sqq.

disease 'entities' is *only* possible in terms of cerebral anatomy or through other somatic examination methods, whereas a sharp clinical differentiation and definition of disease entities is doomed to permanent failure. The concepts obtained are not for that reason in any way worthless, their utility is simply transferred out of special psychiatry into general psychopathology. Thus, the concept of reaction also appears to us to undergo a transformation such that, from a concept of a group of degenerative diseases, it becomes a general psychopathological concept for abnormal mental states that occur in all, or at least in very many and in fact very varied, psychoses. In this sense, the concept of reaction needs to be both restricted and extended.

A *restriction* of the concept appears to us necessary in the following way. When a person developed completely curable abnormal mental states as a result of menstruation, physical tiredness, hunger, imprisonment, homesickness or the death of someone close, these were referred to in all cases as reactive psychoses. According to our differentiation of *causal* and *understandable* relationships, we will draw here a deep distinction between menstruation, tiredness and hunger on the one hand and homesickness and death on the other, while imprisonment possesses something of both aspects, although more of the latter. In the first cases, things that are entirely extraconscious and physical act on the mental disposition. They alter the mental disposition in unknown ways and as a result abnormal mental phenomena of a subjective and objective nature appear. There is *only* a *causal* link between cause and effect. In the latter cases (homesickness, death), the extraconscious basis of the emotional upset is the cause of a change in the mental disposition (in a wide variety of ways: increased irritability, change of consciousness, tendency to certain sets of feelings, etc.). This is a causal link, but one in which both extraconscious aspects are only imagined and hypothetical. However, *in addition to this,* there is an *understandable* link: we understand the emotional upset from the situation and we usually understand to a considerable extent the form or content of the psychosis or both from the emotional upset. How we understand here, we will shortly see. Initially, we confine the concept of *reactive psychosis* (the terminology naturally, as ever, is arbitrary) to

the abnormal psychological changes that occur in response to an *experience*. The *significance* which the processes have for the psyche, their *experience value*, the *emotional upset* which is understandably associated with them – and not certain physical effects – justify designating a resultant abnormal state as a reactive psychosis. In prison, for example, the causes of a psychological reaction are the awareness of the significance of this process and the possible consequences, together with the atmosphere of the situation, the loneliness, the darkness, the cold walls, and finally and above all the tense uncertainty of what is going happen. In addition, however, the limited food consumption as a result of a lack of appetite and poor eating, the exhaustion due to sleeplessness, etc., have a purely physical effect on the resultant mental disposition. Both sets of causes perhaps combine to bring about the picture of prison psychosis.

An *extension* of the concept of reactive psychosis is irrefutable in the following sense: this concept includes *all* abnormal mental states that occur in response to an *experience* and in direct relationship to it, *reversibly* and in such a way that the *contents* of the new state have an understandable relationship to the experience. Whether such a reactive psychosis occurs in a psychopath, a schizophrenic or a patient with an organic disease is immaterial. The *types* of reactive psychoses, however, will be very different.

After crudely defining the concept of reactive psychosis, we must now consider *how causal and understandable relationships are associated in this concept* so that we can talk about it again subsequently in an abbreviated form without causing problems.

To assume that some mental process, some understandable relationship is *real* implies the intact functioning of an extraconscious mechanisms which has to be conceptualised as something that is extraordinarily complicated, but almost always entirely unknown. We have learnt to see that *causality* is infinite and that, in relation to the causal relationships, the *understandable* relationships provide an *extra* for certain aspects of nature which, however, should never displace causal thinking. Furthermore, we observe that in *causal* psychological thinking, the additionally conceived extraconscious bases of mental states and understandable experienced relationships also appear as elements in a causal chain.

Now, in a large number of cases of reactive behaviour, we do not think at all of causal relationships between the extraconscious bases. We are content to put ourselves into somebody's elses position and thereby recognise the understandable relationships, for example, between misfortune and the corresponding depression. This is because we never know anything directly about those extraconscious causal relationships (or mechanisms) and in those cases in which the whole individual *mental disposition remains more or less the same* during the reactive behaviour, we have no reason to think of them if we do not specifically want to think about the extraconscious (e.g. physical) bases of human *type* differences that are to be postulated. It is different in all *those* cases of reactive behaviour in which a change of consciousness, a hysterical delusion, a hallucinatory paranoid state, etc., occurs in response to an emotional upset. In these cases, the extraconscious basis of the emotional upset has caused a temporary *complete change in the whole mental disposition* and in the extraconscious mental mechanisms in which the psychotic understandable relationships now have their abnormal bases. The first case involves differences of degree from our own reaction, the latter the occurrence of new – abnormal – extraconscious mechanisms.

In the one case, we are not at all inclined to abandon empathetic psychology; in the other, causal thinking is necessarily involved as well. Nevertheless, there are transitional stages between the two cases, which we ignore when we endeavour to provide an explanation in principle. The *variability* of human reactive behaviour lies, in the first case, in the *variability of understandable relationships* (the occurrence of which we attribute to the individual character disposition).[9] In the second case, it lies both in this variability of understandable relationships and also in the *development of very different altered mental dispositions* with their new mechanisms as

9. "Each sex, each class, each individual acquires their spiritual wounds on the battlefield that nature and external circumstances have allocated them and each has another point at which they are most vulnerable, another sphere from which violent upsets most readily arise: in one case their money, in the other their external appreciation, in the third their feelings, their beliefs, their knowledge, their family." (Griesinger: Psychische Krankheiten. 1876; 4th edition: 170.)

a result of the emotional upset (the occurrence of this type of pathological reactions we attribute either to a congenital abnormal mental constitution or to an abnormal constitution that has developed for the first time as the result of a process). Thus, totally different, altered mental dispositions are seen in the paralysis of all emotional impulses, in a clouding of consciousness, in a considered hallucinatory paranoid state, in Ganser's twilight state, in stupor, etc. All these conditions can be the expression of the new mental disposition produced by the emotional upset. We must consider this new disposition to have been engendered just as *causally* by the *extraconscious* basis of the mental upset as the objectively observable *physical* changes in emotional upsets, such as vasomotor, motor and secretory changes. We describe the mental states that emerge in the new disposition produced by the upset as reactive if any obvious understandable relationships are observable between the new state and the experience.

We must, however, principally distinguish from the *reactive* psychoses those psychoses that are merely *induced* by an emotional upset. Thus, death for example induces a catatonic process or mania or a periodic depression. The emotional upset is only the last and possibly dispensable trigger, as a result of which a disease develops which would ultimately have occurred even without this cause and which now proceeds according to its own laws in total independence of the psychological cause. Psychologically there is the difference that *reactive* psychoses only occur in response to an *unpleasurable* experience, whereas a *pleasurable* experience – albeit very rarely – can be the occasion for the outbreak of a disease state caused in some other way as a result of the associated disturbance of equilibrium. Thus, psychasthenics complain about an increase in their symptoms after very enjoyable experience, about the 'backlash' that occurs. Such symptoms then have nothing to do with the content of the experience. Psychoses that are purely induced are of the same nature as those that occur spontaneously, whether they are processes or temporary phases. In *spontaneous* psychoses, a primary growth of the disease is observed which can only be explained physically, without relation to the personal destiny and experience of the patient and with an arbitrary content. In curable phases, there is the tendency

afterwards to recognise the disease clearly and to view it from the outside as something entirely foreign. In *reactive* psychoses, either an *immediate* reaction to a decisive experience is observed or, as it were, a discharge following a *prolonged* period of unnoticed maturation with an understandable relationship to events and daily recurring impressions. After the psychosis has run its course, there is the ability to state unreservedly in a *critical assessment* that the psychosis was pathological. There is, however, also the tendency for the psychotic contents that have grown out of the events to continue to exert an effect on the subsequent life and hence an inability to distance themselves emotionally and instinctively from the pathological contents despite having adopted a correct *intellectual* attitude.

In addition to the spontaneous and induced psychoses, we must distinguish from the genuine *reactive* psychoses those abnormal states produced *purely causally* by emotional upset *without* there being an understandable relationship, such as the vasomotor neurasthenic symptom complexes with anxiety states, etc., following catastrophes. These distinctions are *in principle* all very simple. In reality, however, these cases consistently represent transitions, mixtures of reactive and spontaneous, understandable and purely causal moments. The schematic clarity of the principle, however, is necessary to ensure we do not, for instance, subsume specific cases within the system, but analyse them from all points of view. In individual cases, for example, a disease episode which, by nature, occurs spontaneously can take its contents precisely from the last experience, and one is not in a position to separate the reactive aspect from the episode and yet cannot *totally* deny the reactive elements.

Understandable relationships which constitute *individual* aspects of the psychosis but *never* represent *the whole* include the following: the abnormal state of mind, as a whole, serves a particular purpose of the patient, for which also the individual features of the disease are more or less appropriate. The patient wishes to be of unsound mind and develops a prison psychosis, he wants to have a pension and develops a pension neurosis, he wants to be cared for in an institution and develops the varied symptoms of the malingerer, etc. These patients strive instinctively to fulfil their wish along these lines. Their wish fulfilment occurs *through* the psychosis ('purposive

psychoses'). In other cases, patients achieve their wish fulfilment *in* the psychosis itself. We then refer to a flight into psychosis. What reality does not offer them, they experience in the disease. In still other cases, all anxieties and needs, as well as all hopes and wishes, appear as actually fulfilled in the psychosis, jumbled up and one after the other, in a delusional and hallucinatory form.

If we wish to classify reactive states, we can do this *firstly* in terms of the *causes* (prison psychoses, homesickness psychoses, governess paranoia, earthquake psychoses, etc.). There is a particularly important distinction between the very violent emotional upsets arising as a result of *sudden* events (fear, horror, anger, e.g. following sexual assaults, earthquakes, catastrophes[10] in particular, death, etc.) and the slowly increasing, deep emotional changes which arise from a *permanent* fate (decline in life expectations with increasing age, life imprisonment[11], etc.). If we wish to analyse the understandable relationships, we need to look at the specific contents in detail.

Secondly, we can classify them according to the *peculiar mental structure of the reactive states* which manifests itself both in the objective phenomena (orientation, motor behaviour, memory, etc.) and in subjective experience (modes of feeling, object awareness, type of contents, fantasy, etc.) and indicates different types of extraconscious mechanisms and changes of disposition. Thus, clouding of consciousness, considered paranoid states, depression and protracted fluctuations of affect[12], pathological affects, etc., are distinguished.

Thirdly, the reactive states can be classified according to the *nature of the mental constitution* that occasions the reaction. This can be divided into the two large groups of *psychopathic* and *schizophrenic* constitutions, of which the former represents a permanent state and the latter a progressive process. Psychopathic reactions would, for example, include hysterical psychasthenic mood reactions. The concept of a reactive psychosis in schizophrenia was first evoked by

10. Stierlin: Über die medizinischen Folgezustände der Katastrophe von Courrières. Mon. f. Psych. u. Neurol. 25.

11. Rüdin: Habilitationsschrift. München, 1910.

12. Bresowsky: Über protrahierte Affektschwankungen und eknoische Zustände. Monatsschr. f. Psych. u. Neurol. 1912; 31: E. H. 239.

Bleuler. Among the acute psychoses of schizophrenia, he distinguishes between *episodes* that occur spontaneously as a result of the disease process and *reactions* that occur in response to an external experience as a result of the schizophrenic change. What differences are to be expected between episodes and reactions in schizophrenia? Episodes leave behind a *lasting* change, reactions *revert to the previous state*. Episodes contain *general* contents from any past time, reactions have *specific* contents from one or more *experiences* out of which the psychosis developed *continuously*. Episodes arise *spontaneously*, reactions are temporally linked to *events*.

The modern theory of reactive psychoses to some extent involves a revival of *earlier theories* of *psychic causes*. However, the modern theory is based on a new fundament. When earlier authors found psychic causes in 60–70% of their cases, this only implied that the contents of a whole range of mental illnesses can be linked by an understandable relationship to earlier life events. We now distinguish those cases in which not only some contents are adopted arbitrarily, but in which brief, definable psychoses arise in a clearly reactive way to experiences. Furthermore, we distinguish those disease episodes that assume *arbitrary contents without experiential value from earlier life*. We distinguish as well disease states which are merely *brought on* by a mental upset, which is, so to speak, the final straw that breaks the camel's back (mania, catatonic state, etc., as for example, by someone's death), disease states that follow a course totally independently of the last psychic cause. Above all, we distinguish the causal moment strictly from the understandable relationships and never believe we can explain a mental illness *solely* through a 'psychic cause', although we might understand its manifestation psychologically to a large extent. Where older psychiatrists (such as Esquirol, German translation pp. 34–55) separate the mental illnesses due to *'passions'* (e.g. monomanias) from mental illnesses due to *'exhaustion of the organs'* (e.g. dementia in the elderly), this contrast still persists today in the totally different form of the distinction between *psychological understanding* and *causal explanation*. However, whereas we find cases in which psychological understanding cannot provide any service (as for example, in senile dementia), we now accept that we can principally *never* do without *causal* questions,

even if we do 'understand' a large amount. From where does the mental constitution which made these understandable relationships possible originate? This question is also asked in the case of reactive psychoses in the strict sense. This question allows to go beyond the deceptive causal satisfaction which earlier psychiatrists associated with the observation of a 'psychic cause'. There is now an increasing interest in the *understandable* relationships that develop out of a basis of the inner life which is pathologically altered through processes that can be causally explained.

The *now* widespread view of psychic causes has most recently been presented in context by Bonhoeffer.[13] Bleuler extends the occurrence of 'psychic causes' much further. We believe he is right, on condition that we distinguish *causal* and *understandable* relationships in the whole theory of psychic causes. There is then a series of transitions in two directions. 1. On the one hand, there are abnormal states of mind that are causally determined by an emotional upset (catastrophes psychosis) *without* there being many understandable relationships between content and cause. On the other hand, there are changes in mental constitution resulting from extraconscious processes in which *nevertheless* the individual phase or episode shows extensive understandable relationships with the fate of the individual. 2. On the one hand, there are psychoses that are determined by an emotional upset as an essential cause and *also* show convincing understandable relationships between experience and psychosis content (*genuine reactive psychoses*). On the other hand, there are psychoses that have arisen through processes whose content does not show any understandable relationship with events, although the contents must naturally come from previous experience, but the value of this experience, their value as events is not the decisive factor for penetrating the content of the psychosis (*pure phases or episodes*).

Those psychoses that may be counted as schizophrenia in Bleuler's sense, we shall get to know in the following examples as reac-

13. Bonhoeffer: Wie weit kommen psychogene Krankheitszustände und Krankheitsprozesse vor, die nicht der Hysterie zuzurechnen sind? Allgem. Zeitschr. f. Psych. 68: 370 et sqq.

tive psychoses. We will consider them *phenomenologically, causally* and *from the point of view of genetic understanding* and will have as our main aim in this the elucidation of the relationship between events and acute psychosis, in other words, the reactivity.[14] The first case is psychologically crude and simple. It will be interesting more *in terms of the principle*. The second case is psychologically more refined and should arouse interest *in itself* through the relationships that are investigated in it.

Moritz Klink[15], born 1879, a physically extremely strong day labourer, experienced two brief, eventful episodes of acute psychosis in June 1911 and June 1912.

Previous history

Heredity: Father died of apoplexy. One brother was in a reformatory up to the age of 15.

Childhood (own statement): Brought up by the father's stepbrother in a small rural village and then by the grandfather as his parents were dead. Impoverished circumstances. As a boy, he was always happy and liked singing. In school he learned easily. Because he played pranks – of which he was always the instigator – more than he learned, he only stayed on until the 5th class (school of seven classes). – Bed wetting throughout the whole of his time at school. At the age of 11 years, typhus, during which he also experienced psychic phenomena. He had sat in a corner, hidden himself and on one occasion had wanted to put on a sheet as a pair of underpants. At night he had sometimes thought that he was already far gone. He was confined to bed for about 8 months. When he got up, he was no longer able to walk.

He was able to recount a few particularly vivid 'dreams' from his childhood. When he was 10 years old, his grandfather died. Between the first and third days after the burial, he saw a grass snake under his pillow, he had screamed and then he had slept on. Shortly afterwards, he had very clearly seen his grandfather. He had called out for his grandmother in his fright. When she asked what he wanted, he was already awake and no longer saw anything. Immediately

14. In the present state, perhaps always by its nature, a psychopathological question can only be investigated in terms of the whole. We must collate, as far as possible, *all* the material available to us from cases intended to contribute to *one* question. Only in this way can the case descriptions retain their usefulness for subsequent researchers as material for further investigation.

15. *All* names occurring in the case histories are naturally pseudonyms and not real names.

afterwards he fell asleep again. – Following a murder, he had dreamt shortly afterwards that he saw the victim lying under the poplars, just as he had seen him shortly beforehand in reality. He had cried out and woken up; then it was over. Once more he immediately fell asleep again. – As a boy, he had not been particularly fearful. Admittedly, he had not at first dared to do the 'cat run' along the ridge of the roof, but had then tried it on his own and showed it off to his friends. – For a while he had not been able to look if someone had bled.

After school he had worked in agriculture and then as a coachman. 1899–1901 he was in the *military*. In 1902 he *married*. The marriage was soon an unhappy one.

During his life he suffered several *accidents* without any after-effects. He had fallen from a tree and recovered consciousness in bed. A piece of railway track fell on his head.

Custodial sentences. In the military, detention for insubordination. 1898 three days' confinement for dereliction of duty, 1899 three months' imprisonment for theft (he stole money from the chest of drawers of a maidservant which he immediately drank away). 1899 three days' confinement for dereliction of duty, 1905 three weeks' imprisonment for fraud and embezzlement.

The patient had, *until recently*, always *worked regularly*, most recently as a day labourer in the Coal Syndicate.

In terms of his *alcohol consumption*, we learned from the patient himself that earlier he had drunk a lot as a coachman before his time in the military (how much, he no longer knows) and that he had been able to tolerate more then. In the military he had drunk almost nothing; later at work, as was normal, on average 6 bottles of beer daily (1 bottle = 0.7 l). In the past few years he had sometimes been drunk. When he became angry, he had drunk. That had probably happened twice a week, but also not at all for weeks at a time. In the last few weeks before both his episodes of psychosis (1911 and 1912) he had not drunk more than usual, he had worked regularly and had not noticed any decline in his capacity for work. He, nevertheless, considered himself a heavy drinker and "to set a good example to his wife" (cf. later) wanted to go into a clinic for alcoholics. He explained, however, that he had no craving for beer at all (he had never drunk schnapps) and that it was not difficult for him to stop drinking. He had once done so for eight days without difficulty to show people. He had only drunk more when he became angry. He confirmed statements by his wife that he wet the bed and destroyed furniture when he was drunk: in 1907 he had sometimes, but not often, had episodes of bedwetting again, and, most recently, once in this year when he had drunk too much. In 1907 he had also *once* destroyed furniture in his drunkenness and anger, i.e. broken off ornamentations, etc. They had been repaired subsequently. The landlady with whom he lived alone for the last 6 weeks before his second illness (1912) stated that he was a diligent and sober worker. His wife, however, blamed the unhappy marriage predominantly on the drinking. It had started within a quarter of a year of the wedding. She states that he was never particularly coarse towards

the *children* – even when drunk – and that he had never had *fits* of jealousy. On the other hand, he had almost never given her his wages. Each of the spouses went their own way.

These circumstances, however, are undoubtedly not due, or not solely, to the alcohol. The *marriage* was concluded in 1902. He adopted two illegitimate children of the wife (not by him) and she had a further child by him. In his opinion, the marital discord first started in 1904 when the family moved to Mannheim. In 1905 his wife went to work at a brothel as a cleaning lady where she had learned all the wrong sorts of things, had dressed up, had gone out with men and had no longer worried about the housework. He had, therefore, been obliged to live alone with the children. He had eaten out and naturally had no longer given his wife his pay, and she for her part lived off her earnings as a prostitute. The wife described the situation somewhat differently. Her husband had *demanded* of her that she should give herself to the men for money; she could go out again in the evening and immediately earn 10 Marks. Her husband had *sent* her to the brothel. For no reason he had stopped giving her the weekly wages. *Therefore* she had to earn a living herself. She had *actually* been a prostitute for two years.

The husband, as he recounted, had always become extremely *agitated* about his wife's unfaithfulness. She promised him, for example, to go with him in the evening to the Apollo Theatre. When he came home from work, she had already gone off with someone else. When he became angry and in his anger drank more; *such* events were almost always the cause. His wife had completely neglected him.

His wife complained of *maltreatment*. Thus, one morning two years previously, the husband had come *back* from his way to work and thrown pepper onto her genitals so that she had been almost unable to walk. The husband admitted that, but refused to give further information and explained angrily: if I had had dynamite, I would have stuck dynamite in her.

In their *sexual intercourse*, the wife had not noticed anything abnormal in her husband. He did *not* have a particularly large appetite. They had had intercourse for the last time in April 1912 shortly before she left him. As regards his extramarital sexual relations, the wife knew only that he had once spent the whole of his payday in a brothel many years ago after the marriage. He admitted this, but it had only happened once. Otherwise, the patient claimed he had had no other sexual relations during the marriage and particularly in the *last few* years, he had not been interested in *any* girls. Before the marriage, the patient had had several relationships, which he recounted with a certain pride.

It is apparent from the patient's behaviour that *his wife is extremely important to him*. He barely thinks of anything else, almost runs after her, is always ready to forgive her everything and now wants to go into an institution for alcoholics "to set her a good example." Only very temporarily, both in 1911 after the first psychosis and in 1912 before and after the second psychosis, had he thought about divorce. However, he had immediately abandoned any such thoughts and

had only been concerned to get back together with his wife at any price. "You only have *one* marriage."

The husband's attitude to his wife as described above undoubtedly plays a role in the outbreak of both psychoses. On both occasions the wife had left him – which had not occurred at any other time – on both occasions he had had to live alone and on both occasions the acute psychosis erupted after a period of a few weeks, on the first occasion lasting 2 days and taking about 3 weeks for complete restoration and recovery; on the second occasion lasting 7 days, but then progressing immediately to a complete recovery. We now turn to the first psychosis.

The first psychosis (June 1911)

The wife had a relationship with the night lodger, Martin Bauer, who lived with the family. The husband threw him out. Bauer fetched his brother and the two of them *thrashed* Klink very vigorously with a length of cable. That was the beginning of May 1911. In the middle of May, the patient had continued, his wife had told him to stay at home in the morning. He however had gone to work. As he left, his wife said: Just wait and see what happens! That evening he had worked until 8 o'clock. When he came home, his son told him that his wife had 'run off' with Bauer. Klink was very unhappy, but assumed that his wife had been abducted by force since she herself had asked him to stay at home.

The wife told us that she had gone to Frankfurt with Bauer: "I had nothing from my husband, at least I had money from the other." He gave her 'his whole payday'. In Frankfurt she had worked in a bar and her lover in a factory. She left the children with her mother who lived in Mannheim.

In his despair, Klink *sold all the furniture*. What he could not sell, he gave away. The children did indeed live with his mother-in-law. He took private lodgings with a landlady.

In the next few weeks after the abduction of his wife, K. recounted further, he became *increasingly agitated*. He worked as a pitch coal driver in the Coal Syndicate, where he was constantly provoked by the *taunts of his fellow workers*.

On 16th June, Klink was told by his foreman that he had seen his wife on Bauer's arm in Ludwigshafen. Klink cross-questioned the mother-in-law but discovered nothing. On the following day he went back to her and learnt that his wife was with her sister in Ludwigshafen. Klink found his wife there and greeted her with the ironic words: "Now Madam, back from your travels?", to which the wife responded: "Yes." When he asked whether she wanted to come back to him, his wife said "Yes", but she was totally monosyllabic and frightened. Klink now saw Bauer in the room, became intensely angry, but managed to control himself and went home alone, completely *afraid of Bauer* and *without the courage to take his wife with him*, although he remarked that she would gladly have come with him. This was on 17th June. The patient waited the whole week to see whether his wife would come. But she did not.

On Saturday (24th June) in the evening he thought that several people had climbed onto the roof and were shooting at him with revolvers. He had not seen the people and had also not heard the report of the shots. He had only seen the smoke. No-one had hit him. Two policemen were also present.

On Monday 26th June, he had gone early in the morning to the labour exchange. He had given up his job with the Coal Syndicate because his fellow workers had *teased* him so much and he was now looking for new work. From this point on, the patient himself no longer knows what was reality and what was not; he believes that most of *what relates to Bauer was from now on probably his illness*.

Bauer asked whether anyone called K. was there. K. answered: "Yes, he's here." B. responded: "I am going to shoot him dead so that he suffers", and produced a revolver with 6 bullets which he pointed in K.'s direction. Bauer then went into a neighbouring cafe and wanted to take the carving knife; K. saw that he already had the knife in his hand, but the bar staff refused let him out and took the knife from him again. K. went to the police to report Bauer. Two policemen accompanied him back to the labour exchange. They asked whether Bauer had shot at him? "No." They could, therefore, not do anything if he had not committed an offence. "So you have to be shot dead first before you have your rights." K. obtained a work pass for the sawmill. For the whole morning, K. then thought Bauer was following him. He constantly heard him, but did not see him. Bauer said that he would make sure that K. was not employed in the sawmill.

From 1.30 to 6 o'clock, K. worked in his new job at the sawmill. On the way home from work, he again saw the two Bauer brothers in a bar. They wanted to go after him, but their way was barred by some people with whom they were sitting.

At home, K. ate his evening meal. Then it seemed to him as if someone had said there was a man there who wanted to speak with him and that he should go to the police. It was as if this had been spoken from within him. He thought that perhaps his wife had sent someone to the police, her brother-in-law or someone else. He, therefore, went to the police at 8 o'clock. Outside he sat on the bench. Suddenly the two Bauers rushed up to him. When K. saw them, he leapt up at them and thought: "They are either going to beat me up or shoot me or do something." A policemen shouted that he should stay back and let them go (none of this was real in the patient's current view). On the street, some 200 workers then came towards him, all armed with revolvers. They called out: "That's the murderer." He did not hear the report of any shots. In addition, the workers could not hit him at all because he believed himself to be protected as the result of an invention: no revolver went off in his direction, only when the weapon was turned away from him did it go off.

K. then went to the police station. He was asked there what should happen to his wife. He said she should come home, the bed were still there. The policeman said: he must pay 250 Marks. He said: if everything turns out right, the 250 Marks will be paid. He had not asked why.

The policeman then thought he had a lung disease and should go to the doctor. At 9 o'clock he was taken by ambulance to hospital. The person accompanying him said the two Bauers would also go to the hospital. He answered that he did not want to see them. However, he could already see them in a car behind the ambulance. He saw them again in the hospital.

He explained in the hospital that he wanted to go to work at 6 o'clock early the following morning and he wanted to leave again now, but was kept back against his will, locked in a cell and deprived of his clothes. "And I was in there for a while and then all at once I started." He had raged, had seen his wife, his children, the two Bauers and other people. He yelled that it was their fault he was here. Bauer should not now do to his wife what he had done to other girls (in fact he had already lived at the expense of a girl for 26 weeks). During this time he had constantly struck out at Bauer. Wife and children said they did no longer wanted to have anything to do with B. But B. had constantly picked up his wife and said: she was not allowed to leave. In this way, according to the patient, he had gone on until he had become tired and fallen asleep. When he woke up on Tuesday morning, everything was past.

The *reports by other people* confirm and supplement his statements. According to his landlady, with whom he had lived alone during the last few weeks, he had seen people climbing onto the roof on Saturday, shooting at him, heard them cursing and saying he was the murderer. He saw rats, mice and tigers in the room and was very frightened. His speech was totally confused. On the street, 170 cannons had shot at him, but none had hit him.

On Monday evening in the hospital, according to the doctor's report, he was very restless, ran to and fro in the cell, struck the wall, saw the night lodger Bauer and talked to his wife and children. On Tuesday morning he was calmer, said that people had shot at him, but that he was invulnerable. He still saw all sorts of animals.

On 28th June (Wednesday), K. went to the *Heidelberg Clinic*. On admission, he was calm, orderly and completely oriented, understood clearly and gave appropriate responses. He recounted his previous history correctly. Of his experiences on Monday evening, he talked only of the discovery of his invulnerability. This was related to magnetism, but had not yet been fully worked out, he had to think about it further. He expressed this with great confidence and with the conviction that he really did have an invention.

His subsequent behaviour was calm. He *planned to get a divorce*. After a few weeks, he had complete insight again. He ascribed his illness to the fact that he had been so boiling with rage that he could imagine people in his mind and saw them before his eyes because he was thinking of them. He had also seen the 200 workers in his agitation. "The people did not have the courage at all to look at me, my facial features must have been completely disguised." In his fear of *Bauer*, he thought that *everyone* who came up to him wanted to shoot him dead. He corrected the idea of the invention: there is nothing in it at all. He had now completely abandoned it: "*I have now directed my thoughts back to my*

family again."

In the next few weeks he showed very little emotion in his requests for discharge, which at the time was attributed to his chronic alcoholism. He now repeatedly tried to discover where his wife was staying, but unsuccessfully. As early as 2nd July he wrote to his wife: "Dear Marie and mother! I am now doing nothing but working and am associating with better circles. The heavy drinking has now ended. I should like to devote myself better to nature… When I come home, a new life will begin. It may be possible soon, but may also take a few more weeks. That is entirely up to the doctors. Please write to me this week, if no-one comes, how you are, what the children are doing, above all, whether everyone is healthy, and finally whether Martin Bauer and Karl have come to their senses yet. To plunge a family into such unhappiness. But I am patient, you know this, mother. I believe in God and fear no-one. You have often seen that. The time will also come when we are together again. I end my letter in the hope that every one is healthy. Your most respectful Moritz Klink."

On 6th September, K. was *discharged* in good health. Immediately after his discharge, he again worked regularly but – according to his wife – did not bring the money home. New furniture was purchased – as K. had sold the old furniture when the wife had run off – for about 475 Marks on instalments. The couple moved in together again. His drinking remained the same. The wife could not recall any unusual traits in his nature. She found him normal. The only striking feature was his reading. He read no newspapers, nothing at all, apart from certain books which he mostly had delivered from abroad. Three years previously he had ordered books from a travelling salesman, which the wife subsequently had not accepted. What sort of books these were she does not know. He owned the seventh book of Moses, sometimes read from it and kept it under lock and key. He said that it was stated in there that it was possible to see ghosts. That he himself could see ghosts he never said. He ordered books on medicine from Leipzig; as he himself said, to obtain an idea about gallstones from which his wife was suffering. From America he received books from 'Prof. Sage'; however he gave this up because it was too expensive. In March 1912 he had 'Prof. Roxerie, Kingstown' tell him his horoscope. "He told me my life as if he really had been with me", and had warned him to beware of a particular person. He refused further correspondence because of the high price, although the professor reduced it from 25 Marks to 4 Marks.

The second psychosis (June 1912)

With the irregular lifestyle of the two spouses, the due payments for the newly purchased furniture were not made. For this reason it was *taken away from them on 7th May*. His wife then went back to her mother with the children and he again went into private lodgings. The furniture was apparently returned to them, but his wife did not want to go back to him. Throughout the whole year, K. had not been agitated at all or very little so, but now the

agitation began again. Day by day he thought: "My wife is not interested, well, she can do what she wants.". "We have now been married for 10 years and we are sitting on our own." "If she does not want to, just let her go." "It is not good, going home to strange people." Such thoughts and others came to him in the evening. In the morning he went straight off to work, worked the whole day – work came easily to him – thought about nothing, but in the evening at about 7 o'clock when he went home, everything started up again. He did not say anything about it at all. He did not tell any of his friends anything. He arranged his journey home in the evening so that he went past his mother-in-law's house in order to see the children in passing. Sometimes he would be lucky and see them, but usually not. Then he ate his evening meal, stayed on his own and went to bed at about 10 o'clock. He slept well and had no striking dreams.

During the whole period after the furniture had been taken away, he had seen his wife three more times: on the same day (7th May) and two days later he went to her, by which time she was living with his mother-in-law, to persuade her to come back. It was in vain. On 27th May (Whit Monday), he went to the bar where his wife worked as a waitress to talk to her. This did not work because there were too many people there and because she had to serve. "In anticipation of this", therefore, he had already written a letter which he gave to her saying that she could read it at home. It stated that things could not go on as they were, she should consider it carefully, they wanted to live together again, "he tried to sort out the matter amicably." If she did not want that, he would take the children away from her and give them to the orphanage board to bring up. He reminded her about her reputation, what people would say, etc. His wife opened the letter immediately, read some of it, then tore it up and threw it onto the fire. The landlady also looked on disparagingly while she was reading. K. was extraordinarily agitated, but remained seated and drank with two colleagues. In the evening he went to bed early.

K. specifically maintained that he had not had a relationship with any girl or had sexual intercourse during the whole time. He had not made any attempt in that direction. "Everyone is different."

At the beginning he had thought: women always come back straightaway, if they don't come in three hours, they come in three days, if they don't come in three days, they come in three weeks, if they don't come in three weeks, then they do not come back at all. Now that time had passed and he thought: she isn't coming back. Initially he "made light of it", took the first steps towards *divorce* and to have the children taken away from the wife, was summoned, but then *became extremely agitated*, let the matter drop, became calmer and thought: "*I'll think about it some time*, go to work."

On *Saturday 1st June*, he worked until the evening and was then not entirely well, restless and anxious. These were the *first signs* of the psychosis from which he suffered in the next few days in Mannheim. On *Saturday* (8th of June) he was admitted to this clinic and displayed no longer any signs of psychosis.

The *objective history* is sparse. The landlady with whom he lived during the previous few weeks describes him as a diligent and sober worker. In the night of Sunday to Monday, he had become restless, saw figures coming up to him which wanted to do something to him. He was afraid that his wife was forcing her way into the room and draped the windows. On Tuesday he went into hospital, was for the most part calm, then again in a state of general restlessness, scraped on the floor: his wife were sitting underneath; he could hear and see her. The spots on the floor were to him the eyes of other people. In the night from Thursday to Friday, he was very restless, knocked on the doors, said the doctor had won money and he must collect it.

Klink's *self-description* of the psychosis is very detailed. His written statements confirm his verbal reports, and he has obviously an excellent, constant memory. Shortly after the psychosis he started to write the self-description, then he refused to continue with it. What is written is so good that we reproduce it here in full. The first part concerns his marriage. Although many repetitions occur, we reproduce it unabridged as it gives a good picture of the personality and its problems. The second part relates to the psychosis.

The self-description is reproduced verbatim with all the spelling mistakes and grammatical errors. Only the rearrangement of some largish sections of text for the sake of correct chronology and also the division into paragraphs and the italicisation of some words are my work.

Self-description. First part

To the Management of the Psychiatric Clinic, Heidelberg.

I can describe my marital status and my illness as follows. I married on 13th December 1902 in F. To begin with, we lived happily together, then on 15th August 1904 we moved to Mannheim and there unhappiness awaited us. In about mid-March, 1905, my wife went to work in the Gutmannstraße, also known as the Ehrenstraße, as a cleaning lady, and what she did not know then, she learnt in the company of prostitutes. She worked there until 22nd May 1910 or 22nd May 1909, I cannot exactly remember now. She had three children, two of whom I gave my name to, and the third remained with its father in F., Mr A…! I suffered an accident then on 4th or 10th May 1910 when moving embedded railway lines, when a five-metre long piece of track on the ground broke off, struck me on the head, injured the right side of my head and also injured my right foot. My illness does not come from the large amount of drinking, but *mainly from thoughts which I had about my wife and children*. I admit that, because I drank, things went so far that last year I went into the clinic. Because on 2nd January 1911 I took in a lodger by the name of Martin Bauer from Mundenheim who started a relationship with my wife and she immediately fell in love with him. On Shrove Tuesday, we attended a masked ball in Ludwigshafen and from then on it was finished. When I came back, I was heartily thrashed by Martin and Karl Bauer. I then showed my wife Martha

Katz and Martin Bauer the door and had the police ban Martin Bauer from the flat. He was then working with me in the Industriehafen Non-Syndicated Coal Association. Out of pride, I stopped working on 9th May 1911 because I was too well known. I then enquired on 16th May 1911 in the Mirror Factory and immediately obtained work. I worked on 17th May 1911 until 8 o'clock and when I came home at 8:45 the children were standing at the front door and crying. When I asked why they were crying, they replied that their mother had gone, so I asked where she was, whether she was with their grandmother or in the town! I was then told in response that she had *run off with Martin Bauer*. I stopped working in the Mirror Factory on 18th May and started work again on 19th May at the Non-Syndicated Coal Association. I then thought about the fact that my wife had disappeared with Bauer, that they were making a fine life for themselves! And that I should look after her blood, which I recognised, but which in reality is or was not the right blood. Very fortunately, in my agitation I was still able to look after myself, I had her banned from the house, which was confirmed and registered in volume nine, page 49, in the Grand Ducal district office. I then *lived for the day*, had *all sorts of thoughts*, what would yet happen to me and the children. Where I was living, I came to hear that my wife was receiving a number of men, which also considerably contributed to *making me agitated*. Then when the 1st June came, I had to or wanted to move out, and *in my agitation I sold my furniture* and when I got nothing for it, I gave it away because people gave me nothing. The two children, Adolf and Frieda Katz, known as Klink, I sent to their grandmother. My daughter Maria Klink who was born on 6th February 1904 in F. I took with me to my private lodgings and paid four Marks for the child. At that time I was living with Mr C., M…straße No. …., 3rd floor. Here also *I was unable to control myself, thought constantly about what else might happen to me*, which then did in fact happen in the end, which had nothing to do with my drinking, otherwise I would have long since gone to the clinic, there were just thoughts, worries and upset that my wife no longer bothered about me, went around with others and would not give up the waitressing. She never went out with me any more because she had enough other men, and when I had gone to work, then she was certain that I would not come home for the whole day so that she could do what she liked. When I came home in the evening, however, the children told me. There was someone who had been with her, they had shut themselves in and when children of 15, 12 and 8 years old are there, it is easy to imagine that the children do see things and are curious about what is going on, so they tell me everything I grew very fond of my children by giving them as something. So my wife left me in the seventh week, I then lived *restlessly*, but worked every day, could no longer eat, had to work hard so I kept going by *drinking* until 21st June, on 23rd June 1911 I was then brought to Mannheim Hospital and on 25th June I then went to the clinic in Heidelberg until 6th September 1911. I had *already wanted to get divorced last year*, but did not do so, and if I had done I would not have gone into the clinic at Heidelberg this year. I had been advised enough against going back to my wife any more

as it would no longer do any good living together with her. If I had followed Dr K. last year, when he told me that I should divorce her, when I was with Dr K. in the consultation room, I did say that I would arrange it once I was free outside again, but that did not happen because we became reconciled with one another, simply for the children's sake I did that. But now ??? I have the same old thing again, to begin with we lived together well. I was discharged on 6th June, worked for five days with the company A… Woodworks, then I went to the H… Oil Factory, where I worked for nine days, until we, I and my wife and children, lived together again on 20th September. I bought furniture from the F. company on instalment, on the 15th of each month 20 Marks and 21 Marks rent, which would have been fine if my wife had accepted it. Initially it was fine with her, but then she was really rude to me for buying the furniture on instalment. I put down 41.70 Marks and paid off four instalments and paid the rent until 1st April. *My wife was no longer interested in the whole family situation and then I lost heart also* because I was not allowed to demand from our oldest son, that he should work, which hurt me. He left school one year ago but has not worked six weeks, I constantly insisted that he work and if he did not do so I would have him put in the workhouse, so that there was a *constant argument in the family*. She went to work as a waitress every day, courted the other men, and many nights did not come home, and if I had beaten her up, I would have been locked up. In this way then I made great enemies but also great friends who were on my side. Already last year she wanted to run off with the *electric conductor*, such a mother, does she not have any love for her children? That was the first piece of news that I learnt on 7th September after my discharge from the Heidelberg Clinic. The conductor had persuaded to think hard before she would return to me. He then arranged to come with her so that he came to my flat every day, which is confirmed by the landlord. He pointed out to me that the tram conductor came to my wife every day, but other men had come as well. You do not need to be an alcoholic to take that to heart, how a wife can twist a man around, and in addition the man from the tramway is already married, and also has one or two children. I found out he gave my wife 20 Marks to buy him three shirts, which she did. The shirts cost 12 Marks, so what happened to the other eight Marks???

I worked most recently with H… Carters and Gravel Works from Wednesday 19th April until Saturday 1st June 1912 as a day labourer. I worked every day, with one and a half days' break. Then I was once *summoned for a guardianship matter* and the second time I was *sued for furniture matters*. I drank my beer in moderation every day during work, I spent two Marks each day and my wife thought that was too much, three bottles of beer cost 60 pfennigs. One loaf of bread 26 pfennigs. A pork chop or sausage and two Marks are gone immediately and then one does not have anything hot. If you eat at lunchtime that costs 60 pfennigs or in the evening 50 pfennigs, so that *she did not cook* she went serving so that the children, as well as myself, were left to their own devices. I often said to her that it could not go on like this, that things must change,

she should stay at home, at her housework, the son should go to work and she should cook and then we should have a different life, but it was all no use! I am going serving and you can do what you want. The wife was responsible and the husband was responsible, she had no interest in paying for the furniture or the rent, so that on May Market Tuesday we *had the furniture taken away,* I wanted to go after it, she refused and said she was going to her mother, I should just take my daughter with me, which I didn't do, but in the evening I took my oldest son to sleep with me.

I then went to my wife twice and asked her what was actually wrong, whether she really wanted to bring me back to Heidelberg. She told me that she was renting a furnished room and went in. I then slept eight days in an inn, then I rented a place to sleep with widow Mrs K. in the S…straße No. … on the third floor. I then informed the mayor's office very respectfully that the children should be taken from my wife because my wife was leading such a bad life and the children required a different upbringing as I *was applying for divorce*. I was therefore invited before the orphanage board and I was told I should apply for divorce to the District Court and the children would then be taken from her straightaway. I said that as long as my wife had the children in her hands that I would not pay her a penny, which I did. My wife would have felt quite comfortable if I had given her 10 Marks or so every week and she could hang out with others. When a wife lives with men other than her own husband, then he need not be responsible for anything, the men who consort with the wife should look after the family, I was warned enough last year I should let her go, but always thought of the children, what would happen to them, so that I took my wife back. But it has been my ruin to now. Everybody[16] wanted to marry her or love her, they went every Thursday to the Apollo Theatre when my wife was free, or otherwise went on excursions together. She would promise me in the morning that we would go out together in the evening, but it did not happen. Instead when I came back home, my wife had already long since disappeared and left me a message she was coming back soon and we would go to the Apollo Theatre. But my waiting was in vain, she never came early, her time was usually between two and three o'clock, or even later. On one occasion she was not well, then she came home at half past eleven. You do not need to be an alcoholic! No common sense can tolerate that! *How my wife can destroy one by spite, hate and bitterness. I will get a divorce* and have the children taken away from her and have them put into an institution and will be happy to pay whatever it costs, "but from me she won't get" a single farthing. She sleeps with her son of almost 16 years of age and the two girls who are already 12 and 8½ years old, is that an upbringing that is acceptable, no, there is still right and justice and on that I base myself. *I will now ensure that I get divorced* and that the children will be taken from my wife so that she also sees what maternal love or parental love is. A woman who can leave her children and consort with other men, that is no wife. How the doctors decide,

16. Martin Bauer und der elektrische Straßenbahnschaffner.

that I will leave to them, because this I firmly declare that no-one believes me at all, I know that quite definitely. Nevertheless I am not going to lose heart, because I accept my fate that is given to me, but I will be heard later. It was or it is totally unnecessary to describe the state of my marriage because as long as you stay in the Clinic, you have no rights. There is nothing more to be said, you just have to wait and see what happens to you, it is in their hands whether freedom or permanent stay in the institution is to be expected, the right is on my side, but you never find that here so that it is a matter of not losing heart. Finally, I should like to inform the doctors that I have lived in L 3 No. … with Mr M… landlord of the Red Ox and Mr M… informed me that my wife received visits from many men during the day. I lived with Mr P… U…straße No. … when I was told that my wife received visits from many men. I lived in the F…straße No… 3rd floor with Mr R…, master butcher, where I was given the same news that my wife received many men, it could not go on like this and I had to move out. This is how it went on with me elsewhere that I lived, but the doctors say that Klink is addicted to alcohol. I leave these gentlemen to their beliefs and I claim my duties and rights, even if I can no longer find them here. Because I am tied down here. Nowadays you are not allowed to tell the truth at all, otherwise you are put into jail if you tell the real truth? That can also happen to me because I have gone too far with the truth. People who tell untruths nowadays get much further.

Second part

On 1st June, I worked until seven o'clock in the evening when I already felt *unwell*. I drank two glasses of beer with H., had a shave, went home, paid my lodging money to widow K…, she said besides that I should not worry myself unnecessarily and should ignore it. Which is what my housemates also advised. Afterwards I went out for my evening meal and also drank two beers, looked for a friend in order to go for a walk in the woods the next day, did not find him, drank a beer at the bar, enquired about him and went off again straight away. I set off home, heard him in the other bar, drank a glass of soda water and we talked also about getting up early and leaving at half past four. Afterwards I went to my three housemates in order to go to sleep. We went home together and already they noticed that I felt *anxious*, they constantly told me I did not need to fear anything because we are all at home with you. I locked doors and windows but still got up fairly regularly and *looked around to see that I was still safe*.

Finally, I fell asleep peacefully until *four forty-five early on Sunday morning. All of a sudden* I started up, heard *my brother-in-law* in front of the house cursing and *threatening me*. I then got up to see what was wrong, but saw no-one, then suddenly another brother-in-law came along too, I also heard his wife talking, my mother-in-law, and both my unmarried sisters-in-law, all of them *said I was completely right* in what I was doing, and then they had also surrounded my wife as well as the children. They wanted to bring her to me, but she did not come.

My two brothers-in-law and mother-in-law then said, if you don't go to him, he will divorce you because he has already applied to the mayor's office and you will have the older children taken away. To this she said he can't do that and he won't do it either. She called me and I answered, but saw no-one. And I immediately thought that it might in fact have been an illusion for me. My housemates wanted to take me with them but I didn't go, I told them what had happened and they laughed at me, and I also did not go for a walk with my friend. When I was alone, it was even worse, the argument became more violent, but I could see no-one. My housemates said they heard nothing, I was simply imagining it, there was no-one there scolding me. Only I insisted that the relatives had it in for me, that they would fall upon me and so I stayed home. At about 12 midday one of my housemates came and then took me with him, I was by that time already a little calmer when I came out onto the street! Suddenly I again heard that my brother-in-law, together with his wife and mother-in-law, wanted to attack me. They threatened to beat me to death, or I will stab him or I will shoot him down, because he left my sister, the damned fool. But then I immediately heard, you are not going to do anything to the man, I have known him since he was a child, he never does anything to anyone, then my brother-in-law said we'll get him out of his lodgings tonight, he should simply to go to his wife and children, perhaps he would be happy to go down, but he is frightened of me now, I am not going to do anything to him but I'll slap his cheeks so hard he won't know what hit him. Then I again heard them *mistreating my wife and children*, they were crying for me and I then called out, and there was always an answer but no-one came and I saw no-one either. My relatives constantly said to my wife, just go to him or we'll beat you, you're entirely to blame that he has left and you have nothing to eat! We cannot feed you and keep you and your husband lives here and can keep his fine wages for himself. He is happy with that because he has told you and the orphanage board that he is not going to pay a single penny for you or for the children. Then my oldest son aged almost 16 years said if our father wants to put us in an institution I'll shoot him down. My brother-in-law then struck my son violently and said to him, now you want to lay hands on your father, he would help you as soon as he comes out. My wife then complained to me that my son made it so hard for her, he no longer wanted to work at all and he had abused the two girls so badly that she no longer dared to go out waitressing. She begged me, however, from the bottom of her heart to come home so that the children could see a father again and that I should come down on the oldest one. But to this I answered I am not coming home today, and to her I said *she should just come to me sincerely and ask me* and then I would consider what I was going to do. I heard that the *children were hungry*, I called out often that they should come up to me, I had bread and sausage there, they could eat their fill, I would also give them money so that their mother could also cook them something hot to eat. But none of the children came. I then divided the bread and sausage and called them and said kind words to them, I saw no-one and just heard my wife complaining that I should come back home.

I and my comrades then went to the V… pub where I drank three glasses of beer and my other housemates were there too. A good friend of theirs was celebrating his birthday there and I waited there until all four of us left together.[17] We then set off home together and next to our rooms we drank or rather I drank a beer. Then I heard again, *we'll get him out tonight,* break the windows down and if he is sleeping carry him out with the bed and all. And if we do not get him tonight, then I will go past the gravel-pit tomorrow and I'll settle with him there. At half-past five all four of us lodgers went to bed to sleep. They all told me to be sensible and dismiss the thoughts from my head, there was no-one there and no-one wanted anything from me, I would make myself worried about it, but there was no point. Finally I fell asleep peacefully and then I woke up again, looked to see whether the windows were all still closed, whether the door was still closed, it was still closed but my comrades had opened one window. Then I became uneasy again, heard people *climbing about on the roof to come and get me*. I called to one comrade to say that they were looking for me again, but he said be sensible, go back to bed and sleep, you won't be able to go to work tomorrow at all.

I went back to my bed, but could not sleep. My *wife* came to me in my thoughts, but it was all an illusion, she said kind words to me, I promised her, but did nothing afterwards, then *Martin Bauer* came to me and lastly also the other lover, the *electric conductor,* together with his wife. But all four of them were *entirely naked*, none of them had any clothes on. They *then wanted to torment me* and behaved *immorally* together. They asked me whether I liked it and if not they would kill me, I then got up, no longer heard anyone speaking but just saw my wife with the children together with Martin Bauer standing on the ceiling in my room.[18] Then only my wife was talking and she said that she would no longer come back to me, *she was engaged to the conductor*, because he had already been thrown off the tramway because of me and *now she had to marry him*. Otherwise things were going badly for her. The conductor's wife then wanted to come to me, but I did not do it. I told her then that she was not yet divorced so she could not marry. They both then said they were already together, which was the main thing. I, however, wished the happy new couple every happiness

17. In the bar someone said: "We won't do anything to him, we've known him a long time", and someone else: "I'm going to shoot him down." But they had their backs turned to him and he did not see their faces, just heard their words.

18. They were having sexual intercourse together standing up. The conductor called out: "You'd like that too, wouldn't you?" The patient answered out loud. He saw everything with his eyes open. Further details are very vague: he had actually not seen where and on what they were standing, but had only listened to their words. When he turned away, he saw nothing; "when I looked to the side I saw them again." Whether he saw anything with his eyes closed he does not know.

and a rapid marriage, but promised that I would not now get divorced so that they could not marry.

In all of this I became very tired, but could not sleep. Finally everything appeared in front of me, all sorts of thoughts came to me, all of a sudden I or my room was crammed full with *relatives from my side as far back as the oldest generation on my father's side*. In other words, my great-great-great-great-great-great-great-great grandfather who supposedly told me that he was born on 15th April 1475 and the same grandmother on 15th March 1473, and *nothing evil could befall me*, which is what the same relatives said as far down as my father and mother together with my eldest sister who has also already died. Finally between eleven and twelve o'clock at night I became awake again, but still thought that I had been severely deluded yet was no longer able to control myself, but my father and my mother, whom I did not know at all, then also said to me they had died so early that I could not imagine them, and he said that he was wounded in 1866 and 1870–71 in the campaign, my grandfather also told me of 1848 and my father's brothers told me of those who had been wounded and died in the campaigns and that they would *take me under their protection*, which then went on until one o'clock. They all came to my bed and asked me what I wanted and why I was disturbing them in their grave. I answered that I had not called them, they should just sleep quietly, which is what they also wished me, only they still all appeared by my bed and said what all their names were, how they all were related to me as far back as the oldest generation of fourteen hundred and fifty-seven years.

Then towards daytime I slept and in fact very well. On Monday morning I was very tired, yet still wanted to go to work, but could not. My landlady, widow K… said I should just stay at home, I should get up and drink coffee and she would make me some tea which I drank and I should go to sleep. Then she sent for Dr C. of M…straße Mannheim.

When I then went to my room, I heard *my wife* complaining and moaning, heard *her brother* cursing with her because he could not overpower me, he had become angry because I was stronger than him. Her brother had my wife living with him, he then wanted to chase her out, she should just go back to me, she had married me so she should live with me as well. I then heard how *my wife was abused*, then I defended her in my thoughts and asked that he could do nothing to her, but then heard my mother-in-law talking and saying, you see, *Moritz is stronger than you,* he has power over you so that you cannot abuse Martha and the children. Finally I recovered, got up and then saw on the opposite side that all *my relatives were on the roof* and all of them were calling to me to help them come down again, in my delusion I saw what actually had to be done and helped them down. But they got back onto the roof again and I saw then that it was a *fine wonderful plain* and that the figures were surrounded by a *beautiful glow* and suddenly I heard moaning, *my wife had fallen through a hole in the roof*, my mother-in-law also fell off the roof and each of them broke an arm and a leg, my wife had apparently also broken the small of her back. She was taken to the

general hospital where *she then begged me for forgiveness* for what she had already done to me, she could not die otherwise. and I should keep the children with me after all. *I then forgave her everything* and promised her that I would go and fetch the children immediately and that I wanted to see her once again with them, but she refused this, then I heard that her mother had heard everything and she then said to me that *all of what she had just told me of that was untrue*. She was sitting at home quite happily and healthily and her son had gone abroad and she would be happy once more if I were with her again. However, she was not allowed to any more, the *electric* was staying permanently with her and they *would now soon marry*. My brother-in-law now came, his mother explained the events to him, what had happened between me and my wife and that the mother had told me the truth that my wife had deceived me.

About six o'clock on Monday evening, *Doctor C…* of M…straße Mannheim came to me in S…straße. He told me I should not go to work for the time being. It would be better if I were to recuperate for a couple of days and he asked me whether I had already had a problem with my nerves and I told him last year. Then I talked about 23rd July to 6th September. That was when I was in Heidelberg for 10 weeks. He then said that it was in fact not so bad, but I should just not go to work, otherwise it might become bad. I should come to him early tomorrow during surgery hours and he would then give me a certificate for hospital and I would, therefore, need not go to Heidelberg. But I said I would rather go straight to Heidelberg because I was also in hospital here for two days last year and had no rest and became increasingly more restless, but when I went to Heidelberg from that moment on I was happy and saw and heard nothing more, so that Dr C … then said that if I thought that things would be calmer for me in Heidelberg, he would advise me to go there, so that I would be recovered again in a week to a fortnight. I should come early on Tuesday to the surgery and then he would grant my wish.

My eyes were then affected and I *saw everything double*, my eyes sparkled, and it was as though there was *lightening flashing in front of me*.

Throughout the whole day I then *saw figures*, I heard the *neighbour's people complaining about the image they saw of me*, I did not want to work at all, I would earn my money more easily that way. Then I said that I had lived here with my family since 15th August 1904 and that I had worked every day. I *was ashamed* and *hung a tablecloth over my windows* so that the people could not see anything any more. I then calmed down and went to bed again, but could not sleep, got up and sat down in the garden house and my landlady had milk fetched for me, which I then drank. After nine o'clock I lay down to sleep and then I saw a familiar white man standing in the window with a *pick, spade and shovel* and I then heard that my relatives said Aha, now they've got him, now he's lost, but I was not afraid at this because I recognised the face, I went over and asked what he wanted, and he answered that *if I did not let him have my wife so that he could marry her I would have to die*. Then I stood at the window and saw the figure going to and fro, took the curtain in my hand and saw that the person in the

window had disappeared. When I moved away from the window, the person came back. I then pulled the curtain back and covered the window again with the tablecloth.

Suddenly about *twelve high-class gentlemen* then came to me, but said nothing about me because I did not understand them. Finally *I drove them out* and then some *men dressed entirely in black* came in. There was *a small boy* with them whom I did not know, who *revealed to me* that I had chased them out. They had then struck two people dead and finally had found me still in bed, *but could not strike me dead.*

Finally, the *doctors from Heidelberg* came, the professor together with Messrs Kronfeld Ranke Willmanns and Schultheiß and two warders with them and then the professor held out my photograph to me which I immediately recognised. Suddenly they placed a larger and a smaller plate on my head, which I tried to remove but could not. They also had largish and smallish *brushes* in order to make *me* completely and *totally black*. I pulled the blanket over my head, but finally the blanket was gone and I saw that I was now quite black, then the men laid themselves down to sleep beside me around the table as if there were hammocks. When I then saw that they were asleep, I got up and went to another room to my comrades, one of them took me back to my bed and very fortunately the men had disappeared.

And then I wondered about how they had got out because all the windows were shut. I then collected my thoughts together again and I firmly decided to dismiss the thoughts from my head and now sleep quietly. Only when I slept I heard something else and I looked around, saw my wife, the electric tram conductor together with his wife and Martin Bauer. The conductor's wife stood beside my bed and begged, but I turned her away and said she should stay with her husband. They were also all black but were able to clean themselves immediately and said that they could save me *if I left my wife to them*. They then *cut me lengthwise into pieces* which I felt, but I accepted my *fate*.[19] The conductor undid the plates which the doctors had fastened to my head and fastened them on to Martin Bauer's head who should have had my name, but they did not understand my name correctly and he claimed he was Valentin Klint, not Klink, and they thought I was dead. So the conductor married Martha Klink and Bauer the conductor's wife.

After 12 o'clock midnight on Monday, I heard something whirring and got up to see what it was. And it looked something like a *Zeppelin*, only at the front just like a horse and a driver who steered the vehicle, which had stopped before my house on the street and anchored itself firmly, but it was still floating freely in the air, from which *a horde of men* leapt out who were disguised and *were looking* for me and who wanted to *take me with them*. They looked first

19. While being cut up he "felt as it were twitches". He had no pain, saw no blood. He had heard however: "I'll cut him into pieces". But he really did see Bauer, he was kneeling on the patient when he was lying in bed.

on the opposite side and then a woman said there is no-one here, who are you looking for and they answered nothing, so the woman then said just go straight over there, you'll find him there straightaway, the person you are looking for, that's him standing there laughing at you. I actually stood at the window in my delusion and watched the whole procedure and was pleased that it was so nice. Finally then they also came over to me, found me, but they couldn't get in because the windows were locked as well as the door. I was pleased to see how eager they were but they could not get hold of me. One of them placed a notice on my window, but I was cleverer than them because I was not curious about what was written on it. All of a sudden I heard that the *men had damned me* to the deepest damnation. Then I heard wife and children together with the other relatives complaining that they *also* had been *damned* by these people and yet they would not have believed it of me that I would do this to them. *If they had known that, they would have treated me differently. But I said what is done is done, and I know only duty, right and justice, those are my three qualities. And no lies, as you have tried to fool me the whole year.*

Finally everything disappeared from me and I saw that what I had just seen could not have been possible, and then opened one of the three windows and breathed in a little fresh air. Then I went back to sleep and when I was asleep I had a beautiful dream. All of a sudden *three or four men grabbed me and took me away*. I *wanted to cry out*, but *was forbidden* from doing so, if I uttered a sound, I would have to lose my life. Then I came into an *enormous large black hall*. There the people were *sorted*, I was naturally no longer so calm and started to speak. Then they put me far down a shaft where people were disembodied and their spirit was caught and kept. Finally I was saved, I was overlooked when my turn came to be disembodied and the man who did this had a small shovel and then stabbed the people in the chest and body, twisted it around and so took everything out of the body, threw it away and someone else caught the spirit. It was not long before the spirit started talking. Suddenly the order came, you must not disembody Moritz Klink, he is a *special man* because we must first let him finish his training. The answer then came it's too late, I heard that and I called out it is not too late, I am still alive. Then the doctors and the professor from the Heidelberg Clinic came and looked to see whether I really was the man because others wanted to be freed. But I was the right Klink because my photograph did not lie. And so I was taken to the surface because it was said that I had to be spared and first had to *undergo my examination*. I was then intended for higher people and *all my relatives were spared* and were not disembodied, but were immediately transported to their home. But they were curious about what would become of me and what was going to happen to me now. They were just happy that they were saved and I abandoned myself to my fate and said that they did not need to worry about me. *Contracts* were then *placed before me*, they were read out, but I asked that I should not sign them because I was still very inexperienced. The gentlemen then made an appointment for an examination early Tuesday morning at half-past eight. I was then disturbed from my sleep

and then very fortunately lay in bed in my home. And then I actually thought about what had actually happened. And said to myself, thank God that it is not actually true so that you only deceived yourself and that it doesn't exist at all.

I felt weak and longed to go to the hospital, but much more to the Psychiatric Clinic in Heidelberg, because I knew how I had been last year. I then heard, still on Monday night, people threatening me because they had had intimate intercourse with my wife which I claimed was why I also wanted to apply for a divorce. They all came up to the house, but no-one came to me in my room.

Finally, *Tuesday morning* came. I considered what I should do now, whether I should go to work or to Dr C… at his surgery. Because I was very exhausted, Mrs K… gave me tea which I drank and I wanted to go for a walk. Only I felt that I was weak and laid down again in my bed. Suddenly I was *informed of the examination* and I lay on my back, when I saw all the well-known doctors, together with the management of the psychiatric clinic. Pictures were shown to me, all of which I knew, through glasses. But *I was able to answer all the questions* that were put to me. The others hesitated and had false names they called themselves Klint and I was the right Klink because I was the right one in my first picture and in the second picture I was cut up, so I said immediately that they only wanted to deceive the gentlemen, they are not him. I was the right one and *received the highest award, namely the fox*. And *I was declared the brilliant sun king*. And received the title of a senior director. It was written down and I was to be in the psychiatric clinic on 5th June for a meeting. I was to receive 20 Marks for travel money. The name Klint was also written down and when the wrong people were brought round and saw this title and the clothes they were pleased, but when they came to the other side and saw their wrong names, then they became afraid and they then looked at me but it was too late, they were lost, because they were damned as traitors, and slanderers, they were disembodied and went to hell, the examination was now at an end and they then let me lie because I was in my bed and I was also very happy that I had escaped from the thoughts, but it did not last long and I was then called again because someone was to come and collect me, but I wanted to get dressed straightaway to go to Heidelberg. Now I saw to my astonishment that the black men wanted to shoot me down. Only the daylight hurt them and they withdrew again. Then came those of the day but I was no longer in my room. And this whole thing apparently came about because I apparently said *Senn Sadorie*[20] which had enabled me to make contact with the evil spirit world. I was then told I should have left the *Senn* out and should have said *Sadorie Marckius*.

Then the *commander of the night* drove up in a basket at 12 o'clock midday on Tuesday and wanted to take me away. He said that I should come onto the roof and should go with him and I said I cannot get onto the roof because I'm still flesh and blood.

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20. The word is a complete mystery to him. He heard it said during the psychosis. Whether the word occurred at all in his reading he does not know.

At this point, the self-description ended. We only learnt about the further course of events *verbally,* although his refusal to give information became increasingly apparent as the days went by. We describe initially the further content of the experiences before then reporting what can be established about the general psychological state.

The last situation which was described in the self-report was interrupted when at *2 o'clock* a warder whom the patient immediately recognised again brought him in an ambulance to the Mannheim hospital. In the hospital he immediately asked to go to Heidelberg. At the door he was asked to provide information about his personal identity and then taken to a cell.

In the cell he heard that everyone had to go to the hospital because he was in there. He heard the door constantly opening and shutting, the rattling of carriages. He heard the doctor's voice: we'll send that one to Heidelberg, it's what he has asked for.

The commander of the night then re-appeared with a black beard, dark eyes, dark clothes, long boots, and had a camera in his hand which he introduced through the window. The patient stood in the light and had to look into it. The patient as the 'brilliant sun king' was more or less the same for the day as the other person was for the night. He now ordered the patient to switch places, the commander of the night wanted to give orders by day because Klink was ill. They changed positions. Then the commander of the night said it was a breach of wage regulations, a state of affairs which puzzled the patient. The commander of the night had issued commands by day without the permission of the commander of the mountain party (the most senior of all the people who appeared). The patient answered that he had not agreed anything.

Between 8 and 9 o'clock in the evening he heard his wife. She said that he had been given *30 years' imprisonment*. He saw his wife as a photograph in the window. He believed in reality she was in the next cell. He told her that his case had not yet come up for trial, he would accept nothing. He negotiated with his wife. She asked for *forgiveness,* he said: only when the sentence is over. Because of a noise then, his wife and he were to be *decapitated*. He heard his wife being seized. Then the commander of the night re-appeared and said nothing was to happen to him. He heard the executioner's block being removed. The commander of the night photographed his wife. She was suddenly hanging over the mouth of the stove like a wax doll. However, he heard her run away and saw himself hanging over the opening and was photographed. The commander of the night photographed Klink in order to keep his face in mind for as long as he was giving commands during the day until Klink was healthy.

Through the skylight he now saw a *basket* and *in it, a head* with a moustache which talked to him and said to him that the *spirit of the night* had committed a *breach of wage regulations* and would be killed and *the patient also* would be shot for breach of wage regulations. Two straps then appeared and the whole cell with the bed was then lifted into the air by a motor. He saw two totally new straps. He felt that it was going up. He saw through the window that he was at

roof level. The doctor called: we will get the military to come and shoot him dead. The spirit of the night itself appeared in white clothing and reassured him: just be calm, they will not do anything to us. At first only 50 policemen came to arrest him. He just heard them, he did not see them. He heard orders being given: fifty. Then soldiers were called in who wanted to shoot up at him from below while he and the cell were hanging in the air. He heard the steps of the troops, but did *not* hear them shooting. The spirit of the night who was observing the enemy with a torch said that first he and then the patient would take 12 shots. The patient heard nothing, but saw above the skylight a large, light-coloured bullet fly past. It was as if it were day. It was said: now he's dead. An officer came (as if mounting a wooden staircase) to see whether any fraud was being perpetrated. He could be heard in front of the door. He saw that the spirit was still alive. Further shots were fired. Then it was said that there would be more shooting the next morning at 5 o'clock.

Now the '*Southern German mountain party*' advanced: "The commander with the whole of his privy council and his officials." Who it was, he doesn't know. The mountain party put the soldiers to flight.

The man in the basket – a sort of observer – afterwards wanted to torture the patient. This happened as follows: he wanted to put the patient in his place. The latter refused: "it is too lonely for me, I won't do it." The latter 'reported' him and the patient was given "30 years for disobedience". Why he had to obey, he does not know. He now wanted to go to sleep, but the person in the basket demanded that he remain awake, otherwise he would report him again, and then he would face the death penalty. He also demanded that the patient should behave calmly so that he was not heard. Finally, the man in the basket said he would give the patient a lot if he left him his brain. He wanted his brain in fact because the patient was cleverer than him. After all, he had been better than everyone in the examination and had the 'fox', the award which is the sign of cunning. The patient was now no longer in control of himself. He fell asleep and for the whole period was between sleep and waking. But the man in the basket did not let him sleep, woke him up so that he immediately came to and also saw that man again. Then however he did fall asleep. When he woke up again, he had the feeling as if there was a hole in his head, as if he could put his hand into it. He thought: now I have been tricked, he has trapped me by cunning. He heard said: he's completely taken his reason away from him now. The man in the basket had *taken his brain out*. When he now saw that the patient had the fox, he said "Oh, breach of wage regulations", and accordingly the man had to be condemned to death. In addition, the man explained: I will put another brain into him, he took the brain out the head of a 6–7-year-old boy with an instrument and put it into the patient, while the latter's real brain lay in front of him on a table. The patient grasped at his head with his left hand and threw the child's brain at him: "if I have already lost my reason, I don't need that either." At the same time, he had the feeling that he was no longer in control of his senses, that he could no longer think any more. The man now

threw his right brain down from above and said he himself now deserved to die because he had committed a breach of wage regulations. The patient wanted to put his brain in his pocket, but had no clothes on and let it lie and placed it beside him on the bench. Everything in his head was empty. He now fell asleep again, but immediately started up and saw that the brain was dry as if it would crumble away. He took it and threw it into the corner. For a further while he had an empty feeling in his head, then something else happened now, he no longer thought about it and someone said he is still intelligent. He had sat down, thought about what had happened, felt his head and realised that it was all nothing. Then he thought: you have concocted some really stupid things. He heard it strike a quarter to. "Then I was happy again that it was all nothing." He was completely relieved, but had sweated.

On *Wednesday morning*, the patient was imposed a sentence of 30 years, wrongly, as if he had committed "breach of wage regulations". Then he heard the order: the man is to be freed, is to receive a reward. He was to be released immediately. Then he again saw policemen, who arrested him and wanted to take him to prison.

That morning, the situation changed and from then on remained the same until the end (transfer to Heidelberg on Saturday). The patient is *on a ship*. The ship is travelling on a *canal*. He is in a cell, through the window of which he can see the bank. On this ship innumerable scenes were now played out in an increasingly tangled confusion and with frequent repetitions, which the patient recounts: execution, burning, hanging, crushing, starvation, being eaten up by wild animals, condemnation to 90 years of imprisonment on an island, etc. That is, all of this did *not* happen, but *was supposed* to have happened. The following in particular may be described. Policemen said: "We're going to get him out and chuck him into the water or we'll let him run across the field and shoot him down and then we can share the money." Or "we'll cast off and sail away and open it at the front and then it will sink" (the ship). Then they consulted, they wanted to leave the patient to die of hunger and collect and share out the reward intended for the patient. – Suddenly the window opened, lions and tigers came in and came up to the patient. When he reached out for them they had disappeared. – He heard the ship's engine going, noted they had stopped before a lock to allow it to open. – The bolts were released so that the ship would sink. But it did not sink because the canal was not deep enough. He saw water enter the cell, but not a lot. The three-part floor was opened and he saw water through the crack. – The trees – in his opinion real and seen the whole time – were suddenly less clear. He felt the ship going sidewards and being drawn over to the hostile bank. The trees disappeared. One bank was in fact 'home', the other 'hostile'. Here there were large holes, down which people who were not to be decapitated were made to disappear. In one of these the patient was supposedly let down 25 metres and there they wanted to let him drop into an 82-metre deep hole. In between whiles he heard the captain: "He is not getting anything more to eat; he is going into the water; he is going to be decapitated;

he is going into the hole, etc." His wife was thrown into the water three times. He heard her cry out and shriek. But each time she came back to the land. Then his wife was thrown to the rats in a hole. Again she called for help. He answered that he could not get out, the people would not open up. But he asked: "if you want to chuck me out, chuck me down where she is." – Another time he again heard his wife saying that a telegram had come, he was not to be killed, he had been granted his 30 years. He had to be taken to Heidelberg.

In the hole, his *wife was now finally dead* and eaten up by rats. His children also were killed. But on the following day, the patient saw his wife's face on the wall, talked to his wife, who now appeared as a *ghost*. She said that their oldest son had thrown the two girls into the water and finally he himself had been thrown in. Then she explained to him how he was to die so that *he would come to her*. He must also be drowned. *She still liked him*. She then lay beside him at a certain distance. But no contact took place. His wife complained once that she was hungry. He placed a piece of bread on the bed. In this way his wife now accompanied him *constantly* as a ghost until finally he came to the Heidelberg clinic. He did not take her in with him. She complained that now she was being abandoned and said: "Don't you know me and the children any more" and "Farewell Moritz, we will not see one another again" and went away. At that moment he was filled with pain. But by the time he was in the bath in the clinic he had 'forgotten everything'. Only the idea that his wife really had died still accompanied him for some days.

From the moment of his entry into the clinic, he heard no more voices and saw and experienced nothing else. He was extraordinarily *weak and exhausted* (weight loss during the psychosis from 156 to 138 pounds) and slept solidly. He also gave the impression objectively of an exhausted delirious patient. When he woke up on Sunday, he again thought his wife was dead. Only over the course of a few days did it become clear to him that everything had been an illusion. Before we describe the long-term state and the subsequent course, we reproduce the relatively little we were able to discover from the uneducated and not highly observant patient about the general psychological circumstances in the psychosis.

At the beginning of the psychosis until his admission to the Mannheim hospital, one scene followed on relatively slowly from another with relatively long interruptions in-between. The same scene never repeated itself. Day by day the experiences became more numerous, ultimately 'febrile'. The beginning 'was mild' compared to the events in the hospital. However, as far as he was concerned, the patient always remained *fully conscious*, *was totally awake*, can *remember* everything (with the exception of individual details, e.g. the name of the commander of the mountain party, etc.).

At the beginning of the psychosis he was entirely free again for relatively long periods in-between times, as is apparent from the description. When the events became more plentiful and more continuous, he regularly managed to orientate himself completely and to dismiss everything. He lay on his side and

then the naked people were gone. Or he got out of bed and it was gone. He repeatedly then said to himself: it was an illusion what sort of stupid nonsense was that. "At times I did not know where I was, I was overwhelmed by thoughts, but pulled myself together and then knew what was going on." Finally in the hospital, he got his bearings from the warder, looked out of the door and found: it's not a boat, but the hospital. He wondered to himself: it's a boat and yet it's in the middle of the city. But those were only brief moments and he does not know at all whether he managed to orientate himself in the last few days. "Then it took firmly hold of me." "I no longer knew whether it was day or night, thought on Saturday that it was already Sunday." He did explain, however, he had been *totally awake* and would have been able to orientate himself if he would have been approached by something which was real. "I knew everything that occurred." He would always have known that it is the year 1912. When he was transferred from the hospital to Heidelberg he knew immediately what was going on.

The patient was not able to describe clearly the nature of his states of consciousness. He emphasises his complete wakefulness, but on another occasion repeated that his orientation in the interim periods was like reawakening. It was however *not*, and he emphasises this, like waking from a dream. The comparison with a dream seems inappropriate to him: what he experienced was all too real and he was totally awake.

During the whole period of the psychosis he *slept only very little and briefly*. "Otherwise I would not have lost so much weight." Sometimes, however, he believed that he was overwhelmed by sleep for a while (cf. the description of how his brain was taken from him during his sleep). He was quite extraordinarily weak, in the end had pains in his limbs and fell asleep at times in the ambulance even during the journey from Mannheim to Heidelberg.

The description of his experiences appears to us too orderly. He is not truly aware of the *contradictions* which in the course of the psychosis show the same experience in very different lights, but always recurring consistently in his memory. That is most apparent with the brain scene.

The patient's *consciousness of his own personality* was, as far as he states, always preserved. He had admittedly become amongst others the brilliant sun king but always felt himself to be Klink.

He never had a feeling of strength, a feeling of power, *never did anything active*, but simply had to speak and respond to all questions and orders. He felt himself entirely powerless, passive, dependent. I was "as if taken prisoner." At the beginning of the psychosis he was very *frightened*, but very soon – after the 'examination' and the 'cutting up' – the anxiety disappeared. He accepted what happened more *indifferently*, even if it was totally appalling. "I could not do anything; it was simply a matter of surviving, nothing else, what can you do when you are in it. I was totally indifferent to what would happen." "You simply have to see how it goes." To his mind he never had a feeling of happiness when he acquired high titles and the like. When he emerged from his experience for a

moment, he felt *relieved*. When he looked out of the carriage during his transfer to Heidelberg, he said, "I was happy that I was out of the delirium. Everyone should go through it at some point. I was *happy to have peace*."

In the last days of the psychosis he had hardly thought at all about his state. "I was in such a jumble that my thought processes had gone." Sometimes, however, he had "laid himself down totally indolently" and said: "what has all that got to do with me." He thought to himself I will only answer as much as I want; when I am tired, I will lie down on my side. When he moved, someone immediately called: 'quiet.' Apart from these minor traits, he had never resisted, but had let everything flow over him.

As far as the way in which *the contents of his experience were presented to him*, the patient cannot give any very clear information. I had the impression that in his descriptions, the material descriptive element was too much to the fore in relation to how things really were. After all, he had a wealth of hallucinations. Optical: figures, pictures, animals, Zeppelin, basket, etc. During the whole psychosis, he heard voices whose nature could not be established but which were apparently embodied. In addition, states of awareness undoubtedly played a major role, but he said nothing about this.

Following the end of the acute psychosis with his admission to the clinic – while he was under our constant observation – Klink was constantly collected, orderly and orientated. However, *psychological transformations* occurred in him during the weeks that he remained in the clinic. Initially he recounted his experiences without reservation, wrote the self-description, until – after about 2 weeks – he said he would write nothing more and he wished he had not written the rest. In the self-description, it is also stated that he wanted to get divorced from his wife, but now the opposite was the case. He had only the one wish, to talk to his wife. "First my wife, then I'll finish the description." His wife came and said she wanted to stay on her own and not to live with him any longer. On the following day he declared that he now no longer wanted to continue with the description. "I have put it behind me, I am quite relieved and lightened." He is without doubt in a better mood than before his wife's visit despite the unfavourable outcome. He explained that he had done what he could, he had wanted to go to the institution for alcoholics in order to set his wife a good example, etc. Now it didn't matter to him. Then, however, he again said: "My wife has no reason to get divorced. I will not allow myself to be divorced." He does not push at all for discharge: "That is up to the doctors. I have no say in that at all."

Verbally also, the patient now became difficult. He often refused downright to answer, particularly in respect of the last part of the psychosis in which his wife appeared as a ghost. He stated: "When I start telling something like that, my blood immediately starts to boil and makes me sweat." "Anyway, if I were to tell anything, I don't have it as it was, the words are missing." "I can remember everything but don't want to go into it." "Why should I get upset up each time and constantly repeat it. Only when it's clear in my head (he meant his relationship with his wife), then I'll write it down outside and bring it to

the clinic." "I have already said enough, there aren't many who say that sort of thing." During his narrations, his actual agitation can be objectively observed. He becomes red and pale, sweats, appears embarrassed (on being asked about the elevation of his person, feelings of happiness, etc.).

It is now also very striking how he thinks about *the future of his marriage with undeniable optimism*. However, he does sometimes say that if his wife is once again unfaithful: "then firm action is going to be taken, then it will be divorce", but without true seriousness. His wife, who has long been a prostitute, refused to get back together with him, visited him once, but then did not come back again. However, he received a letter from his sister-in-law, saying his wife would come back to him if he kept his promise: handed over his wages, drank nothing. He justifies the fact that his wife no longer came: she was embarrassed, because the last time she had made such unfavourable comments about him to the doctors. He believes his marriage will turn out well, actually there is no doubt for him: "Last year I needed two days. On Sunday it will be good" and with this comment he was discharged on Wednesday 31st July.

He was generally somewhat mistrustful towards the doctors, without having *specific* delusional ideas. He thought people perhaps wanted to make him mad or the like, or again they thought that he was mad, that he was stupid. People helped his wife but gave him no rights at all. "Nowadays the man has no rights any more because it's women's rights."

The patient's *behaviour* in terms of movements and gestures is natural. His facial expression is unremarkable. Perhaps sometimes a certain euphoria appears without sufficient cause. The whole appearance of this tall, strong man has something exhausted about it.

To characterise his nature, we add further a few passages *from letters*: on 28th June 1912 he wrote the first letter:

"Dear sister-in-law… Once again now I also ask most sincerely for forgiveness from the whole family Katz (wife's family) and relatives very sincerely. In that I now see that I must bear the main blame… I have my past life before my eyes, the present also. But the future should, nevertheless, be a happy life for our family. I have something important to say to my dear wife and children because I now no longer have any peace in concealing myself from you… I hope that my dear wife and the older children will forgive me everything, which I will also do in order to lead a peaceful life again… Respectfully M.K."

He also writes "Please respond quickly… and finally

Hear this, dear sister-in-law mine,
I, your fifth step-son in line,
In drink did I my deathbed find
I cried: "Oh Martha, please save me"
But none there was to hear my plea,
So in fear and torment did I sink
yet ever further down in drink.

For, dear sister-in-law, think thereon,
That what God does, that is well done.
Your brother-in-law sends his kindest regards
to all his relatives
Respectfully Moritz."

On 7th July he wrote to his wife:
"Dear wife and children!
I inform you most humbly that I should like to speak to you… (wants to go to the "Blue Cross" and to an institution for alcoholics, promises, etc.) …. I look forward most certainly to seeing you on Tuesday at mid-day. You should also come so that I, afterwards, can be quite calm and certain of what you will receive when I go away for a cure. Best wishes….M.K. Dear wife, when you come, bring something with you for me to smoke. To our imminent reconciliation."

In analysing the patient, we can first of all characterise the appearance of the acute psychosis from a subjective angle, the *phenomenology* of the psychosis in its essential features. Secondly, on the basis of the data from the case history, we can form an opinion on the question of the *cause and hence the nature of the psychosis*, and thirdly we can investigate the *understandable relationships* between the patient's lot and his experience in the psychosis. We had no opportunity to examine the objective manifestations of the psychosis, the changes in mental functions in terms of *performance*, in the way that experimental psychopathology allows in other cases, so that in this case, as in the following one, we must refrain from using the viewpoints of *performance* psychology.

1. In terms of *phenomenology*, we confine ourselves to the second psychosis, the only one for which we were able to investigate the patient personally and refer to the description towards the end of the case history (p. 361). The nature of the patient's *general state of consciousness* is not definitively elucidated. His descriptions sometimes sound as if he had experienced a dream-like reverie succeeded by a period of awakening. On being questioned, however, he constantly emphasises his *complete consciousness* in all his experiences, his *total wakefulness*. He slept occasionally and was clearly able to distinguish this sleep *in the psychosis* from wakefulness *in the psychosis*. He has an *excellent detailed memory* at all times of the psychosis and this was shown to remain completely unchanged in numerous investigations

and in the written self-account. This is, therefore, quite different from the nature of memory of dream states. His state of consciousness, moreover, was such that *real* facts which occurred to him externally were *correctly recognised* as such. To this extent, he was *orientated* during his psychosis. He knew what was going on when his landlady brought him tea, the doctor visited him in the apartment, he was taken to the hospital and when he was transferred from Mannheim to Heidelberg. At the beginning he was often aware of his 'delusions', his illness, but less so later on. Whereas, initially, he lived either in his experiences *or* in reality, increasingly *reality was merged into the experiences* and, for example, the same cell was mostly seen as a ship's cabin but for brief moments also as a hospital cell (*dual orientation*).

The experiences were initially individual scenes that followed one another, interspersed by intervals. Later, the experience became increasingly more continuous, uninterrupted, 'febrile'. Initially, the same event did not recur twice in the same way. Finally, frequent repetitions occurred in an ultimately confused chaos.

Initially, the patient had vivid feelings of *anxiety*, a great fear of persecution, but soon this feeling completely *disappeared in the psychosis*. He became strangely *indifferent*, let everything go, looked on from the outside, was not afraid, was fatalistic. He was totally lacking in any semblance of activity. He abandoned himself completely *passively*, felt absolutely powerless and submissive. When the experience stopped, he had only the feeling of relief that he now *had peace*.

We *characterise* this type of short-term psychosis in summary as follows: with a *completely alert* consciousness and a *preserved capacity for orientation*, an extremely *rich experience* occurs which develops out of initial individual *scenes*, out of *fear* and out of *persecution mania*, in the course of which the anxiety entirely disappears and gives way to a feeling of total *indifference* with *passive, submissive abandonment*. Lastly, there is a reliable, *detailed memory* of all the details.

2. When we ask about the *causes of this psychosis*, then at the same time this is a question of diagnosis. At the beginning of our investigation, we believed on the basis of the case history data, the vivid sensory nature of the experiences, the total exhaustion as a result of

the psychosis and the ultimate sleep followed by insight that this was an *alcoholic* psychosis. We were obliged to *abandon* this opinion for the following reasons: the *psychological type* of the psychosis was not in any way an alcoholic one and the fantastic nature of the experiences, their relationship and the capacity for orientation argued against delirium. Only the onset involving anxiety and persecution associated with orientation suggested alcoholic hallucinosis; the subsequent course with indifference and passivity but without fear provided a decisive argument against this diagnosis. Furthermore, the *case history data* point to the *consumption* of alcohol but *not* to *alcoholism*: his criminal convictions were not convictions for alcohol-related (violent) offences, he had worked constantly without any decline in performance, his behaviour at home was not that of an alcoholic; despite his justified jealousy which distressed him so much, there was no typical alcohol-induced pathological jealousy. No signs of *addiction* to alcohol could be found and, in fact, it was more likely that the increased alcohol consumption was a reaction to the distress caused by his wife's behaviour. Finally, the patient's *general behavioural disposition* argued against alcoholism: there was absolutely no alcoholic humour, no arrogant lack of insight. He admitted to drinking alcohol without any reservation and was also prepared to go into an institute for alcoholics if this was what was wanted. In addition, all physical signs of alcoholism were absent.

Looking at the disease history as a whole, there can be no doubt that both psychoses are of a *reactive* nature. *Living together with his wife and children was extremely important* to the man. He describes convincingly how much the contemptuous treatment by his wife distressed him. *Twice* the wife had *left* him. He had to live alone, suffered extraordinarily, always thought about his lot during his free time and on *both* occasions developed his psychosis, on the first occasion *after about 7 weeks*, the second *after about 3–3½ weeks*, and in each case the *content* of the psychosis was constituted predominantly by the *relationship with his wife*. We will detail the individual comprehensible relationships shortly. First of all, however, we ask about the cause which produced such a psychotic reaction to his lot in this man. Was it his permanent emotional constitution that had existed since childhood? (Was it for example a *hysterical* reaction?)

Or had a process altered the man and was it a reaction on the basis of the change engendered by the process? (Was it a schizophrenic reaction?) We are of the latter opinion for the following reasons: the psychosis itself does *not* exhibit the clouding of consciousness which is typical for such *severe* hysterical reactions, the hysterical aspect is absent, and there are also no theatrical traits in the psychosis. There are no hysterical signs. The characteristics of acute psychosis present include the fantastic nature of the contents, the rich experience without any marked clouding of consciousness, the preserved capacity for orientation and the good memory, which we are frequently accustomed to find in psychoses of certain processes. A specific *start* to the process was not apparent, but the patient's strange reading material, his rigid behaviour, the enduring after-effect of the psychosis which prevented him from obtaining any clear objective emotional attitude despite a rational insight into his disease, his constant uncritical desire to live together with his wife despite all her infidelities and rejection, his optimism about this relationship, his tendencies to delusional ideas (mistrust of doctors) and finally his somewhat strange letters support the existence of such a process. Even if a process in the strict sense cannot be considered as *proven*, nevertheless the fact that the psychoses are neither alcoholic nor hysterical and that they at least belong to the family of usual schizophrenic eventful psychoses should be convincing. A more detailed differentiation is not possible at present when we have only a few fairly broad definitions of illness. Those who consider the *psychological* type of a psychosis as decisive will probably consider the diagnosis of schizophrenia as definite in our case, whereas those who require the demonstration of a process *beginning at a specific time* and of *incurability* must remain doubtful and possibly attribute the impossibility of these decisions to the patient's low level of education.

3. The *understandable relationship* between the patient's marital fortunes and the content of his psychosis is obvious. Not *any old contents* of his past life, but contents of the *most recent* actual emotional upset occasioned by his lot are incorporated in the psychosis, there is not the obvious relationship of all psychotic contents with contents acquired some time previously, but the relationship between

a triggering event and the psychotic experience. The only question that remains is *how far* we can extend our understanding and where vague and unfounded interpretation begins.

The patient *himself* is clear: "My illness does not come from the large amount of drinking, but it is mainly thoughts which I had about my wife and children", and after a detailed description of the relationships he opines: "You do not need to be an alcoholic! No common sense can tolerate that! How my wife can destroy one by spite, hate and bitterness." Beyond the simple observation of this relationship, the patient provides no help through his own assessment, but only through his descriptions.

We now turn to the *first psychosis*. The intense emotional disturbances from which the psychosis was to emerge seven weeks later had begun when his wife had run off with her lover, Martin Bauer. The patient describes to us his agitation, his thoughts, how the two of them are now leading a fine life and he has to pay. He describes how he tries to help himself by having them banned from access to the house; how he lived for the day and abandoned himself to his thoughts as to what would happen to him and the children. His agitation is increased by gossip about other infidelities by his wife. In the increasing agitation, he sold all the furniture a fortnight after his wife's departure; what he could not sell, he gave away. As he was now living in private lodgings, he writes, "I was unable to control myself, thought constantly about what else might happen to me." He 'lived restlessly', but worked every day, could not eat any more and 'kept going by drinking'. When his wife returned to Mannheim, he tried to persuade her to come back with him, but was greatly afraid of her lover who was present at the time and who had beaten him up on one occasion several weeks previously. He achieved nothing, was tormented still further by teasing by his fellow workers and then, after eight days, fell into a psychotic state which developed slowly over the course of several days from a collected state of mind and then disappeared within two days. His condition started with a feeling of fear and a sense of being persecuted; he moved in the real world, went to look for a new job in an orderly fashion at the labour exchange, but was constantly pursued by his wife's lover in the process. A large number of unknown

people then appeared, 117 cannons, etc., that were directed at him. At the climax of his illness in the hospital cell, he saw his wife's lover and saw his children. He struck out at the lover. He demanded his wife for himself, but the lover picked her up and held her fast. In this way he raged for several hours until he fell asleep and awoke the next day, recovered apart from the lack of total insight.

The content of the psychotic experiences, therefore, comprised the anxieties and wishes of the patient which had constantly occupied him during the last few weeks before the psychosis. The same anxieties and wishes caused by the long sequence of emotional upsets that had resulted in the change in mental mechanisms to the transient psychosis. In particular, the anxieties found their embodiment in the psychosis through the persecution by the lover. Out of fear of Bauer, as he himself states, he then thought that everyone who came up to him wanted to shoot him dead. But his wishes also found their fulfilment: he beat up the lover and was near to winning back his wife.

Can we go still further in our understanding? Can we understand the phantastic pursuits by hordes of people and cannons, the discovery of invulnerability to bullets, the content of the voices saying he was a murderer, etc.? We know that the Freudian school would point out to us here a number of relationships: some childhood memories or other lie behind the peculiar sexual relationship with his wife with its lack of sensuality; his desire to murder the lover resonates back against him in the accusations of his persecutors that he is a murderer; his suppressed feeling of inferiority is represented in his consciousness through the feeling of invulnerability to bullets and through the pride of the inventor, etc. For us, *this* understanding has little force of conviction. It is an 'as if understanding' which has a certain plausibility in terms both of the accusations that he is a murderer and of the idea of the inventor and the invulnerability, but does not bring us any satisfaction. Arbitrary associations, i.e. associations that are not *understandable* through the affect-related experiences and events but instead are *casual* and which can arise from any previous and current impressions could, in our opinion, produce the same result. The difference between the understandable relationships which we acknowledge and those we reject lies

in the degree to which the psychological empathy (and not rational comprehension) permitted by the quantity of material available, makes the psychological relationship obvious to us. By its nature, this obviousness necessarily entails that there is an entire range of transitions from *convincing* relationships through *dubious* ones, more or less *plausible* ones, to relationships that are *entirely unconvincing*. Somatically oriented psychiatrists usually set the *limit too low*; the Freudian school *sets no limits at all* and not infrequently makes a judgement on the basis of *rational comprehension* of associative relationships rather than on the basis of broad *psychological empathy*.

The disease course in the early period after the psychosis is characteristic. The psychosis must have brought with it as it were a discharge, a relief from his oppressive worries and anxieties, a release from pressure and despair. During the first few days he is *content*, talks about the idea of his invention, wants to *get a divorce*. However, after some weeks he says: "I have now directed my thoughts back to my family again." He attempts to get his wife back in a planned and consistent manner, no longer wants to get divorced and then actually goes back to living together with the family.

The development and course of the *second psychosis* have a great similarity to the first. The psychosis here erupts more rapidly, lasts longer (seven days) and is considerably richer in terms of content. Once again his wife leaves him after many tribulations over the year: the electric tram conductor emerges as a new lover. Again it takes some time before the patient, abandoned to his thoughts, becomes psychotic as a result of his emotional upset. Once again the content of the psychosis is clearly related to events, once again he feels released after the resolution of the psychosis, wants to get a divorce, is unreserved in the information he provides and then again, after a few weeks, devotes his attention entirely towards living together with his wife, gives up all plans for divorce and at the same time becomes more reticent, more negative towards all the questions about his lot and his psychosis.

As regards the patient's state of mind at the time his wife left him again, his unsuccessful attempts to bring about a reunion and the rapid withdrawal of his application for divorce, we refer to the relevant account in the case history. The psychosis again occurred

on a Saturday evening and a Sunday (*possibly* the longer lack of distraction provided by work plays a certain role in this).

The change in the mental disposition and the extra-conscious mechanisms whose origin we glimpse in the constant emotional upsets in a schizophrenic constitution first became apparent in vague *anxiety* and in the *feeling of uncertainty*. After just a few hours, however, the vague feelings were already assuming forms, initially only those relating to the relationship with his wife: his brother-in-law and other relatives threaten him, then they admit he is 'completely right' and want to force his wife to return to him. The voices of the in-laws call out: I will stab him, and then: You are not doing anything to the man, I have known him since he was a child. So it goes on backward and forward. Then he heard his wife being abused, his children were crying for him, his wife wanted to go to him. He then adopted a gracious attitude: she should come to him in all sincerity and then they would consider things. He called his starving children to come for bread and sausage which he divided up, but no-one came. This, therefore, initially involves the *psychotic embodiment of processes* which were actually possible in his current situation and which *constitute the actual content of his life in recent times*.

In a second phase, fantastic embodiments appear, but these are still in entirely the same comprehensible relationship to the cause of the psychosis. Both of his wife's lovers, Bauer and the electric conductor, and the latter's wife appeared completely naked, wanted to torment him, copulated with one another while asking him whether he liked it. His wife explained she wanted to marry the conductor, the patient wished them luck, but refused to divorce her.

In a third phase, the patient's ancestors, who are totally unknown to him, appear in his delusions, telling him their story, assuring him that nothing can happen to him, that they will take him under their protection. It is possible to *interpret* this scene as a wish fulfilment of a drive for protection and safety from the persecutions and to understand the ancestors' accusation that he was disturbing them in their graves – he had not invoked them consciously at all – *as if* an unconscious wish on his part had called them up.

We, therefore, now have three motives for the psychotic contents: 1. Embodiment of the wish for a further reunion with his wife and embodiment of obstacles to this. 2. Embodiment of the persecution by his wife's lovers and relatives actually possible before the psychosis. 3. *Perhaps* embodiment of a wish for greater strength, for protection and security. These three motives run through the whole of the subsequent psychosis. However, only the content relating to his wife remains clearly recognisable as such, whereas the persecutions and the elevation of his own person assume a fantastical nature and can only be understood as being related to the original persecution through a complicated symbolism.

His *wife* broke a leg, was seriously ill and asked him for forgiveness, which he gave. The counterpart to this was then that everything was a lie, that she was not in danger of dying at all, that she wanted to marry the conductor. – When he was condemned in the course of the prosecutions, his wife and children were condemned *with* him. They were astonished, would not have believed that he would do that to them ('as *if* understandable' as a wish fulfilment). If they had known that, they would have treated him differently. – His wife repeatedly asks him for forgiveness, is with him in the hospital, is mistreated, saved, calls to him for help, and finally is murdered in a hole. He asks to be thrown into the same hole. Now his *wife* accompanies him as *a ghost*. She tells him how he must die in order to come to her, who still likes him. She was now constantly with him as a ghost at a certain distance. He laid out bread for her to eat. Finally, on his admission to the Heidelberg clinic, *he* left her and she now complained for her part that she was now being abandoned: "Don't you know me and the children any more?" "Farewell, Moritz, we will not see one another again", were her last words. – In the end, therefore, the psychosis allows the patient a relatively complete fulfilment of his wishes as regards his wife after much to-ing and fro-ing.

The *persecutions* initially appeared as threats related to his marital conflict: he was to die or agree to the marriage of his wife to her lovers. Then, however, the persecution, protection and elevation of his person becomes a uniform sequence of fantastical experiences which, in quantitative terms, occur most frequently in the case

history. The patient is condemned, is to be 'disembodied' with many others, is 'sorted' in a large hall, saved by chance, then after brilliantly passing a test deliberately allowed to live. 'Contracts' are presented to him, he becomes the 'brilliant king of the sun' or the 'commander of the day', commits 'breach of wage regulations' without knowing it by ceding his job to the commander of the night because of his illness, is again prosecuted, shot, etc. Through the trickery of someone else, his brain is taken out, confusions occur, etc.

Apart from the general mood of persecution and of being saved and protected, we cannot discover any convincing understandable relationship between these contents and the traumatic events which gave rise to the psychosis. We know that the Freudian school would not just discover such relationships individually through symbolism, but would make *everything* understandable. Since only a *possible*, but not convincing, interpretation can be obtained by extrapolating the symbolism from *other* cases, we refrain from extracting the symbolism from the writings of the Zurich School that might be applicable to our case. Since *we* were unable to observe *this sort of* symbolism in numerous conversations with the patient about his contents – apart from the few possible complex effects which we have recorded in the case history – we must provisionally abandon any attempt to probe the understanding of this case further. We admit, however, that we do not believe we have even approximately exhausted the possible limits of understanding here.

After the psychotic episode is over, the patient feels free, speaks without reservation, writes his self-description. He is full of natural indignation towards his wife: "I will get a divorce and have the children taken away from her." When, in complete contradiction a few weeks later, he has only the one thought of how he can get back to his wife again, he also becomes reticent and negative, although his condition could not be considered as psychotic. He promised to send the remainder of his self-description as soon as he was back together with his wife. This he has not done.

Dr Joseph Mendel, born 1883, Jewish, in May 1912 experienced an acute eventful psychosis over a period of 14 days. To assist in reviewing his case, we

present first of all a timetable of the main events: 1904 high school graduation, became a lawyer; 1906 plan to switch subjects, decline in application; 1908 philosophy studies; 1910 more marked change, intensive philosophical studies in Munich; 1911 articled clerk at home, state examination in December; 1912 at home; February appearance of the Lady X; beginning of April, examination disappointment due to poor grade; 8th May unexpected appearance of the Lady X; 12th May (Sunday) travel to a health resort for neurasthenia; 14th May (Tuesday) admission to the Heidelberg Clinic in the middle of the acute psychosis.

Previous case history on the basis of the relatives' reports

Heredity: Father nervous, irascible, eccentric, very independent. All of the father's siblings unusual, lived a secluded life, had little human understanding of the idiosyncrasies of others. One brother died from tabes. *Mother* nervous, mother's relatives unremarkable. Grandparents on both sides unremarkable.

The patient was the oldest of three children. His brother was nervous and had frequent mood swings. The sister also was nervous, suffered from her stomach and had a tendency to physical complaints.

The *parent's marriage* was a forced one for the mother. There was considerable disharmony in the marriage. The father was a businessman and very well off.

Childhood: Learned to walk and talk somewhat late. No bedwetting, no anxiety states, no fitting, no fainting fits. However, even as a child he *liked his comforts and was dependent on others*. To begin with at school he was a good pupil, subsequently an average one. *School was a torment to him*. In the final years, despite his ability and his hard work, he was a poor pupil. He was always very agitated in examinations and reticent in answering. He left in year eight of his secondary school because of poor grades and started work as a salesman. The job did not suit him, he was very depressed. After six months, he studied privately for school again, went back to school and, now that the marks were better, passed his school leaving examination with good grades in 1904 at the age of 20½ years.

Until that time he had not been quick-tempered and had no mood swings, but even as a child he had a tendency to fantasise and, as a pupil, had already displayed an interest in philosophy.

Physically, he was significantly stronger than later and was a good gymnast. In sexual relations he was unremarkable.

After graduation (1904) he went to university to study *law*. He worked hard in his career, but was very lacking in independence. He was not active. At the same time he had a lively interest in philosophy and literature and, even at that time, expressed a wish to devote himself to these subjects.

In the fourth or fifth term (1906, six years ago now) *his application declined*. The interest in law turned to disgust and loathing. He increasingly studied *literature* and *philosophy* and seriously *intended to switch subjects*. Since that time he had drunk more alcohol and fairly often appeared tipsy, although he himself always disputed this.

Since 1908 he felt *misunderstood* and badly treated by the family, particularly because they did not approve of his change to philosophy. He had scenes with his parents because of this plan. These scenes upset him considerably. Among his comrades also he felt uncomfortable, increasingly isolated himself, company did not suit him, people had so few interests (they were lawyers and medics).

During all those years he was often *moody*. This had become much more apparent since 1910. Since then, in his brother's view, he had *changed considerably*. He kept his parents in the dark about the fact that he now exclusively studied philosophy in Munich; he wanted to write a dissertation (his 'system') (cf. later). Since then he had been strikingly *taciturn*. He complained about the traffic, about his company which he did not like. His constant theme was that he *did not feel well*. In addition, he became much more *mistrustful* by nature. After leaving Munich, he was deeply *depressed*, *unapproachable*, had no appetite, was *quick-tempered* and at the same time had *absolutely no initiative*. On the one hand sometimes very suggestible, in other respects he was totally unapproachable, particularly as soon as he became aware of any attempt to influence him.

The change in the patient's nature was apparent to some extent as an *exaggeration of character traits that had always been present*. He was always critical and very sharp (he himself said: I am *more negative* than my brother; I see the drawbacks more rapidly), but now a nihilistic *scepticism* developed. He never had any initiative like normal people, but now he lost almost all sense of initiative.

His *behaviour* since the time in Munich (the last 1½ years) was described by his brother: He "liked to play the lunatic", particularly when he was drunk. He pretended to be indifferent, but without being so internally. Now and then there was something forced in his behaviour. Then, in the last few years, he had been remarkably brusque and insulting to acquaintances, although generally very shy. He was remarkably cleanly, washing his hands very often, but had no phobia of bacteria. In sexual relations he was always very reticent.

He had frequently uttered statements such as "Science is nothing, never yields results" and similar statements in the last three years. His sceptical utterances, however, were dependent on his mood. Internally he had felt himself to be far superior to others for five years. Moreover, he was considered in his circle to be a highly gifted lawyer.

In *December 1911* he sat his *state examination*. He had not worked for it at all, viewed the whole examination as humbug and could not resist to express occasionally opinions which were deemed 'frivolous'. Thus, as a motto on his work he wrote: "Haven't you seen the little Cohn." Moreover, he was extremely happy with his work, considered it to be good and was convinced he would gain a first.

At the beginning of April he received his *grade*, but it was a *poor second*. This had *upset him considerably*. For a couple of days he had been unable to eat or sleep, wanted to be left alone and, apart from his sister, permitted no-one access to him. On the first day he had become drunk, got up late the following morning and was very moody. He then had a scene with his mother who had given him

a lecture. Loss of appetite and a 'nervous stomach condition', sleep disorder and depression peaked off after eight days, but he remained easily agitated and somewhat nervous.

From the middle of April onwards he became calmer and more approachable, decided to qualify as a lawyer and began to work 'mentally' on a legal topic. He read widely in legal books. However, he noticed that he did not achieve anything, declared he had no stamina and became increasingly moody. In the evening, he had stared at his brother several times in the last few weeks: you don't know me any more, do you? The brother is convinced that this was said in all seriousness. He was not in any way theatrical by nature.

On 7th May they had visitors. In his depression he was unable to be polite enough to a young girl and that appeared to make him even more depressed. His mother remonstrated with him in the evening that he should finally decide on a career. He remained silent, ate nothing. On 9th May, an acquaintance who asked him about his job upset him noticeably. His ill humour had disappeared again by 10th May. On that day he even said things were going better. On the evening of that day, however, the encounter took place with the bicycle on the walk with his sister (cf. later). His remarks were interpreted *as if he did not know whether he was hallucinating or not*.

He now began to *sleep very little* and was given sleeping agents by the doctor. He complained of headache and said he needed rest.

On *Sunday, 12th May*, on the advice of the doctor, he travelled *to a large health resort* for recuperation. His mother asked whether someone from the family should accompany him or whether he should not go to N. under medical supervision. The doctor considered that unnecessary. So he went alone, went to the hotel, ate an evening meal and went to the concert given by the spa orchestra. There he suffered an '*attack*', a state of agitation, was detained and taken to hospital. To begin with he was in a single room, but later shared with other patients.

On Monday, his sister and uncle came. He said to his sister: Hanne, I'm not mad, am I? Whereupon he burst into tears. On the previous day he supposedly said he was the Emperor of China. Now he told the doctor: today he was the Pope. He said that laughing so that his sister had the impression he wanted to pull the doctor's leg. He had probably been irritated by the questions. During the visit, the patient had been entirely calm. An attendant came with them when they drove by car to the Heidelberg clinic. In the car he became alarmed when he recognised Heidelberg. He suggested driving to the hotel. He was alarmed again when the chauffeur asked for the clinic. On his arrival at the clinic he no longer responded. On taking leave of his sister, he was friendly in a forced way. In this way, the patient entered *the clinic on Tuesday evening*.

Objective observation in the clinic during the acute psychosis

He sat slumped in the reception room, staring out in front of himself, and did not stand up when the doctor came in. He answered questions about his

orientation correctly in a quiet voice: he had come from N., had become agitated there, had run up and down in the resort park, but had not taken off his clothes as had been claimed. He had been brought to the hospital and there had been given injections. He smiled at the attendant and the doctor when speaking. He accompanied them to the ward without resisting. In the private room he behaved calmly, was seated in a cowering position at the foot of the bed when the doctor came in, but immediately lay down normally.

On the next day (*Wednesday*) he was again orientated and had no symptoms, "only fantastic ideas, which I do not know whether they are fantasy or reality…, for example, I do not know whether you are actually sitting here or whether you are someone else." "I believe possibly rather that you are me." Asked about his 'fantasies', he said: it is a long story, if I start on it, it will take a long time, I do not know all the dates. He talked about a Lady X., of the great impression made by this figure, how he thought it was his sister. "When I saw her, nervous twitches occurred in my face and strange feelings."

He also described his current state: I feel all sounds inside me, the noise outside now I can hear as 'revenge'. I also understand the birdcalls. Now the train (railway) is saying: I should be quiet. It's saying now: "Woe betide you!"

He went on and reached the following conclusion: "well, it is quite justified if people play with me, because everyone is in me and I am in every one; because only fantasy is reality and the world (reality) has become fantasy for everyone through me." He no longer had strength like others: "as soon as someone else sees that, they have the same strength as me." "I am not God, but his son, like everyone else as well… You must put a special meaning in my words, otherwise it is rubbish. Everything came to me in the last three years. When I say that to other people, then it is a delusion of grandeur."

He said all these phrases in a quiet voice, very slowly, *as if* he first had to ponder for a while between sentences, but looked intently at the doctor during this time. It was not possible to obtain a brief description of his experiences. A normal conversation with him was impossible. He suddenly interrupted himself, listened out of the window, asked whether the doctor had not just heard how the dog had barked, "you fool, you fool". He heard the goblins talking, teasing him, heard the voice of Lady X. Chairs spoke when being dragged across the floor. In between whiles, he was totally attentive, smiled once at the doctor, and then looked sombre. Sometimes his appearance gave an *impression* of helplessness.

He repeatedly intimated that he suspected the doctor was someone known to him. In response to the question who he was, he hid his head in the pillow, sobbed but without giving the *impression* that he was particularly affected emotionally. Then he said quietly to himself: "This question should not be asked." His gestures had something theatrical about them. Finally he said in self-pitying tones that he was the son of a man who was considered to be mad. "You already know who I mean." After a long pause and under persistent questioning, he said without any pride: "I am the son of King Otto of Bavaria."

He promised to follow the instructions to stay in bed and shook hands in a friendly farewell.

During the night, the patient slept little despite sleeping agents and repeatedly got out of bed. In the morning he said: he had been engaged in a battle and it was not yet at an end. He wanted to redeem the world and this had not yet been achieved. When he had said on the previous day that he was the son of King Otto, that had not gone as far as today; today he was the devil. He had heard voices throughout the night calling to him and teasing him, coming from the furniture and from the street. Once again a normal discussion was impossible. He rambled in his speech and said for example: "The world is in me. You also are in me, I am also in you. The world for me is fantasy, not reality. The voices also are in me, because the world is in me too."

His facial expression appeared mostly neutral, then again helpless. He held his hands up with his fingers outstretched. He explained this by saying that his skin was itching as if small worms were crawling about inside or there was rat poison in them. On the doctor's departure, he initially did not offer his hand because it was itching; after some hesitation, however, he shook the doctor's hand with a friendly laugh. Throughout the day he would suddenly run impulsively out of the room with rapid steps, stop undecidedly in the corridor and then willingly allow himself to be taken back. In the middle of the conversation, he once ran off to the toilet and remained sitting there for a long time.

During the following night (*Thursday to Friday*) he soiled his bed with faeces and urinated into the drinking glass. The reason he gave was that he knew that it was improper, but voices had commanded him.

In the evening he said that people had wanted to poison him in N. with morphine injections, but then corrected himself, saying that it had probably had only been to sedate him. Here also he had noticed a bad odour to the food. He temporarily suspected that the Ministry which had refused to return his examination work to him wanted to do away with him with the help of the hospital.

His condition improved from day to day. The patient still heard teasing voices in the garden, "but he did not listen." *After a further 10 days* he was totally collected, normal and approachable. Initially he said he was trying to get over it himself, but sometimes he was unable for a short while to separate clearly reality from fantasy. He tried initially to pass off the psychological content of his experiences with a joke, but now he was ready to provide detailed information and accept that his condition to quite pathological.

His brother, who visited him (*27th May*), found his state to be better than he had seen at any time in the past two years. He did not return from the walk with his brother, but instead travelled *home*. On the next day he *returned to the clinic* tired and somewhat depressed. Then began the detailed questioning which will form the basis for the description of his experiences.

The life history, recounted by the patient himself

As a child, the *scripture lesson* had meant something to him. He already had *metaphysical* tendencies, sometimes liked going to the *churchyard* and had a tendency to *thoughts of mortality*. At the age of 18 years he read Schopenhauer. In his first terms he listened to Wundt, without properly understanding him, read Eucken and Nietzsche. He followed these philosophical studies *as well as* his legal ones.

Six years ago he suddenly returned home from Munich during the term-time to talk to his parents; he wanted to *switch* to philosophy, had an aversion to law. At the time he was "nervous, like everyone undergoing an internal upheaval." He viewed his action as the first expression of his own will.

However, after some time he abandoned philosophy, turned seriously to law and learnt enough to sit the examination, so much so that he was even considered to be a very good lawyer in his circle of acquaintances.

Four years ago he took up philosophy again and, in fact, concerned himself for a long time and exclusively with the problem of the relationship of body and soul. In this question of parallelism or interaction, he studied: 1. Fechner, Spinoza, 2. Busse, Rehmke, Ebbinghaus, Wundt, Paetzold, Avenarius, Mach, 3. Drews, Plotinus, Plato (translation in Diederichs), Kierkegaard, Bergson. The outcome for him was that, whereas originally he had tended to parallelism, he now thought that both theories could be defended with equal justification.

Two and a half years ago a change of direction occurred, stimulated by his brother's studies. He studied Fries, Apelt and then Kant. The feeling increasingly overcame him that his gifts lay in the field of philosophy and he was of the opinion: "I cannot take up any practical legal career before I am clear philosophically."

One and a half years ago, when he had to undergo further practical training as an articled clerk, he could no longer bear it and deliberately deceived his parents who believed that he was working as an articled clerk, whereas he travelled to Munich and devoted himself exclusively to philosophy. He attended a philosophy seminar, but left it because the teacher proceeded too slowly and too simplistically. He remained on his own and worked the whole day with enormous intensity. During this time he was aware of his ability and obligation to create: "in six months, I must have my system; otherwise I will shoot myself". In this way he would justify himself retrospectively to his parents and finally become a philosopher. His main subject of study was first Kant and then Husserl who impressed him immensely with his acuity. He found Rickert to be much less acute, to be general and wordy, while Natorp was totally retarded. Conversely, in addition to Husserl, he devoted himself to reading passages from Bergmann, Bolzano and Brentano.

After just four months, his interest waned: in Husserl and his acuity he discovered contradictions; he himself did not develop any system. He was fearful that his deceit would be discovered. No-one knew about it, that was obvious

to him, because he did not want to be untruthful to his parents while telling others the truth. His acquaintances, therefore, all believed that he was working as a lawyer. He now became aware of insinuations from his acquaintances which appeared to suggest that they knew about his deceit. One day, this led to a scene with a friend who was totally unaware of the situation and received a reproachful letter from him, which he was totally unable to understand. Since in the patient's opinion it was now 'out', he left immediately, initially to go to his brother to talk to him about how he should tell his parents.

The brother (according to the brother himself) found him deeply depressed. He was "exceedingly sad, lacking in any initiative, no longer even had any pleasure in philosophy. He was totally passive, you could do what you wanted with him. However he was not physically neglected."

The patient then went home to his parents. Naturally, they were unhappy. They had always urged him to take up a particular career and were against philosophy. He was now working on a regular basis in a district office and proposed to sit the last law examination when the time came.

He read no more philosophy, had completely lost his self-belief in philosophy, but still thought a lot about the problems and developed the views that had constantly surfaced in him into a system. He became a consistent sceptic. Although in discussions, for example with his brother, he found pleasure in his critical acuity, scepticism to him was not a mere theoretical game but a genuinely experienced torment. For a long time he had felt that he ultimately *could* consider nothing to be true, that he was *incapable* of adopting any definite opinion, not only in science but also in life and art. He, therefore, doubted everything and occasionally took these doubts to their logical conclusion: I cannot assert any proposition, not even this proposition, I cannot assert anything at all, it is pointless talking to me; I myself am behaving pointlessly when I do anything other than think about the pleasure of the moment. While his friends found his attitude incontrovertible and consistent, they thought that it could only be put into practice in the lunatic asylum. At these words, it suddenly struck the patient where he was and he said in embarrassment: Ah, I am in fact in the lunatic asylum.

In describing his scepticism, the patient came to talk in particular about Kant's dialectic, i.e. the parts that deal with infinite regression in causality etc., and also all the logical considerations that somewhere produce a circularity.

He was despairing, despairing about his future and about life. However, that was only *one* side of his spiritual life at this time.

He turned to more literary interests and was furious that his father had such a low opinion of this 'novel reading'. He read many such things. He now remarked on his relatives' behaviour during that period: they had constantly teased him because of his philosophy, said he was too cerebral, he was eccentric. His friend and his brother liked teasing him, although not maliciously, but with empathy and sympathy for him. However, he thought they had treated him 'too lightly'. He then went to the Ministry as it were to spite them, because

he thought the others believed he was embarrassed by his failure. He went regularly, but did not work at all for his examination. Because he considered himself to be a good lawyer, he believed he would succeed even without working; and he approached the examination in the knowledge: either I will get a first or I will fail.

Whereas up until that point the patient had told me his life story *without reference to the illness*, in what followed he now gave me a description of the *forerunners of his illness and of the psychosis itself*. It will be apparent from the description how far he possessed insight into the details and how far not.

The patient was lively and very ready to offer information. He often walked rapidly up and down the room, eagerly imagined himself back into the psychotic states and thus described them very vividly. He approached his acute phase with complete intellectual insight and even had a certain interest in disentangling and verbalising the mental processes. In so doing, he often struggled for the right word, sometimes corrected himself, rejected expressions that were suggested. He gave the impression of definitely visualising the past, but an adequate description was difficult because of his high degree of self-criticism.

The increased capacity for empathy in the last three years

About three years ago (end of his studies), he very gradually noticed a change in his capacity for empathy. He had always needed to understand a lot, but this had always required preliminary *mental* work. He now began to empathise much *more directly* and *more intensely* without having to think first. About two years previously (immediately before his departure to Munich for the philosophy studies), this capacity for empathy increased again; since February 1912 (meeting with Lady X.), there had been a further marked increase; in April (the examination failure), once again an increase. He empathised so intensely that he thought for example: no-one understands for example, Irene Triesch in so acute and refined a way. He felt everything to the extreme when he read Dostoevsky. Hamlet upset him so much that he was unable to sleep the whole night. At the same time, a desire for education drove him ever further on. He wanted to understand as intensely as possible. But never in all those years did he "lose himself in empathy". It always cost a certain *effort*, whereas the intense experience of the past psychotic phase came *entirely of its own accord*, was of a totally different immediacy and resulted in his 'losing himself completely'.

A year ago he had read Wölfflin's Dürer. He felt himself very inferior in terms of knowledge, but far superior to the author in understanding Dürer's works as far as the *person's emotional expression* was concerned. He felt a direct emotional significance of the pictures which did not emerge to the same extent in Wölfflin's description: for example, the first self-portrait: awakening of self-awareness. In the position of the hand, there is a sort of fright: this is me. An entirely new experience flared up in him, of the kind expressed in the phrase: "Who sees himself doubly, dies." The series of woodcuts of the life of Mary and

the Passion made a particular impression (also in particular pictures from the old picture gallery in Munich).

For a long time (for 2–2½ years) people around him had *seemed* different to him. It had happened gradually that his *attitude* changed. He did not believe that people *had become* different. He had a strange feeling: people felt and experienced in a more complicated manner than they themselves knew. They did not become aware of their own complexity (particularly women). In these feelings he himself was aware of something abnormal. He knew: others did not have this.

The last external experiences before the psychosis

In February 1912 he saw *a lady* on the street who made a great impression on him. He felt immediately that unconscious complexity of being that has just been mentioned. He felt the strange nature. She was capable of colossal development, but still so naïve, not at all aware of herself. Perhaps for that reason he was so attracted. He saw in her face how varied and refined her feelings were. He observed her in the theatre. She had also rapidly understood him. He noticed that immediately from changes in her face (obviously delusional). The subtlest understanding went back and forth between them, an understanding of what the other felt. He had then often seen the lady in the street. Officially there was never any personal acquaintanceship. He never attempted to approach the lady. She lived in different social circles from him so that there was never any opportunity for acquaintanceship. Subsequently this lady plays a significant role. She had travelled to a distant country. He believed she would not return. On 8th May 1912 he saw her on the promenade in his home town. He was extremely surprised, asked his sister whether that was Miss X. and called out: "Yes, she really is there." Not seriously, but in his surprise he felt the need to have the reality confirmed.

In addition to this lady, the problems of *career* and *lifework* played a role in the mental upheavals that preceded his illness. He thought that he would get a first in the examination or fail. "I feel so good, I think I will get a first", was his mood. Then came the great anger about the poor grade. He thought that he had been given poor marks because of frivolous comments on his part. He became convinced that everything was not above board. *In April* he learned of the bad examination grade (further details in the objective history). The three stages in the emotional change were therefore: 1912. *February*: saw Lady X. *April*: examination failure. *8th May*: saw Miss X. again. The subjective history shows unmistakably the effect of these external events on his mental state. On the outside he had never shown anything, he said. When he saw Miss X. again, he behaved in conversation as if he had not experienced any particular impression.

The delusional experiences after the examination failure

Not until later, and unwillingly, did the patient give expression to thoughts and experiences that had occurred to him after he had received news of the poor

grade and before the development of the psychosis. He had the idea that he had been deceived in the State examination. He had been unjustifiably discriminated against. The Ministry obviously wanted to get rid of him.

In the street, judges and civil servants avoided him. People did not greet him and assumed the most impenetrable expression. People towards whom he felt antipathy were frightened of him, probably because he looked so furious.

When he went through the fields, he felt that all the farmers knew him and wished him well. They teased him in a friendly way with their sayings, which meant that people sympathised with him. He felt that a *revolution* was approaching, that in general people were ready to start.

Then there were evil people who were against him. There was constant friction and certain events whose actual significance was not clear to him: one day (perhaps eight days before the acute psychosis) he received a catalogue of second-hand novels from his bookshop. The individual names and titles undoubtedly alluded to himself. Either someone who wished him well had sent them to him, or someone who wanted to make him do some stupidity and then ridicule him. At any event it had *not* been sent by the bookseller, but someone had acquired an envelope from the bookshop with the stamp and forged the dispatch. Although he bought a lot there, the bookseller had never sent him recommendations. A novel entitled "Diligence and Work" was supposedly a joke about certificates that had been given to him for his activity as an articled clerk. His diligence had once been particularly praised. "Unceremonious discharge" alluded to his rejection by the ministry. The name Ohnet was to be read as Oh net (= Oh, not). "Down with Napoleon" referred to him. Now (*after* the acute psychosis) he said: "I'm not worried about it." Both views – it was allusion or simply a harmless catalogue – co-existed in him at the same time.

In the street and in bed he sometimes (not often) heard words that referred to him. In the street: "That's the man", "His father still gives him his clothes", "Don't go so fast, a bit slower", "He still goes walking, he is not yet so far gone". In bed: "One would think that a person could manage that," "Gently, gently. You mustn't say anything."

Four days before the outbreak of the psychosis a serenade was sung in front of the house. In it were the words: "We will be victorious over Napoleon." That related to his belief of being able to abolish the State examination as an insane method of testing.

Even now after the psychosis, the patient was not clear about all these experiences. He admits the possibility of illusion for each individual event, but "*there was a mass of experiences which all pointed to the same thing*." He had *not* established an actual system. *Everything was unclear*: the intrigues of the Ministry, the portents of a revolutionary process, the allusions to him, etc.

The last days before the psychosis

Of the last days before his departure to the health resort (12th May), he reports the following: On about 8th May (on the day on which he saw Miss X.

again) he was in his room in the evening. This looked out onto a square and the houses opposite. In the house facing his, a *child* was often undressed in the evening and he was able to watch this through the window. On that day it was totally different from usual. The child was as if dead and was *wrapped up* after being undressed. It was totally stiff and looked like a *mummy*. The child was taken away, but after a while the whole process repeated itself in exactly the same way. The Venetian blind was then drawn back and the room was lit up. The length of time of this was normal. The repetition occurred immediately without a long interval. When he saw that the child was as stiff as a mummy, he *immediately related the process to himself*, particularly as a lady had waved at him from the middle floor a couple of days previously. He immediately wondered whether it was someone else and not a maid who was wrapping up the child, whether the whole thing was not intended to give him a sign. The meaning at that point was unclear to him. Only on the journey to the health resort did it become clear to him: "I should become passive myself and abandon myself entirely to what happens to me (wrapping up), then somehow it will become clear (lighting up of the room)." In the following days, this meaning then assumed a religious slant: he had to abandon himself so that the Golden Age, redemption, should come. Whether the process involved hallucinations or interpretations on his part he did not know. He found no yardstick for judging whether these were hallucinations. He considered it unlikely. He did not consider the referral of the process to himself to be abnormal in the situation, but entirely understandable.

At about two o'clock in the morning on 10th May he experienced the following: he was sitting at his table near the open window. The shutters on a window opposite were half closed. The room was suddenly illuminated with a searchlight to see whether he was awake and then it disappeared again. A *cinematographic show* then began on the shutter. He saw how he himself got undressed there, slowly, ponderously and tiredly. Immediately he thought, everyone on the street can see that. He wondered what it meant, then the same picture recurred. He went over to the window and undressed himself and then the show suddenly stopped. When it had disappeared, he actually did undress himself in the knowledge of having understood what it meant: "That must be someone who means well with me." He thought of Frank Wedekind. During the cinematographic show he saw the street at the same time. There was no doubt about the reality. It lasted about three minutes. Even now he can only believe these were hallucinations because of their unlikelihood. The moon was shining at the time. He had no light in his room. – On the same day a woman met him in the street. Immediately he was overtaken by the idea: "That must be Mrs Frank Wedekind." He knew her from before. That is exactly how she looked. She looked away rapidly as if in pain.

On the day before the journey to the health resort, on 11th May, he went for a *walk* with his sister. He already then *felt* that the surroundings were different. According to his specific statements, however, his sensory *perception* was *not* altered throughout the whole psychosis (no increase in intensity, etc.). It was *eerie*.

A cyclist crossed the path. The light from the lamp alarmed him. He had the sensation of something out of the ordinary, something supernatural. He thought of the possibility that it was a light with which they were being observed. However it did not become a definite thought. He asked his sister and was annoyed when she explained it was merely a lamp. "That it was a lamp, that was clear to me." But he had thought his sister had experienced it exactly as he did.

The feeling that his sister felt in exactly the same way as him had previously been present in the most vivid way. He felt in her an *extension of her person* 'or something similar' that now completely understood him and shared exactly his fluctuations in mood. He then believed *it was not his sister*. He asked her directly about this. Although she did look like her. Suddenly the eerie feeling came over him, totally without reason, merely as a feeling. He loved this sister very much, who was not his sister. He had various thoughts: the external person is secondary. There is a possibility of a *change of soul*. It was a different person in his sister. This person he then felt to a certain extent as his own. He felt *duplicated*, but *duplicated in a different sex*. The feeling of duplication was at that point still unclear and was not to become clearer until later. Perhaps it flared up now only for a moment. This feeling of duplication at any rate disappeared after two minutes. There only remained the feeling of the *eerie* and the *unusual*. Following the scene with the cyclist, he was moody. He thought that his sister did not understand him, or that she did in fact understand him very well and was only pretending.

That evening he also said to his sister immediately after the cyclist scene: *"Am I mad, then?"* He thereupon felt a *violent pain in his head*, in his brain, as if something had been destroyed. He went on: *"It's urgent, to the lunatic asylum*!" He was totally clear about the fact that people, particularly when they knew everything that he *was thinking*, must consider him to be mad. *He himself, however, did not think he was mad*. He felt his condition to be 'entirely real' and thought: "I am indeed alone, but why should I call that mad." Nevertheless, he then thought constantly: everyone else knows it as well and is just pretending. The general pretence worried him considerably, everything was uncertain to him.

The acute psychosis

On Sunday 12th May, he journeyed *to the health resort*. On the *railway journey* the experiences of the acute psychosis began to acquire a cohesive nature. The weather was wonderful, the mountains and sunshine were like pictures by Thoma. It was so beautiful that he had the feeling of the beginning of the Golden Age. Young people climbed into the carriage, a girl and a boy. They played songs on a harmonica. These touched him extremely deeply. He *related them to himself*. "It has something so colossal…" He turned away and could not help crying.

The patient remarked that actually he had never previously had any deep understanding of music. He had always turned to literature and the creative

arts. Now began this experience of being affected by music which was to play a major role in the subsequent course of events.

Any comments that were made *related to him*. When he was crying, the boy said: "Stop, play something happy." When the music did not touch him, it was: "You played it wrong." For the most part his emotional responses were strong and differentiated. When he did not respond, everyone laughed. Allusions were made to previous experiences. The thought came to him: *everyone else knows everything about me, the slightest detail*; he concluded this from the allusions to such details. – He had the feeling as if he was constantly going backwards and forwards with the train; at one point someone said: "That was St Petersburg." Once he got out, but collected himself and climbed back in again and duly arrived at the health resort. It appeared to him as if everyone wanted to tease him good-naturedly. In all these processes, the following idea had now overtaken him: I and everyone (for exceptions see later) are in reality dead; in reality there is only the metaphysical world. Space and time no longer exist in reality. According to his feeling, everyone was already living completely in the higher world. Only because he clung so much to the world had he 'taken along' space and time and still had to see everything in human terms. He was still human, but *also* already dead. People were all in heaven already. He would follow and drag them all to a level higher still. First, however, he still had to free those who were not dead, i.e. wait until they were dead. He thought of killing by ideas, etc. He must, however, not *betray* the fact that he still felt as a human. The others, however, in fact *knew* how things stood and therefore laughed at him because he was still going backwards and forwards in space. He was possessed by the feeling that the metaphysical world, the Golden Age, *was imminent*. The contents of the words he heard from fellow travellers are comprehensible in relation to these ideas: "He knows nothing at all"; "watch out, don't say so much, otherwise you'll give him away"; "he has no idea at all what he is going to do this evening. He is going to copulate naked on the stage." He was aware here that, if this demand were made of him, he would do it. The people would not worry him. Perhaps everyone would get undressed and then the Golden Age would be there. Many phrases had a *sexual connotation*. To protect himself from this, he went into a compartment where there were only women. But immediately one lady said to another as she opened a large bag: "Look, what a heavenly bag." As he observed from the facial expression and the loud laughter of the other, this was meant symbolically. People knew that he was not very aroused sensually and that he had only rarely experienced lust. In this sense, it was said teasingly, without malice: "He felt a stirring in May 1911." On one occasion it was said of a girl who was waving outside: "That's his bride waving."

The patient talked about his sexuality without importunity and without prudery. He recounted that he had always been only slightly and very rarely sensual. He was almost frigid. In contradiction to this were the 'lewd excitement' which he experienced in the subsequent course of his psychosis.

The idea of the Golden Age now took constant hold of him. The weather in the health resort was splendid, as if a precursor of the Golden Age. If clouds appeared, then these also gave him pleasure. The impression could be compared with that which he had experienced before the pictures of H. v. Marée in Schleisheim. It is hot, he thought, so that everyone can get undressed. All ugliness will disappear.

Girls nudged him in the side. Everything related to him. He did not react because he thought he *must be calm;* he was not allowed to say anything, otherwise he would not bring about salvation. A *compulsion almost overcame him not to be allowed to ask*.

In the train he *still wondered* what now was actually reality. He was *aware* of the many *contradictions*, but considered them possible. "I have experienced both, the metaphysical world and the real world which I considered to be pretence and which I simply had to look at." The nearer he came to the health resort, the less he thought along these lines.

At the health resort, he descended from the train and went out of the station to *take a carriage*. As he went to the coachman, he heard a call: "Oh wait, Joseph is coming." To his question as to whether he would take him up to Hotel X., the coachman answered: no, I'm not going up there today. The patient had the feeling that all the coachmen would react in the same way, but he found one who was prepared to take him. Then he thought: I'll just see whether I'm right, whether people really are dead and are only there in appearance; I'll just see how they react. Instead of a couple of pfennigs as usual, he gave the porter 3 Marks. He was never entirely sure whether it was reality or appearance. The porter looked at him wide-eyed for a moment, then suddenly seemed to understand, smiled, thanked him and went off. He let him go and thought: it really is the Golden Age, money has become incidental in the world. When the carriage arrived in front of the hotel, the coachman demanded 3 Marks 10. This struck him as being a *strange* figure and he saw the coachman's *deliberate* control of his features. It was apparently a joke. Money had no importance. It was a further confirmation to him. If money really is incidental, I'll just gave him 10 pfennigs. However, he did not have the courage to do this and paid the right amount. Perhaps it still is reality, he wondered doubtfully.

He then went straight into the *hotel*. He asked for a room with an unimpeded view. He was given one with a partial view out the back. Shortly afterwards someone knocked: "I've just realised we have a better room." He said: "I'll take it." Again after a short time there was a knock at the door: Waiter: "We have an even better room." Again he inspected at it: "Good, I'll take this one." That now was to him very *remarkable* behaviour. He thought: I must just keep seeing everything in human terms; they see me as a fool; *I'll just see what else happens*. Then he thought he should wash himself: "Perhaps then I'll be clearer." He ordered a bath. In the bathroom there was *no chair*. That confirmed to him (it was a very good hotel) the current unreality of the illusory world. After he had bathed normally, he went for a *walk*. It was the so-called Carnation Day in the

health resort. He laughed about the pretend foolery. But he thought: well, I'll wear a carnation as well, and he bought one.

During this time, the idea of the Golden Age occupied him constantly. The realisation now surfaced in him that his sister, mother and other relatives were still alive: "I must free them first." Linked to that came the idea that his sister had poisoned him. She had done it from a noble motive; when she saw that he was becoming mad and he then said it himself, she wanted to spare him that fate. These and many other ideas he had forgotten in the subsequent course of the psychosis and did not return to them.

He then *returned to the hotel*. On entering it he heard the porter ask someone else: "Is he still working miracles?" The other answered: "Yes, very much so." The patient laughed out loud. When entering his name, he wrote under profession: "Convalescent", "to keep unwanted visitors away". He had been in a somewhat *frivolous mood* and had done such things deliberately, but without any feeling of playing a role. After a short time, the waiter came and asked whether he was a doctor (he had written Dr M.). He said no and found this strange as well. A spa pass was ordered and in addition he was given a concert ticket. Astonished, he asked whether he needed two passes, a spa pass and a concert ticket. It then immediately seemed likely to him that 'the lady' would be with him, hence the two tickets. The hotelier's wife however regarded him in this situation with a look which made it clear to him, that she had doubts about his state of mind.

The patient then ate *his evening meal*. The people sitting around him made allusions to him, knew about his examination. He drank his wine and sat there quietly and inconspicuously. After his meal, he went to the *concert* in the resort garden. As he had entered through the gate, he somehow generally related the music to himself. It started up at precisely the moment that he entered. Music, which had previously exerted no effect on him at all, now took hold of him, roused him almost to a state of franticness. He felt how his whole body with all his muscles to the music responded, how all feelings, all laughter and crying, in all their shades, found an echo in him. The course of events then proceeded as follows: when he had reached the terrace of the resort garden while listening to the music, he felt the urge to follow a particular path. He felt that he was treading exactly in the footsteps of another person. "I felt I could escape the urge. But I wanted to give up my own will, wanted to give in and abandon myself" (the system of the wrapped-up child came to his mind). The urge became stronger, suddenly he stopped: "I must stop here." His body now began to follow the music rhythmically in its movements. At the same time his head remained completely clear; he noticed that people were laughing at him, that someone whom he looked at sharply, went away, etc. The body movements came *automatically* as if of themselves and *yet he wanted* them. The muscles now worked by themselves once he allowed them to do what they did. Now – he felt – he would have been *no* longer able to escape the urge. He did not need to pay any attention to his body, it was working entirely by itself. These rhythmic move-

ments were accompanied by a very intense experience. Initially he felt: the lady was not yet there. Then: she could be there now. – Now I felt: she was making the movements too. About 10 metres behind me, her back turned to me, she was following my slightest movement. He did not see her and had not seen her, but he knew it quite definitely. This intense reality was overwhelming. He trusted his senses less. 'It was evident', if it is at all necessary to use an expression from the doctrine of normal conviction. He knew quite certainly: it was that lady. He knew that she was making exactly the same movements, although he did not feel or perceive her physically in any way. If the awareness of the presence of the lady was accompanied at all by a pale image, he at any rate imagined her in normal clothes without any striking features.

Finally, the music expressed wild outrage. He felt violently seized and then the music and the urge to move was finished. He now took the *conscious decision to behave normally*. With this intention he went over to a waiter and ordered a cigar. But it was not long before he was overcome by the urge to walk to and fro again. "I could still have controlled myself, but once in it, I was powerless." He remarked how he lost control over himself, he started to run, knocked over the waiter, leapt over the terrace balustrade and plunged into the park in the awareness: *the lady* who had just been copying his movements *had gone*; I must follow her; he had the feeling that he was following everywhere that she had just been; in contradiction to this, the idea came to him that he was rushing along all the paths that she had taken *that morning*; and the thought that perhaps she was no longer there at all. At other moments he felt the lady again as his own other-sex 'Doppelgänger'.

On his wild run through the park, he was then *seized by resort guests*. This he accepted. He was completely aware of the situation and became calmer for a moment. Shortly afterwards the urge overcame him again. He cried: "Look out, it's taking hold of me again; grab me. Not enough, not enough, a couple more here." After about half a minute he became calmer again and this recurred *like an attack* several times. He always had the feeling of the proximity of the lady each time. When a totally unknown lady went past, he cried out once: "That's her; she should go to the devil." In this case and in another case he saw precisely that it was not the specific lady, but he thought of the possibility of transformation. From a distance, he saw a lady getting out of a carriage. It was immediately clear to him: "That's her." He had to be near to her. He was not at all sexually aroused in all this, he simply wanted to be near. He felt that perhaps the courageous nature – almost everyone, he noticed, was afraid of him – with which the lady went up to him, impressed him and made him think of the emotional identity with 'the lady'.

On the way to the hospital, the 'attacks' occurred several more times more. During them he experienced an *enormous strength* and felt how weak everyone was who was holding him. For this reason he cried out: I'll now give you "the strength of 10 people" and increased it a billion fold. He then felt how his strength declined considerably and he was finally totally exhausted. On this

journey he cursed the Good Lord out loud for giving him the philosophical system (scepticism). "I am going to force things, he should destroy me or he should give me insight."

In the hospital he saw a tapestry of the Road to Golgotha. He stamped and called out: "I have always looked for you; I'm the eternal Jew, aren't I?" Subsequently the idea came to him for a moment that he was entering a monastery and was Brother Medardus (E. Th. A Hoffmann). For the most part, however, he was now consumed by the idea that he was in a higher world. He felt elevated, in heaven and yet condemned to continue feeling as a human and to see others as humans. At the same time he knew exactly where he was and was now taken to the *cell for raving lunatics*. He went in happily with the words: "Oh, that is splendid, there is nothing I can destroy here" (totally empty room). "And the sacrificial alter of humanity is also there." He then struck the toilet standing in the cell in his anger at the Lord God for burdening our existence with so much dirt and the feeling it was right that humans sacrificed in this way to our Lord God for it.

He recognised the nurse accompanying him immediately on each occasion as 'the lady'. This time she also had a physical similarity. The similarity with the picture by Leonardo led him to the name *Mona Lisa*. The lady accompanied him during the subsequent course of the psychosis as Mona Lisa.

Several *sequences of experiences* now alternated for a while in a fairly disconnected way: he was possessed by the awareness that everything inorganic had a soul (reminiscent of Fechner). On getting undressed, he had thrown down his shoes, which he then saw as brutality, picked up the shoes, stroked the floor and then placed the shoes down gently. He placed his trousers carefully and gently on the 'sacrificial altar'.

Very generally, the patient maintained that *everything* that he did in the psychosis had a *reason*. "And in fact often a *dual reason*. There was a sensory and a transcendental motive, for example, in the soiling of the bed: sensory reason: the physical urge in the state of sleep; transcendental reason: elimination of everything impure from that metaphysical world, which was within him. "It was not a failure of inhibition. I could have held it back."

He felt a strong *need to curse*. His philosophical system (sceptical despair) was a determining factor in this. He cried out: "Our Lord God, I curse him, we are merely there because he fucked." At the same time he hurled his shirt button and tie furiously at the wall, for a moment experienced painfully the injury to the inorganic soul, but was then clear: "Stop, I am the Lord God, I have killed him. I should not behave in this way." When he threw the shirt button he thought: it is going to thunder now. He heard here the music from the resort park, thought of 'Siegfried' and "in reality *romantic events* seem to be repeated." He heard Teutons moving and for a while lived in this sphere. He "felt that everywhere in the world the romantic stories were now being played out in a new form."

However, the sequence of experiences of the *Golden Age* again took over. He thought: if God had not sinned, there would be no misery. Therefore, the new

God (he himself) must condemn himself; he must remain in the cell *forever*, then the Golden Age would exist. Occasionally he was overcome by the awareness that he himself had created the fantasy world, but very rarely. He was pervaded by a *feeling of giant strength*, clasped his fists in anger, but did not think of doing anything to anyone.

He believed he was now faced with the same temptation as God. Mona Lisa was standing outside. He could procreate children with her and called out that Mona Lisa should come in. When the door opened, he called out rapidly she should stay outside. In this way he fluctuated between luring and rejecting her.

During these hours, the sense of the presence of the other person and of *duplication* now also developed further. Previously he had experienced this episodically; *another* person present who empathised in the slightest detail and moved with him, who was then he *himself* in duplication, he himself as woman. Now in the cell, the duplication became completely clear. The *other person was now in him*, he felt the female body in himself. He felt the female breasts, the round hips, the female genitalia. *At the same time* he felt his own male form and genitalia. However, he felt *himself* to some extent as the core, as more real, the female *as if transparent, as if ghostly*. And yet he felt the life of the female body, the breathing, etc., very clearly. As a man he felt himself tall, had a giant member and felt beautiful like Dürer's Adam. He touched himself in his beauty. All men will now be as tall and well-proportioned, he thought. Copulation then occurred between himself as man and himself as woman. It was a feeling of love without any sexual arousal, "such a free, elevated feeling", but the sensory feelings of copulation were there without lust. When the copulation was over, the whole experience of duplication had disappeared. It may have lasted perhaps ½ minute. Fairly *suddenly*, the situation changed. A *rapid transformation* happened in physical terms. However, he was aware that he was still the same, *remained mentally the same*. Even later, when he became God and others, he was always aware: I am Joseph Mendel, who has now become God. A few days later in Heidelberg, the same experience of physical duplication occurred once again. Apart from that it never returned.

Even before this copulation experience, he had received an *injection* from the doctor. He had cried out extremely loudly. The nurse (Mona Lisa) was helping. He was aware of the situation. The nurse was embarrassed and he said good-humouredly – as he always was in between whiles: "Ah, just look how the Mona Lisa is bashful." After the injection, a drowsy state occurred in which the female sensation appeared vividly and resulted in the copulation described. Then he experienced that transition into another state, a change. There was nothing female left, just he quite alone. Now he was 'terribly randy', felt the urge: "now I should masturbate" and did so; "there was not much to it", he said. After this act, he fell asleep and had a quiet night.

In general, the patient remarked that the description was not easy. "*It is so terribly illogical*." However, he emphasised that the circumstances which he

described certainly existed and that the dramatic world processes which began particularly on the following day assumed predominance among the related experiences. On that day, the ideas of dual reality, Golden Age, his own struggle, relationships with the Lord God, etc., formed the prelude. In between moreover, as he stressed, the doctor had also appeared to him as entirely real and not merely an apparition. There were constant *fluctuations* in his condition.

On *Monday*, the following day, he believed on awaking that *he must have been in this cell for an eternity*. However, he "*now felt normal*." He wanted to go home, asked the attendant to bring him clothes and to fetch a psychologist. He was totally lucid and orientated, waited a long time for the doctor's visit. However, he was not entirely sane: "Things were in the air; what I had experienced was not eradicated." As a fantastical experience it was attenuated. He felt as he had done at home before his departure for the health resort. He thought: perhaps that was all yesterday, perhaps it was not an eternity ago.

In the course of the morning, the fantasies began again. Initially it was somewhat confused so that the patient has no precise memory of the chronological sequence of events. "*There is a gap here; I don't know the exact beginning*." For example, he was lying on his bed, had the impression: I have conquered the Lord God; not God the Father, but Jesus. He lay there with his eyes open. The sun shone through the frosted glass panes into the cell. He had the feeling that space had disappeared. This cell was the only space, it was floating outside the world. Creatures apart from him existed outside space. He no longer had a yardstick for time; he lived without any sense of time passing. Doctors, hospital, all that had disappeared for him. He lived exclusively in the enormous events outside the cell with the supernatural beings. He was immediately aware of these events, and in addition he heard voices and sometimes saw something, as will become clear in the subsequent description. The events now proceeded in a relatively coherent sequence.

He was, therefore, aware: the whole of humanity now consisted only of supernatural beings; they lived together in the highest state of bliss under the sovereignty of the old God who unites Judaism, Christianity, etc. Only Buddhism and the religion of Confucius were still outside. The previous world was dead, only he was still human. Now he experienced with colossal certainty how everybody begged God to save him as well, to free him from the cell, from space and time, to allow him to die and to make him a supernatural being like them. Out of this there then arose a struggle. God would have carried out this redemption if the patient had been satisfied with the same state that the others had. He, however, demanded: all beings should be equal to God, only then will I leave the cell. All plants, animals, the whole inorganic world should become God-like. The inorganic world was represented to him by the grain of sand, which spiritually is just as complicated as other souls. The grain of sand should also live God-like in the supernatural world. He often perceived himself as a grain of sand. In addition, abstract concepts should also enter into that world in a God-like state. All virtues and also all vices: lewdness (= Venus),

treachery, hypocrisy, etc. Each creature should *have all of that in itself* like God, he demanded; and each creature should be able voluntarily to call up all of that in them. A colossal change would therefore happen in heaven. It would be a pleasure to live there. One could not be angry with anyone because they were *everything at the same time*. The patient noticed: everyone else was helping him and imploring the Lord God to give way. He made further demands: Rhine wine and tobacco should be in heaven also, as well as a little crap and piss. "If we have that on earth, it should be up there as well." Inorganic materials, elements also helped. The grains of sand as angels teased the Lord God. He himself enjoyed that. Perhaps he would have agreed to everything, but then the patient made a further demand: the Devil and hell should also ascend. He thought, perhaps Frank Wedekind is the Devil and as a consequence: the Devil is in fact much more refined than the Lord God. The patient noted at the same time: our Lord God does not have this power. God became very serious. The voices stopped. Then he saw how the shutter to the cell went up and a ghost flitted into the room. It was see-through like a shirt, without a clear shape. It flitted under the bed. It was the Lord God. He was uneasy: what did he want? A voice called out: "You must now." He felt an arm movement. That was death. Like an electric surge it went through his whole body. But the patient was stronger. God had wanted to take him into heaven *without* fulfilling his demand and *kill* him for it. Now that the patient had proved himself to be *stronger*, the Lord God must 'enter into him' and increase the patient's strength still further. Then the patient would himself have to survive the battle with the Devil.

Now *God's entry,* and hence that of the whole supernatural world to increase his strength, took place in him. He felt how God entered into him through his feet. A tingling went through his legs. His mother entered. All the geniuses entered. One after the other. With each of them he felt their expression in his own face and recognised them from that. In this way he felt how his face took on Dostoevsky's expression, then that of Bonaparte. At the same time he felt their whole energy and strength. D'Annunzio, Grabbe and Plato came. Like soldiers in step they marched into him. When the air came, when women came, when heavenly love came, it was gentler. Abstract concepts also entered in: lewdness, the Jew, the fool. He felt Anatole France and with him the essence of his works: irony, crying, delicacy. One followed on constantly from the other. He did not notice subsequently what was in him at every moment, "but it could be called up at any time". He felt his facial muscles much softer and more pliable than ever before. He now possessed the *capacity for all moods*. And he felt possessed of *giant strength*. During their entry, he constantly made 'catatonic movements', to make way for the beings and to arrange them. Voices helped, e.g.: 'now the elbow'. Initially everything was confused, there was a constant switching of places, finally there was a certain order. They sorted it out between themselves. The great men sat in his head, the artists in his facial expression, the warriors in his arms; the Lady Mona Lisa took her place in his heart. Right inside his heart were stone and a grain of sand. Finally the entry ended. It was sealed off. Now,

it will begin. He thought of the symbol of the wrapped up child: I must not be active, I must remain lying down and wait. Which is what he did.

Once again now the flap in the corridor wall of the cell opened. The patient saw the *devil*'s head looking in at him. He saw him physically. With his horns, brown and hairy, he looked like a faun. The eyebrows were red. The patient was not in the least frightened, because he knew: I will certainly overcome him. In the knowledge of his strength: he called out to the Devil standing outside: 'open up'. The flap closed. The devil admitted defeat already and joined the others in him. His strength again increased enormously. With this 'victory' came the awareness: the Devil gave in so rapidly not just because of my strength, but because I wanted to take him up to heaven.

Now, however, the patient had the thought: there are still a *host of gods outside me*. These, he felt in his colossal strength, would all enter into him voluntarily. He believed that his cell lay on an enormously long corridor onto which many other cells fronted: in these were to be found the other gods: Baal, Buddha, Mohammed, etc. A battle might be necessary. However, he knew that now the devil would help. At that moment the attendant came and he took him for the form in which the devil had come. He had brought lunch. To the question: should I eat? Came the answer: yes, yes, to give you strength. He now consumed the food voraciously. The first bites he managed to swallow, but then he simply devoured it. He felt that the whole world in him wanted to have something to eat, everyone was hungry. He already noticed how everyone in him was eating. Everything in him was consumed with frenzied greed. He felt it throughout his whole body. His breasts were pulled from within. In this state he seemed to himself like Buddha, whom he believed he had seen portrayed in this way. But Buddha was not yet in him. The battle must now begin. He called out: open up. Immediately he heard one of the cell doors being broken open as if with axe blows. Buddha appeared. The 'battle or entry' moment did not last long. Buddha entered in. This repeated itself some 20 times: 'Open up', then axe blows, then entry of the god. When he again shouted 'open up', there was no longer any knocking. This was a sign that now *all the gods of the earth were in him*. He felt fulfilled by them. He only had a tiny amount of space – the cell – still round him, otherwise all worldly processes were metaphysical. Now he wanted – to some extent to test his strength – to perform the *most mighty action*. He commanded: "*Let space disappear.*" It didn't. Despite the huge events he still did not have enough strength, although in the awareness of great effort he was always ready to fight, in the knowledge of his strength his fists clenched and his muscles tensed.

Now there was an *interval*. After a short while he felt without seeing: a goddess was coming now. He felt that she was outside and he felt: it was the Mona Lisa. It was a new temptation: if he now procreated humans with her, that must be a happy race. But he had the awareness: I must not do that. There are still more *gods outside the earth*; I want to make *everything into one*. Here he was overcome by the frightening thought: perhaps there was something similar

here to the infinite regression in scepticism. But he made up his mind: I want to try to make all gods into one. He noticed at the same time that the Mona Lisa understood him, she also joined all the others in him. That this was the same Mona Lisa who was already within him did not matter. The outside and inside was sometimes totally the same to him.

Now all gods that had ever been revered on earth were in him. The Mona Lisa cried because the other goddesses who were sitting with her in his heart were more powerful and more beautiful. That upset him and he comforted her. All gods and geniuses had a specific place in him. However, the initial localisation (warriors in the arm, artists in the face, etc.) had gone. The world of all the gods was compressed into one area and one by one, as if separated by bulkheads, other groups followed throughout his whole body. They had *no unity, did not understand one another.* There was now the *task of creating unity and order.*

In the meanwhile, the attendant (= devil) came in again and brought, as the patient remembered well, coffee with croissants. The same process occurred as before, the whole world ate greedily in him.

There was also the visit of the *senior medical officer.* Because of the winking eye movements, the patient thought he was the embodiment of a bird, but perhaps also he was the Lord God. At any event, the being was playing a role in the world of illusion. For that reason he initially gave meaningless answers, was aware of it himself and thought: the other person is also pretending. Thus for example he said out of the blue: "There are bugs running around on the floor, but there are none in the bed," and laughed at this. Then, however, he wanted to behave in a human way in the human world of illusion and answered the question about his illness : "I am suffering from a religious delusion system", because he knew that it must seem like this in human terms. He stresses now that at that time he had no insight at all, let alone being temporarily sane. To the question about a legal article he answered correctly and also explained that mental infirmity was not punished. The thought then came to him: the Ministry of State is perhaps to blame for my madness. Because if the senior medical officer really were human, that was clear to him, then he actually was mad. The patient remarked in general in this respect: *"I always thought a whole host of things at the same time that were not in the same sphere."*

Now the task was to create *order* in the world of gods and geniuses. Thinking of the symbol of the wrapped-up child, he lay there passively. The Mona Lisa would help. He now noticed that all the gods were moving out again. Terrible battles took place outside, which he sensed. The gods could not agree. Finally managed to achieve unity in their discussion. Now the entry into him occurred once again, precisely as before; one after the other. He created space with his movements. Towards the end he noticed the Mona Lisa raising his eyelid from inside. She wanted to see whether he was asleep yet, because his sleep was the sign that everyone was in him. He did not sleep. It transpired that the decision had been premature. The order came: everyone out. This whole process of entry and exit now recurred endless times. He felt it was due to the 'betrayal' which

something committed each time. Finally the entry proceeded without further disruption. He had the feeling that endless eternities had passed. Now he began to drowse, not exactly to sleep. That was the sign that everything was in him. Now he thought: I must still *face the battle with the other gods who do not belong to the earth*. He felt increased life in him. He felt muscular sensation, intellect, strength, the giant heart with the goddesses in it, the giant steps of the warrior gods. (He said spontaneously here that his pulse constituted the basis for this.) He was capable of enormous love.

He opened his eyes. In the ceiling, there were all sorts of cracks. Instead of these he now saw all the gods on the ceiling. All of them presented themselves to him and looked at him lovingly. One, the sun god, looked at him for a particularly long time. It was a piercing look, obviously in order to strengthen the patient's look. This sun god had an almost blinding look. The actual sun which shone in through the window appeared pale beside it. The god had a trailing moustache and looked wild. Death lay to one side as a skeleton. It was knocked out and defeated for all time. On seeing the gods, he felt how he became stronger. He now had the awareness that he could see everyone and everything. Then he noticed: the devil, vices, hell were embarrassed. He ordered: everyone to assume any form they wanted. In all these processes, his ego was no longer his personal ego, but the *ego filled with the whole world*.

Once again the thought overcame him: I must still go to the *extraterrestrial gods*. At this thought, everything became dead still. It was clear to him: these must be giant worlds. Everything shrank in him before the terrible experiences that were still to be experienced. Everything was ready to die. He felt the huge battles take place, felt victory and the entry of the defeated. Further battles, further entries and so on until rest. Now the *earthly world in him had become very small beside the giant extraterrestrial world*. He was deeply sad. A sort of homesickness possessed him. Previously everything had been happy in him. Some of them had tickled him, the Swabians had shaken his hand, etc. Now all that had gone. The battles which he now felt, but which others had experienced, had resulted in the entry of those worlds and the anguish of the earthly world. An eerie stillness prevailed. Immediately he had the thought: I cannot create *any order* in this *giant world*. He could not grasp *infinity*. He appointed the old God as sovereign. He himself (the new God) wanted to reign and live *simply in that earthly* metaphysical world for which he felt homesick. When he had appointed God, *he no longer needed to worry about order*. He still commanded the earthly beings: "Whoever does not want to remain here, can go to those higher spheres in the giant world." In this way – so he *felt* – he was *at the same time freed from the sceptic regression ad infinitum for ever*.

Through the whole sequence of events, there ran one feeling: all the geniuses have *paved the way* for me; I am actually only the *integrator*; that is why I have the strength. He believed that all the great beings had the evil eye: Frank Wedekind, Mizzi Schaffer, Irene Triesch; these people were death. He had *withstood* them all, and as a result everything had become possible.

As is apparent from the descriptions, he had the *most contradictory ideas* the whole time. He was not just aware of that now; he had been aware of it at the time. He was often in doubt. His mood frequently had *something strained*, *something querulous* about the fact that *even in the supernatural world* he could not *escape his doubts*. He often wondered: are those my friends? Or not? "I had *twenty different views* of how to interpret *the same process*." Doubt had always been present on occasions, but now increased considerably in the further course of events. Only one thing he always knew with certainty: Mona Lisa will not leave me. When the doctor asked whether he had read Dante, the idea came to him: is Mona Lisa my Beatrice?

On Monday evening a doctor came. He was taken from the cell to another room. A man with a bandaged head left the bed into which he came. Apart from him, there were three others in the room. As he was lying there, the thought came to him: I may have saved hell, gods and everything, but I have forgotten *purgatory*. That will come yet. The three people certainly wanted to help him. He asked them whether they would wake him when the battle approached him. He thought then that the others understood him immediately. They answered: Yes, yes, we'll wake you. At the same time the birds twittered. He understood the significance: they also would wake him. Now he was calm and he slept briefly. At the beginning of the night he woke up and similar events to the previous ones began. He commanded: open up, heard axe blows, the whole of purgatory entered. It took a long time. Finally he called upon abstract concepts to come and ordered: "everything that exists should come"; "nothingness"; "the opposite of everything"; "the opposite of opposite" and so on ad infinitum. Finally everything was saved and he was calm. He joked the whole night with the three others, prophesied: tomorrow morning there will be fine wine, Burgundy, Bordeaux… They laughed. *During this* he always had his metaphysical ideas: robbing and murdering is just as justified as love; there are no *value differences* any longer; this and similar ideas in his opinion were related to his philosophy: scepticism.

On *Tuesday morning* one of the others was discharged. Two still remained there. At coffee time he felt extraordinarily happy. He thought: "I have managed something great. But why then am I myself still imprisoned. Even if I am merely a grain of sand. Because I have made everyone a god. Perhaps the Mona Lisa will free me." He crept under the bed covers, felt a draught of air as if he was being stroked. He uncovered himself again and now thought: "I am a great oaf. I thought I had saved the world. But I am *Brother Medardus*. 3000 years have passed. I am in the real world. But everyone that I knew is dead." He now had the feeling of great *loneliness and sadness* (confusion of 'Medardus' with a friar's story, as he himself admits). It was clear to him: "That was all stupidity, what I have done until now." He prayed fervently to a crucified Christ hanging above the door. He did not know what was wrong with him. He was terribly *uneasy*. He decided then to pray for all eternity. The two others in the room were crying. However, one of them at one point made a joke. The patient

was praying: Thy will be done. The other said: No, his will be done. To which the patient responded inadvertently: My will be done. When he noticed this, he said: You rascal, shut up.

For two days he had not washed. *Flies* often settled on his face. Out of tenderness, he thought. However they disturbed his sleep. He would happily have slept; if I do that, then perhaps I will be saved. One of the others placed some paper over his head to protect him from the flies. But he did not sleep properly, felt his body been stroked, felt himself to be female, heard a voice saying he should become a woman. The link with what had gone before was now almost completely broken. He thought: perhaps I am becoming Pope. When he read 'Speyer' on a board, he thought: I must go to the Bishop of Speyer.

Just then a *Zeppelin* went by outside. He stood naked at the window with a female feeling. The Zeppelin came very near. He thought it was going up to heaven. He felt as if he had grown wings. But they could not grow. Thoughts of the supernatural world from before reverberated in his head. Everything that did not want to remain on earth should go up. Perhaps he himself would go too. However, the Zeppelin flew off without him. That hurt him. He remained behind in the awareness: now I must stay in this state in this cell for all eternity.

On *Tuesday afternoon* his uncle came. He conversed normally, but in between whiles made odd remarks. He himself was aware of this at the time. Then his sister came in. He felt strange towards her. When both had gone, the other two patients in the same room teased him: Don't you have a pretty little sister; and you leave her lying there all alone. That made the patient extremely angry. Now clothes were brought for him. He washed himself, got dressed, but wobbled somewhat. He heard someone saying that a Russian chapel was being built here. He: Is Dostoevsky here? The others: Yes. He: Then I'm staying here. When his uncle and sister collected him to take him to Heidelberg he did not want to go with them; I'm not going without the other two (that was also founded in metaphysical ideas). When they said they simply wanted to go for a walk, he went along too. He had great *distrust* of his uncle and sister. Of his uncle, he thought: that is my cousin in the figure of my uncle. Of his sister: perhaps it is my sister, perhaps the lady; my real sister is the lady. "*The whole delusional system now changed*." The lady and he himself were *children of King Otto* of Bavaria. They had been conceived by thought transference. "Thought conception does exist." He believed they had to free the king who was imprisoned for being mentally ill. The patient thought the experience contents had become one degree more real, less fantastical. Then the thought arose, Frank Wedekind was King Otto moving among people in this disguise. The delusion that the Ministry was working against him, which had occurred even before the acute psychosis, now surfaced in this connection. Now it became comprehensible to him. As the son of King Otto, they wanted to eliminate him.

On the *car journey to Heidelberg*, he saw en route the man with the bandaged head who had left his bed when he came into the other room. He made a deep

bow. This encouraged him in the idea that he was the Crown Prince. He often leapt up in the car. As they approached Heidelberg, he thought it had become the new capital. Just before Heidelberg he saw the lady on the road. He leapt up madly. She looked very sad. He knew that he had to go to the doctor. Of the clinic he thought: perhaps it is the castle. It appeared to him as the two, both castle and lunatic asylum. He had constantly vacillated and doubted and finally even asked other patients where he actually was. The attendant who drove with him in the car appeared to him as a friend: he pressed his hand so lovingly. In the bath, his nails were cut. He accepted that good-humouredly. When it was finished: "Look out, I can still scratch with them."

In the first night *in Heidelberg*, he was living in Neuschwanstein. On the wall, he saw King Otto, a crown pressed onto his head. Before him stood a Jew. In what happened subsequently, the patient *lost the chronological sequence of events*. This was *no longer so relatively cohesive an experience as in the health resort*. Apart from the relationships with King Otto which constantly recurred, all the other different complexes of experience occurred transiently; he felt that he was being autopsied. It did not hurt, but he felt his back cut open, a leg cut off, but ('whoops') everything sprung back again in the old place. He was invulnerable. He experienced this autopsy in such a way that he felt himself to be in the bed and at the same time in the autopsy room. "The others think that they had got me outside and were cutting me up and at the same time I am lying here." Then again he thought he could feel himself being eaten up by worms. Then rats were eating him up again. He felt the gnawing and biting everywhere but they could do nothing to him because he immediately grew back again so rapidly. Then he once felt himself to be poor Lazarus, etc. He himself was alternately the Lord God and the devil. That appeared to him of no importance. All opposites were in fact the same. In summary, the patient thought that he experienced in the psychosis everything that he had ever read or had pictured in his imagination.

When all these relatively incoherent experiences in Heidelberg had lasted two to three days, during the night *a new attitude to everything arose in him*. The thought finally took hold of him: it was impossible to resolve the contradiction that God and devil were identical in him. "And the two is one" – "No, it doesn't work." He prayed to God to help him and to bring about the Trinity: "I, God, devil." His ego here, as before, was not the individual ego, but the ego = everything that is in me, the whole world. But everything that was in him was again in everyone else. Such thoughts and the increasingly chaotic experience brought him 'to a state of madness'. He said to himself totally voluntarily: *"I can no longer bear the fantasy world*; *I* want to go back to reality." He was aware in this that fantasies were more valuable than reality, they were more real than reality; he was aware of the beauty of fantasy. But: "*I can't stand it any longer.*" He stressed that he still possessed absolutely no insight – there were several more days on which voices and other experiences still occurred frequently – that while he was able to distinguish clearly between 'reality' and 'fantasy world', he did not

know which he should consider to be actually real. Whereas initially he tended entirely towards the fantasy world, doubt gradually increased.

There was a knocking on the wall. He heard Frank Wedekind's voice. He felt it like a *suggestion* that he should now return to reality, that he had shown himself to be incapable of redeeming the world.

By chance he placed his *hands behind the back of his head*. He felt how the beating of his pulse which he sensed throughout his body was calmed as a result of the pressure, that head and heart which previously had been intertwined were now separated from one another again. This device that he had acquired involuntarily, placing his hands behind his head, he then used deliberately in the subsequent course of events. Another device came to him as if suggested: he said *endlessly out loud to himself*: *I am so stupid, a mill wheel is going round in my head*. In this way, his thoughts were interrupted and he was *distracted* from the fantasy experience. He had hummed this to himself in this way for whole nights. All of this occurred *involuntarily*, but he *then* felt his *will* and the *effort* that it cost him to gradually return to reality. He undertook to behave once again like a normal person and to look at everything like a normal person. His last active effort had been when he ordered a cigar in the health resort. Until that night, he had totally abandoned himself to events, which were often accompanied by the symbol of the wrapped-up child. Now active effort began again, not out of any insight, but purely from his *will* because "he could no longer bear it." Before we describe the subsequent course and his ultimate insight, we will try to depict something more of the kinds of previous mental experience.

In the dramatic world experiences, everything was simply '*evident*' as *reality*. "I experienced what went on outside *directly* and this always corresponded to a twitching in my body." "Inside me and outside me, it was the same." "*This evidence of feeling is the strongest that there is*. If I myself had seen the opposite, that would have been completely immaterial. It always has been; it is so, there is no doubt at all – i.e. at the moment of experience." At the same time vague *images* of the events accompanied him, sometimes somewhat more intense and sometimes also almost purely mental. Nevertheless, the content of these ideas was always absolutely certain. "Just as Kierkegaard demands that one must even believe in paradox, that is how I viewed it."

The world of illusion and the supernatural world were for him completely *clearly separated*, but only distinguishable by the way he *felt* about them. In the train to the health resort, there were four people sitting on the left who were alive and four on the right, who were only an illusion and were dead. He *felt* that directly. He heard a voice to this effect: he does not notice at all that he was 'one-sided'.

The patient had a whole series of *sensory reference points* through which he knew about that world process. He stressed, however, that the certainty of the evidence had not come from this; this certainty was a *direct* experience. He knew everything quite definitely. Among the sensory reference points, *physical sensations* played a major role. "I always related *the same* specific physical sensa-

tion to *the same* metaphysical process" (in the entries and exits). For example, the tickling by his mother was a very specific type of tickling. With these physical sensations he thought: I must see myself in human terms, but he felt that in reality he was something quite different. He believed he encompassed everything that went on outside the small room. However, he noticed the *contradiction* of the way in which the spatial and the actually spaceless metaphysical process intermingled with one another. Only during the entries did he feel like someone who encompassed the whole world; on the exits he also felt spatially alone and isolated.

In addition to the immediate experience of the evident metaphysical reality, however, he was entirely capable of thoughts, of considerations of possibilities: *perhaps* still other gods existed, it was *possible*; I must wait and see. He was also capable of intervening periods of doubt, as is apparent from the earlier descriptions.

Other *sensory reference points* were the *knocking* with axes which he heard, the cessation of the knocking, the *steps* of the people passing outside and then, above all, the very large number of *voices*. These came from outside just like something actually spoken and were very varied in their nature. The Swabians called – he thought, right outside the window – "Bravo Josef", "we're here again"; "the wine is there as well"; "a bit of crap is there as well." Many voices were further away as if people were calling very loudly from a long distance, sometimes as if an echo was borne to him from far away. The grains of sand spoke as little angels like children's voices. They were as close as if they were speaking from the corridor, etc. In himself, he heard sounds as if bubbles were popping, his stomach rumbling. He also transposed the voices into these physical processes so that he thought: it sounds like a ventriloquist. Furthermore, he heard voices in all the *noises around him*, from scraping chairs, a train whistle, the noise of carriages, etc. He usually understood the *meaning* of the birdcalls without hearing words from them. Then, *in* the twittering he also heard *words* in a bird's tone of voice, not like a person speaking: "You fool"; "he won't help you" (when he prayed to God). In the sound of the carriages he heard farmers walking in wooden clogs, goblins working, Hephaestus forging (he considered himself for a moment to be Hephaestus as one leg was paralysed). The puffing of the locomotive said: up, up, up into the air, the whistling: poison, poison.

Overall he had *seen* little: the illusions in the cracks in the ceiling, the gleaming sun god, King Otto on the wall, the devil behind the flap, the Lord God coming through the air like a transparent cloth. The people whom he saw, he saw correctly. When he mistook them for other figures, that "lay simply in the system", not in *the perception*. He gained confirmations of these mistaken identities – "I would not have needed them however" – from the peculiarities of their behaviour, from their distant similarity. He was, however, barely aware of this in the experience. In between, he constantly had the feeling: perhaps it isn't her, etc.

In Heidelberg, he also had *illusions of smell and taste*. The food tasted strange, the air had an odour of laboratory smells. He thought of poisoning, believed that it perhaps came from the Ministry of State.

The patient had no *pseudohallucinations* in *any* sensory modality. He had only illusions and genuine hallucinations. *Some* of the *sensory illusions* are *listed* here: the voices of the little angels (grains of sand) prayed very softly for him to the dear God, but quite clearly audible to him. – He heard *no* commanding voices. "The ideas, the experiences obliged me." – All the gods were *mute*. Only once did the Lord God say "You must" (see above) when he had flown into the cell. He received no answer to his questions to the gods and geniuses. He recognised the geniuses purely from the feeling and from the sensations of the visual expression. Even his hair assumed a different hairstyle. – When he hummed: a mill wheel is going round in my head, he actually felt a wheel in his head, felt it like a coffee mill in his chest. He often had the feeling that his body had changed. The blow was like an electric shock. It was sometimes as if a current passed through his body.

During the psychosis – so the patient maintains – all his *actions were motivated*. Meaningless movements, 'catatonic movements', did not occur at all. He did not shake hands with the doctor because he thought that the doctor would then be damned. He ran into the corridor because he wanted to free King Otto. He allowed himself to be brought back because he then saw that it was not yet time. He knocked on the door of his own room in the hotel because he did not want to disturb a potential thief, in the awareness: it was all immaterial and justified, I must allow everything to happen, etc.

He had *never* been *disorientated*, only *distracted* when he had been right in the middle of his experiences. Thus, he had urinated into the water glass: he thought the chamber pot had gone as the attendant had taken it away. He looked for a bucket, saw the glass, thought the patients in the health resort also had glasses and used it. This was 'the earthly reason'. He could, however, not wait a moment longer as "the rest of the evil had to get out." That was the 'transcendental reason'. This *duality of reasons* he stressed further in the belching and flatulence, in the nocturnal soiling of the bed: it had happened in his sleep in the awareness: it is good that everything unclean (metaphysical) is now out. The dirt was then immediately very unpleasant to him. He did not smear it.

He had *never* been actually *helpless*. He was always able to orientate himself. When the doctor came, he always thought: what does he actually want, what does he actually think of me? Then he would say something merely to see how the doctor reacted and to draw conclusions from this; for example, he said without reason: "Why are you so alarmed?" *"Although I was mad, I was still in my right mind*," the patient now believed. As far as his *mood* in the psychosis was concerned, this was naturally *fluctuating* and very varied. "I actually *always felt uneasy*." He felt alone in the room and the thought of lying there for all eternity (reminiscence of the Tannhäuser idea) was awful. He could not help thinking: soon no one will come any more. Then he had a *cheerful* feeling when, for

example, the Swabians came. Often he was humorous, made jokes and thought: I will not deny my Swabian nature. When the gods moved in, he asked: Are there many left? With his jokes he wanted to prevent the emotion of the silent gods to take hold of him. However, at the same time he felt himself touched, had a feeling of responsibility about his task. Yet he was also once again *indifferent*: if it doesn't succeed, then no matter. He did in fact decide to make every effort, but the outcome to him was *irrelevant*. In everything he never felt himself to be 'great': "*I am destined; I must do it*" was his mood. He thought about it little, but experienced everything directly *passively*, although in the awareness of being equipped for the battle if the challenge should come.

Further details which may also be mentioned: for a while he felt as if his *right arm* was *paralysed*, his elbow was painful and he was unable to move it. As a result, he felt like Frank Wedekind. On one occasion also one *leg appeared to him as if paralysed*. He *never* had the feeling of *horror* at being unable to distinguish illusion and reality. Never disorders of balance. No acute hearing of sounds (in particular no hyperaesthesia). Never dizziness, headache only once at home (see above). No tinnitus. He had noticed no apparent episodes of sweating. There was a constant *knocking* everywhere in his body (heart). – Constipation, but urinated often. – *Evil* taste in his mouth to the extent that he once said: "This halitosis must come to an end." – Sometimes he shook his hand in the feeling that he was shaking hands with the Swabians on their 'entry'.

Both the course of events in *combating the psychosis* and the later *insight* are as complicated as all the details of this psychosis. After he had discovered the *method of distraction* described above, he fought off his ideas in this way, *even though* he still believed in them. "*After the maelstrom of fantasy had once been resolved in this way, I was able to come to myself*." He took great *efforts* from that night onwards *to behave like a normal person*. In the resort park, self-control had ultimately become impossible. Now it resumed. He made a great effort to "assess calmly like people do it", as for example when he was talking about a newspaper to the attendant or the doctor. At the time when he *wanted* to return to reality, it was *irrelevant* to him whether it was reality or fantasy. He wanted because he could no longer bear it. The experience was *finished*, not *judged*. He was not yet thinking about it.

Only when, over the course of time, his inner life had *reverted* to normal did he reflect for example: I have the *feeling* of having any eternity behind me, but in *reality* I must accept that it is May 18th. These reflections soon resulted in his acquiring complete insight in his *intellectual* assessment of the illness. However this approach was not simple: "There is for me *no criterion* as to why the hallucination was less evident than reality"; "I do not have any criterion against which to judge whether it was *metaphysical reality or fantasy*"; he made such objections 'as a joke' and 'as a philosopher'. Naturally he knew that someone living in reality and he as such a person could *only* see the illness as fantasy. Several weeks later he talked along these lines about his psychosis: "I *doubt* reality; *theoretically, not practically*; I would be permanently locked up

if I considered it to be real." He was sorry that the fantasy world was slowly disappearing from his memory.

After the psychosis

There are many things from the days *before* the psychosis which he does *not know definitely* whether they were reality or the psychosis. For this reason, he feels *so uncertain at home* and does not want to go back. He does not know how to behave because *in the past* he could not distinguish clearly disease content from reality in individual cases.

He has no insight about the events *before* the psychosis. The referral of the swaddling of the child to himself he considers not to be pathological 'in the situation', even if mistaken. Conversely, he still considers that it was correct to relate to himself the content of the second-hand catalogue that was sent to him. He considers it impossible to explain this opinion and his views about the machinations of the Ministry entirely as delusions of reference. He said anxiously and somewhat angrily: "if I were to consider that pathological, then I must consider myself to be *completely* ill, the best that I have, my intelligence and everything…, if I were to come to deduce that."

Over the course of time it became *embarrassing* to him to provide information about himself. Previously he had talked to me more freely "in defiance, because I was still doubting." "*When you're healthy, you don't like talking totally correctly and objectively*." He was embarrassed because the experiences were real and he was awake in them. That distinguished them from dreams which could be recounted objectively without embarrassment.

After the acute psychosis had disappeared, the patient went *to the country to recuperate*, but still frequently returned to the clinic for consultation. A series of further abnormal manifestations were observed:

The *mood states* were initially still extreme in some cases. The patient sometimes felt very happy. "All melancholy, all pressure, all depression has gone. All of that has been cleansed by the delirium." This had been necessary as it were "to get rid of the tension." "Now that all philosophical torment has been cast aside, I can live quite naturally." In this way, *life-affirming moods* occurred that he had never had before. He felt himself "totally different, strengthened." He joked the whole day, felt cheerful and merry, joked also about his own condition. Throughout all the past few years, he said, he had in contrast always been depressed.

As against that, however, *contradictory* moods *soon* made themselves felt. He felt hopeless, saw himself unequal to any lifework, did not know what would become of him, saw life as an impossibility and had suicidal ideas, although not serious ones. "I just don't *want* to take my life, I can't do it". Such despairing hopelessness could reach extreme levels and sometimes occurred *episodically* so that it appeared spontaneously and disappeared again after an hour.

In the first few days after the psychosis, he was *at home one day*. Here he experienced a very brief *remarkable state*. He had a sort of dream, yet he was not in a

half-slumber and despite his eyes being closed he *was completely awake* with the total awareness of his physical location. He suddenly experienced 'a change' with dizziness and confusion in his head and in this completely waking state saw in *the room of imagination* with great clarity how an attendant brought a glass of wine into the room, which the patient refused. Again a slight 'change' occurred and he now saw in the pupil of the eye a *death's head*. He looked it straight in the eye, laughed at it and in so doing felt his strength. He felt a pressure on his eyelids to keep them closed. The death's head disintegrated. A small after-image remained that looked like an eye and soon disappeared. He had the feeling that his own head had become a death's head. He felt how the skin on his head disappeared, how the bones and teeth chattered. He observed this without fear and horror as an interesting phenomenon. He simply wanted to see what would happen. Then suddenly *everything had gone*, he opened his eyes and was as before. This whole state, during which he was always totally awake, lasted perhaps 30 seconds at most.

In the subsequent weeks, the patient read in the country (Anatole France, amongst others), sometimes went into town to the theatre and decided to make art history or literature his career. Often he doubted his strength and energy. However he constantly has this prospect in mind.

Despite his regular life, many manifestations still appeared. In the evening, he would sometimes feel *uneasy* when a bird called out in the valley and then came nearer, as *if* it meant something. He thinks it was 'on the borderline'. Healthy people could have precisely such feelings. Or when a cupboard was moved in the next room, he heard again the moaning of the matter. The spirit of the air floated into the room to him with the wind. In the barking of the dog he heard: "you fool, you fool." All of this comes to him even against his will. He is aware of the abnormality and unreality of it, but sometimes is so unable to defend himself against it that the 'You fool' almost angers him. However all of this were similar to the way in which a sane person deliberately adjusts their feelings and hearing in this way.

Once – so he told with reluctance – on a walk in the wood, the 'King Otto' fantasy world overcame him again with the awareness that it was real: King Otto was his father, Frank Wedekind = King Otto, Mrs Wedekind and Mizzi Schaffer and Lady X., his sisters. That lasted probably a *quarter of an hour*. Otherwise, however, he also sometimes thought about this and in fact occasionally said: "In fact, no-one can prove to me that I am not the son of King Otto." Even before his illness, Mizzi Schaffer, other actresses from the Residence Theatre, Lady X. had appeared to him as people of his kind. There was no doubt. "*I know with absolute certainty* that Mizzi Schaffer was interested in me." He had admittedly *never got to know her* and she could only have seen and observed him often in the theatre. But he had noticed how she had drawn her husband's attention to him in the carriage when driving past; 'a fine man'. He looked around. And once in the theatre, she had been sitting behind him. He clapped overly loudly at a joke and attracted the audience's attention. Then she undoubtedly made a remark which was intended to mollify him.

Sometimes he had a *headache* in the back of his head. Never dizziness. At night in bed he sometimes saw lightning, bright lights, kaleidoscopic wallpaper patterns on the ceiling in vivid colours. These were mosaic-like, alternating patterns, never flowers, figures or other shapes. Sometimes a little tinnitus.

Things went best for him during the initial period after the illness when on medical advice he did not think about the future, but devoted himself solely to recuperation. He believed that *as a result of* the presence of his mother he had started thinking about the future again and had again suffered depression. His mother, he said, was suspicious that he was still ill – from which he concluded that mistrust is general and not pathological – she irritated him with banal conversations. He was obviously not fond of her presence. He felt well on his own.

On 23rd July, the patient experienced an *abnormal state* which lasted 3 days. It began with an attack in the early morning which lasted at most 12–15 seconds. It was a *fairly painful* tetanus. He was totally immobile, could not open his eyes. It then became very bright before his eyes and he saw – with his eyes closed – in the distance a small statuette of Jesus. This moved him. The rays fell upon him. He then felt seemingly dead, felt he had totally vanished to just a mathematical point. Then he saw the emergence of a cloud of smoke, Jesus had disappeared. A devil emerged from the cloud of smoke and suddenly everything disappeared. He felt himself totally free and able to move. During the attack he was *quite clear*, *fully conscious* and, as he said, oriented to his actual situation.

For the next three hours he was under the impression of the 'transcendental significance' of these events. He felt very exhausted. The experience had been so vivid that he could not believe it was just an illusion. He thought: The devil has done this. Immediately he heard a voice: You fool. He thought: No, God has done this, and immediately he heard in the crowing of the cock: cock-a-doodle-doo = you utter oaf. So his thoughts went back and forth and during those days this thought process became a *helter-skelter* of ideas, a *constantly recurring alternation of yes and no*. It was quite frightful. The thoughts overwhelmed him with their *quantity*. It was "a regression to infinity." He had a mad fear, said he would rather go down with the Titanic on the ocean than experience that feeling – he would go mad straight away. In his fear of madness, he had himself voluntarily re-admitted to the clinic and then everything was immediately over and he was able to be discharged the following day. During the next few weeks he was well.

A letter from the patient which he wrote to me on 4th June is appended so as to characterise him. It shows clearly hebephrenic features and the strange sense of humour without an actual underlying cheerful tone which the patient also described to us himself.

4th June 1912

"Dear Doctor! I have now been here since yesterday and feel very comfortable in these splendid surroundings despite the passing rain. The return of my old freedom has as yet not led to any set backs and I believe also with relative

certainty no more will follow in the foreseeable future. There are only a very few strangers here and that is entirely pleasant as far as I am concerned. The birds sing here quite differently from in Heidelberg, the locomotives emit their smoke through funnel and whistle into the 'upper airs' with totally different sounds. The trees rustle here when the wind passes through them to show their reverence for the law of causality. Only one thing seems to me still the same. Shall I tell you? I am risking a lot if I do. – But you have become my confidant in so many things that I also do not want to keep this back. Sometimes at dusk I sit vacantly in my six-windowed tower room and hear the monotonous clanking of the tugboats on the river, then I feel now and again how the floor suddenly shrieks when someone moves a heavy cabinet or an oak sofa from one place to another in the room next door. If, in the very early morning, my next-door neighbour angrily knocks over a chair onto the floor because it is in his way while he is searching for his rear collar stud which has probably fallen under the bed drawer from the bedside table during the night – where else could it have fallen? – then I feel also how the very well laid floor defiantly resists this unjust pressure and does not yield. And it is so strong because it feels it is in the right and has the strength.

As far as the state examination is concerned, however, or those book offers which gave rise to much concern, I believe with good conscience that I can assume that this and similar sources of mental agitation have disappeared. The comparison with hardened lava or extinct craters, the known outlets of former volcanoes, does not seem all that inappropriate to me and if perhaps a bit obvious.

If it is not too immodest of me for once to assume the position of the psychiatrist, I should like to declare that until now I myself have been relatively spared from the arch-enemies of mankind, alcohol and tobacco. Only once was I attacked this lunchtime by the former demon in the form of a pudding with *wine* sauce. Unfortunately, it did not strike me until too late that 'friend' alcohol had here sneaked up cunningly on me and, before I noticed it, duped me. The bitterest repentance came too late. But from now on careful attention will be paid.

On Friday morning I intend to return to the psychiatric clinic for follow-up of my mental state. I would very much like to see you or to receive something from you in writing to read. That would be no more than right and proper after I have helped compile so extensive a medical history. If you require further additions to your investigations in one form or another, I am naturally at your service. Yours sincerely, Your devoted Josef Mendel."

Once again we analyse our patient 1. phenomenologically, 2. in terms of causal relationships (diagnosis), 3. in terms of his understandable relationships.

1. Phenomenology. The patient's *state of consciousness* was lucid. He was fully awake. There are no characteristics of *clouding* of

consciousness. Neither he himself believes that he had been in a dreamlike clouding of consciousness, nor are there objective signs of clouding of consciousness (reduced capacity for perception in the psychosis, amnesia, clear chronological differentiation between clouding of consciousness and waking state). The patient has an excellent and detailed memory of everything he experienced.

His state of consciousness would have allowed him to remain completely *orientated* throughout, if the quantity of significant, powerful experiences had not constantly shifted his orientation. As a result he presented with the characteristic symptom of *dual orientation*. This symptom consists either in the fact that the same processes, perceptual content, personal actions, etc., have a dual meaning for the patient (e.g. the attendant is both attendant and devil) or, if the experiences are totally removed from the present situation and the actually perceived world, in the *ability to immediately comprehend the situation correctly* if something real impinges *urgently* on the patient *without* abandoning the psychotically experienced world. In the first place, the dual orientation differs from doubt, which *vacillates* backwards and forwards between two interpretations of the process: the process in fact *possesses both* interpretations. The dual orientation also differs from the process of regaining full consciousness after a mild clouding of consciousness with dreamlike experiences (e.g. the initial stages of delirium tremens). This process of regaining full consciousness is experienced as a sort of *awakening*; it is immediately *associated with complete insight* since clouding of consciousness of this nature always involves only *a few, unrelated experiences* which, as soon as the patient actually orientates himself again, no longer have any residing experiential *value* either.

Bleuler has described the dual orientation as a typical schizophrenic symptom in both acute and chronic states.[21] Chronic patients have "in many relationships a form of *dual-entry bookkeeping*. They recognise correct relationships as well as incorrect ones and respond according to the circumstances in terms of one or other type of orientation – or both together." Of the twilight state of schizophrenia, to which our patient would probably be assigned,

21. Bleuler: Schizophrenie, pp. 43, 45, 47, 180.

Bleuler writes: "*Dual registration* of external events (in terms of the dream and at the same time in terms of reality) is usual, *even in severe cases*."

Our patient's self-account provides some characteristic contributions to the way in which such a *dual orientation* is experienced in acute states. At the beginning of the psychosis, the patient experienced both: the metaphysical world and the real world. The real world was a pretend world for him. However, he still had his doubts; for example, he did not have the courage to give the coachman just 10 pfennigs in order to obtain the desired proof of the mere pretence of the real world. As the psychosis progressed, the doubts increasingly disappeared, but his correct orientation persisted *as his orientation in the pretend world,* in addition to life in the actually real, metaphysical world. He knew that in the pretend world he was now being brought into the cell for maniacs, that he was suffering from religious delusion, that he was being transferred to Heidelberg. Throughout the whole of the psychosis, he constantly sought to poke fun at this pretend world, which was in fact merely illusion. He was always able to *distinguish clearly* the pretend world from the metaphysical world. *No confusion, not the slightest* sign of *helplessness* occurred. Accordingly, what the patient did was also in many cases *dually motivated*. He had, as he says, an earthly and a transcendental motive, a motive from the pretend world and a motive from the metaphysical world, as for example, when he evacuated his faeces: out of a physical urge and also out of the knowledge that "the last evil must be eliminated from his metaphysical being." Finally, when the patient *wanted* to return to the 'real' world of illusion despite considering the metaphysical world to be the only true one, he also clearly distinguished between the two realms. In this way also, therefore, the patient was *always correctly orientated*. Certain actions that come across objectively as confused, such as urinating into the drinking glass, were explained to us by the patient, who remembered them well, as being due to distraction. At the time he was too much in the metaphysical world; for transcendental reasons he had to evacuate the 'residual evil' immediately and did so into the water glass as a result of incorrect, uncontrolled notions which are described in the patient's history.

So that this experience of dual orientation should not appear as an individual phenomenon in our patient – it comes across peculiarly as a philosophical reminiscence – we append by way of comparison certain passages from the self-account by Nerval[22], who suffered an, in many respects, similar schizophrenic psychosis:

"At this point began for me what I will call the *encroachment* of dream into reality. From this moment on, everything assumed a *dual aspect* at times – but without my thought processes abandoning all logic and without my memory losing the slightest detail of what occurred to me." … "I do not know how to explain that in my thoughts the earthly events were able to *coincide* with those of the supernatural world; it is easier to sense this than to express it clearly." … "What these people said to me held a *dual meaning,* even if they often showed no awareness of it, because they were not in the same 'state of mind' as I. … However, to my mind, the earthly events were *linked* with those of the invisible world. That is one of those rare relationships for which I cannot account to myself and which it is easier to allude to than explain."

If we now bring to mind the ways in which the *contents of his experience appeared* to the patient, we can first of all establish in negative terms: *delusional perceptions* – both hallucinations and illusions – play no major role. The voices and the visual, olfactory and taste hallucinations or illusions that occurred are presented in the case history on p. 388 et sqq. Bodily sensations that were always experienced in a certain relationship to metaphysical events appear to have played the greatest role.

The *perception* of actual objects as such was unimpaired: no changes in intensity, usually no tendency to illusional transformation, but on the other hand there was a constant tendency to see unreal *meanings*.

Actual *pseudohallucinations*, detailed, vivid images appearing without or against his will, did also not occur according to the patient.

If then neither delusional perceptions nor changes of perception nor pseudohallucinations represent the metaphysical experience in the patient's consciousness, how then was it represented? a) Through the delusion of significance, b) through the various dif-

22. G. de Nerval: Aurelia. German, Munich, 1910.

ferent types of evident, virtually or totally non-graphic moments of awareness.

a) At the beginning of the acute psychosis, a particular kind of *delusion of reference* occurred in the patient's experience, which we wish to call a *delusion of significance*. Delusion of reference refers to all those direct delusional experiences in which external events are wrongly deemed to relate to the patient's self, e.g. when a paranoid subject knows immediately that people conversing together are talking about him, when he knows that a smile or a gesture applies to him, and so on. Whereas here the *content* of the delusion is entirely clear, there is a type of delusional experience in which objects directly assume a *significance*, a *mysterious*, *ghastly* or *unearthly*, *metaphysical* significance, at any rate a significance that is far from clear and which is *enigmatic*. The objects and processes *have a meaning*, but *do not signify something specific*, something that can be formulated conceptually. The delusion of significance is rarely purely objective; in most cases the person of the patient himself plays a role in it. The significance mostly refers to them in a mysterious way. Certain *specific* contents, a clear delusion of reference, always immediately arise from this delusion of significance. For our patient, the world is mysterious and then wonderful, as if it were the Golden Age, the music is strikingly significant, people all know something or say something about what the patient is thinking in relation to his idea of the onset of the Golden Age, but without providing clarity. At the same time, simple delusions of reference, obvious allusions and so on also occur.

In order to illustrate clearly the *delusion of significance*, which we cannot help but consider a phenomenologically very characteristic and elementary mode of mental experience, we *compare* it here with a case of severe delusion of significance in relation to mystery and persecution. *In phenomenological terms,* it shows *the same thing* as our patient along the particular lines mentioned here. Otherwise it is entirely different. It involves a process in which reactive moments seem to play *no role whatsoever* and concerns a delusion of significance whose content is along the lines of *persecution*, whereas with our patient the content is that of a change of the world to the *Golden Age*. (The most important passages are highlighted in italics.):

Jakob Veit, born in 1880, single. Very gifted child. Successful businessman, most recently in New York. Never previously ill, always nervous, particularly in high summer.

In summer 1907, his circle of friends and acquaintances noticed that he had changed and was saying strange things. At the end of September he suddenly destroyed all the furnishings in his room, was taken by force to hospital where he was treated with compresses for agitation. Shortly afterwards he was transported to Germany. On 12th December he was brought to the Heidelberg clinic, was completely oriented, but withdrawn and unresponsive. He grimaced, pulled faces, adopted catatonic positions, yelled inarticulate sounds in a loud voice. Suddenly he broke out into violent laughter, then again stared in front of himself, bit his pillow, struck his leg with his fist, etc. At the same time his attention could always be attracted and for the most part he responded, but in a jokey, inappropriate way. (Ill?) "I couldn't care less." (Confused?) "As far as I know, yes." (For how long ill?) "For the whole of my life." (Since when worse?) "There is no worse and there is no better. There is only a good. There is only one god." (Who was the doctor?) "Mignon." On one occasion his condition was interrupted briefly by a more depressive state: sombre mien, turned away indignantly when people approached, refused all contact and all questions: "I am not answering any question, you ask me the same thing 1000 times." Sometimes a droning sound.

At the end of January, the patient became responsive and completely normal. He was now happy to provide detailed information, did not exhibit any abnormal traits, but did not have any insight at all into the fact that he had been ill. He now recounted his experiences:

"On 28th September 1907 an ambulance-chaise drove up to my home and without any reason four to five men took me away by force and carried me strapped to the ambulance." This 'act of violence' is still as much a riddle to him now as it was then. 'Possibly' Isaak Rosenberg had a hand in the matter. The situation had arisen more or less as follows: On the previous day (27th September), he had been in the cafe in the morning. The waiter was a tall, strong man *who hopped rapidly and mysteriously past him* and shook some potash into his coffee. For that reason he left the coffee. Then he went to the office and worked until the evening. From work, he then drove to Rosenberg without eating. He wanted to return an umbrella he had borrowed from the latter and ask him something. In fact a burglary had been committed at the office and the patient had suspected the locksmith: because the locksmith had *behaved so strangely*: "*he seemed fishy to me*." He had recounted this to Rosenberg. The latter, however, had responded *so strangely*. Then he told Rosenberg he had not had any news from home since the 9th, he had been so worried and wanted to telegraph. At that point R. said with *such strange hand movements* it would be better if he were to wait a little. In short, Rosenberg had behaved *oddly*. He now wanted to ask R. about all of this.

He travelled there by metropolitan railway and rang at R.'s door. An unknown young lady opened: Mr and Mrs R. were not at home. He decided to wait below

in the street. Everything was then so *odd*. So many *carriages* drove up to the house and numerous bags were unloaded and carried into the house. *Very many more carriages were running on the railway* than usual and *strangely all the carriages were empty*. *'Something' must be going on in New York*. *Everything had changed*. A man came out of the house with an open collar and a *piercing look*, it was a *detective*. Soon, a whole number of such people were in the street. In addition, an *old lady* was going up and down, constantly looking to knock him over the head. Then *a dog came which appeared as if hypnotised*, *like a rubber dog, moved by machinery, like a child's toy*. The people increased in number and he noticed that *'something' directed towards him was going on*. He became worried about his person, "no fear, just worries about my safety." For that reason he positioned himself in the entrance door between the columns that stood there, "It made me think of Samson." In this way, the people could only approach from in front. But all of them simply went past him, although *in such a way as to cause* the *newspaper* he was carrying under his arm to *flutter violently* and also they all *clattered with their umbrellas as if there was some machine in them* and as if they wanted to frighten him.

Rosenberg now arrived in his car. Initially he wanted to *avoid* him. Then they went up together. In the house, *everything smelt* of dried meat. Mrs R. *took off her clothes*, not completely, but more than was seemly. Soup was placed in front of him but he did not eat it. He asked for a piece of bread which he devoured with great appetite.

Shortly afterwards, he went home. There were living pictures there as in a cinematograph. He saw two dogs which were pulled back and forth as if on a lead, they looked like bulldogs, but as pictures they were as small as mice. Then he saw a picture of Gabriel Max on a white table. This was so *remarkable* that he once again became worried about his safety. His framed pictures on the walls made jumping movements. There must have been people in the adjoining room, in the bathroom, to cause these phenomena. "Afraid for his own skin," he did not go to the toilet that evening because *'something' must be going on there*, and instead he urinated into handkerchiefs and laid them on the window so that they did not smell. He placed a chair in front of the door so as to hear anyone coming in sooner. He attempted to get to the bottom of the incidents by emptying the cupboards and taking down the pictures. The *noises in the street were remarkably loud*. He heard *a knocking at the door*. At night he slept little. Finally, nothing else mattered to him. The following morning he did not get dressed at all, but turned everything upside down in his search for the cause of the incidents. Then R. and another friend came and shortly afterwards he was taken away by carriage. He astonished himself by how courageously he had fought the four men. He was not by nature so courageous at all.

He was taken through a large gate. Then he must have fallen asleep. While he was recovering, someone was working on his sexual organs: it was a totally indescribable sensation as if an electrical whirlwind was going around. He was held down in bed by some force or other. The greatest pain however was still to come: a rubber tube was inserted into his nose (probably feeding). He felt

himself as if in a Middle Ages torture chamber. Often he felt dizzy, so that everything spun around. His spinal column was as if made of rubber. He was wrapped up, laid in the bath and he had also been beaten. His terrible restlessness improved when he sang. He probably also yelled: kill me. This is the best thing you can do in such a situation.

Of the subsequent course of events he wrote: "I felt psychologically or physically ill. I was frequently asked whether I was already married and they tried to persuade me on a number of occasions that I had a child in Paris – they did this a few times – so that at times I *considered everything to be a crude mystification and a farce* despite the severe pain to which I was subjected. I cannot say which day I was discharged from the 'hospital' since I was not informed of such things. I was led through various offices by an official, taken to the pier in an open carriage and handed over to the North German Lloyd steamship S. On the day of my arrival in Bremerhaven, a man accompanied me to a cab and took me to a building which I recognised as the police jail in Bremerhaven from the 'rules and regulations' boards. I gave the prison guard all the information he required… we drove to Heidelberg. I had the impression that all which was done to me was complete monkey business which would come closer to be resolved on my return to home, and I was in a good mood and attempted to amuse myself after such a long difficult time which I had undergone with all sorts of practical jokes and at the same time by thinking through everything that I had experienced I tried to establish a point of reference that could help to explain what had led to my arrest on 28th September 1907 in New York. The doctors at any rate were confused about my mental state because of the way in which I behaved in the initial period and I can assure them that I felt and feel mentally and physically totally normal, healthy and strong… I admit that I am guilty of some mistakes as a result of a lack of understanding about my own situation and ask that no notice should be taken of these."

These last remarks already show that the patient is almost completely without insight. He is collected, makes rational plans for the future, has an urge to work, is thinking about an imminent military manoeuvre, gives extremely quick-witted, intelligent responses, is normal in all respects, in a word: he is sane except on one point: he does not realise that he was mentally ill. All that he did was in fun and for amusement. He holds to his hallucinations as reality, even if everything is an enigma. "I would have to see myself as mad if I had imagined that." There were quite definitely pictures in his room and there was quite definitely a live dog in the street for a few minutes as well as a rubber dog controlled by machinery until it sprang away again alive. He puts forward his *explanations* of his *elementary experiences* as *mere suppositions*. He distinguishes critically between experience and interpretation and he does *not* find an explanation that satisfies him. He also considers the assumption that R. had been behind it all to be *mere supposition*. The act of violence and all the other experiences from that time remain a *puzzle* to him. The patient was discharged in this state. Some months later his brother reported that the patient had initially not wanted to

believe in his illness, but subsequently he had gained total insight. From the outset he had worked extremely well in the brother's business, but had then joined a large commercial business in which he had also trained and was now going to a large city as branch manager. He has been living there for 4 years. We did not hear of any further illness. In 1912 he took out a life insurance policy. From the information from the insurance company we were able to infer that he was working successfully in his business.

b) While the delusion of significance plays an important role only at the beginning of the acute psychosis, most experiences during the acute psychosis appear to the patient as contents of awareness which probably form the framework for most of the contents and which, *supplemented* by hallucinations (voices, sounds, etc.), make up the psychotic experience.

Such awareness contents have been described by Ach in normal psychology as the non-graphic presence of a content. Such totally non-graphic awareness, for example, provided the patient with the contents of the supernatural world process. The extent to which graphic elements are otherwise involved is difficult to determine. The patient was unable to supply any clear information about this. We may assume that there are phenomenological transitions from totally pure awareness to visual concepts and from there to pseudohallucinations.

The patient's contents of awareness are now fundamentally distinguished from the usual awareness contents in that they occurred to him entirely without his will *as an external process*, not as *purely subjective contents independent of the direction of his own thoughts*. In this relationship, pathological contents of awareness are to normal contents of awareness what pseudohallucinations are to imaginings. We can divide pathological contents of awareness into two groups: *physical contents of awareness* and *delusional contents of awareness*. The former gives the patient something convincingly present in a non-graphical way, which in certain circumstances might also be perceived by sensory organs. Delusional awareness convincingly presents the existence, the reality of spatially distant or non-spatial processes which could not be perceived at all in sensory terms. An example of physical contents of awareness is the lady who copies all his movements behind his back. He knows this precisely, directly,

even though he does not perceive her in any way. Delusional awareness is found in many earthly and supernatural processes. In individual cases, it is *difficult to separate the individual contents in terms of the nature of their existence* during the wealth of experiences at the peak of the psychosis.

The *absolute conviction* possessed by the patient of the reality of all the contents presented to him in so non-graphic a way is constantly reiterated. Everything was to him *'simply evident'* as reality. "I experienced what went on outside *directly* and a twitching in my body always *corresponded* to it." "*This evidence of feeling is the strongest that there is. If I had seen the complete opposite, that would have been completely immaterial.* It always has been; it is so, there is *no doubt at all*." The patient stressed to me on several occasions the lack of importance of a sensory representation. The *absolute* conviction during the experience could naturally be *doubted afterwards*, as is apparent from the patient's history, just as we wonder after a perception whether its content also really existed.

From the series of the patient's particular experience contents, we should like at this point to highlight just one aspect as being of interest. After the dramatic world events, the patient felt that only the space of his cell still existed. Otherwise all space was at an end and the Golden Age had dawned. Now he wanted to perform the most powerful act of all. Space should no longer exist. He ordered space to disappear. But nothing happened. He did not have the strength. – This appears to be a typical experience. In content-rich psychoses, events often proceed to a climax. The patient has enormous strength, sees action after action in the psychotic realisation and now comes to the last one: he wants to be dead, the real world must disappear, and so on. And naturally this cannot help but fail. A change then occurs temporarily in his consciousness, a sobering-down, a pause, and then the experience begins again. To characterise clearly this *experience of the failed catastrophe*, we present an example from another case by way of comparison:

The patient, bandmaster Beinmann (classic dementia praecox, initially paranoid, later catatonic form), compiled a written self-description, particularly on the effect of apparatuses. We are at the point at which he expected to have to

die and to enter into eternal bliss. He was in an overwhelmingly joyful mood. "My joy that I was now going to heaven grew constantly, oh and the joy, I saw Emmy there (his deceased sister), oh Emmy … Then I called out with a fairly loud voice: "So farewell sweet art and… well… let's go, I will count to three, then it will happen… one… two… three. Just wait for go. So… 1, 2, 3 go!!" But then nothing happened, the apparatus snapped and restored my *natural mood* to me. Father then said: "Karl, you must lie down now and be quiet." At that time I really thought I would die, I would be burned to death by electricity, I would simply feel a surge and then I would be happy."

The patient's *awareness of personality* in the psychosis also had as it were a *dual orientation*. He was always aware that he was Josef Mendel but at the same time he was God, the son of King Otto, the whole world, etc. – On numerous occasions a *duplication* of the patient occurs. These are not totally clear phenomenological facts here. We know generally the experience of personal duplication in the sense that two personalities are actually *experienced* one beside the other with their wealth of feelings, and we know the form of duplication in which the individual only experiences himself once, but *sees* another outside him which he is obliged to consider as his double *without* also *experiencing* this from within as a duplication. The patient felt himself to be duplicated in a different sex in his sister, but also later in the lady Mona Lisa who accompanied him. He later felt himself physically to be of both sexes and experienced the sex act between these two people in himself. Lastly, he felt himself on one occasion being dissected as the other person, while he himself was lying in bed.

In respect of the abnormal *states of feeling*, we refer to the multiplication and deepening of the empathetic experiences before the psychosis and also to the overview of his abnormal feelings, p. 390. We will highlight specifically only one feeling which appears to us to occur characteristically in such forms of psychosis: the ultimate *feeling of indifference*. The outcome of the whole process is immaterial to him, he feels himself to be passive.

This feeling, which we also noticed in the first case, is described by another patient who experienced the War of Religion, world conflagration, a crackling of gunfire and the thunder of cannons "which in reality would not have been heard in the wildest tumult of battle": "Moreover, I had undergone the most fearful

phases of my hallucinations with stoic indifference, as if I had been aware that the whole commotion was mere humbug and would soon stop."[23]

In the face of the psychotic process, the patient on several occasions was aware of *compulsion*, to which he initially *abandoned himself*, but from which ultimately he attempted to *escape* by distracting himself. As he had stepped onto the terrace during the music in the health resort garden, he felt the compulsion to follow a particular path. He had to follow precisely in the footsteps of someone else. He abandoned himself to the compulsion to follow the music with physical movements, etc.

The *movements* which the patient made in his psychosis were, in his opinion, *always motivated*, even the strangest movements that were incorrectly interpreted as 'catatonic'. When he performed such movements, he wanted for example to produce more room for the beings within him, help them to move, etc. This claim of a consistent motivation for motor manifestations that appear as 'catatonic' during the psychosis is not unusual in such types of highly eventful acute psychoses, and again we quote Nerval:

"The cataleptic state in which I had found myself for several days was explained to me scientifically and the reports of those who had seen me in this state drove me into a sort of irritation when I saw that the movements and words, which for me coincided with the different phases of a logical *chain* of events, were attributed to mental confusion."

Among the phenomena in the area of volition, there is another striking and characteristic fact, the *feeling of extraordinary strength*. Our patient felt himself to be infinitely superior to others in terms of physical strength. He felt that ten men would not be able to hold him. This feeling of giant strength is also common:

"I then had the idea that I had become very tall and that I would destroy everything that approached me with a flood of electrical forces. There was something comical in the care with which I held my forces in check and spared the life of the soldiers who had seized me (Nerval)."

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23. Fehrlin: Die Schizophrenie. Published by the author. (Self-description of a schizophrenic).

2. Causal relationships. Few will doubt that our patient's condition involves a schizophrenic process. As we do not know anything about the cause of these processes, apart from a frequent similar hereditary tendency – which is not present in our case – we can only ask *when* the process *began*. It is obvious that the *decline* in the patient's *assiduity* and the beginning of the deep *aversion to law* six years previously may be seen as the first expression of the process. Four years ago he began to *feel totally misunderstood* by his family and *withdrew* from his friends. While both these periods may be taken as the first, very mild episodes of the process, it became obvious and beyond all doubt *in the last two years*. He became mistrustful, depressed, laconic, complained constantly that he did not feel well, became irritable, withdrawn and lost almost all initiative. This more severe phase initially regressed, but a longer-term schizophrenic state persisted: he was brusque and insulting to acquaintances but otherwise very shy, his behaviour was bizarre after he had drunk alcohol and sometimes spontaneous ("He liked to play the lunatic"). We are unable to find any trigger moments for the individual phases or episodes from his history.

From his adolescence onward, our patient had shown a greater than usual *interest in philosophy* and also an above-average need for culture, a finely developed sensitivity. With such a disposition, it is easy for us to understand why the patient should devote himself passionately to the study of philosophy whenever his disease progressed. It is generally a characteristic of this process that those affected devote themselves to the deepest problems, questions of philosophy, life and religion, particularly at the beginning. With his particular predisposition, this trait inevitably came strongly to the fore in our patient. We will attempt to understand this relationship better in the next section, as well as the fact that philosophy resulted for the patient in the harrowing *experience of scepticism*. We are, therefore, of the opinion that the study of philosophy and particularly scepticism are the *consequence and expression of the mental change induced by the process*.

His *incapacity for work* may also be viewed as an associated consequence of the process. This, together with the philosophical fiasco, formed the main substance of his suffering in the last year before

the acute psychosis: a fate that is understandable up to a certain point, *caused as a whole* by the process itself.

Three months before the psychosis, a certain transformation occurred in him as a result of the *impression made by a lady,* although he did not make personal acquaintance with her. Nevertheless, broadly speaking everything remained as before until the time, one month before the psychosis, that the *examination failure* occurred.[24] From this point on, he became substantially more ill and also now started to appear ill to everyone else. Over the next few weeks a number of delusional ideas developed whose understandable relationship with this failure is undeniable. Following further episodes of depression as a result of scenes with his parents over the choice of career and as a result of questions by others about his occupation, the acute psychosis flared up after a period of about four weeks, preceded two days previously by the totally *unexpected reappearance of the lady* which produced a deep impression.

On the basis of this brief résumé of the data, we are of the opinion that this was a *reactive* psychosis. The process created the *predisposition* for such a remarkable reaction to a severe trauma to occur at all. *Additionally,* the process produced the *mental change* that brought with it the philosophical fiasco culminating in scepticism and also the incapacity for work and the inability to find his place in the real world.

Scepticism and incapacity for work had already introduced a tension into his emotional life, which was released in direct chronological relationship with the examination failure. After all his *inner* failure, he had as it were ventured everything on this one card: he had expected a first. When disaster occurred here, he was completely despairing and a pathological change then developed *immediately* (both reported by the relatives and described by himself) from which the severe acute psychosis developed after four weeks. The degree to which the subject matter of the psychosis is

24. Both he and his immediate circle expected a first and were very disappointed and surprised by the poor second. In addition, the poor grade represented a barrier to his employment in the civil service. He now had the prospect of having to wait a very long time and perhaps of never being employed.

also understandably related to a large extent to the traumatic events from which the acute phase developed reactively will be seen in the next section.

The reactivity of the psychosis in this case is not clear *to the same extent* as in the first case. If we ask: would the psychosis have occurred even without the specific traumatic events; in our first case we would unhesitatingly answer no. Klink would have remained healthy if his marriage had been happy – at any rate for a long time. In the present case, we must answer: if he had obtained a first in his examination, the acute psychosis would probably *not* have broken out *when it did*. The *psychological destiny* occasioned by the process, however, would probably have resulted – the longer it lasted, the more minor the cause – in the same type of psychosis at some point. Finally, we cannot estimate to what extent a *disease progression*, which to a certain extent was already imminent, was also induced by this reactive behaviour. After the psychosis, the patient returned to being as normal as he had been previously. No progression in the process was observed. We must, therefore, consider the concomitant effect of a disease progression to be very small.

The *reactivity* was apparent *after the psychosis* in the fact that the patient had an aversion to his home situation, which once again confronted him with the problems of a job; that he did not feel at ease when his mother, who had previously made so many demands on him relating to his career decision, visited him; that he immediately suffered a slight relapse on his first visit home and returned to the clinic.

The process as such is naturally still ongoing: his delusional attitude to certain events before the psychosis, his episodic states, certain traits which are particularly apparent in his writings and which point to fundamental changes in his personality, all are characteristic of the long-term schizophrenic state.

3. Understandable relationships. We will first try to understand the understandable relationships which happened *before* the acute psychosis whose occurrence we consider as a *consequence* of the process. We then want to try to understand the *content of the acute psychosis* itself, as far as this is possible for us.

The mental changes, the various *new frames of mind* or *new vital feelings* that occur as a result of the schizophrenic disease processes are difficult to understand and difficult to describe. It has not been possible to describe them in such a way that it could be said these frames of mind occurred *solely* as a consequence of these processes. Moreover, we can only study them with the prospect of any success in more sophisticated and more gifted people. If we succeed in finding them in such people, then we will discover them more easily in the unsophisticated form of the more usual cases. However, more gifted patients with a schizophrenic process are rarely – in many cases because of lack of opportunity – the subject of scientific study.

We will first attempt to provide the material of the *objective signs*, the thought contents, the idiosyncratic nature of the value judgements, the way of life, etc., and on the basis of these and with the aid of the *patient's descriptions* which he gives of his previous states of mind and the *judgements* he attributes to them, attempt to probe the subjective source of the purely external signs. Such *psychological* investigations will enable us to define more clearly the nature of these symptom complexes than is possible with a purely subjective assessment of the *objective* symptoms as impaired *performance*, eccentricity, confusion, incoherence, mannerism, autism, etc. Unfortunately, our patient also tells us nothing that is absolutely clear in this respect, but as a concrete contribution we consider him not without value in terms of material.

Three phases of increased philosophical pre-occupation occurred, 6 and 4 years before the psychosis and then in the last 2½ years. We have reason to believe that on each occasion a progression occurred in the process (suddenly strange behaviour in other respects as well). From the first phase we learned nothing more; in the second phase the *mind-body problem* preoccupied him (cf. case history p. 374). As the names of the philosophers he studied and their sequence show, the problem for him was *not a cold scientific question*, but the expression of a *metaphysical tendency*. Whereas this question is relatively immaterial to the purely scientific person who is always firmly grounded in empiricism because it cannot be answered at all and because he is able to use sometimes one mode of representation

and sometimes another as a tool for his empirical purposes, this problem is an *experience* to the metaphysicist. Something of the essential nature of the world lies for him in the presentation of this problem. The way in which our patient tackled the problem and how he resolved it is remarkable. His conclusion that both theories can be accepted with equal justification is theoretically irrefutable, a sign of honest criticism. At the same time, however, it is a sign that he is *incapable of satisfying his metaphysical bent*. Metaphysics requires not simply the experiencing of the substance of the problem as something overwhelming, but also the ability to adopt a view, to create, for which critical thought is only a *means*, not a *criterion*. The patient was unable to do this and he experienced the first failure of his metaphysical needs.

When the patient resumed his philosophical studies 2½ years ago, he experienced almost the same thing once again. Obviously driven by the urge to produce a 'system', by metaphysical need, by the drive to find a world view, a conception of the world, an understanding of the whole and 'philosophical clarity', the patient nevertheless increasingly turned away (cf. case history p. 374) from ideological philosophers and towards the pure *logicians*, the *purely scientific philosophers*, who fitted in with his *critical intellect* but not his need for a system. Thus, Husserl represents the climax for him. When subsequently his ability to create a 'system' fails, however, and in addition he believes that he sees contradictions and errors in Husserl, the progression to total despair, to scepticism was inevitable.

And yet this *progression* was only apparent. Scepticism was *from the outset* the appropriate expression of his frame of mind. On the one hand he possessed the urge for a world view, but *out of an inability to adopt an opinion, he turned to purely intellectual, rational methods*, clung to these as it were to the absolute extreme, studied the eminently difficult Husserl – whose *subject matter* did not fulfil his needs in the slightest – because here he found the greatest *certainty*, the greatest critical acuity, until here too in the end he experienced *intellectual* failure. Even before this, he had felt that *ultimately* he *could not* consider *anything to be true*, that he *was incapable of any reliable attitude* not only in science but also in his way

of life and in relation to art. To some extent he possessed the tools (critical intelligence, sensitivity, empathy, etc.), but he was unable to accept the volitional aspects in the adoption of any attitude with a *normal awareness of certainty*. He would stress two points in particular in philosophical discussions, which always became the endpoint of his thought processes in the intellectual field. He had come to know *infinite regression* in Kant's dialectic, the endlessness of the causal chain, in which empirically we can never reach the absolute, the ultimate. In all logical deliberation, he found greater or lesser *instances of circularity,* in the knowledge of which his structures always collapsed. He found infinite regression and circularity everywhere and was never capable of driving a stake *arbitrarily* into the endlessness of constant regression around which he could base actual detailed investigations, or of adopting a *self-evident* precondition with *complete perspicuity* in order to escape from the circularity. His complete uncertainty in adopting an opinion was also reflected in the patient's scepticism towards his hallucinations, which he did not approach with complete insight, but with just such doubting, tormented vacillation.

In order to characterise the psychological peculiarity of the sceptical attitude of our patient as clearly as possible, we will compare it with the usual psychological forms of *scepticism*.[25] The most common form in which we meet scepticism is the following: people who are totally governed by their instincts, deny themselves nothing and at the same time remain purely in the sphere of the more sensory enjoyment of life and the struggle for power and recognition, who do not devote themselves to absolute values for the sake of these values themselves, employ sceptical thought processes as a means of justifying their actions and characteristics in a sophisticated way to themselves and to others by presenting opposing demands as

25. The fact that scepticism as a *theoretical* thought structure in itself says nothing specific about the psychological *source* from which it arises is probably self-evident. Theoretical scepticism occurs essentially in two forms: 1. as a *denial* of all values, of truth as well as of ethical, religious and aesthetic values, 2. as an acknowledgment of the existence of values as claims, as the assertion that people can *never* understand these values but always only accept them in contradictory ways, in disguise, etc.

extremely dubious and unjustified. The driving psychological force is the absolute will to follow the drives and inclinations, to obtain what they want, even if that is the opposite today of what it was yesterday; scepticism is one of the *aids*. Our patient differs from such sceptics in that they are *very definite* people who know in each case what they want to do, whereas our patient *universally lacks any such certainty in his attitude*, and also in the fact that scepticism is *merely* an aid to them, whereas in our patient it developed out of an unquestionable *original* devotion to values.

Another, rarer form of scepticism is the *purely theoretical scepticism*. People who know in every practical case exactly what they want and what is clear to them, what is understandable, and who in the course of general epistemological considerations come to the conclusion that there is no certainty anywhere, that all experience of certainty is but habit, etc. They consider this opinion on purely scientific grounds to be necessarily justified, but fully accept practical certainty (Hume's *belief*). These people also differ from our patient in a similar way to the previous ones: their scepticism is *purely intellectual* and is made the content of their thought as a theoretical insight, whereas the scepticism of our patient is a *harrowing daily experience* of which the theoretical formulation – which does not differ in the slightest from the well-known thought processes of the philosophers – is *merely an expression.*

A further, third and very rare form of scepticism is the sceptical mental attitude of people who are universally cautious and doubting about an ultimate judgement, whether it is a scientific judgement or a value judgement, but who are not tossed back and forth between arguments and counterarguments, reasons and counter-reasons, positive and negative assessment in a permanent state of fluctuation, but who experience a subjective, psychological unity *in their theoretical doubt* and who, moreover, in every situation *in practice* perform an action, come to a judgement for that moment, reach a decision where real life requires a decision. If the greatest possible variety of content, the greatest possible breadth and freedom of spirit combined with personal *unity* in life is a criterion of mental health, these types of sceptics are the sanest of people. Our patient represents precisely the opposite of this type of person:

constant *vacillation* instead of unifying doubt, constant *uncertainty* instead of a practical attitude, constant *destruction* instead of vital creation. He lacks unity, his soul is torn apart by a constant for and against, reasons and counter-reasons. This eternal for and against which stretches into infinity is so intolerable to him at the climax of his pathological states that he believes he is becoming mad and would rather founder in the ocean and die than experience such loss of his self.

This scepticism, which is not *a sceptical mental approach to things in the presence of an inner unity*, but an *inner sceptical disintegration*, occurs not infrequently to a lesser degree as a result of a *congenital predisposition* – naturally only ever in the more sophisticated, more gifted people whose spiritual life finds particular expression in philosophical structures. These *internally shattered*, sceptically *experiencing* beings in many respects resemble our patient. What is the result? In the minority of cases in which there is a congenital predisposition, a tormented but honest life, in which the lower rungs of that healthy sceptical mental attitude are reached, a weak life but which in this weakness ascends the possible rungs of health. In the majority of cases, however, the person creates externally what he does not possess internally. He acquires for example a philosophical system[26], to which he adheres with delusional fanaticism, to which he clings as something tangible that, like a formula, provides him with certainty wherever he applies it in life – although always only after bludgeoning the case into his system following long deliberation. At the same time, such people seek to impose their system fanatically on others, they are seeking power and recognition with it. This power and recognition offers them an external substitute for their now forgotten inner weakness. These people sometimes suddenly become happy with their system after previously being the unhappiest, most tormented of creatures. Since, however, the system is an artificial structure and does not have its source in their innermost experience and is not the expression of a corresponding *inner*

26. A *system* must be distinguished from *systematic work*. The former is scientifically impossible since it is an endless task – hence, in the present case delusional. The latter is the basic condition for scientific research.

unity, total uncertainty, total abandonment to momentary impulses and drives is once again expressed in their way of life. Uncertainty, unreliability, dishonesty on the one hand, a permanently fanatical rather than a calm conviction on the other hand, are necessarily associated psychologically.

Something comparable to this 'normal' progression now also occurs in most *processes*. The time of *harrowing uncertainty* is followed by the time of a certain *satisfaction with the delusion*. In more gifted people, the delusion then also assumes objective form as a world system or the like. It does not appear merely as a subjective delusion related solely to the person themselves. That is now the *particular characteristic of our patient,* namely that he had previously acquired the extraordinary uncertainty through a process, but had not followed the usual route to a delusional system. He is extraordinarily tormented. At the same time, however, he has acquired a degree of insight and capacity for discussion so that he – an unusual case – is still able to empathise with healthy people, people are still happy to converse with him and enjoy the flexibility of his mind, the sensitivity and relative breadth, the search for honesty; whereas it is normal to register the delusional system, note the impossibility of discussion and feel no empathy with the entirely 'mad' world of the patient. What in the 'normal' person is viewed as *constriction within a system* can be compared in the event of a process to *segregation of and integration into the delusion.*

However, not only the latter, but also all parallels between normal uncertainty, sceptical disintegration and the uncertainty of our patient, normal fanaticism about a system, superstitions, etc., and the delusion of other patients in this group is *only a comparison*. If, however, we wish to establish what are the *'process-related' characteristics* of these mental processes, we cannot do this clearly. In the first place, it is the way in which these people view the whole, their concept of the world, their world view and, secondly, it is the *extraordinary* uncertainty, the *excessive* vacillation and the infinite disintegration of the inner life. We see the former, for example, in the drawings of such patients who always depict the cosmos, i.e. the cosmos as the patients conceive it, what appears essential to them; in the writings which seek to present a new world view,

a new discovery of the innermost relationship, a new religion, etc. We see the latter – all of it always clearly only in more sophisticated personalities – in the complaints about the hardening of their own emotions, their debasement, their inability to understand something, complaints which sometimes appear similar to those in cyclothymic depression.

The most common outcome, delusion, is not present in our patient.[27] However, in the contents of his *acute psychosis* which arose reactively on the basis of the examination disappointment, the *urge for the whole* as well as the *sceptical despair* assumed concrete shape.

It is obvious that with the patient's new frame of mind, as a consequence of which he was only interested in ideological matters and as a result of which he was incapable of adopting any opinion in his uncertainty, the exercise of a profession was also impossible. He recounted how he was unable to decide practical matters as such, but always entered into a discussion of the most fundamental legal principles and composed long treatises, how the banal details of the profession nauseated him, how he was unable to get on with colleagues who appeared so lacking in culture to him, how he was merely offended and how he had the deep awareness that he must first be philosophically clear before he could devote himself to the legal profession. At the same time he was, according to his immediate circle, extremely gifted legally and he was generally expected – by his legal colleagues as well, as was indicated to us – to gain a first in the examination. That he passed the examination without having worked for it in itself shows his ability. It was not *intellectual* deficiencies, but changes in his *volitional life* and his *value judgements* that made him incapable.

The patient's *acute psychosis* went through two phases: the first phase of precursor symptoms, the first change in his mental disposition (lasting about four weeks from the examination failure) and the second phase of temporary upheaval in his mental disposition and the psychotic events that were made possible as a result. We

27. The patient's *episodes* of delusion are nowhere developed into a system and do not relate to his world view. He is quite vacillating and uncertain about them.

have described the form of these events phenomenologically in the first section. We now turn to the content.

The patient himself constantly emphasises the extraordinary *wealth* of events. A vast number of ideas dominated him at the same time. The same process probably had 20 different *interpretations*, he stated. It was all so *contradictory*, 'so fearfully illogical'. It is for this reason totally impossible to 'rationalise' the psychosis, to find an interpretation with a logical reason guiding the psychosis. Much of what he experienced occurred only *transiently* (romantic age, spiritual life of inorganic matter, etc.), because, according to the patient, he now experienced almost everything that he had ever read or imagined as reality. Despite this, some *underlying motifs* can be traced in the mass of experiences, some underlying moods can be recognised as a source of numerous rational themes that run through the whole psychosis and that are understandably related to his life story, his deepest experience and his failure in his career. We now want to distil these underlying motifs from the mass of *random associations and reminiscences* that determined the course of the psychosis as well. We are far removed from *any kind of 'understanding'* of the content of the psychosis as a coherent meaningful structure. The three *underlying motifs* are: 1. the *examination failure*, 2. the philosophical *scepticism*, 3. the relationship with the *lady Mona Lisa*.

The *examination failure* was objectively the trigger for the psychosis. In the first few weeks, it conditioned the content of the delusion of reference, the assumptions of impending events, the voices. Allusions were made to his job, his assiduity, his lack of a job ("his father still gives him his clothes"). He could not help suspecting that the ministry had unjustifiably marked him down because it wanted to exclude him for some reason or other. There were, however, indications that a revolution was afoot to abolish the ministry and the examination entirely, that the population of farmers sympathised with the patient who would perhaps play a Napoleon-like role in it. It is actually possible to understand a number of the delusional and hallucinatory contents that occur in these first weeks as if they were the *expression of his wishes*: the ministry has treated me unjustly, I want to destroy it. Even if this meaning allows us to do nothing

else than *summarise most* of the subject matter that occurs as a precursor to the psychosis in *one* formula, a descriptive interpretation is still entirely justified. To what extent mechanisms of separation of mental processes and their re-appearance in the consciousness in a pathological form actually play a role here, we must leave unanswered in this and in all previously known cases. However, we may postulate such mechanisms as a *supposition*.

At the beginning of the events of the most acute phase, the job motif plays no role. The Golden Age is there. Of such trivial misery there is no longer any mention. Not until the transition of the subject matter of the delusion to the King Otto complex do such ideas re-emerge towards the end of the psychosis. Because he was the son of King *Otto*, the ministry wanted to eliminate him. Following the resolution of the psychosis, any thoughts about his career put the patient into a black mood, and the thought of his career was the painful theme in all his spontaneous gloomy moods.

Thus, the most acute phase of the related events was actually a flight from the reality of the job problem. It sits as a period of heightened feeling between the delusions associated with his job, which were so present to the patient beforehand and afterwards. The occupational problems had simply been forgotten. Instead, the determining factor for the experiences from the patient's life history was to a considerable extent the torment of the *scepticism* and the philosophical fiasco that he had suffered. This relationship is *repeatedly stressed by the patient himself*.

At the beginning of the psychosis, he *cursed* the Lord God for having given him scepticism and he determined: "I am going to force things, he should destroy me or he should give me insight." He later experienced fulfilment in the form of a struggle. He then often cursed God who had burdened our existence with so much dirt, stamped furiously in front of the image of Christ: "I have always looked for you; I'm the eternal Jew, aren't I." Out of his sceptical despair, as he himself says, arose almost a *need to curse*: "Our Lord God, I curse him; we are merely there because he fucked." "If God had not sinned, there would be no misery."

It was consistent with his philosophical metaphysical need that now the Golden Age dawned, that he participated in the 'meta-

physical world', even if he was *still* condemned to live in the pretend world. He saw how all the gods swore to redeem him as well. But that only happened after a struggle. He for his part made *demands* and made his agreement to enter the metaphysical world dependent on their fulfilment. These demands were the *expression of his sceptical and nihilistic views*: all beings should be equal to God, all differences of value should cease, the devil himself should enter the metaphysical world. He was victorious in the struggle. He now had all gods and geniuses in himself. He now had to *create the unity and order* that he had previously demanded. The whole should be a unity. The contrast of yes and no, struggle, vacillation, disintegration, the opposition of God and devil should cease. *Unity of the whole* was now the problem. It did not succeed. Disunity and conflict remained permanently. When finally the *terrestrial* world had been made homogeneous, there then came the *metaphysical* world. In the face of this, in the face of infinity, he felt helpless. It was *the same* as in scepticism, so he now felt, it was the same infinite regression here in the metaphysical world which had previously destroyed my thoughts. In the psychosis, however, resolution was achieved through willpower, whereas in reality this did not occur. He *arbitrarily restricted himself* to being God of the earthly world and set the old Lord God up as the god of metaphysical infinity. In this way he felt happy and homely.

Doubt was now *constantly* associated with this relationship. He suffered, had a 'depressed mood', from the fact that the doubts would not leave him here either. He could not get enough of *repeating aloud the same energetic declarations*: "And thought conception *does* exist", "but I *am* the son of King Otto", etc. The *establishment of unity* in fact was *never achieved* in the psychosis either. He flew into a rage because it did not succeed. "And duality *is* unity", he declared vigorously. This was followed immediately by "No, it doesn't work." It was impossible to resolve the contradictions, God and the devil could not be identical. Out of this a new attitude then emerged towards the end of the psychosis: *he could no longer bear it and wanted to return to the world of illusion, even if it was only illusion*.

The third constant motif in the psychosis is the *relationship to the lady Mona Lisa*. This lady had made an extraordinary impression

on him in the street two days before the psychosis, having not seen her for a long time and ultimately having believed that she had moved to a distant region. She accompanied him in various forms throughout almost the whole psychosis. He believed at every opportunity and in every experience that it contained a reference to this lady: the two tickets, the compulsion to follow in the footsteps, other persons totally unlike her physically. He saw her everywhere in others (change of soul), he felt her presence without seeing her. He saw her in the nurse, whom he called Mona Lisa. Under this name, she appeared as a goddess in his experiences, as the only being he could completely trust, with whom he was actually safe. The thought came to him that she was his Beatrice. He saw her on the road on his journey to Heidelberg, etc. At the beginning of the psychosis he experienced her as his own double, with whom he had sexual intercourse. She was seductive, but he was not permitted to father children with her because he would then commit the same sin as the old God who brought misery into the world.

Undoubtedly the symbolism of other understandable relationships plays a role in the psychosis. The patient himself interprets symbolically the swaddling of the child, which was intended to show to him that he should behave passively and devotedly, and also the opening of the bag by the woman in the train with the words "what a heavenly bag." This symbol of sexual significance in the narrower sense stands in relative isolation. It is not possible to say that *sexuality* in an elementary form plays a major role in the patient's psychosis, except in the few cases where it clearly is such. An understanding of the cosmic events specifically as sexual symbols, by analogy with Jung's works, is not in the least convincing to us. We adhere firmly to the original quality of mental events and drives and do not recognise the sexual *alone* as the *sole* original. There is no doubt in our opinion that the world view exists for its own sake. Sexuality plays not the slightest role in it.

Following the resolution of the acute psychosis, the patient found himself in a particularly happy mood. Once again we had the impression here as it were of a discharge of tension which the psychosis brought with it. His brother found the patient to be better than he had seen him in the past two years. After some time, however, the

old complexes (job, despair about his tasks in life, his philosophical and literary capabilities) recurred and the patient found himself in the state one may assume existed prior to the time of the examination disappointment.

We cannot draw any general conclusions from our two cases. What we intend to do is to stress that only a *collection of material* of suitable cases with the *most detailed* case history can promote empathetic psychopathology and also to show that *methodological clarity*, *separation of viewpoints* and abstract activity are particularly necessary. We have attempted to provide a contribution in both these directions.

In addition, we believed we had to recognise the justification of Bleuler's transposition of the concept of reactivity to schizophrenia, a view based on the impression gained from a larger series of less sophisticated cases and which is illustrated in our two case histories.

Kraepelin's school and other psychiatric circles mostly associate the concept of 'degenerative' with the concept of reactive psychosis. They use the term in the *diagnostic* sense. Bleuler's view signifies an extension of our psychological understanding, which in principle is as justified as the previous extension from normal psychology to degenerative prison psychoses.

Reactivity in this sense does not however appear to be found in *all* psychoses. The *organic dementia processes* reveal only a totally momentary reactivity that is a necessary attribute of every living thing, *not a relationship of fate and psychosis*. In many cases of the dementia praecox group also (in the severe, apparently organic catatonias in the narrower sense), we cannot identify such mental reactivity (the Zurich school, however, believes it to be universal in this group of illnesses). There appears to be a deep chasm between those mental illnesses which exhibit *continous understandable mental relationships* despite all the insanity and upheaval and those mental illnesses which consist of simple destruction and for which our understanding achieves nothing beyond the observation of an *impairment of the normal relationships*. In these latter cases, however, objective *performance psychology,* which is relatively unsuccessful in the former, finds a suitable subject for analysis of the change in

objectively measurable mental functions by means of experimental investigation (in paralysis, senile dementia, arteriosclerosis, etc.).

The major difference between many schizophrenic and organic psychoses is also found in the systematic study of a large number of *prison psychoses*. Schizophrenic prison psychoses possessing the characteristics of reactive psychoses – which are, therefore, easily confused with degenerative, totally curable prison psychoses – are not that uncommon. We observed on one occasion in Heidelberg, a typical Ganserian symptom complex in a schizophrenic following imprisonment – otherwise a very rare case. However, *reactive prison psychoses* were *never* observed in *paralytics* and other organic patients even though a large number were present in the patient material of mentally ill prisoners.[28]

We are no closer to resolving the problem of establishing *types of reactive psychoses* and perhaps of determining the *specific nature of schizophrenic reactivity*. The best discussion of the latter problem can be found in Bleuler's book. We also do not venture to study the question of whether specific *psychological groups* can be constituted within the subjective forms of experience of a coherent nature because of our lack of cases.

28. I owe this information to a verbal communication from Wilmanns.

Josef Berze (1866–1958)

Josef Berze was an author of significance in the development of the concept of schizophrenia, even though his writings have largely been forgotten. He studied medicine and took his medical doctorate in Vienna in 1891, where he was appointed senior physician of the State Lunatic Asylum in 1902. In 1907, he was promoted to departmental head and Deputy Medical Director. In 1912, he qualified as university lecturer under the later Nobel Prize winner Wagner von Jauregg in the Department of Psychiatry of the Vienna University. In 1913, he was made director of the Lunatic Asylum in Klosterneuburg and in 1919 he returned to Vienna as director of the Lower Austrian State Lunatic Asylum 'Am Stierhof'. In 1921, he was awarded a personal chair. He retired in 1928. The so-called insufficiency hypothesis played an important role in his schizophrenia studies. According to this view, schizophrenia was a dynamic process, leading to a dynamic reduction and an energy deficit. These components of a defect and an adynamic breakdown occur predominantly during the chronic course of schizophrenia.

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The Nature of Psychic Activity: an Attempt at an Energetic Explanation*

The concept of psychic activity may seem to be easy to understand, but this is not the case. One sign of this is that there is no generally accepted definition. According to Eisler (38), the views of various authors on this term may be summarised as follows: "Consciousness is associated with an activity, which it activates in thinking and wishing and which, in the form of 'reactivity', forms on a lower level the basis of perception and feeling. The highest degree of this activity is self-activity, the spontaneity of the ego and of the reasonable will, which adapts ideas to reality and actively structures the conditions of life. Psychic acts do not exist independently of consciousness, but are themselves specific connections of experience, characterised by 'feelings of activity', and are as such absolutely real". Further clarification is provided by the authors in that the 'passivity' of the consciousness is by no means understood as the opposite of activity, but as a distinct form of the activity in the broad sense, whose triggering conditions are different from those of the activity in the narrower sense. The 'passivity' of the consciousness is only 'relative'. "It is admittedly not spontaneity, but nevertheless reactivity" (Eisler). It was Jodl who described this view precisely.

An argument against this view is that the stimulation detected by our peripheral senses evokes what are best called impressions without our active participation. But this is only apparently the

*Reference: J. Berze. "Über das Wesen der psychischen Aktivität (Versuch einer energetischen Deutung)". In: *Die primäre Insuffizienz der psychischen Aktivität*. Franz Deuticke, Leipzig und Wien, 1914; chapter 3: 91–105.

case! For these impressions are not yet psychic or conscious phenomena; these only arise when the "consciousness registers the impressions", as a result of a conscious act called perception. We call those impressions, which became conscious through the act of perception, perceived impressions or sensations. Admittedly, the preconscious and propsychic impression is often confused with the conscious perception and vice versa. However, it is under some circumstances disturbingly ambiguous, if the term sensation is used on the one hand to refer to the stimulation of the senses (impressions), i.e. to that which can be experienced (can be found in our inner world) simply because it is part of our inner world in the form of an impression, and is on the other hand also used to refer to the conscious experience which only arises after the impression or complex of impressions has reached consciousness, i.e. when through the intervention of the psychic activity a selection of the total set of perceptible events transform into *actually* perceived events.

If we accept that sensation requires activity, we must state that everything that possesses consciousness has this as a result of psychic activity. The factor which we refer to as psychic activity (conscious activity) now acts either spontaneously (self-activity of the ego, spontaneity) or as a result of provocation by other factors, by impressions (reactivity or receptiveness).

Sensation however does not usually remain as a simple matter. The process known as perception occurs at the same time, with the aims of distinguishing and isolating what is perceived. It will be shown later (Chapter II, 9) that most acts of perception are automatic and therefore unnoticed and that it is only necessary in special cases to perform an intentional act of perception which ensures that its result will not elude the process of internal perception.

Although a clear separation between the phenomena of impression and perception is not possible, their different psychological significance must be kept in mind.

H. Spencer (152) clearly stated: "In impression, consciousness is occupied with the feelings of the organism. In perception, the consciousness is occupied with the relationships between these feelings". Perception already contains a relationship, a linkage, an interpretation (Sully), interpretation and identification (Claparède),

in other words, thought or 'thought elements' (Messer). As Messer (103) said, "we may separate the impressions themselves from the moment of perception, which we call understanding or opinion". However, we cannot always – in fact only rarely – find the separation of those two moments in the phenomenon of perception. The reason for this is that the sensations immediately evoke other functions of psychic activity, which come into play as an intentional act (Husserl), an act which manifests itself as the experience of there being an object of perception.[1] The result is that we only exceptionally, if ever, consciously experience pure impression and this is almost, or almost always, coupled to simultaneous interpretation of there being a corresponding object, or at least an attempt at this, or an uncertain interpretation. It is also clear that we may not speak of pure impressions when we do not know how to interpret them. Even in this case, the psychic activity is directed towards an understanding of the meaning of the relevant sensations. Only a reliable interpretation is still missing and there is thus far only the understanding that this sensation complex has an objective counterpart coupled with some hesitant attempts at interpretation.

These arguments also show that it may be necessary to distinguish between perception and those acts which lead to recognition or, more precisely, which lead to re-recognition, since every act of recognition is based on the repetition of recognition. Recognition is essentially the confirmation that the perceived sensation complex agrees with a sensation complex which has already been experienced and interpreted, either in all details, or at least in apparently essential characteristics. The presumed character of this process will be discussed at a suitable juncture. It will only be pointed out here that this act is essential and inherent in the act of perception in all cases in which the recognition occurs promptly, whereas there is presumably a distinction between the act of perception and the act of recognition in cases of problematical recognition.

1. cf. Messer (as cited): "As the something towards which it (i.e. 'the intention') is aimed is always an object, we can also speak of 'an act of an object-consciousness'."

Evaluation is already inherent in assuming the existence of an objective counterpart of the percept. As already stated, 'thought elements' are involved in perception. However, acts of perception and recognition may be followed by acts of analytical and synthetic activity, to thought in the more restricted sense, to evaluations and conclusions. In all phases of any series of acts, intentions may be developed, leading to acts in the narrow sense. Even sensations can trigger these. The transition between ideomotor actions and deliberate actions is smooth.

All this can happen through one initiating act, directly triggered by the sensation complex and active in the sense of reactivity, in that this one can, or its result, cause the next one. On the other hand, we usually do not refer the results of all acts in a series of this sort to reactive psychic activity with the same confidence. We may be so certain that we are in a state of receptivity in the case of perception that we are only able to come to the conclusion that there is psychic activity – or any form of activity or reactivity – on the basis of a fairly complicated argument and not just by observing the phenomenon in isolation. Thus, while we may usually be totally convinced of the reactive character of the act of perception which results from the psychic activity enslaved by the sensation complex, we are much less sure about the reactive character of subsequent acts, and this uncertainty becomes more pronounced the more acts there are between the act in question and the act which triggered the sequence. We very often consider that we are engaged in spontaneous activity – as in the pursuit of further thought processes or in the performance of a deliberate act stimulated by a link in this chain – when it is really only a question of extended reactivity. Admittedly, when we are retrospectively considering the development of a series of acts (for which there is seldom an occasion), we sometimes remember the sensory impression which stimulated this thought or which encouraged us to take this or the other action. However, we think that we were purely active rather than reactive in thinking or acting. The initiating perception can however be replaced by an idea which 'crops up' in us, in other words, develops without our participation, in the sense of an intention which induces a reproduction. It can however also be replaced

in us by a revived thought, a reactivated effort, a feeling awoken in us. In other words, such an act, which has been described above as the endpoint of a necessary succession of acts triggered by an initiating act, can be the result of conscious experiences – which have themselves not been subjected to an act that would lead to the isolation of one experience from the flow of internal experience. It is always the case that the more we have the impression of spontaneous activity, the more the reactive character is disguised of the act which initiates or prepares subsequent acts[2] and, as mentioned, the further the act in question is in the sequence of the acts initiated by the conscious experiences. The deception may be supported by the real or apparent possibility consciousness offers the ego of deciding to permit the act to proceed as a personal decision or of inhibiting it. Where there is not this feeling of being able to prevent this act, then the deception of purely spontaneous activity is also missing. Compulsive behaviour is a pathological example of this.

However, we have the purest impression of spontaneous activity when the activity is determined by the 'subject's own impulses', for the 'ego's own aims' on the basis of the 'subject's personal force'– we will investigate later what this means – and the motive is hidden if at all possible by events in the sphere of sensation. This is obviously not in contradiction to the claim that such a thing as absolute spontaneity does not exist (A. Fouillée).

What is essential in our investigation is not to establish the borders between reactivity and spontaneous activity, but to study the character of activity in principle, in whatever form it appears, and then to discuss the question as to whether and how an energetic interpretation of the acts can be attained.

If we consider the physical world from the point of view of the physical individual as the centre of action,[3] we recognise a relation-

2. Habitual efforts and chronogenic and phasogenic efforts (cf. Semon, Mneme) may remain fully unnoticed, but initiate whole reactive series. See too comment VIII.

3. This view is undoubtedly the only correct one, as the relationship between object and action, content and act, only results from the receiving and acting functions of the individual as action centre (cf. "Merkwelt" and "Wirkungswelt" by J. v. Uexküll).

ship which is analogous to that between the content of ideas and actions, namely the relationship between objects and their effects on the individual (sensory stimulation) and the individual with his effects on the object (movements). Only the latter are the product of the subject's force, whereas the sensory stimulations are the products of other action centres outside the subject. However, the latter can be seen as supplying the movements of the subject with time and direction. They provide the trigger which determines that the subject who is ready to act does in fact react with a specific movement at a specific time.

We must therefore state that the occurrence of a movement as such reflects the performance of a subject, but that the form and content of an individual movement is an expression of the actions of objects or the stimulation from these objects. If we transfer this insight into the physical world, the result is as follows. The occurrence of the psychic acts, which we call conscious acts, as their common result is consciousness, then expresses the performance of the subject, although the design of the individual act expresses the action (synchronous or earlier) of sensory stimulation.

As movements and actions, from the point of view of the individual as action centre, are composed of other elements as the action of objects – we can designate the former briefly as motor and the latter as sensory –, so must also the psychic acts, the conscious activity as such, be based on other elements than the contents of those acts (i.e., the imagined content of the conscious experiences) or, more briefly but less precisely, than the idea.

There has never been any doubt about the quality of those elements which make up ideas. The dependence of our whole world of ideas on the functions of our senses is so evident that the only possible assumption is that the impressions from the reception of stimulations, the new and revived sensations[4] on which these impressions are based, must be those on which the world of ideas is built up.

The answer is not so clear to the question as to the foundations of the efferent side of psychic phenomena, psychic acts.

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4. The original and mnemonic sensations according to Semon (cf. Comment VIII).

As is well known, according to association psychology, there is no such thing as psychic activity, but the whole of mental life is based on sensations (cf. Ziehen). The apparent success of this psychology in deriving all psychic activity from sensations, is mainly due to the use by its practitioners of the illegitimate trick of ascribing to sensations, not only the characteristics of quality and intensity, but also the emotional tone. This emotional tone is then allegedly inherent to sensations or complexes of sensations and is the active motive.

This sensory viewpoint is certainly supported by the fact that pure activity – activity without sensory content – is impossible. In other words, all activity can manifest itself only on the basis of its contents, or, as Fouillée said, "tous les faits de conscience sont sensitifs par quelque coté".[5]

If an activity demands material on which it can fulfil itself, if, for example, an act of perception is not conceivable without the sensation complex which forms its object, an act of recognition without something being perceived, an act of thought without something being recognised, that can be classified, compared, related, linked or dissected, a genuine wish without an imagined goal, it nevertheless cannot be disputed that all these acts represent something quite different from that material from which the ideas arise as the result of the iconoplastic function of the cortical sensory centres, and which only serves as the basis on which the acts can manifest themselves. This difference is so important that any explanation, which assumes that the acts are like the ideas derived from psychic elements like sensations, is clearly impossible.

We therefore regard physiological psychology as fundamentally wrong if its analysis of our psychic phenomena allegedly only leads to nothing but elements of ideas and sensation and their mutual interactions. We rather support the view – expressed in some form of apperception or act psychology – that there is psychic activity which is unrelated to perception and is manifest in acts. We return to the basic demand for physiological psychology, that we need to assume not only elements of psychic content, the **sensations**,

5. Fouillée, La psychologie des idées-forces 1893. Quoted by Eisler.

but also elements of psychic acts, which we wish to designate as **intentional elements**, as something is intended in each act. The universe of these intentional elements, the intentional world, may be compared with the universe of sensations, the idea world,[6] just as in the physical sphere, the motility (total of an individual's actions) is compared with the sensitivity (total of the actions of objects on the individual).

We will base our attempt to illustrate the character of the intentional elements on actions in the strict sense, voluntary movements.

Many psychologists and physiologists consider that it is possible to see the cause of our actions (particularly actions in the usual sense or complex movements) totally on the basis of ideas of movements remembered on the basis of the kinaesthetic sensations when the movement was performed in the past. Other workers consider that there must be something else which is present in our consciousness at the time when the act is initiated or implemented. They mostly assert that there is such a thing as nerve sensation which, together with the actual sensation of movement, makes up the conscious experience in the moment of the action. These authors (e.g. Bain, Helmholtz, Wundt) then consider that it is just a question of sensations, albeit central sensations, not peripheral sensations based on events in the periphery, the actual sensations, which include the kinaesthetic sensations. It is however evident from the work of these authors that they understand something with the word sensation which is different from the strict use of the word and indeed must be different, as the nerve sensation contains a factor which is missing in real sensations and which is nevertheless essential for nerve sensations, namely the factor we refer to as intentional. The same applies to Meynert's innervation feelings. This author starts with the primary mode of movement, i.e. coordinated movements which are triggered from subcortical centres. He then infers a secondary mode of movement, voluntary movement, from the primary mode. He argues that the cortex could never stimulate movements if the

6. More precisely: idea content world. Ideas also of course include ideas in the normal sense (thoughts and fantasies) and perceptions, i.e. perceptional ideas.

innervation feelings of specific movement forms were not fed into it through the primary form of the movement of subcortical centres. He also argues elsewhere that the innervation processes from the hemispheres, which we call acts of will, were nothing else than the perception and memory images of the innervation feelings, which accompany any form of reflex movement, as they are transferred into the cerebral cortex as the primary basis of similar secondary movements triggered by the forebrain. The memory images are then associated with the intensity of that force which allow them to produce their effects along centrifugal pathways whenever the forebrain evokes them in the form of secondary movements. In his article "Über die Gefühle" (Feelings), Meynert writes more precisely on the nature of innervation feelings. The innervation feeling is a state of the brain and does not arise from the feelings which accompany the movements themselves in the form of muscles pressing on nerves or in the form of tension and relaxation feelings in the skin and joints. This is evident in the fact that we have a very clear sensation of the force transmission of a conscious movement impulse in an attempt to move paralysed limbs, in which no movement at all is actually managed. It is easy to recognise that if Meynert were not under the pressure of, you might almost say, his overvalued idea that "the ganglion cell does not receive any other specific energy than the ability of sensation" and that "according to this we will succeed in localising purely sensory impressions", he would certainly have abandoned his idea that innervation feelings were perceptions in the sense of a sixth sense, the muscle sense.

This is because the consciousness of the force performance, i.e. the application of the subject's own force, can never be equated with sensory perception, as sensory perceptions, however much they may differ from each other, have this one thing in common that their experience is not accompanied by the consciousness of applied force, the reason for this being that the sensations are the result of the function of extra-individual forces, objective functions, and not the result of the function of the ego, like a conscious movement impulse. In addition, Stricker has spoken of consciousness or feeling of motor impulses or (much less appropriately) of the consciousness of the activity of motor centres, with which he

could only mean consciousness which does not only correspond to sensation of muscular action, but the internal perception of the intention. Among more recent authors, Goldstein should be mentioned, who argues that muscle actions, the basis for the spatial factor of perception, reach consciousness by two routes, firstly through the act of innervation and secondly through the sensations of movement. Goldstein bases this assertion on Stricker's views (see above) and on Sachs, who speaks of the perception of innervation processes.

Whether these authors are speaking of innervation sensation, perception of the innervation processes, the feelings of motor impulses, consciousness of muscle action, or whatever, they are indubitably thinking of a real and undeniable component of the conscious experiences immediately preceding spontaneous or deliberate actions. This component is best described without prejudice as the internal aspect of energy consumption in the brain (Fouillée) or as 'sensation de l'effort' (as other French authors describe it). However, these authors are wrong if they assume that the somatic process corresponding to this psychic component can be found in the innervation of the motor centres. There is no psychic correlate which corresponds to the excitation of the motor centres. Aside from all other proofs which could or have been presented,[7] this is shown by the fact that cortically mediated purely reactive movements are clearly not associated with anything in the consciousness which could be related to the activity of the motor centres, while the existence of such an activity is beyond any doubt.

What at any rate is certain is that if the activity of motor centres should have a psychic correlate, this could not be of the type that it is possible to derive the will from it, as Meynert believes, when he explains that "the innervation processes from the hemispheres, which are called acts of will, are no more than the perceptional and memory images of the innervation feelings". The basis of views of this type is that the process which leads to the innervation and should be regarded as its proper cause,

7. cf. Semi Meyer (108). Comment IX.

namely the process of triggering the impulse, is confounded with the innervation itself, which is to be regarded as the immediate effect of the delivered impulse, and that the conscious experience corresponding to the process of impulse delivery, the intentional experience, as we say, is then erroneously related to the process of innervation.

If we strictly distinguish these two processes, then we must conclude on the basis that only one of them, the process of impulse delivery, has a psychic correlate, namely in the intentional experience, that the basis of the psychic phenomenon known as the will must lie in the total of the individual processes of impulse delivery or their psychic correlates, the intentions. The consciousness of the application of one's own force, the energy expenditure, in the intentions is the essence of the conscious will.

The results of brain physiology and brain pathology provide convincing evidence that we should regard the two types of process, intentions and innervations, as having different localisations. Whereas the seat of the latter is indisputably the motor fields, we must assume that the seat of the intentions is in specific intentional fields, forming together the intentional sphere. The localisation of the intentional regions within the cortex has not yet been established, although there is some preliminary evidence. There is known to be a form of akinesia characterised by a lack of drive to perform movements and is – as e.g. Rosenfeld (139) considered – "*not easy* (emphasis added by the author) to distinguish from abnormalities in movement caused by defects in mental or emotional excitability and which has been referred to as an abnormality in the will". In our opinion, there is no distinction at all between these motor abnormalities, as the lack of motor drive in these cases of akinesia is nothing but a partial manifestation of defects in mental or emotional excitability, and thus the expression of an intentional defect, a defect of the will in the strict sense of the word. If Hartmann's assumption that stimulation to movement arises from the left frontal lobe, i.e. that the cases of akinesia based on defects in motor drive to intentional movements can be regarded as frontal akinesia, were to be confirmed by additional evidence, then it would merely show

that the relevant cortical regions have at least partial intentional function.[8] But it would not prove that the intentional function is restricted to the cortex of the frontal lobes. Moreover, the motor intentions are only a fraction of all intentions and we do not know how many and which intentions are present with the motor intentions in the frontal lobe cortex, so that the possibility remains open that other cortical regions subserve the intentional function and combine with the frontal lobe cortex to make up the intentional sphere.

What then do we mean with the other intentions, aside from the motor intentions?

Just like movements, or external actions in the conventional sense, we are capable of performing psychic or internal actions. Just as the performance of an external action requires delivery of impulses in the form of motor intentions, each psychic act needs impulse delivery in the form of an intention corresponding to its content. The feeling of exertion of force is exactly the same whether I concentrate my attention on an object after overcoming various distracting stimulations, or whether I press my foot against a resistance. The reason for this is that in both cases I am aware of the efficacy of the force used in the impulse delivery in the intention. As is well known, it was attempted to explain the feeling of exerting force, the feeling of activity, in internal acts, more exactly in active attention, on the basis of the sum of tension sensations, linked with possible states of consciousness. These tension sensations were said to be just movement sensations arising from the innervation of numerous muscles needed for fixation. However, we regard this as an absolutely inadequate explanation of the feeling of activity,

8. According to Brodmann's most recent publications, two main zones in the frontal lobes must be distinguished which are of quite different structure: the precentral region, which is the centre for voluntary movements or the primary motor cortex, according to clinical and physiological experience, and the frontal region, the actual frontal lobe cortex in the strict sense, of which the function is largely unknown, even in man. The precentral region is present in all mammals and its relative surface area only fluctuates within narrow limits. In contrast, the frontal region is very inconstant and is totally missing in most primitive lines (lecture in the Zeitsch. f. d. ges. N. u. Psychiatrie, Referatenteil, VII, 5).

with only meretricious justification in the fact that these innervations do not only play a role in attention to sensory impressions (for which their purpose is obvious), but are also activated in all other psychic acts, e.g. by considering something (active reproduction), thinking hard, etc. This may however be an inessential secondary effect or co-innervation, which may be due to the fact that the internal energetic situation in any sort of psychic activity is more or less similar and that this co-innervation is therefore evoked in a similar way as during the process of sensory attention, the most fundamental of all forms of psychic activity. However, the essential character of the conscious experience of active sensory attention is certainly not included, if it is regarded as feelings of tension of this type. The only reason that this idea was raised at all was because active sensory attention is the least suitable of all forms of psychic activity (although the most basic) to serve as substrate for the analysis of the experience of conscious experience in psychic activity, as specifically in this case, the external situation demands a sort of tension and directedness which then masks the internal tension and directedness that forms the essence of the intentional experience. The further we move from the form of psychic activity which takes its material immediately from the world of the senses, the more clearly we see the actual experience of activity, the internal process, the intentional factor – for example, in active reproduction, when conceiving a thought, when actively following a train of thought, when considering, when drawing a conclusion. These conscious experiences of an active character of psychic experience can be differentiated clearly from those of passive character, such as the appearance of a memory image as a result of an associative trigger, a spontaneously arising thought, a feeling, exertion, impulse to action, an unplanned chain of thought ("something thinks in me"). There are also all combinations of the two types of conscious experience, as when all sorts of passive processes may be triggered by the activation of series of associations or links during a psychic activity and are mixed with the immediate results of the activity.

The world of the intentions therefore includes not only intentions in the sense of external actions, from the simplest spontaneous action to the most complicated deliberate action, but also intentions

in the sense of internal actions, active attention, active thought, evaluation and conclusion.

Neurologists and psychiatrist have as yet only studied one aspect of the world of the intentions, in so far as they result in external action. Even this only happened after Liepmann initiated a deliberate study of the apractic symptoms. In contrast, there has as yet been really little research on intentions as a basis for internal acts. Most importantly, there has been no attempt to develop a view of the origin of the intentions (in general, also those directed towards external action) or for the origin of intentional elements as the basis for the whole of intentional life.

It is a fundamental result of research in various areas that everything that we call psychic activity is a product of development. Psychic activity is not contained in what a human being has at offer at birth, even though there may be some development in this direction in the late intrauterine life. The soul is a tabula rasa for all experiences; there are no impressions and no intentions. Put somatically, this means that the cortical consciousness organ is presumably receptive, but has not yet received anything which could be active as impression or intention. Provision with impressions and intentions comes later in life. Our impressions are then indubitably the result of sensory stimulation to the sensory fields. But how do the intentions arise?

As already explained, the essential difference between the impressions and the intentions is that the former result from the function of extra-individual forces (stimulatory forces) and the latter from the function of the individual's ego. We can therefore express the question as follows. How does it happen that those areas or layers of the cortex which make up the totality of the intentional sphere become the bearers of the ego functions? Or more precisely: How does it happen that the ego becomes active in the intentional sphere?

In the same way as the impressional sphere originally does not contain any impression, and thus has to receive these impressions by sensory stimulation, the intentional sphere originally does not contain any intention, and therefore the intentions also need to be transferred into the intentional sphere from other regions. Which regions are worth considering?

The palaeoencephalon acts like a machine, in that stimulation of receptors leads to response (motor). The relationship between stimulation and response is phylogenetically inherited. When there is no relationship, there is no reaction to stimulation. The palaeoencephalon has no mechanism for the association of new stimulations, for which the response is not inherited, with the inherited motor combinations (Edinger).

The receptions in the palaeoencephalon correspond to the impressions in the cerebral cortex. However, the response (motor) in the palaeoencephalon corresponds to the so-called 'cortical' movements in the cerebral cortex (called the practicons by Edinger). As mentioned above, Meynert based his discussion of cortical movements on the idea that these movements could be derived from the primary form of movement, i.e. from the movements triggered in coordinated form from the subcortical centres. However, Meynert presented this derivation in an unacceptable manner. He assumed that the motor region of the cererbal cortex, which has not yet a motor function in the new-born (Soltmann), assumes a motor function by virtue of the motor nuclei transferring to it the so-called innervation feelings, which are accompanying all forms of reflex movements. According to Meynert, this happens on a pathway which he evidently assumed specifically for this purpose and which was thought to lead from the neural nuclei to the cortex (cf. Meynert, Psychiatrie, 1884, page 144, point 3 'pathway 7 a T 7'). Leaving aside for the moment the fact that there is no other evidence for these fibres, it is far from evident that there is any need to postulate their existence on the basis of psychological and physiological considerations, as the innervation feelings in the sense of Meynerts, which could perhaps be transmitted by these fibres, or indeed any phenomena in which the activity of motor centres become conscious (cf. Stricker), do not in fact exist.

In the attempt to explain the genesis of the intentional factor we will presumably therefore have to stick to the basic idea that this factor can be derived from the function of the subcortical centres, but will have to avoid the error that Meynert committed in his depiction of this derivation. We can only be successful if we base

our argument on the distinction between the process of impulse delivery and the process of motor innervation which is the direct result of the impulse delivery and keep in mind that only the former has a psychic correlate, namely the intention.

Simple reflexes, whether they are mediated through spinal centres or centres lying in subcortical brain areas, cannot provide us with a basis, for the reasons explained above. Only movements should be considered of which the excitation is caused by a subcortical cerebral organ, which sends out its fibres to the cortex or to those cortical regions serving the intentional function. Which movements are these? If it is correct that automatic movements of instinctive nature are localised in the thalamus and its adnexa, or that movements of this sort are thought to be mediated by the thalamus and its adnexa, which is an assumption supported by previous research, this is a convincing indication that we should start with these movements, particularly as it is also known that centripetal (efferent) pathways lead from the thalamus to all cortical regions.

Even though the movements mediated by the thalamus and its adnexa are usually designated as reflex acts and are only distinguished from simple reflexes in that they are referred to as higher or complicated reflexes, it must be borne in mind that the role which the thalamus plays in mediating these movements is not equivalent to the role of the reflex centre in simple reflexes. The centre of the actual reflexes directly subserves the execution (innervation) of the corresponding movement. According to present knowledge of the thalamus, we can basically only say that its functions include motor drives, that it can be described as a centre for impulse delivery for complex movements, indeed movements that can hardly be distinguished from conscious acts[9] on the basis of the complexity of their structure. These movements should best be distinguished from the actual reflexes by referring to them as primary (subcortical) automatic reactions.

If then the thalamus serves the mediation of movements triggered by specific stimuli in some way or other, nothing can be said

9. cf. Probst (133).

against the assumption that the thalamus excites the cortex in two ways – firstly by the stimuli themselves, perhaps, as Edinger thinks, with a multitude of associations, and secondly, the motor drives which originate in the thalamus or are at least mediated by it in the sense of the instincts, i.e. in the form of relations, so-to-speak phylogenetically acquired drives. Just as the stimuli from the thalamus to the cortex, working together with the stimuli passing through direct fibres, serve to assemble the impressional content, the motor stimuli from the thalamus into the cortex provide the basis for the intentional life. One might say that the transfer of these motor stimuli provides the possibility of converting movements of instinctive nature (such as the typical instinctive movement of eating) which some authors think are localised in the thalamus and adnexa[10] into cortical movements or, respectively to convert the impulses which produce those movements into intentional forms of the cortex.

But how should we see this process of transfer of the motor drives to the cortex?

The production of a motor capacity or of motor drives in the palaeoencephalon, in the sense of the relations, is based on the precondition that the apparatus is present in these areas of the brain which is needed to respond to stimuli with reactions, e.g. with exertion of individual energy or motor effects in the broadest sense. All cases of triggering reactive effects by stimuli correspond to conversion of a part of the potential energy (tension) stored in specific motor elements into kinetic energy (living force). This energy conversion induces a state of tension in the energy carriers, tending to lead to discharge. If the excitation is adequately intense (or the stimuli causing it), the discharge will in fact take place – as the release of

10. Incidentally, we are not forced to assume that all relations considered here must be exactly localised in the thalamus. Phylogenetic relations localised in other subcortical regions may play the same role, as long as the conditions for their transfer to the cortex (the intentional sphere of the cortex) are operative in the same manner as in the thalamus. However, it is probable that such relations act on the cortex through mediation of the thalamus, so that it might be said that the last hand from which the cortex obtains its motor drives is in fact the thalamus.

the motor impulse. This is also how it happens in the areas of the palaeoencephalon which we are considering.

If the impulse is only communicated now to the cortex, this might really produce nothing else but the innervation feeling as described by Meynerts, in other words, a phenomenon which would, as already discussed, be totally inadequate for deriving the phenomena of will or aspiration. However the situation is different if this state of tension awaiting discharge is communicated to the cortex before release of the impulse. It cannot be doubted that this secondary tension state in the cortex can correspond to no other conscious phenomenon than the consciousness of an urge towards an active performance causing release. This consciousness is the essential component of what we call the intentional factor.

As the movement resulting from the impulse is also reflected in the cortex via the kinaesthetic sensations, this will ensure that either a movement, which on the basis of relations is generated by our drives and mediated by the thalamus or possibly other parts of the palaeoencephalon, or the elicitation and success of this movement will lead to three consecutive conscious phenomena, which are associatively linked, more or less clearly mutually demarcated, and therefore separatedly identifiable constituents of the entire course. 1. Perception of the stimulus itself, 2. The consciousness of the state of tension which was produced by the stimulus, linked to the urge for release, 3. Consciousness of the developing release, together with the perception of the movement bringing release (in general, action).

Conscious intention then develops from the conscious phenomena mentioned under points 2 and 3. In other words, if in future instances the same stimulus is again experienced either in its original or in its mnemonic form, then the urge under point 2 develops as a consequence of the consecutive associations which have been established during the previous course. This is then characterised as intention, as it is directed towards causing that movement which triggers the new experience of the specific motor sensations experienced when the movement previously occurred – or promises the recurrence of the success from this movement.

However, all that remains of the earlier experience of the state of tension in the cortex corresponding to the intentions are reac-

tion forms, not, as Wernicke would say in the sense of his well known theory, memory images with stored force, which make it possible that the corresponding action is initiated by using this stored force after an adequate trigger. There is no force store of this sort in the cortex. The force with which an intention is activated in a specific psychic moment is rather taken from the total store of force which is active in this moment in the intentional sphere (cf. introduction). We should therefore regard the implementation of a specific intention as follows. In response to a specific stimulus, a portion of the currently available psychic force is concentrated by a process of unknown character, involving a form of reaction which is adapted to the stimulus, and represented in the cortex as a disposition, resulting in the execution of the intended action (internal or external action).

As we have seen, transfer of the tension states in the palaeoencephalon to the cortex in the sense of relations is only the basis for the cortical intentional efficacy of drives in the sense of primitive drives or primitive intentions, for which the relations in the palaeoencephalon form the inherited somatic foundation. However, these primitive intentions are the foundation for the later development of the whole world of effort, the world of intentions.

Grouping of the Schizophrenias according to Essential Psychological Differences*

A certain psychological commonality undoubtedly encompasses all of the schizophrenias however different they may appear. This is not altered by the circumstance that nobody has hitherto succeeded in grasping the common essence fully and exhaustively defining it conceptually. However, beyond what they have in common, broad psychological differences are apparent within the schizophrenias which compel us to establish subgroups especially with regard to their psychological conditions; however, these subgroups have nothing to do with the familiar external differentiation of hebephrenic, catatonic and paranoid forms, but are the result of differentiating whether the symptoms of the psychosis can be identified as an expression of a currently existing basic psychotic disorder or not, and, in the latter case, whether they represent simple deficiency symptoms or are symptoms of psychotic development on the basis of a deficiency. It will have to be taken into account that this grouping by no means signifies only a differentiation of cases, but also and, to an even greater extent, a differentiation of stages as the usual way is that schizophrenia initially allows the psychotic basic disorder to be identified ('fresh cases') and then, when this basic disorder ceases, a deficiency schizophrenia ('old cases') develops, which can ultimately form the basis for psychotic development, which has often also commenced during the basic disorder.

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*Reference: J. Berze. "I. Gruppierung der Schizophrenien nach wesentlichen psychologischen Unterschieden". In: *Psychologie der Schizophrenie*. Springer-Verlag, Berlin, 1929; I: 4–15.

Apart from the lack of a generally accepted psychological or psychopathological terminology, a disregard for these circumstances particularly explains the often-broad divergences in opinion of authors in the areas of the psychology and psychological theory of schizophrenia.

The concept of *psychotic basic disorder* requires clarification, as is apparent from the literature. It is often mistaken for the concept of psychotic *primary symptoms*. Psychotic primary symptoms are immediately noticeable symptoms, which differ from other secondary symptoms only in that they cannot be traced back further psychologically in any way. The psychotic basic disorder, in contrast, is *not* in itself demonstrable phenomenologically; rather, it can only be indicated from the totality of the primary symptoms and in fact on the basis of analogies, as has already been expressly remarked and will later be shown in more detail. Furthermore, the primary symptoms of a certain psychosis can be ever so numerous and nevertheless have their common basis in a single uniform basic disorder. It is, therefore, quite incorrect to describe the attempts to establish the basic *disorder* as a search for *one* cardinal *symptom*. The assumption that a '*universal*' symptom must correspond to the actual psychotic basic disorder is equally wrong. How the symptoms of a psychosis develop never depends on the type of the psychotic basic disorder alone; always and particularly with milder degrees of the basic disorder, the overall psychological constitution of the individual otherwise comes into its own. The latter also appears to have a considerable influence on the degree of development of certain psychotic *primary* symptoms. This is sometimes also apparent from the fact that in the individual cases sometimes one and sometimes another primary symptom becomes obvious to a degree that determines the overall picture. Moreover, other elements of the psychological disposition can obviously have a qualitative effect also in altering primary symptoms so that they are distorted, so to speak, and can, therefore, be recognised only with difficulty and uncertainty as being in essence identical to symptoms which present themselves in their usual form. All of these elements may be an obstacle to the universality or the establishment of the universality of a primary symptom, even if it can generally be ascertained without doubt.

What occupied the broadest space from the start in the description of the psychoses first summarised as dementia praecox (Kraepelin) and then as the group of the schizophrenias (Bleuler) were the *secondary* symptoms. The *primary* symptoms, which were not emphasised at all initially, only occurred alongside insofar as they were identified at all. Bleuler was the first to make a clear distinction between primary symptoms, i.e. "immediate mental expressions of an organic process" and secondary symptoms, i.e. "partly psychological functions under altered conditions, partly the consequences of more or less failed or even successful adjustment attempts to the primary disorders". With this, a highly important step had been taken; attention was drawn to primary symptoms and a way was shown which could bring us closer to the psychological essence of the schizophrenias, away from the secondary symptoms that were to a large degree dependent on the overall individual psychological constitution with regard to the nature and extent of their development and which were extraordinarily varied for this reason. At the same time, however, as soon became apparent, the foundation was laid for an error with major consequences. From the fact that the primary symptoms, in contrast to the unimportance of the secondary ones, had been described as necessary essential manifestations of the schizophrenias, the view was deduced – but probably not in Bleuler's sense – that they would now have to be really present in every case of schizophrenia at any time. But this is not the case. On the contrary, the number of cases of schizophrenia in which not a trace of the actual primary symptoms (signs of the process) can be found is extremely large.

How is this possible? Astonishingly, this problem has not even been formulated correctly, let alone explained adequately.

Every organic process becomes the cause of performance disorders or can, at least, become the cause in two ways: firstly, as long as it persists, it has an immediate disturbing effect on a certain function or on certain functions, and secondly, it produces lasting changes in the organs affected by it (lesions, deficiencies) which in turn produce deficiency symptoms. Consider any organic process that has caused change in an organ. It will always be found that after the conclusion of the process, the symptoms of the living process,

the *process symptoms*, are replaced by symptoms that outlast the process or *post-process symptoms*, which can gradually disappear under certain circumstances, namely, when the organ change is reversible or when the impairments can disappear perhaps as a consequence of compensatory processes; on the other hand, they can persist permanently. With more prolonged processes, we also see that while they are still in train more and more post-process symptoms will be added to the process symptoms as a result of organ changes which the process has already produced in its course so far.

All of this is also true for the genuine process schizophrenias. As long as the organic process underlying them is in train, the schizophrenic basic disorder presents itself in its associated primary symptoms as a direct result of the process and an expression of the fact that it is a *current* process. At the same time, however, the organic process of schizophrenia leads to a general organic destruction, which, in the psychological sphere, corresponds to a gradual destruction of the personality. This persists as a *post-process* disorder even when the organic process has already run out so that the basic disorder has cleared; in the case where the destruction produced is finally incorrigible, it persists for the remainder of life.

However, a large proportion of the secondary schizophrenic symptoms persists with this. Instead of their former dependence on the primary disorders, they have, so to speak, achieved a kind of autonomy. It could also be said in concrete terms that the mental life that had been pushed onto a wrong track by the process was continuing on this wrong track even after the process had ceased.

The great majority of schizophrenias, when they come to our observation, are already no doubt post-process psychoses. This is apparently contradicted by the fact that a correct process stage or a correct process phase has never before been observed in many of them. But only apparently! Varied experience teaches us that the extent of the post-process schizophrenic personality change is by no means continuous with a linear relationship with the intensity of the basic disorder, let alone with the extent of the manifestation of the primary symptoms during the stage of the living organic process. Rather, there are cases in which a strikingly slight persistent personality change has resulted after an extremely impres-

sive process phase with quite pronounced primary schizophrenic symptoms, compared to those cases in which a process phase that can hardly be diagnosed with certainty because of a lack of marked symptoms has led to a profound destruction of the personality. They lead us across to those schizophrenias, which, although characterised as post-process, appear to have developed completely without a preceding process stage.[1]

The field of post-process personality changes, which have arisen from a phase of the organic process of schizophrenia that remained latent, is immeasurable. The range extends from the slightest personality changes, which manifest themselves only in certain more or less striking character traits and are often not even identified as originating from a psychotic root, to the most pronounced schizophrenic final states and comprises also all gradual transitions between those two extremes.

Two important questions must also be at least considered from this aspect and must obviously also be partly judged: the question of the *schizoid personality* and the question of the *schizophrenic* (or schizoid) *reaction type*. The inclusion of certain assumptions derived rashly from genetic results that have as yet not been elucidated has confused this question to a considerable degree. It is only possible to untangle this confusion by deliberately avoiding the consideration of any genetically based suppositions.

Bumke already contributed to the question of the schizoid personality when he pointed out that we must first of all attempt "to separate from the psychopathies those cases that in reality are disguised schizophrenias" or that we must continue in the direction already taken by Wilmanns. With the disguised schizophrenias also, we shall have to maintain, in principle, the distinction between those that are in process and those that can be regarded as post-process states. The assumption of disguised schizophrenia *in process* is suggested particularly for those cases in which a schizoid personality has, so to speak, developed in front of our eyes and

1. Kahn (46) refers to dementia praecox processes that "are to such a large extent and for so long under the surface, as it were, that they elude our diagnosis as process diseases temporarily or permanently".

has become more and more pronounced until it finally makes the transition to genuine schizophrenia, that is, for those cases in which schizophrenia has occurred via a 'schizoid personality' without that 'break' ever becoming apparent, which in typical cases demarcates incipient schizophrenia from the prepsychotic state. On the other hand, the assumption of a disguised schizophrenia leading via a slow and gradual organic process to *post-process* state fits more for certain schizoid personalities that have remained unchanged for a long time. Pronounced schizophrenia can still develop in these too, even after many years, as the process that, at the time, caused the schizoid personality can occur again even after a long cessation and can now lead to full development of the psychosis and even to strikingly rapid progression, as some cases show; in a similar manner, we can observe the sudden onset of stormy manifestations in cases of originally obvious schizophrenia even after it has been arrested for decades, often leading to rapid progression of schizophrenic dementia, manifestations that we must associate with a flare-up of the organic process after long quiescence.

In this connection it will also have to be borne in mind, as Neustadt (75) recently stressed, that "the age at which hebephrenia occurs is remarkably early, quite apart from the rare cases of dementia praecocissima (DeSanctis, Higier, Weygandt) and dementia infantilis (Heller)" and that early disease, which leads to considerable mental weakness when fully developed, in all probability can produce changes that correspond to some form of 'schizoid personality' when it follows an abortive course.

But what about those other 'schizoid personalities' which remain as part of the schizoid families whether in a process or post-process state after thoses cases which are schizophrenias, even though 'disguised' schizophrenias, have been excluded?

It is theoretically possible that among the 'schizoid personalities', that cannot be regarded as *acquired* in the described sense, there are also psychopathies, *congenital* psychopathies, which are connected in some way with schizophrenia, perhaps in that there is a congenital defective tendency in them that produces an abnormality of the foundations of mental life, which is analogous to the mental change that has resulted only from the organic process in the acquired

schizoid personalities. It would also be possible that this defective tendency can be attributed to a genotypic factor which is identical with the one – as the case may be – underlying the genetic disposition to schizophrenic process psychosis. However, this connection is only possible but has not been proven. In fact, it has not been confirmed that there are cases among those resting schizophrenias, which remain after the exclusion of disguised schizophrenias, for whom such an explanation could apply.

This certainly does not apply for the vast majority of the described remainder. Even in entirely schizophrenia-free families, there are psychopathies of various kinds, often in not inconsiderable numbers; these psychopathies for the most part cannot be distinguished from analogous types occurring in schizoid families. It is a gross error indiscriminately to call these psychopathies schizoid also and to evaluate them as schizoid, if or because they occur in certain families along with schizophrenia and along with schizoid states characterised as abortive schizophrenia (in the process or post-process stage); this has led to highly doubtful conclusions in the genetic field, conclusions which are, so to speak up, in the air. "Where", asks Ewald justifiably, "are the characters that we used to call reactive labile, hysterical, fantastic? Where are the paranoid and where are the epileptoids? Where are the unstable and sthenic, those with a labile personality consciousness and the stubborn? The broad mantle of the schizoid state embraces them all". It can hardly be doubted that many of the types that Ewald lists can be counted among the schizoid persons at least occasionally, since an abortive schizophrenic process can damage that mental superstructure, which with normal development guarantees more or less extensive control of certain characteristics so that the latter then come to light as sharp, striking, stark, undiminished features, in which a main characteristic of many schizoid personalities can surely be glimpsed. On the other hand, it must be remembered that most of the types listed by Ewald probably have nothing to do with schizophrenia nor with the schizoid personalities that merit this name.

The types that are incorrectly described as psychopathic must also be excluded. In agreement with Bumke, Bostroem (18) makes the statement, which surely applies to *these* types, "that in the

so-called schizoid characteristics, we are dealing with features of *normal* mental life". The characteristic psychological symptoms of schizophrenia, thus, "cannot be regarded as an intensification of schizoid characteristics". Bostroem, therefore, also prefers "to speak not of schizoid but of 'dystonic' characteristics". (Perhaps it would be better to say 'asyntonic' because nothing but a lack of syntony is meant while on the other hand expressions formed with 'dys' rather indicate something pathological). Only when demonstrable pathological elements[2] are to blame for the fact that some character features appear abnormally sharply or else that they appear distorted and twisted can their bearer be regarded as psychopathic. The idea that a fluid transition from the 'schizothymic' lying within the range of the healthy leads to a schizoid state that can be regarded as psychopathy can be granted a certain justification only in this sense. It can sometimes be that an insidious process allows a schizoid personality to proceed gradually from a 'schizothymic' (asyntonic) one.

Bostroem (loc. cit.) also points out that a further psychological connection can be seen between so-called schizoid personalities and schizophrenia in that 'schizoid' or, more correctly, dystonic (asystonic) personality characteristics "become apparent as symptoms of psychosis". In the same way, however, we also see "in schizophrenias that have affected persons of a *syntonic* nature a corresponding cyclothymic form of symptoms". The *schizophrenic* symptoms specific to the disease process result in pure form "only after elimination of the pathological details of the dystonic or syntonic personality", and we shall also have to take other personality types into account.

The second question mentioned above, that of the schizophrenic (or schizoid) reaction type, has hitherto been treated only as a question of the genotype. For the majority of cases, a genotypic factor or factor complex will surely have to be regarded as the basis of this specific reaction norm as of the reaction types generally. This

2. These are often external elements, which allow certain, especially asocial features of the personality to emerge. For instance, a 'feeling of unlimitedness' [cf. Holländer, (40)] can result from a particularly favourable situation in life for an appropriately predisposed person, leading to a certain independence, an uninhibited self-realisation.

way of seeing things, however, must not induce us to disregard the possibility of this or an analogous reaction norm developing in the course of life under the influence of external factors, that is, the possibility of an acquired exogenous schizophrenic reaction type occurring, and we should also not completely reject the possibility of the determinedness of the schizophrenia or schizoid similarity of many a 'reaction' due to the uniqueness of the noxious agent or combination of noxious agents – *without* a specific reaction norm whether constitutionally given or acquired previously. According to Kahn also, "the view will have to be accepted that disease states culminating in schizophrenia can arise in the idiotypic case even without the presence of schizoid and schizophrenic dispositions, which, at least currently, cannot be distinguished from the constitutionally based cases" ('schizoform state'). "The non-genetic schizoform mode of reaction arises from the interplay of a number of exogenous causal conditions, which coincides broadly with Bumke's schizophrenic modes of reaction".

On the other hand, however, for the cases where we believe ourselves compelled to assume a *congenital* reaction type or, as Kahn says, an 'idiotypically based' schizoid mode of reaction, we should not be satisfied simply with the idea that the reaction is, so to speak, derived *directly* from the *genotype* or, in other words, that the genotypic factor (factor complex) in question achieves an influence on the phenotype only in the situation which has arisen through the factors acting as a stimulus to the reaction. Instead we have to expect that such cases consist of a previous phenotypic change that has remained asymptomatic until then only to become apparent in the mode of reaction as a specific constitutional disposition under the influence of those factors which have triggered the reaction.[3]

What the authors, who have dealt in more detail with the schizophrenic (schizoid) reaction type, mean in this regard has not been stated clearly enough anywhere by them. According to Popper (79), the reaction "draws everything … out of the individual in question which was previously more or less latent in specific individual idiosyncrasy and essence". Only something phenotypically

3. These considerations do not apply only for the *schizophrenic* reaction type.

given can basically be called 'latent' and only for as long as it remains hidden. The manifestation of the reaction type signifies that this latent phenotype emerges from concealment, in that it produces symptoms or colours symptoms produced otherwise. It is possible but not certain that Popper means it that way. Kahn (45) says in some places: "The wheel of schizophrenia is set in motion through some environmental factors striking the genotype or the schizophrenic (or schizophrenia-ready) part of the genotype…". According to this, something is meant that till then had been merely genotypic. However, it is difficult to make out how environmental factors can be said to 'strike' something that is not already somehow realised in the phenotype.

The genetic problem is pushed into the background for Popper. According to him, the conception of the schizophrenic reaction type is of value "purely clinically and practically". The schizophrenic reaction would have to be "demanded strictly from the schizophrenic disease process and from the reaction concepts of schizophrenia generally". Kahn, conversely, places the genetic side of the problem in the foreground. The schizophrenic reaction type put forward by Popper, just like the schizophrenic process psychoses, according to Kahn, belongs "genetically to the overall schizoid-schizophrenic group", in which the *sine qua non* is the hereditary tendency to the schizoid state. "The hereditary tendency to the schizoid state" appears not infrequently to be "realised phenotypically in schizoid personality types".

We can only speculate how the phenotypic change, which is possibly the basis of the schizophrenic (schizoid) reaction type, is characterised, as nothing that can be comprehended descriptively is possible. In all probability there is no uniformity here either. Perhaps everything that has been said regarding the problem of schizoid personalities will apply also for the schizophrenic reaction type overall. Here, too, besides disguised schizophrenia or permanent changes following mild process phases, there will be cases of a conditional schizoform mode of reaction (Kahn) and there will ultimately also be cases that are not really a schizophrenic mode of reaction, but rather the reaction of a dystonic personality in Bostroem's sense. Moreover, the difference between the carrier of a somehow determined 'schizophrenic reaction type' and a schizoid personality who is similar to him with regard to the conditionality consists fundamentally only of the fact that the former does not exhibit 'schizoid' features in his habitual state or that they are not developed in him

to a degree enabling them to be diagnosed, especially as we can also see schizoid personalities reacting in the same way.

Those schizophrenic psychoses, which merit the designation of symptomatic schizophrenias, must be separated in principle from the manifestations of the schizophrenic reaction type.

Kronfeld (57) clearly points out the ambiguity in the use of the word 'reaction'. In the received sense, every psychosis is ultimately a 'reaction', that is, a reaction to the totality of its conditions. However, in psychiatry we understand by a reaction type "something essentially different, that is, the *mental processing of experiences*". The need for some additions to this definition becomes apparent when the concept of the reaction type is contrasted with that of the symptomatic psychoses. It is not irrelevant to determine why the mental processing of experiences bears pathological, e.g. schizophrenic traits or sometimes even develops into psychosis, e.g. a schizophrenic psychological character. We can speak, strictly speaking, of a pathological, e.g. schizophrenic reaction type only when this is explained by a *constitutional anomaly* of the psychological foundation, whether this has been present from the outset as a congenital personality tendency or has arisen as an acquired personality change only in the course of life. However, this does not apply to the proper symptomatic psychoses, e.g. schizophrenia. Here the pathologically altered mental processing of experiences is a partial manifestation of symptoms that are related not to a constitutional anomaly that is already present but to a transformation process that is only *taking place currently*. This distinction in principle between the manifestations of the schizophrenic reaction type and symptomatic schizophrenia must be maintained even in the face of difficulties that arise in cases when a process that can possibly account for the occurrence of symptomatic schizophrenia is found in an individual who we suspect for genetic reasons belongs to the the schizophrenic reaction type.

If we speak of *symptomatic* schizophrenias, we assume the occurrence of *idiopathic* schizophrenia. The problem of emphasising and defining the idiopathic schizophrenias, however, is extremely difficult, much more difficult than demarcating any other idiopathic *disease* against its analogous symptomatic forms. This is due to the

fact that we have no right to regard the idiopathic schizophrenias as a clinical unity. Kronfeld stresses correctly that even if we had found that the group of schizophrenias forms one complete unit in terms of its psychological characterisation, "we still would not know whether this psychological unit corresponds to a clinical unit". However, the same also applies for each subgroup of the schizophrenias regardless on which aspect the classification is based, accordingly it also applies to the subgroup of the idiopathic schizophrenias.

In attempting to define the idiopathic schizophrenias, we must undoubtedly start from Kraepelin's dementia praecox. But the boundaries of this group are known to have been expanded more and more so that they finally included much more than those core groups that would have a claim to be called idiopathic; Kraepelin saw himself virtually compelled to define it more narrowly by separating certain forms, particularly those designated by him as paraphrenias.

Obviously general points of view are necessary if a useful definition of the idiopathic schizophrenias is to be achieved. Above all, it must be stressed that idiopathic schizophrenias are schizophrenias due to a process, or *process* schizophrenias. The result of this is that the very first requirement is to separate from dementia praecox in Kraepelin's sense all forms that can be identified from their mode of appearance as mental developments ('mental processes') whose bizarreness has its roots in a congenital degeneration or in an acquired alteration of the personality of a different kind. Therefore, certain '*degenerative*' character developments, which have a broad similarity to process-type hebephrenias, also have to be separated. In particular, certain *paranoid* developments, which today are still generally lumped together with the process-type paranoid dementia, also have to be separated. The fact that nothing can be found in them of the specific schizophrenic thought disorder and the symptoms immediately grouped around it, that the *current* personality does not prove to be disturbed, that there is a well-structured delusional system in the intellectual processing of the delusional ideas developed under the influence of pathological attitudes, that even after a long period of development (of the mental process) no kind of 'disintegration' manifestations

become apparent – all of this is generally explained by the low intensity and by the insidious character of the supposed living process. However, it would have to be recognised that there is no reason at all for supposing such a thing in many of these cases. In all probability, the great majority of the paraphrenias already excluded by Kraepelin must also be separated, but not because it would be justified to assume that they are based on a *different* process than the process schizophrenias, but because they obviously are due not at all to a living process but, like the majority of the paranoid developments mentioned above, they are due to permanent changes in the personality after a concluded process. On the other hand, for most of these forms or cases that, as we said, should be separated, an association with the process schizophrenias exists insofar as the personality changes from which their symptoms emerge are the result of a concluded *schizophrenic* process phase that often remained latent. This assumption is also supported by the fact that in quite a few of them, a process sometimes commences after a decade or an even longer period of undisturbed mental development, either suddenly or increasing gradually, which, so to speak, illuminates the scene with its specific process schizophrenic symptoms. This change in the overall picture is sometimes very striking, especially in cases of paranoid development and also with some paraphrenias. With regard to the paraphrenias, Bleuler already emphasised some time ago that everything that has been presented as reputedly characteristic of the paraphrenias also occurs in cases "that demonstrate a typical praecox picture for years". Bumke (23), who stresses that the word 'paraphrenia' today signifies only "a question mark and covers an open but unsolved problem", argues overall rather *for* the separation of the paraphrenias and schizophrenias, but readily admits that "most cases that *at the start* correspond to Kraepelin's description of the paraphrenias *later* prove to be schizophrenias". When we say despite all this that the designated forms should be separated from dementia praecox when singling out a schizophrenic core group, this is because the recognisable relationships are not always sufficient for securely establishing the presence or the kind of their relation to schizophrenia.

Although we are not justified in describing dementia praecox as a clinical unity in the resulting narrower definition, even if the results of genetic research in particular appear rather to suggest this, as Wilmann (120) among others emphasises, what is common to the forms belonging to it, as far as we can judge at present, is that the underlying organic process is announced exclusively by the symptoms, including physical ones, which we call schizophrenic, in other words, that we encounter the schizophrenic independently in these forms. This is certainly a criterion of very small and merely relative value! But is it not like that wherever idiopathic has to be distinguished from symptomatic and does it not have to be so as long as the essence of the process that is regarded as idiopathic has not been identified? Through the use of hitherto unconsidered investigation methods or by using newly discovered ways of investigation each new day can lead us to results that show us that this or that form, which we have hitherto regarded as idiopathic, should be classed with the symptomatic ones. This happens with the epilepsies and also with the schizophrenias. What will remain finally after those forms, which have been identified as symptomatic have crumbled away from the subgroup of those schizophrenias, which we currently call idiopathic, may still not form a clinical nosological unity. In all probability an idiopathic residual group will result, whose members are genuine to the same extent, a group of genetic degenerative forms, which differ among themselves only in the sense that the degeneration affects either that partial cerebral system, whose functional deficiency is responsible for the the schizophrenic basic disorder, on its own or else together with one or another partial system. Whether this residual group will have a *substantially* smaller scope and content than dementia praecox in the narrower definition described above remains open.

All processes, which are capable of damaging or involving that partial cerebral system, will be able to lead to symptomatic schizophrenia. The schizophrenic manifestations will be pushed to the background by other usually general mental disorders or will finally be completely suppressed the more the process extends beyond it. Accordingly, we see the symptomatic schizophrenic becoming

apparent often only in brief phases of the disease occurring sporadically. Sometimes, however, persistent personality changes result from such temporary phases in the symptomatic schizophrenias also, which can give a 'schizophrenic' stamp to the total picture in further periods of its course.

An appropriate selection among the schizophrenias should be made even if it is not simply a question of the general psychological symptomatology of the schizophrenias, but also if it is our aim to provide descriptions of the psychological symptoms, which are characteristic of the individual subgroups of the schizophrenias, that can be separated on the basis of their genetic aspects, and in particular when it is our aim to find the primary schizophrenic symptoms. The entire group of schizophrenias includes the following subgroups in this psychopathogenic respect:

1. Active process schizophrenias, i.e. schizophrenias with an underlying organic process at the time of activity of this process. The latter can have an acute onset and follow an acute course or can develop insidiously and have an insidious course. Cases in which it comes to a conclusion rapidly contrast with those in which it persists for many years. The course can be continuous, intermittent or remitting.

2. Inactive process schizophrenias, i.e. process schizophrenias in stages of temporary arrest or in that of final conclusion, that is process schizophrenic residual and final states. Even after an arrest for decades a 'phase' of the organic process can commence again and thus make the inactive process schizophrenia active again. This group in all probability also includes the great majority of Kraepelin's paraphrenias.

3. Reactive schizophrenias, i.e. schizophrenias which develop *psychogenically* (*psychologically* reactive) in the form of schizophrenic-psychotic processing of experiences[4] *without* an *active* organic process being involved at present. They can pass quickly but can also assume the form of continuing psychological developments (chronic 'psycho-

4. It should be particularly emphasised that experiences should be understood here not only primarily as those that have external events as object but especially pathological internal processes, such as the experiences of illumination, rapture or striking 'spiritual events' and often particularly impressive sporadic hallucinations etc.

logical processes') and can then be of unforeseeable duration. Many reactive schizophrenias are psychologically produced manifestations of the schizophrenic reaction type. Others can be recognised as reactive psychoses of schizoid personalities. The great majority of cases of the latter kind concern persons with acquired (post-process) schizoidism. This group includes also almost without exception all those cases whose whole range of symptoms, as Bleuler and others after him assume, appears to be caused somehow psychologically only on the basis of milder quantitative deviations from the normal without an underlying process. They lead over to psychological developments on the basis of pronounced process schizophrenic residual states. A large proportion of the so-called grafted schizophrenias belongs to this group: the 'feeble-mindedness' on which the schizophrenia is 'grafted' as a reactive psychosis in these cases should be regarded as a schizophrenic residual state, i.e. as the outcome of a schizophrenic organic process, which took place in early or very early childhood. In other cases, however, the so-called grafted schizophrenia is due to a new phase of the process[5] as can be recognised from its active process schizophrenic manner of manifestation. These cases should then be counted among the active process schizophrenias and not among the reactive schizophrenias in the sense intended here.[6]

4. Complicated schizophrenias, i.e. reactive psychotic developments in active process schizophrenias. Especially when the organic process is of low intensity, active process schizophrenias with a gradual insidious onset and course are where psychotic reactions often occur to the impetus provided by an experience, which acts as a psychological trauma under the pathological psychological circumstances. Usually with an acute onset and initially with a stormy form, they

5. It should not be disputed that the schizophrenic process can also strike an individual afflicted with congenital oligophrenia or feeble-mindedness of any other genesis acquired early. These would, in fact, be true examples of grafted schizophrenias.

6. The question of whether the process itself can commence 'reactively' is irrelevant for our discussion. Where there is an underlying living process, an active process schizophrenia is present, no matter how the process has been caused.

readily mimic the start of schizophrenia generally when the preceding phase of the active process schizophrenia has been overlooked because of its paucity of symptoms. In general, the reactive schizophrenic symptoms predominate distinctly in the overall picture and often obscure the important symptoms of the acute process schizophrenia or even conceal them fully. However, the latter are never completely absent. They only have sometimes to be brought out from where they are submerged by digging deep. Since such reactive psychotic developments do not immediately depend on the organic process, they can come to a conclusion at any time or else regress more or less completely even if the organic process persists so that the signs of the active process schizophrenia continue to exist.

Hans Walter Gruhle (1880–1958)

Hans Walter Gruhle was born on 7 November 1880 in Lübben (Lausitz), studied medicine in Leipzig, Würzburg and Munich and took his doctorate under Kraepelin in Munich in 1904. Gruhle joined the Heidelberg Department of Psychiatry in 1905. This clinic was directed by Nissl from 1904 to 1917, followed by Willmanns. Gruhle stayed there for almost 30 years and was soon one of its intellectual leaders. His "Psychology of the Abnormal" appeared in 1922. Together with Berze, he published "Psychology of Schizophrenia" in 1929. In this work, he described distinguishable manners of experience and differentiable basic aspects of abnormal mental life with great formal precision. On the basis of his own comprehensive education in the humanities and in philosophy, he strove for a scientific explanation for a comprehending psychology and psychopathology in Jaspers' sense. His interests also focussed on issues of social psychiatry and criminology. His study on the causes of moral degeneracy and criminality in adolescents appeared in 1912. His main work "Comprehending Psychology", which was published in 1948, critically portrays general psychology and its relationships to other sciences. He vigorously criticised attempts to overcome the lack of sense and intelligibility of schizophrenic experience with psychoanalytical explanations and interpretations. He was a polymath and critical spirit of the deepest integrity, free of personal vanity and insensitive to the attacks of others. He was feared at conferences because of the sharpness of his comments during discussion. Jaspers wrote that Gruhle was irreplaceable for him if only because of the "daily critical beating" given to the whole Heidelberg group, both during clinical work and in academic

discussion. His tendency to question the teachings of even the great personalities of his time in an uncomfortable manner had a major influence on the development of empirical thinking in psychiatry, but inhibited his own academic career. As the Nazi regime did not consider him sufficiently politically reliable to succeed Wilmanns, he was appointed director of the Württemberg Zwiefalten Clinics and Nursing Homes in 1934 and later the Weissenau Asylum. Gruhle was only appointed professor in the Bonn Clinic after the Second World War, when he was 65. He had already held this post for a short time in 1934 on a temporary basis. He retired from the chair in 1952, but retained teaching responsibilities. After the death of his successor K. Pohlisch in 1955, he returned as professor for a year on a temporary basis, finally retiring at the age of 76 after the appointment of J. Weitbrechts. H. W. Gruhle died on 3 October 1958.

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On Psychology*

1. Psychological Intuition and Evidence

The concept of intuition is greeted with two different notions of value. It is respected, as it is something which not everyone can do and it is not taken seriously, as it cannot be checked. If we first look at how this word is used, the negative connotation is striking, as an insight is something which is not gradually attained, but which is reached in a single bound. Thus, intuition lies close to the brainwave and to invention. It is assumed that neither of these takes place without preconditions or something like prior knowledge, but they are not actually intended. If there is any prior hint, it is only a vague tendency. The brainwave tends to be related to simple and everyday matters. It may be regarded as nice, exciting, original or amusing. It's no heavyweight. The invention tends to be respected and taken more seriously. It tends to be used for more technical matters. This is why it is mostly technicians who describe it with the extreme word of 'ingenious'. The humanist regards it with benevolence, but without enthusiasm and employs such words as 'useful', 'necessary', 'surprising' and 'beneficial'. The word 'invention' is not used in the domain of the arts and humanities, although an inventive insight occurs here in exactly the same manner as in the sciences. Two collections of facts are related to each other which had never before been related to each other. It is irrelevant for the sequence of events whether a connection is formed between everyday objects or between objects of major cultural worth.

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*Reference: H. W. Gruhle. "I. Zur Psychologie". In: *Verstehen und Einfühlen, Gesammelte Schriften*. Springer-Verlag, Berlin, Göttingen, Heidelberg, 1953; chapter I, 1–3: 1–30. First published in: *Der Nervenarzt.* 1943; 16, 281–290.

The origin is what is essential and is dominated by the unique spontaneity of the act. If an insight is arrived at in any other way, one can give an account afterwards of how it was achieved. Two well pipes under the same pressure fill a basin in one hour. The diameters of the two tubes are in the ratio of 2 to 3. How long does the narrower tube need to fill the basin alone? This is the train of thoughts: after one hour, the narrower tube has filled two fifths of the basin. If it needs one hour for two fifths, for five fifths it will need the half of five hours, i.e. 2.5 hours. There's no jump, no brainwave, no surprise here. The thought processes can be retraced step by step, forwards or backwards. In contrast to this, an intuitive jump cannot be traced retrospectively. No specific and no gradual exertion was present. The jump was often surprising, even to me, the one who was most directly affected. It's not that I hadn't often thought about the relevant connections, it's just that the sudden appearance of the new insight was oddly spontaneous. Although this insight is '*my*' insight, it feels as if I was merely the scene where it could happen and not the initiator. The Egyptologist Brugsch reported that he had brooded for months about the significance of an Egyptian hieroglyphic, without reaching any result. However, one morning he found the meaning he had been looking for on a note on his writing table. He had got up himself during the night and written it down. This was intuition. The same story is often told about artists. They are unsatisfied with themselves and the world. They feel that 'it' is developing in them, but that 'it' is not quite ripe. One day, with no obvious trigger, 'it' stands ready in front of them. They call it an artistic 'idea'. The biographies of artists – and of other scholars – contain numerous anecdotes in which they had an unplanned, sudden and blinding insight on a boat trip, when looking at the moon or in the reeds when waiting for the ducks.

In some periods, people tended to see something supernatural in these sudden ideas, perhaps the activity of divine powers, and this is why there was talk of inspiration, illumination or enlightenment. The records of the inspirational communities contain many such examples. However, the content of the concept is then changed somewhat. The surprising character of the insight is then more

important than whether it is actually new. If you read the contents of these inspirations, there is little novel about them. They are declamations which resemble sermons, predictions resembling prophecies and the like. The only thing they have in common with real intuition is that they were *not* specifically planned, although the subject is deeply stirred and feels himself to be the 'scene of action'. This lack of intention is then logically accompanied by departure from the normal state of consciousness, namely ecstasy. This exceptional state is accompanied by changes in motor functions, manner of speaking, facial expressions and gestures. This is an addition to inspiration which essentially belongs to the sphere of the mind. As this enraptured externalisation is mostly inherent to inspiration, the concept of ecstatic inspiration has then been extended to those states of mind which should probably be called 'illumination', in which nothing much remains apart from the ecstatic feeling of happiness but there is no new knowledge. Thus, a person in this state might announce that each blade of grass glowed in his eyes in the light of God's magnificence (i.e. a purely subjective experience), or new insights are announced, although these are far from new, but sometimes quite trivial, once the emotional content has been removed, such as "Mankind is good" or "No-one comes to the father except through me".

Although the tendency is inherent in this exceptional state that the subject announces his new insight in ecstatic sermons, in singing or in stuttering in tongues (Pentecostal visit of the Holy Spirit, the Pentecostal Movement), this tendency totally lacks the higher level of illumination, known as the mystic vision. The mystic has extraordinary insights at the height of his vision, but may not (or more often cannot) pronounce them (ineffable). At the top rung of the hidden ladder of love, the soul becomes totally similar to God, thanks to the unimpeded vision of God. Because of this complete similarity, there is no longer anything hidden to the soul. It is free of the inhibitions of forms, images and perceptions, but has nevertheless the pure vision of God (St. John of the Cross).

Even though the essence of intuition is particularly clear in this vision (contemplation), this is actually a special case, as the contents

of the vision cannot be described and cannot be expressed, so that this vision is not comparable to sensory perception, mental reference or recognition. The mystical vision or mystical intuition is a thing for itself. The reason is that its subject and object merge in it.

Therefore, the discussion has to return to the relatively simple situation, which was described above. What all grades of intuition, in the widest sense, have in common is the feeling of being *the scene of action*, the waiting for arrival, the lack of intention. There were additional variable emotional components, ranging from simple marvel (about the brainwave), to the urge of the inspiration (which is often agonising), the ecstasy of the illumination or the ineffable blessedness of mystic union.

This emotional component, combined with excessively imprecise language, may be the reason that intuition is occasionally described as a *feeling* or that it is said of intuitive individuals that they think or find things emotionally. This is a totally misleading use of words. The nature of intuition has nothing in common with emotion.

If we decide to leave mystic intuition out of the following discussion, there remain two types of intuition which concern the psychologist: the expert's intuition and the intuition of mental production or artistic creation.

While he is maturing, the human being develops a large number of motoric behavioural patterns. He *acquires* these, as there are very few in-born ready made mechanisms (instincts). But he acquires them only with great effort (upright walk). The small child learns from a variety of perceptions – the pressure of his garments, kicking, then later feeling with the tongue, hands and feet, the hardness or softness of a support, the lack of noticeable resistance in the air. It then combines those perceptions with an experience of the movements which are required to master its immediate environment to develop an incredibly finely graduated palette of movements, guided by the equilibrium organs, kinaesthesia, etc. There are a lot of initial failures (knocks, falls, collapsing), but the system becomes increasingly better tuned, until the child finally masters posture, gait, etc. A large number of very fine regulatory mechanisms have developed. These are incredibly plastic and present as *automatic* behaviour, not requiring conscious attention. The same process as

with a small child must only be gone through when a new motor skill has to be mastered, for example, new types of sport – but then it is abbreviated. These new series of movements then become automatic too. The human being has become the stage on which those manoeuvres of his motoric system are completed, mostly without being noticed. The human being is only surprised by his own previously unnoticed motoric adroitness under special circumstances, such as the sudden avoidance of dangers which have just cropped up. He will probably (wrongly) say in everyday language that he ducked instinctively, when he should have said he had ducked automatically. The same applies to the mental training that human beings gradually submit themselves to. It does not need to be described in detail how he gives his thoughts and the language coupled to them so indescribably many instructions and so much practice in the course of the years that an incredibly fine variety of mental automatic behaviour develops, corresponding quite closely to motoric automatic behaviour. He usually does not need to pay this much attention. Under normal circumstances, as with the well pipe example described above, thought processes lead to the desired success, in accordance with practice. The human being is only surprised by his own mental adroitness under special circumstances and then says that he does not know how he came to this idea, it must have been intuition.

Intuition is thus autonomous processing of currently unconsciousness intended automatic behaviour. 'Autonomous' does not imply that it is unrelated or foreign to the ego or that it overcomes the ego, but that the initiating role of the ego (cause) is missing. It is an ungrounded prejudice that mental work is ever only initiated with the full participation of the ego. Without more than a reference to work in a dream, just think of the automatic process of reading or unconsciousness assignment to memory, unconscious singing along or of what is known as *readiness*. If I decide to check that the backdoor is closed before I leave the house, I may be totally distracted by other decisions being demanded of me, telephone calls, etc., but this readiness still has the effect that I finally find myself at the back of the house without immediately knowing what I am doing there. Thus, the readiness overlaps with the *task*. If I am

informed that I will meet my friend X during a trip to Frankfurt, I will certainly not walk past him when I meet him on the street. If I were not prepared (task), I could easily walk past him without recognising him. The task gives rise to readiness, which then not only interferes to control conscious acts, but can also trigger spontaneous behaviour. If I read a text for the meaning, I will immediately notice nonsense or contradiction, but will overlook some printing errors. If I am proofreading, I may fail to notice nonsense, but I will not miss printing errors. In this way, the same act of reading is differently structured by different tasks. I consciously decide on the tasks myself in a case like this. In other cases, the situation lays this down. If I am shown a painting, I am alert from the start for artistic effects. If I am shown a drawing of a newly discovered plant, my selective and summarising knowledge is orientated in other directions, without a special decision.

These examples are only intended to illustrate different aspects of the enormous importance of automatic reactions. The whole economics of thought are based on this.

This is especially clear in the context of *expertise.* If you have studied an area in depth, for example, if you are a botanist who has an accurate memory of the forms in the plant world as a result of years of practice, it will hardly ever happen that you are presented with an unknown plant and will have no idea at all about it. On the contrary, you will at least be able to name the family the new structure belongs to, if not the genus as well. This does not happen by any means in the manner proposed by associative psychologists, such as Semon. These older authors thought that the impression was made up of characteristics: a + b + c … + n. If a new impression is made, it is assigned to an old category, for example, because both share the component d. We are convinced today that it is mostly not a single unit which allows a classification, but the total *Gestalt*, a related totality, a style.

An expertise is characterised by having a knowledge of infinitely many styles. A Delacroix painting is not recognised by the fiery red and Renoir not by his intense pink. The colours do play a role, but the expert has an overall formula available for 'Renoir'. If the expert is standing unexpectedly in a strange gallery in front of an

unknown painting, he thinks immediately of the 'Manet school' and then 'Renoir'. In the next moment, he remains with the first opinion, checks the second opinion uncertainly and then decides confidently: yes, it is a Renoir. What does 'checking' mean in this context? The expert certainly does not look for the signature, or any other detail. It is rather the case that he allows the whole *Gestalt* to act on him for a moment and then makes his judgement. Hofstede de Groot showed JP v. d. Kellen two small Wouvermann pictures which had been in private possession in Vienna and which he had bought at once, as the master had exceptionally departed from his normal subjects (goats and roe deer) and also – perhaps for this reason – had selected another painting style. Hardly had Hofstede de Groot entered the room, carelessly holding the painting, that v. d. Kellen called out 'Wouvermann!'

Hofstede de Groot thought that an overpainted old picture was an early Rembrandt. He sent it to the restorer Hauser for cleaning. The latter reported that the picture was not genuine. The colours come off. De Groot telegraphed back – Go on washing them off! An early Rembrandt was really revealed.

This is intuition, the *expert's intuition*. Precisely based automatisms asserting themselves. Insights do not need to be gradually developed, but are there at once. Try asking such an expert about the proofs for such a rapid and reliable assessment. He may laugh and answer that there is no proof. That's just the way it is.

I know a poorly educated and simple graphologist who has often surprised me by the accuracy of his graphological opinions. If you asked about the reasons for his assessments, he would start on a pitiful pseudoscientific speech in which nothing was convincing and nothing could be understood. But his assessment was correct.

You find this sort of expertise everywhere – not only in art and the senses (wine experts), but also in purely mental matters. We will not consider the role of memory in expertise here. Suffice it to say that there are people with excellent memory but no expertise, although the converse does not occur.

You can formulate it as follows. Intuition is automatic assertion of expertise.

This does not only apply to assessing the style of a picture, an artist or a collection of works, but also to an epoch, the spirit of a period, an expression, a human being. Psychological expertise is thus the automatic immersion in the nature of another, based on expertise. Nothing is calculated here, but 'the other' is there at once. Ingenious people have used the original character of this concordance to argue that man "has a sense which communicates to him the knowledge of the life of other souls". For example, Scheler avoided the task of explaining empathy with others by simply postulating the existence of interpersonal understanding. In this context a number of not very clever sayings were formulated. For example, human experience cannot develop anything that was not already there. This is not the place to examine the origin of expertise. However, once it is there, it can be directed towards very different objects. Just as you can intuitively recognise the style of a painting, in other words, the evident handwriting of the artist, you can apply expertise to the expression of this painting. If you are sensitised by endless practice, you can react immediately to the spiritual stimulation with which the master has imbued his music. The same applies to people as objects. Experts can recognise the style of the living form and its motions immediately (perhaps after decades of separation). Experts can look at a silent and internationally dressed girl and say immediately that she is Italian. Experts can transport themselves into the internal processes of the neighbour and not only 'guess' what is happening there, but also the motives which cause this.

I am as little able to say how I train the synergies in my larynx so that it can sing the note depicted in front of me as I can explain how I have attained the psychological intuition which I possess. A lot of experiment and practice was needed for both. Perhaps this is a good example to illustrate how both intuitions are equally natural or marvellous. Psychological intuition does not contain anything more marvellous than the whole life of the soul. He who has the luck to wonder at the grain of sand as much as at the heavens will not wish to exclude mental life. However, those with the scientific tendency to recognise and systematically to classify all phenomena in the world will not wish to exclude mental life, just because it is

mysterious. As hinted above, the expression that the psychologist or the graphologist has a 'feeling' for others, or that intuition is a feeling, or that the procedure of intuition is related to feelings, are ideas that must be totally rejected. Feelings only play a role to the extent that the *object* of the intuition possesses them and that these are, therefore, objects of my intuition. In addition, I, who have the intuition, can be infected by the feelings of others and can then have them myself (so-called manifestation view). There is therefore little to object to in the use of the word 'empathy' (as in Herder) in less than precise terminology, as the feelings of the other are exactly what is the object of interest when there is intuitive understanding of another person. However, *the act of intuition has nothing to do with feelings*, but remains an automatic act of knowledge by an expert.

If it is not only a question of intuition into the current state of the other, but of recognising the origins of this state, its motives, possible intentions, goals and other connections – if intuition into the entirety of another human being is meant – the situation of the intuitive subject is exactly the same in principle. It has been said that registration of the feelings of the other is only a repetition of one's own feelings, so that this is just a matter of experience. This also applies to some extent even to the registration of a whole personality, although this also includes registration of relationships outside one's own personal experience. This is correct. Thus, the registration of the other's whole personality structure is not a matter of intuition, but of the intuition of expertise. But not quite this either, as expertise has no reason at all to restrict itself to unconscious reproduction of what has been experienced. For example, the expert can recognise a feature in an artist's personal style whose further development can be anticipated by the expert. Or an expert can register the style of a master so acutely that he is capable of predicting that the following change in style will occur when the master gets to know Italy. Later findings have often confirmed predictions of this sort.

Not only the thinker and the artist have 'brainwaves' in which they are the 'scene of action' of new insights, the recognition of new relationships, combinations or forms. The observer is also capable of this. I would like to remind you of the example of the egyp-

tologist Brugsch given above. Extensive knowledge – in this case, insights into the relationships between optical forms and meanings – were so accessible to the researcher that new combinations were automatically formed. This may be by chance. Indeed, a pun or a joke can unintentionally produce new insights, although these can also progress through analogies or similarities. An intense feeling can transport thoughts into new areas, leading to totally new relationships. This, too, is automatic behaviour. Then this concept is not characterised by the reproduction of what is already well known – the example of expertise could lead to this error – but by the characteristic of the lack of specific intention, the feeling of being the 'scene of action'. In the recent debate between Pfitzner and Bahle, I would, therefore, support the views of the musician, in substance if not in form, namely that the act of artistic production produces something genuinely new, something which was by no means anticipated, gradually developed or formulated, but that it really came from Zeus' head, like Athene.

This is a scientific discussion and it is not my intention to engage in an investigation of the mental or artistic process of creation. Only *psychological intuition* will be discussed here. It must be stated that this, too, possesses a productive and creative element. Oddly enough, in the context of aesthetic theory it has been occasionally proposed that a portrait painter must be similar to his model or, at least, mentally equal. This is presumably what Lessing meant when he said that the artist could not put more into someone's head than he had in his own. Waetzold quotes Matthias Claudius with the verse about the painter who painted Socrates:

Otherwise I get everyone right. Just tell me:
Why not this one?
Answer:
First be a great man like him,
otherwise just paint the little men

This is a total error of course, like demanding that a historical biographer must be the equal of his subject. There is however *one* big difference between the portrait painter and the biographer. The painter cannot and need not bother himself about his model's soul. His intuition does not apply to the internal life of the subject, but

only to externals. If the artist registers the externals completely, then he also registers the internals. The form contains the content. However, a painter would never achieve his goal however carefully he studied the *works* of a dead man and then wanted to paint him. (Astonishingly, this has been suggested by Watts.) The portrait painter must only immerse himself in the form. However, the biographer has only the possibility of constructing the essential character of his subject on the basis of all available documentation and then transmitting this intuitively. Both act intuitively and productively. Just as the inventions of the artist are not bound by the facts of nature, but can be allowed free rein, the poet can form his creations as he wishes and, in exactly the same way, the acute psychologist can allow his sympathetic imagination free scope. The difference is that the psychologist and the biographer must keep to the reality of life and the documents, while the poet is not restricted in the same way. The common characteristics of productive intuition are presumably why the latter is described as artistic. This is an error. Intuition is used in science (history, psychology) and in art, but is essentially not artistic. It is wrong to say of a historian, as is occasionally the case, that his procedure is artistic or poetic. No, he may be intuitive, but he is not a creative writer. If the term artistic is used for the historian or, particularly, for the biographer, this can only be applied to the form he uses for his scientific work. To formulate it once again: *Intuition is unrelated to art and is used by experts, psychologists, historians and artists.*

Intuition, as I said above, is a gift. In particular, productive intuituion which produces something new is a talent. There are psychologists and historians (e.g. Haym in his Herder) who possess this quality to a high degree and others who collect large amounts of material, but are incapable of intuitive synthesis. There are also biographers who superbly articulate the mental achievements of their subjects and brilliantly depict their relationship to the ideas of their time, depicting the influence of the period on the subject and of the subject on the period, but who shyly and clumsily ignore their subjects' personality (Justis Winckelmann). Finally, there are biographers whose intuitive talent overcomes their scientific self-criticism, converting a biog-

raphy into a biographical novel, a category which is currently in great fashion.

I have already hinted above that the ability of a sympathetic psychologist to immerse himself intuitively in another living person is unrelated to his intelligence. It may be added that this gift of empathy may be applied in a highly developed form towards the literary or historic model, but is a miserably unsuccessful when applied to his own child, wife or pupil. There are many examples of schoolteachers who write studies of some significance on intuitive insights into artistic or historical relationships, but who are psychologically helpless when faced with the pupils entrusted to them. Practical knowledge of human nature and leadership are behavioural forms with a totally different basis from theoretical or instructional intuition. The biographer has an easier time with his historical subject. He finds a certain number of dates, statements, deeds and works and can then imbue this body with his intuition while sitting at his writing desk. In other words, he can develop the connections with which Dilthey occupied himself to such an extent, both theoretically and practically (particularly in his Schleiermacher). However, there are also people (I don't really know if they can be called researchers) who do not possess the ability or interest for intuitive penetration into a single life, but who compose general aphoristic essays on the knowledge of mankind. Without special research material, without systematic work and only on the basis of general knowledge of human nature and intuition, they express insight into human relationships which communicate knowledge. The essential character of intuition is especially evident in these authors of aphorisms, who release themselves from the effort of proof or literature research. They utter loose inconsistent theses from their treasures, just as if they were the administrators of original anthropological wisdom. The more elegant is the form they use, the more enchanted is the reader. German literature is poorer in such figures than is French literature. Lichtenberg and Nietzsche are often given as examples of this genre. Here are some examples from Nietzsche:

"If it were not for curiosity, less would be done for those nearest to us. However, curiosity sneaks into the house of the unfortunate

or needy, under the name of duty or sympathy" (Menschliches, Allzumenschliches [Human, All too Human]). This asserts that curiosity is a motive for helping others. Many sufferers feel their pain twice as intensely when they are comforted by the curious. But is it not the case that *people who practise charity* are those who are actually free from curiosity and that *those who* just *talk about* it are often driven by curiosity? Thus Nietzsche's first sentence seems to be either wrong, or at least unfairly exaggerated.

"He who is unsatisfied with himself, is always prepared to revenge himself for this" (Die fröhliche Wissenschaft [The Merry Science]). In this example the intuitive discovery of a new relationship is much more evident than in the first example. 'Dissatisfaction with oneself' as a motive for revenge: certainly an unusual but, nevertheless, enlightening relationship. One is familiar with revenge from wounded honour, revenge from rejected love, revenge for damage suffered, revenge for hate for any reason at all. Perhaps someone will want to revenge himself on the whole world for his hunchback. The pubescent prole revenges himself for his poor lot by trampling the rich man's flower bed. Indeed, even before Nietzsche coined this phrase we knew cases which fitted his description. But just think about the aphorism once again "He who is unsatisfied with himself, is always prepared to revenge himself for this" and you become a little uncomfortable about the dogmatic character of this sentence. One knows innumerable people who are unsatisfied with themselves, but who would never think of revenge, even subliminally or symbolically. On the other hand, among the innumerable cases of revenge one can think of only a few in which dissatisfaction with oneself or one's situation was the prime motivation.

"Teasing always shows how pleasurable it is to exert our power on others and to feel our superiority (Menschliches, Allzumenschliches [Human, All too Human]). Who can doubt that everyone has sometimes teased as a result of consciousness of his power? But '*always*'?

This leads to a restriction of the psychological value of aphorisms of this sort. They want to stimulate, dazzle, impress or be paradoxical. This literature genre is primarily intended for the educated layman, not for the scientist. The linguistic form is often

impressive and may even include puns. It brings the kind of spirit into the German language which is commonly known as esprit. The unexpected character of the intuitive relationship always compels you to think or to brood. It shakes customary ways of thought and may act like a bomb or firework. However, once such a saying has been subjected to critical examination, with a mixture of trepidation and amusement, it loses its shine, the surprise vanishes and what is left is the somewhat paltry recognition that the suggested relationship really does occur occasionally in real life. The aphorism often shines with the ambiguity of its words or the indefinite character of its concepts, which are the only reason that it is possible at all. In short, proof is not supplied or only with difficulty and reservations. It has presumably been occasionally stated that the value of a thought or insight into a relationship is unrelated to whether it often or only rarely happens in real life. This is correct. However, an insight of this sort easily becomes just a curiosity.

All psychological intuitions are only suggestions, be they sympathy for the hero's specific motivation or general human wisdom. They will first be checked for their evidential basis, i.e for the *possibility* of a relationship. For example, whether there is a connection between striving for recognition and striving for mastery of those nearest (Nietzsche's Morgenröte [Dawn]). This *possibility* can readily be admitted. However, it is of psychological rather than philosophical interest to examine whether this is a frequent or rare general human motive. Of course, any award is an advantage over the others, although the satisfaction about praise in the press or the receipt of a medal is in many cases the same as that which a woman feels about her clothes or jewels: "It suits me", rather than "I overcome the others" – not even subconsciously.

This example points out once again the lack of convincing character, the unnecessarily generalisation of a rarity or the literary exaggeration in many intuitions of the psychological aphorisms. They may be of greater weight for the philosophical study of values, I will not discuss this here. It is only worth adding how scientific discomfort with such sayings increases when their object is not the behaviour of the individual, but of the *group*.

"The race is corrupted, not by its vices, but by its ignorance" (Wille zur Macht [The Will to Power]). What does Nietzsche mean with the word race? How can a race be corrupted? How can ignorance be inherent in a race? How can you compare ignorance and vice? So many words and so many question marks! Everything sparkles but is alarmlingly indeterminate. The intuition dissolves into something unsubstantial. This is why such sayings earn such applause, because everyone can understand them differently. This is perhaps the reason that the French sayings are particularly impressive in comparison with the splendour of Nietzsche's sayings, as they state intuitions with inimitable linguistic precision. The shorter they are, the more convincing they are. They delight an educated public which enjoys clever ideas. You like to dream about them, but they fall apart when gripped hard, as is the duty of the scientific researcher. For the scientist, evidence does not mean surprising illumination, but ability to withstand testing.

The physicist has a series of formulas which he uses to calculate a result. This is mathematically perfect and passes all tests. However, I still may not understand it. This is of course my problem, related to the inadequacies of my education in physics. I hear an imaginative aphorism which expresses an intuitive relationship which immediately appears evident to me. However, as soon as I attempt to show that this relationship acts in the psyche, I find that it is wrong. A distinction must thus be made between examination of the evidence as evidence and an examination whether the apparently self-evident saying also applies to real life. No answer can be found to the question of how evidence is tested. Think of an example from the area of logic. A mathematics teacher demonstrates a geometrical proposition and develops the corresponding formula. A small proportion of the pupils experiences illumination immediately. This is how it must be; nothing else it is possible. Most of the pupils accept the relationship like much else in life. It *is* evidently the case. You must take note of it, but it is not illuminating. A German butterfly, the so-called wood porter (Satyrus hermione) has a striking resemblance in our eyes to a wilted leaf when it has folded up and turned over. People

speak of mimicry, protective colouring, the struggle for existence, survival of the fittest. Some of the listeners are enthusiastic: how illuminating this is. However, the expert knows that the animal has no enemies at all. It does not need the protective colouration; the relationship is not illuminating. Here are two quite different forms of illumination. On the one hand, there is a complete chain of thought, on the other, the question whether it is applicable to reality.

But let's get back to psychology. A research worker who has immersed himself in the personality of a model suggests that the motive of a specific action *b* is a characteristic trait *a*. This is examined as a general question, with the result that *b* can result from *a* (evident). However, *a* is not present in the model like a characteristic fossil in a geological layer. It may only have become evident on the basis of other cases in which the same *a:b* relationship seems to hold (analogy). Alternatively, the model confirmed the presence of *a* in himself or other biographers have asserted that *a* was present in the model. If this is accepted, this *a* must be borne in mind in all future considerations of the personality of the model. It must become evident and be active under other circumstances. If this is the case, the biographer has the right to refer to *a* in the case of *b* too. This is then associated with other personality traits. An intuitive psychologist may suggest an overall structure for the personality and this structure is retained as long as it is capable of 'explaining' all essential statements, deeds and works of the central character. If essential modes of behaviour cannot be derived from this structure and not be explained as disturbances, a new structure must be proposed.

Each intuition is then only a suggestion which is retained until replaced by a better one. There can never be a proof. The so-called evidence for the interpretation of a human has thus shrunk to the modest significance that it provides the best current insight.

It was said at the start of this study that intuition was not trusted because it could not be tested. The final conclusion must be that the evidence of intuition should certainly not be trusted, but that it should be tested whether it provides the best and most consistent insight into psychological connections.

2. Knowledge of Human Nature[2]

Isn't knowledge of human nature the same as psychology? Not at all! Psychology is the comprehensive study of mental functions, with all its connections to nature and culture, and is a complicated science which is accessible to few people. Knowledge of human nature is the continuously renewed experience with the living people who I encounter. I have known some learned psychologists who do not possess a trace of the knowledge of human nature. I have seen young students who were hungry to learn more of human nature and who have laid a psychology textbook aside in deep disappointment, because they had expected in vain to achieve greater knowledge of human nature by reading it. In the final analysis, we are interested in each other and want to learn more. We must practise this on the stage of life, just as the skier must acquire his art on the practise slope and underway. This does not exclude the possibility that both may achieve modest benefit later from a textbook.

The small child practises practical knowledge of human nature from the first months of life. He sees and notes the benevolent, angry, laughing or crying face of the mother. He notices the pleasant and painful experiences linked with each facial expression. He learns to understand expression. How easy it is to say that and how difficult it is to analyse this statement. But just let us naively assume that we know what it means to understand expression. We then see that we make rapid progress here. Without our being able to analyse the procedure, we know that our vis-à-vis's face betrays his emotions. A mother may perhaps say of her child that his face is an open book to her – although this is not a particularly fortunate expression. But then the disappointments come. The strange face does not show what is really happening behind it. It is not even empty, but portrays internal events which are not happening. The face has become a mask. Try taking a real mask, perhaps one out of Percynski's book on Japanese masks. We are only confident of solving the mystery in a few cases. In most cases, we can say what they are *not* expressing. However, in the search for *what* they are actually expressing, we do

2. Possibly published in: Kölnische Zeitung, 9, 1943.

not find anything specific, but just a range of expressions, which can be associated with the mask, like 'tension'. But how many sorts of tension there are! Admittedly, the mask is dead. In real life, we are so used to how expression rapidly changes, how individual mimetic excitation rushes over the human face, that we find an immobile, stiff face unsympathetic, suspicious or even scary. The immobile face of Dürer's so-called melancholy admittedly seems beautiful to us, but at a mysterious distance. The amimetic face of a person with meningitis is horrific to us. When we see the open and friendly face of a young person, with its constantly changing features, this awakes our confidence. We think we can follow these expressions, even though we would be incapable of classifying one of these expressions to a definite emotion. The same applies to gestures. Many movements, such as bending slightly forward, shrugging the shoulder or a small movement of the hand, seem familiar to us. Perhaps we had not expected these gestures exactly then, but they are appropriate to the situation. But just remember that two good actors can 'understand' exactly the same role quite differently and that both versions are not only possible, but equally satisfactory, and that this then presents a problem. We are astonished to notice that there is only a loose correlation between expressions and their underlying emotions. One actor is not superior or inferior in expression, but uses different gestures, without this bothering the observer, whose knowledge then comprehends the nuance of expression and the breadth of scope of possible gestures. It can even happen that a great actor captivates us to such an extent that we accept odd gestures as being particularly well suited for the feelings represented.

There are few mental abilities which are not preformed in the individual and can, thus, be possessed to a large or to a small extent, i.e. the individual can be richly or poorly endowed with that ability. This is also true for our knowledge of human nature, which seems to provide us with a direct insight into the emotions of our vis-à-vis, but in fact only provides indirect access. One knows people who are withdrawn, are open to the world, mostly intellectual, who are insensitive to others. A lot may happen in the hearts of their family members, but they don't notice it. They may be compared with unmusical people. They listen politely to the trio, but it does not

move them. Try presenting them with a Kretzschmar concert guide and read to them about the notes, the impetus or the hero's desperation, they might follow the sequence of the notes and understand some of this and some of the expressed thoughts. But spontaneously they remain empty. But there are other people, who are often less intellectually gifted, who have direct contact with their fellow men. Each expression in the other is reflected in their own face. I notice this when speaking in small groups. I see dignified people who seriously and attentively follow my thoughts and others whose faces light up in response to my words, or who even imitate my gestures. But don't conclude from the comparison with musical people that these are individuals with good human knowledge: they may follow each sound and expression, but are, nevertheless, insensitive to people in life, are often clueless and often deceived.

There is, therefore, a human ability to react to other people and be influenced by his feelings which different people possess in differing degrees. Some may practise this ability quite naively, some may develop it into an expertise. It can really grow. We could say of those that they are very suggestible. But do not forget that there are two quite different forms of suggestibility. Some are immediately influenced by a foreign *thought*, so that they make it their own (propaganda), but others are only infected by *emotions* (panic).

Knowledge of human nature is admittedly much more than being easily infected. The subject must also account for this and then consciously pay attention to the other party. Expertise does not mean that one only notices the partner's emotions, whether he means one well or not. Beyond the present moment, one wishes to know whether the neighbour is a warm-hearted impulsive person or coolly calculating. In other words, one wishes to penetrate into his character and background. This is more than mild sympathy. This requires an intense mental effort. You must understand the other, remember him in this or that situation, what he looked like then, how he reacted and what he said. You must have experienced him repeatedly in the same situations and also in new situations. You must resolve instances of apparent contradictory behaviour, and finally comprehend his personality so well that you can predict how he will behave in special circumstances.

A brother meets his much older sister after a long absence and they have a relaxed conversation about the character of their mother. The son then hears to his surprise of how his mother used to have passionate attacks of temper, which he had never experienced. He only knew her as a kind, mild, soft and supportive being. He would have thought her incapable of violent attacks of temper. The memories of the older sister extend back to a period when their parents were still young and they often had violently different opinions. The son knew the mother solely as a mother. Thus, your knowledge of human nature can be quite wrong about someone whom you have only seen in similar situations. I watched a young girl grow up over many years and thought that I knew her really well. I then see her one day when she has become a lover and am surprised how many new personal characteristics are, shall we say, unveiled or created by her new internal situation? Or just think about the war. How many facades of artificial restraint are broken down by the impact of war to reveal unexpected traits! One becomes cautious when one tests one's knowledge of human nature on familiar individuals. One is even more cautious when one thinks about *general* knowledge of human nature. The expert will certainly come to the correct conclusion sometimes with strangers. However, he will much more often be wrong. It is particularly difficult to interpret people who are not expressive, however, even in the case of expressive individuals, full of exuberant bonhomie, it may be impossible to look behind their mask. But however great the individual differences are, an expert can of course recognise distinct types of human beings, with all its nuances and different backgrounds – without being able to explain his ability.

Knowledge of human nature in the sense of understanding personalities of course includes answering the question 'Why?' – in other words, of understanding someone's motives. This question occurs repeatedly when the life of someone who is already dead is being discussed. This is in fact the central question in any biography. Answers can only be suggested by someone with expert human knowledge. The most brilliant intuition is often wrong here. This insight leads to an eccentric literary genre with precious few rep-

resentatives (Should we say thinkers or poets?) in Germany – e.g. Jean Paul, Lichtenberg, Nietzsche – but which has flourished in France, with e.g. Abbé Galiani, La Roche-Foucauld, Pascal, La Bruyère, Madame de Staël, Amiel.

Reading these essayists is enormously enriching. They make enormous efforts to propose *possible* motivations. They unroll a tapestry of spiritual possibilities.

Madame de Staël: "Vanity is benign if it can show itself. If it has to hide, it becomes bitter out of fear of discovery. It then masquerades as boredom or indifference. It tries to make it clear to other people that they are not needed". An experienced person will be able to think of examples. Doesn't this clever and informed adage support the idea that you can enrich your knowledge of human nature by reading the essayists?

These essayists sometimes leave the field of the spiritual motors of the individual and address the motives of the group, people or nation, in the conviction that they can say something about their motives. Jakob Burckhardt considers that the innovative strength of some people is related to perpetual dissatisfaction which creates boredom at each new stage, and thereby creates an ongoing demand for new developments. We are quite happy to reflect about this for a few moments, but has anyone ever seen bored people and who are they then? Creativity from boredom?

Finally, there are some thinkers who construct an image of 'the' human being, in the absolute conviction of knowing how *his* construction will act and for which motives. As it is his creation, his statement is incontrovertible. "The reason that the powerful man is grateful is as follows: His beneficiary has both attacked and penetrated into the sphere of the mighty through his good deed. As retaliation, he is now attacking the sphere of the beneficiary by the act of thankfulness". Is this saying of Nietzsche's enlightening? Was this motive at any time manifested? The thought is in fact enriching and inspires us to check its truthfulness. This applies to the whole enormous literature of human aphorism. The ability to empathise with individuals, which has its clear limitations, is here applied in a general and unrestricted way. However, it is quite unfortunate (Klages) when those fully unsystematic thinkers and

poets are called 'psychologists', when in fact this term should be reserved for the scientific researchers.

It might be assumed that a person who has an important role in life and who has the power over others would also possess knowledge of human nature. This is, unfortunately, very often not the case. I am not thinking about the teachers who do not engage in their profession for idealistic reasons. I am thinking of the politicians, priests and teachers whose real power, personal influence, and dazzling charisma is generally accepted. They often have very poor knowledge of human nature. Or was it not the case that Pestalozzi's many economic errors were at least in part due to his inability to see through his opponents. It is sad to see how often a great philanthropist was deceived and exploited. Lover for mankind and knowledge of human nature are often inversely proportional to each other. If you wish to join the aphorists, you could even say that knowledge of human nature excludes love of mankind. Some people who work all their lives for mankind are not acting from love of mankind, but from their knowledge of human nature and from a feeling of duty.

There is one group of people with in-born sympathy and knowledge of human nature: the confidence tricksters. They flourish too.

3. The Character of Man[3]

Many psychiatrists talk of a premorbid character, although few are aware that this is a type of contradictio in adiecto. This poor expression is intended to represent the undoubted fact that a real psychosis, such as schizophrenia, alters a subject's external behaviour and modifies the links between his motives, eliminating some and perhaps adding new ones. (The latter point is uncertain). If there are authors who equate behaviour and character, there is nothing to object to in their use of the expression premorbid character. However, most researchers will deliberately separate character and behaviour and would tend to support the thesis

3. Published in: Der Nervenarzt, 1947; 18: 71.

that behaviour betrays character. Character is then something in the background which causes effects. You can think of it as the nucleus in the casing, although this does not describe the causal role properly. Or think about a catalyst, which causes effects, without being altered itself. However, the comparison is inadequate, as a catalyst only alters the behaviour of *other* substances or at least permits the changes, but one and the same organism acts in character and behaviour. You can employ the image that the behaviour is more like a carnival mask, whereas the 'real' person is only hidden by the mask. This image is better, although it assumes that the 'real person' wishes to express his carnival behaviour. In contrast, the subject only deliberately expresses his normal behaviour in specific cases (even though these often occur). In many other cases, his behaviour comes automatically from his character. It would be inappropriate to regard the normal behaviour of the subject by using the image of a mask. The opposite expression is in fact used, that behaviour betrays personality. As is often the case with metaphors, they only depict one or other aspect of the phenomenon, but not the totality of the phenomenon. We must, therefore, attempt to examine the phenomenon without using metaphors or images.

If I request the reader to think about the unveiling of the character, this is just another metaphor. We would like to know what lies *behind* an action or statement. An effort is made to find the origin and the motive. I have already discussed the difference between motive and cause elsewhere.[4] I do not wish to discuss cause here. Taking the deed here as a simple example (any statement, attitude or emotion would do), if you detect the motive of a deed, you think you have succeeded in penetrating into a deeper layer of the soul, as you would say today. I am against the use of the terms depth and superficiality or of different 'layers' (as Hofmann, Rothacker and others would use today), as I wish to avoid both the cerebral and evolutionary connotations of layer and the connotations of evaluation associated with depth and surface. 'Layer' has too many connotations.

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4. e.g. in: Verstehenden Psychologie, Thieme Verlag , Stuttgart, 1948.

If we have successfully identified many motives for any given subject, then we might be able to discover a pattern, perhaps there is one motive which is revealed many times, perhaps there is a form of family resemblance which unites the different motives, or it might even be possible that those different motives are united into one structure, one building plan. We use the term 'motive' in this context obviously not in the same way as a lawyer, who says that the motive for theft was personal enrichment. An intention is a goal towards which the action is directed, whereas a motive is the origin from which both intention *and* action arise. Motives are, for example, avarice, meanness or anger. These are properly described as properties of humans. This leads back to the thesis that the underlying properties can be deduced from the behaviour. However, the concept of properties is difficult. It is possible to understand these as continuously present character traits. This is where the word 'continuously' slips in. This is intended to exclude moods and whims. An attack of rage is not a property and anger vanishes quickly. However, the continuous tendency to attacks of anger (roughly corresponding to the old expression of the choleric personality) is a genuine property. However, short-term emotions can also be motives. The interaction between motives is, therefore, not the same as the assembly of properties. A deed can be performed for purely rational reasons to achieve a purpose; it can derive almost from chance (e.g. in absentmindedness); it can also derive from a genuine property of the subject. It is the art of human knowledge to find the real motive.

When a deed is considered, for example, a crime, the word 'reaction' is often employed. The criminal reacts to a situation. For example, he reacts to a tempting situation in a store with theft. There are different ways in which we can interpret such a deed. For example, we might think of a reaction as it happens in a testtube, e.g. when a metal reacts with acid, both regularly and governed by the laws of nature. This example from the domain of the natural sciences is often used in psychology. The subject reacts to the situation in a way which is characteristic for him, compulsively, and, governed by the laws of nature. This thesis implies that "there is characteristic way for a given person", and this way is the arrange-

ment of his properties. The word arrangement is meant to imply that this is not accumulative, but organic. The simple expression organism may also be used. Seen in this way, a reaction is simply the answer of an organism to a situation in accordance with laws, the question in this context is provided by the situation. It may not be compared with the reaction of a metal to an acid, but with the reaction of living, contractible tissue to a corrosive agent. The tissue must withdraw or contract.

Another view of the reaction of the organism to a situation is that, although these reactions in accordance with laws undoubtedly exist, the organism, at least the human organism, has the possibility of *choice*. For example, it can retract or roll up in response to damage, but can also tolerate it or overcome it. Which of the three reactions it selects depends on its structure in two ways. It is easy to assume that the immediate automatic reaction without reflection represents its essential kernel. The other reaction, which occurs after reflection, is freely selected and is purely rational, perhaps based on usefulness. For example, in practical politics the subject may decide on the basis of rational reflection for behaviour which contravenes his feelings. However, the fact that he has the possibility of performing such rational behaviour and of not being carried away by emotions is founded in his essential properties, his structure.

It is usual to refer to this structure of continuous properties as character. A politician learns that his political opponent is corrupt. His first reaction is the plan to annihilate his opponent by revealing this. His second reaction is the rational decision not to do this, but to inform his opponent of his knowledge and thus to keep him under control and to paralyse his activity. It is a game of cat and mouse. A keen observer of human nature would conclude that cruelty is an inherent property of his character. On the other hand, the politician is not cruel at all, as he is acting from cleverness. Cleverness is not a property of the character, although it *is* a property of the character to rein in your actual personality in many cases and to let yourself be directed by cleverness. This example is intended to make it clear that it is very difficult to recognise the true properties of the personality on the basis of behaviour. Many authors have made desperate attempts to understand the real per-

sonality of the emperor Augustus. In his 12 years of war he was irascible, coarse, hard, cruel, deceptive, avaricious and dissolute. After he had attained his goal he was cool, adaptable, mild, serious, reliable, incorruptible, just, kind, thankful, loyal and cheerful. This is how authors describe him. Which properties describe his true character? Thomas de Quincey seems to have got it right. He considered that the characteristics of his early years betray Augustus's genuine personality, but that these characteristics were suppressed but not extinguished by his intelligence and his self-control, which matured greatly with time. This is then why the historian could say: "But nobody loved him anyway" (Hönn).

It is quite improbable that character changes. It is a characteristic which is defined in advance as having a constant structure. Its entelechy lays down its possibilities and limits. However, it is manifested in very many ways. A subject's behaviour is never a reliable mirror of his soul. Many potential abilities are not 'exploited' because fate did not provide the opportunities to betray them (Pfänder). These manners of behaviour frequently point to basic properties which are not basic properties at all, but only facades or masks, intended to hide true characteristics, perhaps for purely rational reasons.

It remains unclear to me whether the introduction of the terms genotype and phenotype into general genetics was desirable or necessary. But it is clear that those terms have no place in psychology. The structure of the character is an elementary part of the individual which was part of it since the individual's conception. The extent to which this constitutional impression is realised in the life of the individual is dependent on many external circumstances in the environment, individual fate and also from the individual himself. Many fundamental features are masked throughout life. Others are evident from early youth. Some characteristics are easily recognisable, even though they are continuously hidden behind a recognisable mask. A character is by definition something which never changes, however disparate its reactions and manifestations may be. However, a character can be destroyed by real psychoses, e.g. by schizophrenia. The structure may be totally destroyed or mutilated (cure with defect). It often used to be discussed whether the character was manifested in the richness of the symptoms in the

course of schizophrenia. There are many possibilities. Some aspects of the character may occasionally be evident in the stormy phase of catatonia. Sometimes there is no evidence at all that the character has survived. There is, thus, a character and there is psychosis, which can damage it or destroy it. However, there is no sense to the term of premorbid character.

Character as individuation is, thus, an entelechy which was fulfilled during the conception of the individual. This is the only way to see it. The genomes of the parents must interact. There are three possibilities.

1. The interaction has no result. The organism of one of the parents is victorious. The inferior part vanishes. The child's constitution is the same as that of one of the parents. The constitution is inherited.
2. The interaction mixes up the traits. Some of them vanish. The others give a combination, which, taken together, is a novelty. The individual traits are inherited, but as a whole the structure is new.
3. The interaction is a genuine interaction. There is no displacement of parts or of the whole, but a real fusion in the sense of the chemical combination of two elements. An absolutely new form appears. The traits are not inherited.

Which of these three possibilities is realised depends on how the parental material interacts. This can never be predicted. You can never recognise whether a trait is fully or partially inherited or whether it is totally novel, a new form with new entelechy. A trait and a hereditary trait are not the same. The character is a trait.

It would be logical to refer to the collection of traits as character. However, the majority opinion is to omit intelligence from character. It is regarded as relatively foreign to the personality, as a tool belonging to the equipment, but not to the character of man. The subject *possesses* intelligence, but *isn't* it. This means intelligence in the broadest sense. The other parts of the soul are included in character. These mainly include the spheres of will and feeling. These are supported by the expression of temperament, mimicry, gestures and physical style. Character is, thus, the individual unity of factors of will, feeling and temperament as an unchangeable trait. The character in its entirety with all its possibilities and

limitations can never appear. It can only be deduced on the basis of statements, deeds, behaviour, posture and expression. Character is the regulatory principle, the ordering and managing idea of the individual. An idea cannot appear. The word phenotype is meaningless in this context. Up-bringing cannot change the character. It forms the reactions of the character to the situations it creates for teaching purposes. By structuring the environment (in the broadest sense), it forms the individual's life image. The individual's life image changes with age and under different circumstances and was referred to by Pfänder as the empirical character. He contrasts this with what he designates the basic character, which is what I have attempted to describe here. It seems more expedient to me to use the term character strictly and only for the constant basic character. If you have got to know many characters (more exactly, constructed them as individual ideas), you can combine these arbitrarily and fuse them according to your fantasy to give new organisms. In this way, a character *type* is formed, not as an average (there is no such thing as an average character), but as a distinct type. You can then of course test whether an individual is a close approach to one of these types or not. The term mixed type is meaningless.

It is clear from the above that a characterology has not yet been written. There is a series of books (Kronfeld, Prinzhorn, Hofmann etc.) which summarise the above ideas on character definition and description. It is quite wrong to describe Theoprast as the first characterologist. He only illustrated single character traits (no forms or *Gestalts*) in his images using simple anecdotes. Moreover, it is not quite correct to describe Ludwig Klages as a characterologist or, indeed, as the founder of modern characterology. He presented a rich, vivid and very useful review of aspects which should be used in research and description of character. However, as far as I can see, he never addressed the problem of describing character structures or types. Type research has been zealously practised in the last two decades (Jung, Kretschmer, Jaensch, Pfahler), but employs a weak and vague definition of type. It is a long way from characterology as described here, if only because these researchers only restrict themselves to a very limited number of types (mostly only 2 or 3). This is a bit paltry. There are fine descriptions here and

there in biographies. Wilhelm von Humboldt's sketch of his wife's character may be mentioned as a successful example. Haym's large and fine biography of Herder may be mentioned as an impressive, rich and ambitious biography of a very difficult subject. The old and somewhat eccentric Bahnsen undertook a skimpy attempt to describe character types.

The psychiatrist has the daily or hourly problem of deciding whether a given patient has a unique character and how this character is structured (psychopathic character), or whether a normal character has reacted in an unusual manner to unique circumstances (e.g. pathological reactions to the war), or whether a newly arisen psychosis is disturbing or destroying the personality. For example, it appears that manic depressive disorder leaves the character untouched, but only forces it into a manic or depressive role. It seems that paralysis does not annihilate the character, but only its equipment and confuses its behaviour. It seems that schizophrenia seizes the character itself and dislocates or destroys its structure. For example, it would be an interesting task for psychopathological research to find out whether the types listed by Kurt Schneider are really characters or just forms of life. There has hardly been any research on this.

Kurt Schneider (1887–1967)

Kurt Schneider was born in Crailsheim on 7 January 1887. He studied medicine in Tübingen and first came into contact with psychiatry in 1912 as a doctoral student under Gaupp, a student of Kraepelin. The philosophical basis for his psychopathological and pathopsychological views was due to the influence of the philosophers N. Hartmann, M. Scheler and K. Jaspers, with whom he corresponded for decades. Gaupp recommended K. Schneider to Aschaffenburg, who was another of Kraepelin's pupils and an important criminologist and forensic psychiatrist in Cologne. Kurt Schneider's achievements during this period included qualification as university lecturer ('habilitation', 1919), a doctorate in philosophy (1921) under M. Scheler on his theory of feelings and important studies on "The Stratification of Emotional Life and the Development of Depressive States" (1920), "Abnormal Emotional Reactions" (1927) and "Psychopathic Personalities" (1923). The latter was based on studies on the fate of Cologne prostitutes (suggested by Aschaffenburg) and is even today the foundation for all attempts to conceptualise and classify abnormal personalities.

In 1931, Kurt Schneider was appointed director of the Clinical Institute of the German Research Institute for Psychiatry in Munich. There he perfected his approach of lucid analytical and descriptive phenomenology, with the critical and continuously developed empirical systematology, classically known as "clinical psychopathology". The first rank symptoms worked out by Schneider are an early example of operationalised criteria and have, even today, a major influence on the diagnosis of schizophrenia in the international classification systems.

In 1946, with Jasper's support, he was appointed professor at Heidelberg, replacing Carl Schneider, who had been involved with National Socialism after the removal of Wilmanns in 1933. Kurt Schneider had always rejected this ideology, so that his appointment represented a re-establishment of the continuity of ideas characteristic of "Jaspers, K. Schneider and Heidelberg psychopathology" (Janzarik, 1984). His achievements in this period include the article on "The Assessment of Criminal Responsibility" (1948), which has been extremely influential in criminological and legal literature because of its striking clarity, even though the underlying concept of somatopathological disease has since been qualified. He also delivered the Heidelberg rectorate speech on "Psychiatry Today" (1951). Up to his death in 1967, eight (currently 14) editions of his book "Clinical Psychopathology" appeared. This has now been translated into seven languages. In contrast to Jasper's brilliant "General Psychopathology", Schneider's work became increasingly succinct with each edition. This work was first published in 1950 on the basis of earlier drafts and was said to contain "what I have to say about pathological and clinical psychiatry, on the basis of my own knowledge and what I regard as correct".

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Clinical Taxonomy and Concept of Disease*

I.

It is not possible to have any insight into clinical psychopathology unless two things have been clearly established: 1. The mentally abnormal can occur, firstly, as an abnormal variant of mental being and, secondly, as a consequence of diseases (and malformations). 2. In this second group, the usual diagnostic concepts and terms are partly somatological and partly psycho(patho)logical. The diagnosis is established here on the basis of a dual approach. These two aspects must also be taken into account when classifying the clinical forms if we are to avoid a categorisation that is epistemologically shallow and produces only an apparent order. The system of clinical psychopathology is at the same time that of clinical psychiatry.

For obvious reasons, it has already been frequently remarked that psychiatric taxonomy uses partly physical and partly psychopathological findings. Körtke expressly demanded a dual taxonomy, but did not implement it. We would have to refute the individual features of his attempt one by one. J.-E. Meyer recently recalls a barely known and, also to us unknown, proposal for a dual taxonomy developed by F. Hartmann. However, because of the completely different methodological and clinical approaches, it is not comparable to the one presented here.

We base ourselves in our considerations on an *empirical* dualism.

With regards to the *metaphysical* interpretation of the body-mind relationship, we take no stand. Even if one is not a dualist in meta-

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*Reference: K. Schneider. "Klinische Systematik und Krankheitsbegriff". In: *Klinische Psychopathologie.* Georg Thieme Verlag, Stuttgart, 1931; 8th edition, I–II: 1–15.

physical terms, in the case of paralysis for example one has to say that a specific change in the brain has 'caused' dementia – or at least, that the dementia 'corresponds' to the change in the brain. These relationships can in fact hardly be expressed in any other way, except in a very cumbersome and to some extent unnatural language. Closely allied to this approach is the fact that, in psychoses of unknown physical origin, a physical cause is postulated hypothetically. We have, therefore, adopted this generally accepted empirical dualism as a basis.

We arrive at the following taxonomy:

I. Abnormal variants of mental being
Abnormal intellectual predispositions
Abnormal personalities
Abnormal behavioural responses

II. Sequelae of diseases
(and malformations)

Somatological (aetiological) order:	**Psychological (symptomatological) order:**
Intoxications	
Paralysis	
Other infections	
Internal diseases	**Acute:** confusional state
Brain malformations	**Chronic:** mental deterioration
Brain lesions	(congenital: mental
Cerebral arteriosclerosis	retardation) and
Senile brain diseases	dementia
Other brain diseases	
Genuine epilepsy	
?	Cyclothymia
?	Schizophrenia

Physical causes or correlates may also be assumed in group I. It is, for example, entirely logical to conceive of a certain constitutional

physical condition as the cause of abnormal personalities. At any event, it would be meaningless from our perspective, if for example a person were to react to an experience by way of despair, to seek the origin in the physical. However, the possibility that reactive depression of mental origin might correspond to something physical is also conceivable. Thus, one may assume physical correlates in the left-hand column in group I as well. However, they would have to be seen as morphological or functional variations and not as diseases – in principle, no different from the physical processes that correspond more or less to normal mental life. We can consider them to be likely for all or for some, accept them in some form and either believe in correlates for all or doubt them. In order to prevent any possibility of confusion with diseases, we have not arranged group I in the same way as group II; in other words, we have not listed the clinical terms on the right in the column of psychological findings and inserted three question marks on the left in the column of somatological order. It is in fact a completely different situation from that pertaining to group II, the group of diseases with consequences on the mental plane. At all events, it is only with this group that the diagnosis is a dual one.

If a scientifically rigorous definition is needed for what a 'psychosis' is, we would say: all those and only those mental abnormalities that fall into our group II, in other words, that are 'pathological', which for us also includes the sequelae of malformations. In this case, an abnormal behavioural response, however severe, would not be a psychosis, whereas the slightest mental change as a result of a head injury and the slightest cyclothymic depression would. This definition of the concept of psychosis would in itself be a suitable replacement for the vague term of psychosis which is usually based on the degree to which appearances are abnormal or sociological aspects. It would, however, break too much with clinical linguistic convention to call any pathological mental disorder, even the mildest one, a psychosis.

Nevertheless, in a non-pathological mental disorder one should at least never talk of a psychosis, however 'severe' it might be.

A few other remarks on specific details: only few of the pronounced congenital states of mental deficiency belong to group I.

Most of them, particularly the severe ones, are the consequences of diseases, such as infections or brain lesions or malformations, and are classified as mental retardation or dementia. However, just as abnormal personalities are only variations of personalities, it is often impossible to refrain from viewing intellectual deficiencies also as mere variations of intellectual capacity. In variations above the normal, this is in fact self-evident. It is these simple intellectual variations we mean when we refer to abnormal intellectual predispositions.

Among abnormal personalities, we single out totally vaguely as psychopathic those abnormal personalities who suffer in their abnormality or from whose abnormality society suffers. The only scientifically relevant concept here is the concept of the abnormal personality as a variation deviating from the mean. We may include abnormal vital drives, particularly sexual drives, here among abnormal personalities. (Such abnormalities are also found rarely as a consequence of disease, for example encephalitis, but in those cases they would probably chiefly represent the simple exaggeration or unmasking of a predisposition). We also view addictions as a mere expression of abnormal personalities and behavioural responses, not as a group in its own right. Their psychotic consequences belong naturally to intoxications and as such to the sequelae of disease.

We also classify traumatic disorders as abnormal behavioural responses. By this we mean psychological disorders which result from traumatic events or from persistent exposure to a stressful situation.

The psychological symptoms of the diagnoses 'intoxications' to 'genuine epilepsy' are known to be unspecific. Since Bonhoefer, they have often been known as 'exogenous reaction types', particularly the acute ones amongst them. The psychotic presentations of epilepsy are wrongly not included here. However, without a very extensive explanation, the phrase 'exogenous reaction types' is open to misunderstanding and, therefore, better avoided. We prefer to talk of physically accountable psychoses. Acute and chronic presentations of these groups overlap with one another seamlessly.

Genuine epilepsy is a neurological syndrome and not a disease with a known aetiology. It, therefore, assumes a special position in

relation to the other forms of disease. In terms of the psychological order, however, this does not cause any problem since in this respect it can be viewed as a disease and as a somatic aetiology.

The two question marks to the left of cyclothymia and schizophrenia are not 'whether', but 'what' question marks. There is, therefore, no question here that diseases underlie these psychopathological forms, since otherwise they could not be subsumed under 'disease sequelae'. We will talk about the 'whether' aspect later. Here we maintain the postulate that cyclothymia and schizophrenia are psychopathological 'symptoms' of unknown diseases. If 'postulate' is understood to imply a requirement, then 'hypothesis' might be a preferable term instead.

The fact that we insert a question mark to the left of the psychological findings of cyclothymia and schizophrenia in the somatic column does not, however, mean that we see the physical causes of these forms as each lying in a uniform disease. This is conceivable to us in the case of cyclothymia, but not that of schizophrenia. Between the two forms there are, at least with respect to the pattern of psychological symptoms, which is the only aspect of the disease we know, transitions and intermediate cases, which prompts us to question the possibility of a uniform physical basis to cyclothymia. As yet, no-one has succeeded in separating out clearly any other types from the sphere of these 'endogenous psychoses' and gaining recognition for them. In fact, it is now the case that schizophrenia is now simply defined as that which remains of the class of psychoses with unknown physical origins, when we take away the typical cyclothymic psychoses. Any traits that do not fit in with cyclothymia are grouped together as schizophrenic. There is nothing that can be shown to recur as a common factor in all the presentations which we nowadays call schizophrenia. It is no contradiction that in the presence of a certain pattern of psychopathological symptoms we can say: that is schizophrenia, as distinct from abnormal variations and cyclothymia. But as well as this pattern, there are many other forms which are also called schizophrenia. The disease courses also do not support the idea of a common underlying pathological principle.

There are also transitions between the acute and chronic psychological symptoms of physical diseases and schizophrenias. This is

true for the schizophrenias but not for cyclothymia and certainly not in its depressive forms. Naturally not all diffuse depressive moods should be referred to as 'cyclothymic'.

Our proposal, like any system, resembles a bare tree with bare branches. The wavering foliage on it cannot and should not be brought out. The clinical pattern of symptoms often exhibits a very complicated structure. Among those acute and chronic clinical pictures in explicable diseases, there are also (admittedly rarely) psychoses that cannot be classified under confusional state, mental degeneration or dementia, particularly hallucinoses or paranoid states without any disorder of consciousness and without mental degeneration or dementia. Finally, there are 'transitional syndromes' (Wieck) without confusional state but which, because of their good prognosis, also cannot be described as mental degeneration or dementia. This applies in particular to the amnesic syndrome. These can hardly be referred to as psychoses in the usual sense of the term.

II.

While the aspect of the twin approach to the diagnosis of the sequelae of disease should encounter few objections, the distinction between groups I and II may meet with some protest. This divides mental abnormalities into non-pathological and pathological. We must, therefore, explain our concept of disease in greater detail, but this can only be a clarification of our own concept of disease, not a discussion of alternative models. A discussion of ideas is always of limited value. Everyone has their own assumptions which, if one recognises them oneself, are best left open on the table.

The concept of disease for us, specifically in psychiatry, is a strictly medical one. Disease itself only exists in physical terms and we call the mentally abnormal 'pathological' if it is attributable to pathological organic processes. In the absence of such a basis, the description of mental or even purely social features as 'pathological' is only of significance as an image; in other words, it does not offer any insight. In medicine, in addition to organic changes, 'disease' now for the most part also includes the criterion of lack of well-being and ultimately of a threat to life. It does not just work,

therefore, with a pure concept of existence, but also with a medical concept of value. These criteria, however, are not applicable in psychiatry: many psychotics do not feel unwell; in fact, there are some who feel particularly well and in most diseases, particularly those underlying the endogenous psychoses, there is essentially no threat to life. Thus, in psychiatry only the pure concept of existence remains as a concept of disease. For us, the mental disorders that are determined by organic processes, their functional consequences and local residues are 'pathological'. We, therefore, base the concept of disease in psychiatry exclusively on pathological changes in the body. General pathology cannot provide an unequivocal answer to the question of whether changes in the body can be called pathological if it has to abandon the inclusion of a medical value judgement. This, however, does not prevent us from propounding the concept of disease just described as an idea.

As previously mentioned, from our perspective we may also in practice consider malformations as diseases.

Cerebral malformations are of primary importance for psychiatry, chiefly as causes of many congenital mental deficiencies. In addition to organic malformations, it may also be assumed that there are functional 'malformations', e.g. metabolic dysfunctions. We include these in our diagnostic table under 'internal diseases'. There is a lack of any positive knowledge as to whether such disorders may also be held to some extent responsible for schizophrenia. The mere possibility does not permit us to include something similar in our table opposite schizophrenia or cyclothymia. To assume in the case of the intellectual deficiencies and abnormal personalities in group I that the possibly underlying variations in structure and function correspond to 'malformations' would go beyond all current knowledge, indeed any justifiable assumption. When we refer here to diseases, this is always to be understood to include malformations.

We do not know the disease processes underlying cyclothymia and schizophrenia. However, diseases do underlie them. This is is a very well-supported postulate, a very well-justified hypothesis. The frequently hereditary nature, the fact that most of these diseases run in families, the general physical changes often present, the indisputable precedence of somatic therapy (there are no others in

cyclothymia) are not as important in this as the following psychopathological facts: amongst other symptoms, there are also some that occur which have no analogy in normal mental life and its abnormal variations. In the overwhelming majority of cases, these psychoses are not associated with events and are not in any way occasioned by them in the sense of a traumatic response. Above all, however, they destroy cohesion, interrupt the meaningful order, the continuity of meaning which characterises normal development of life. Here, we cannot discuss in detail this problem of meaningful order in life from a methodological standpoint. A comprehensive discussion of this issue has been provided recently by Kisker.

Certainly this meaningful order is also based on an unexperienced and unexperienceable substratum. Its 'movements' can stretch, tauten, loosen or damage the continuity of meaning, as in certain periods of development (puberty) or in certain depressive moods (subliminal depression), but they do not tear it apart, not even in a psychopathological context. Only disease does this, although it need not do so, particularly at the beginning. These relationships can hardly be expressed in any way other than diagrammatically.

Certainly one cannot force anyone to 'believe' that diseases underlie cyclothymia and schizophrenia, in other words that they are 'pathological'. The postulate can be doubted and rejected, taking as a basis the remarkable fact that at present physically accountable psychoses almost always appear totally different from non-physically accountable ones. How could that be explained?

Our system can, therefore, be condemned as premature and dogmatic. In fact: if we adhere strictly to what is actually known, then the system would have to appear differently, rather as follows:

I. Abnormal variants of mental being. II. Psychotic mental abnormalities. 1. Physically accountable. 2. Physically unaccountable. (II.1 remains dualistic). In this case, our concept of psychosis, which is in fact geared towards disease, would, therefore, not be sustainable while we would still be without an alternative definition. And the concept of disease itself, which is not in itself disputed, would be so limited in its applicability that it would become unusable – e.g. for forensic expert reports. Because what use is a concept of disease in the context of court cases if this concept does not include endog-

enous psychoses? Even the 'postulate' here becomes embarrassing.

What then 'would be' these physically unaccountable psychoses? We refuse absolutely to interpret them as traumatic responses or consequences of persistent exposure to stressful situations, i.e. as 'neuroses', and hence to include them in our group I, although we are unable to justify that here. We simply point out the following: endogenous psychotic presentations can be distinguished far more clearly from neurotic states than endogenous psychotic presentations from those in physically accountable psychoses. Because after all there are occasional overlaps here. All that then remains, if one is not to become lost in speculative philosophical interpretations, is to view these states as one would an anthropological mystery. The fact that these 'endogenous psychoses' exist in addition to the abnormal variants of mental being and the mental abnormalities that can be explained by disease is the bane of human psychiatry. It is a different matter in veterinary psychiatry because there we have only the first and second forms. For the reasons mentioned above, we adopt our hypothesis and thereby the idea of the 'pathological' as a heuristic principle.

That is a declaration of faith and there is no lack of objections to it. Admittedly, there is relatively little dispute about cyclothymic phases and most schizophrenic psychoses. However, there are doubts about certain, mainly paranoid (paraphrenic), psychoses which we have repeatedly propounded for many years. It is, at any rate, no longer possible to see the psychotic phenomena as bubbles that float up meaninglessly and without any relationship from the somatosis. It could then only be assumed that the disease transposes and distorts pre-existing biographical predispositions, conflicts and constellations into the psychotic; in other words, it 'works' entirely or primarily with prepsychotic and extrapsychotic material. The fact that we do not view such forms as characterogenic or neurotic developments (i.e. developments in response to traumatic events) should once again be stressed here. However, the third possibility of the metagenic, in addition to the somatogenic and the psychogenic, a 'straying' of the mind without a somatic or psychological cause, must at least remain open here and perhaps elsewhere.

Very promising positive approaches to a somatic justification, at least of schizophrenic psychoses, have moreover recently been advanced by Huber, even if the interpretation of his findings is still uncertain.

To our mind, physical disorders as an expression of affects, such as a psychogenic gait disorder following a fright, do not in any way count as pathological organic changes. However, they can lead on to such changes: thus, a psychogenic disorder of movement can result in organic contracture and psychogenic vomiting in gastritis.

III.

We now come to a second point in our clinical approach: the question of the transition between simply abnormal mental being and the physically unaccountable, and yet hypothetically pathological, psychoses. In these considerations, it must be constantly borne in mind that 'abnormal' here is intended simply as a variant of the 'normal'. There are, therefore, no fundamental differences from the normal. And when we refer below to 'abnormal' personalities, what is said applies also in exactly the same way to the normal and vice versa. Furthermore, behavioural responses and experience induced developments are also always included in personalities. It would be too laborious to point out these relationships on each occasion.

Let us remain first of all with the physical side. There is no question that a disease can develop as a transition from morphological or functional variants of the body. It should be borne in mind here that it is only permissible to refer to actual transitions if there is a gradual progression, not if a disease suddenly develops out of a condition. Such transitions do exist. There would, therefore, in principle be nothing to prevent the assumption in psychiatry of transitions between certain constitutions, certain conditions of organs or organ systems, and diseases with psychotic sequelae. Leaving aside epistemological and other objections, these transitions would probably also be found on the mental side. There would, therefore, perhaps be transitions between certain personality types and cyclothymic or schizophrenic psychoses.

Theoretically, according to what has just been said, there would be no objection to the assumption of transitions between (nor-

mal and) abnormal personalities and cyclothymic or schizophrenic disease states. If, nevertheless, we reject these, this is not done on methodological or somatological grounds, but because we do not find these transitions in clinical experience. Cases in which there is a doubt as to whether one or other is present are in fact quite extraordinarily rare. There is not sufficient clinical evidence to support the existence of such transitions. There are in fact also diseases that cannot be deemed exacerbations of physical abnormalities and organic dysfunctions, but quite simply something new to which there are no transitions. We might refer here to tabes and multiple sclerosis by way of example – but, in point of fact, most diseases could be mentioned. Clearly the diseases underlying cyclothymia and schizophrenia also belong to these disease forms and not to the forms that emerge without any sharp distinction from merely abnormal functions and states. The importance of the constitution, however, can be acknowledged: it is the gradual progression into disease, the question of transitions, that is rejected here, not the possibility of the precipitous development from a condition. This possibility might be conceivable in these psychoses. Reference can be made here, by way of comparison, to the relationship between the 'chronic alcoholic constitution' and delirium tremens. The former is a precondition for the latter – and yet the delirium does not emerge gradually from chronic alcoholism: something new must happen for this leap to occur.

As already mentioned, cases in which there may be a doubt as to whether an abnormal personality or schizophrenia is present, or whether an abnormal personality or cyclothymia is present, are very rare. We present below a few figures in the full knowledge that they reflect a specific diagnostic approach, so that they are of only relative significance for diagnosticians of a different mindset. We have, therefore, also opted not to work out more recent figures. We came up with the following figures for the Psychiatric Department of the Munich-Schwabing municipal hospital: in the years 1932 to 1936, amongst 1647 cases of abnormal personalities or behavioural responses and 941 cases of schizophrenia, there were 28 cases in which the diagnosis was disputed, and amongst 1647 abnormal personalities or behavioural responses and 166 cases of cyclothymia

there were 7 disputed cases. These numbers are extraordinarily small. If there were transitions between certain personalities on the one hand and schizophrenic or cyclothymic psychosis on the other hand, they should be found much more often in numerical terms. If the diagnosis cannot be established, it is then better to refer to 'cases of unclear diagnosis' or 'suspected schizophrenia' or 'suspected cyclothymia', rather than to 'schizoid' or 'cycloid' psychopaths or behavioural responses. In the individual case, the utmost effort must be made to reach a decision and in almost all cases, a decision can be made without compulsion. The question constantly arises as to whether these rare disputed cases are in fact insoluble, in other words whether they actually represent transitions or whether they merely cannot be classified at the time of the examination or possibly even in the longer term. There may be cases of schizophrenic or cyclothymic psychoses whose presentation initially or even in the long term is so exclusively marked by the features of the personality with its specific way to respond to events and situations, that psychotic features are difficult to establish. A comparison might be made with alcoholic intoxication or even paralysis, which on first sight at any rate may simply appear to be exaggerations of the personality, even though they do not constitute transitions to the normal or to the merely abnormal variation. Something of this kind will also be found here occasionally.

As can be seen, a distinction must also be drawn between the question of transitions in the physical manifestation from the question of transitions in the mental. Where, in the first case, there is a sharp borderline, this does not necessarily always have to be present in the mental sphere as well, particularly at the beginning of a disease and in milder cases. In the matter of the transitions between certain personalities and cyclothymic or schizophrenic psychoses, the remarks on the physical must remain purely speculative, because this is not known either in personalities or in the two forms of psychosis. All that can be done, therefore, is to study the transitions in the mental presentation and then with the limited precision associated with all psychology. We barely ever now find anything here suggestive of transitions. The very rare cases which appear to us at least temporarily or sometimes even longer to be

transitions can be explained in similar fashion to the pure mental exacerbations in physically accountable psychoses, particularly at their onset.

We, therefore, believe there is a sharp differential diagnosis between abnormal personalities and behavioural responses on the one hand and schizophrenic and cyclothymic psychoses on the other. By contrast, there is only a differential typology between schizophrenia and cyclothymia. If, in the five-year period mentioned, we only found 11 cases that were assessed as intermediate on the basis of the final diagnoses among 941 cases of schizophrenia and 166 of cyclothymia, this figure certainly does not do justice to the actual relationships. Since the diagnostic scope of schizophrenia is very broad and vague compared to cyclothymia, it is easy to understand why an atypical case should tend simply to be ascribed to the varied schizophrenic sphere of diseases. For this reason it will rarely be allowed to remain undiagnosed.

In these questions of differential typology (and not just here), it must be clear that the question is not in fact: "Is that schizophrenia or is that cyclothymia?" Instead, one is simply asking: "Does that match what I usually call schizophrenia or what I usually call cyclothymia?" The observation of atypical cases and the number of intermediate cases is, therefore, dependent entirely on the clinical viewpoint concerned.

Psychopathic Personalities*

I.

The following remarks should be prefaced by a brief introduction of the key concepts. In addition to numerous individual features, a distinction is drawn between three complexes of attributes in the mental constitution of the individual: intelligence, physical (vital) life of feelings and instincts, and personality. The latter includes the non-physical feelings and aspirations and the will. These three aspects are intimately inter-related, but can with some justification be considered individually.

Abnormal personalities are deviations from a conceived range of average personalities. What is essential therefore is the average norm, not some value norm. Everywhere abnormal personalities pass seamlessly into states that may be described as normal.

Among abnormal personalities, we single out as psychopathic those who suffer from their abnormality or whose abnormality causes society to suffer. The two types overlap. All that is essential in scientific terms is the concept of the abnormal personality, which subsumes the concept of the psychopathic personality, so that we occasionally use the two concepts interchangeably. The very fact that the second part of our definition of the psychopathic is elaborated from a very relative (sociologically) value-based perspective prevents it from being employed purely psychologically.

Abnormal (and hence psychopathic) personalities are not in our sense 'pathological'. There is no reason to ascribe them to disease or malformation. Their physical correlate would also only be conceivable as a quantitative abnormality of structure or function.

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*Reference: K. Schneider. "Psychopathische Persönlichkeiten". In: *Klinische Psychopathologie.* Georg Thieme Verlag, Stuttgart, 1931; 8th edition, I–III: 17–39.

Abnormal personalities must in principle be clearly distinguished from the cyclothymic and schizophrenic psychoses justifiably postulated as being pathological. There are no transitions, even if the interpretation of individual cases sometimes causes difficulties. Nevertheless, it is possible to acknowledge a certain disposition of personality for these psychoses. Kretschmer believes that the quantitative increase in schizoid symptoms in schizophrenia does not exclude the involvement of a particular 'process factor'. Clearly the 'process factor' is (theoretically) meant physically and the transitions continue to occur in the mental sphere as before. Nevertheless, that is a viewpoint on which agreement is not impossible. It usually happens that cyclothymia develops in a particularly 'normal', unpsychopathic personality, whereas schizophrenia develops in abnormal personalities, which may vary considerably. That is far from saying there are no exceptions in either case, just that this is how it is for the most part.

Abnormal personalities are predetermined variations, but which are susceptible to considerable change through the development of and fluctuations in their background and through the impact of traumatic events, of experiences in the broadest sense. What we understand by predisposition is not necessarily the same as hereditary predisposition. Exogenous intra-uterine factors may also have an effect and in practice even early childhood factors, but in principle these are no longer involved in predisposition. In addition, under our definition of predisposition, no limits are placed on the metaphysical assumption of simply 'being thus'. We shall consider this later in further detail.

Psychopathic personalities are mostly classified by listing types of such personalities according to the salient, predominating characteristics in each case. This was how Kraepelin proceeded in 1896, and this is the approach in all textbooks, as well as our own.

While this method in principle lists the individual types beside one another without any idea of comparison, an attempt has been made by several parties to derive psychopathic types from a characterological system and thus to produce a systematic pathocharacterology. As Gruhle did early on, a table of human characteristics can be drawn up and psychopathic types can be derived

from their exaggerations. It is also possible to include the idea of mental stratification in such systems, in the sense of Homburger and Kahn, and to show within this framework the abnormal and also psychopathic characteristics as exaggerations of the normal. (This psychological 'stratification' should moreover not be confused with the categorial stratification of N. Hartmann.) Others, such as Kretschmer and Ewald, adopted the type of response, the processing of experiences, as an underlying system. These characterological foundations also lead to the formation of types and the use of the resultant forms also remains typological, with the possibility to a certain extent of determining their place within a system. With sufficient constructive imagination, moreover, it is also possible to impose a system on any typology originally conceived asystematically, as Tramer has also done with our own unsystematically listed types. In none of these systems is it possible to derive convincingly all the different types. Clinically important features can often only be made to fit by force, if they are not to be omitted as extraneous. There also always remain empty fields clinically which are only created for the sake of the system and in which no illustrative, living psychopathic type has a natural place. Why this is the case will not be pursued in further detail. It is related above all to the almost universally sought polar classification of characteristics. If, for example, the 'explosive' is contrasted with the 'unreactive' as a necessary polar opposite or the 'weak-willed' with the 'independent', one ends up with forms which from a clinical perspective, at least, are of no interest. Psychiatric interest focuses precisely on the somehow negative variants. Certainly one might be able to show all psychopathic properties in an as yet non-existent, comprehensive characterological system by highlighting individual features deemed to be extreme, but clinically most fields would have to remain empty. A systematic, pure pathocharacterology is simply not possible, at best only a taxonomy of characterological features. And if the psychopathic features were, so to speak, garnered from this, then there is no longer anything systematic present, just those properties by which psychopathic types are customarily known. The result then is no different than if the arrangement had been unsystematic from the outset. The criticism of typological classifi-

cation also applies to classifications based on a system or on which a system has been imposed.

We propose here an unsystematic typology. We describe a series of types of psychopathic personalities that are not comparable with one another, between which numerous and varied combinations are possible and common. Between the prototype and the case where only some features are present, there are also endless intermediate forms. These types will simply be described to begin with and only later will we discuss such listings critically.

The distinctions from the psychoses, particularly the cyclothymic and schizophrenic, do not concern us here because in that case all the symptoms of the psychoses would have to be included. Essentially, the differential diagnosis is established on their part. In very general terms, however, the following may be said. The distinction from cyclothymia is usually easier because it involves episodic states, not long-term states. On the other hand, it is sometimes also more difficult because the cyclothymic symptoms appear to resemble the psychopathic at certain points. The distinction from schizophrenia is easier because its symptoms overall are further removed from the psychopathic than those of cyclothymia. On the other hand, it is often more difficult because schizophrenia involves long-term states to a greater or lesser extent. All of this applies only approximately. Episodic psychopathic manifestations are the most difficult to distinguish in principle from both cyclothymic and schizophrenic psychoses, even if in the long term a decision is almost always possible.

II.

By hyperthymic, or active, psychopaths, we mean the extreme of personalities with a happy underlying mood, a lively (sanguine) temperament and a certain activity. Not infrequently they are kind, ready to help, often hard-working and efficient, but shallow and lacking in any thoroughness, unreliable, uncritical, reckless and easily persuaded. They show a naïve self-confidence and are above all optimists focussed on the immediate and the present. Their behaviour is often informal, importunate and casual. As well as these normally balanced hyperthymics, there are also excited, agi-

tated hyperthymics without an actually happy underlying mood. Hyperthymics often feature in the circle of psychopaths as quarrelsome and unstable personalities. It is understandable that their lively temperament and their exaggerated self-confidence should readily bring them into disputes. They do not allow anything to pass and also readily interfere in matters that do not concern them. They are, however, forgiving and rapidly become good friends again. It is also understandable that young hyperthymics in particular, because of their activity and their liveliness, should like to vary their environment and their position and therefore sometimes acquire an image of social instability. It is not uncommon to find hyperthymic psychopaths among bedraggled, unstable adolescents. Good intentions are rapidly forgotten and bad experiences only superficially assimilated. The confident self-assurance simply forges ahead regardless.

The underlying mood of depressive psychopaths does not have the same close relationship with a specific temperament as that of the balanced hyperthymic. The latter are mostly sanguine, while depressives are often quiet, but rarely phlegmatic people. They suffer from a more or less permanent depressed mood and a pessimistic or at least sceptical outlook on life. Constant anxiety about life and the world hangs over them. They lack trust and confidence and they are incapable of harmless pleasure. They always see the other side of the coin, nothing is perfect, everything is spoilt by something. Brooding distracts from everyday tasks and is never allowed to drop: worries of all kinds, self-analysis, doubts about the value and meaning of existence. Unhappy experiences are felt deeply and persistently and result in crises, but on the other hand genuine troubles often tear them away from their torments. Joyful events rarely do so and in any case only temporarily. It is as though something heavy must always be present: if it does not come from the outside, it comes from within from far below the surface. If an external worry disappears, its place is then immediately taken by cares that are often conjured up from afar or purely internal problems, but which again disappear as soon as something real happens that is worrying or threatening. In these people, it is not happiness that chases away worry, but another worry. These things do not

always lie on the surface; the depressive has numerous masks and disguises. Sometimes he appears extremely happy and active in the form of 'anxiety mania' or 'flight mania', but without actually being content. Many depressives are tirelessly active, diligently performing their duties, but no success ever satisfies them and any rest is associated with the risk of the sudden eruption of suppressed phantoms. Many depressives are arrogant, they look condescendingly on people who have things easy and simple emotionally because of the often associated simplicity and even shallowness. They, the sufferers, view themselves as aristocrats. Others see in suffering an honour which, just like the tendency to introspection and brooding, the embitterment towards life in this world and the internal need for help leads them to adopt fixed, protective views of the world or causes them to wrestle with it, often in vain. A cultivated aestheticism can sometimes be found in their external lifestyle to cover up the internal bleakness. Minor aspects are cultivated because anything major appears doubtful. The opposite, neglect of the outer life and external appearance, is equally understandable. There are melancholic variants, gentle, kind, at the same time timid and easily discouraged personalities, and ill-humoured variants, cold, sullen, morose, mistrustful, irritable, nagging, even evil and malicious depressives. Here, pessimism in the face of fate can have something fanatical: they are triumphant when something goes wrong yet again and also begrudge others anything good that happens.

Not far removed from the depressive psychopaths are the insecure psychopaths. These admittedly are always slightly depressive, but the insecurity of depressives in the face of life does not necessarily reflect a lack of self-confidence. We mean people with internal insecurity and lack of self-confidence. Even these traits are far from always being readily apparent. The inner lack of freedom and the timidity of insecure personalities is sometimes frantically offset externally by an all too self-confident and even arrogant appearance or a striking exterior: they do not want to be overlooked. This applies in particular to people whose insecurity lies in the physical or social domain. The scruples and feelings of insufficiency of these insecure personalities do not always but very often affect their moral behaviour. Such people are constantly afflicted by a bad

conscience and seek to blame themselves first of all for anything that goes wrong. Kretschmer described these ethical scrupulants with unsurpassed insight as sensitives and also portrayed their occasional paranoid excursions, although one should not, as he did, allow these to progress in a direct line to psychoses. Sensitives are people whose life is conducted in extreme and even excessive conscientiousness and purity but who nevertheless constantly brood over matters. As has long been known, most compulsive processes develop out of these and similar natures. Rather than compulsive neurotics, it would be better to refer to anankastic or compulsive psychopaths. Compulsive ideas often strike like lightning, usually triggered by a cue and not infrequently the overwhelming anxiety is accompanied by physical sensations (dizziness, palpitations). Compulsive thoughts control and devalue what substantively is often totally alien to them, totally dissociated from them, does not belong to them at all – like a colour that spreads out and spoils everything and anything. If a new compulsion prevails, in most cases the previous one disappears and its subject matter is now viewed totally critically and even disparaged. However, the old compulsion can soon recur and the new one disappear. Often there is a constant alternation of different, recurrent subjects with one compulsion always being present. The fear also that a compulsion might recur and then not disappear again for a long time is in itself a compulsion. This sometimes causes all sorts of precautionary and protective measures, often of a strange and incomprehensible nature to the uninitiated. Often the primary factor is an insubstantial, anxious uncertainty and this primary compulsive mood then only assumes a concrete form or alternating forms subsequently. These, however, are always deeply associated with the aspirations and value judgements of the person and their life history. Such compulsive ideas arise from the permanent feelings of guilt and insufficiency of an insecure personality. There are people who grasp every pleasure on offer throughout their life without a bad conscience. The extremely insecure personality has no pleasures in life and yet always suffers from a bad conscience. These people live in constant fear of having missed something or done something bad or in very general terms, that something might happen. And this anxiety

draws its substance from an apparently trivial incident: the tune finds its lyrics. One such anankastic woman was once found in a state of extreme introspective anxiety and in response to the question of what she was reproaching herself with this time, she said: "Well, that's the thing, I don't know it yet." This can include the fear of unhappiness, the fear of responsibility and guilt, which can intensify to the extent even of falsifying memory; it also includes confessional scruples. These are people who have the opposite of a 'robust conscience'. It is therefore to some extent understandable now why insecure people often have compulsive thoughts, but not which ones. This could only be shown on an individual basis and an immediate understanding in most cases does not lead far in this respect. It is even more difficult with compulsive urges. Insofar as they are simply intended to ward off compulsive thoughts, such as a washing compulsion or even merely fears of doing something or other, such as killing one's child, in other words not genuine urges, understanding is still possible. However, primary compulsive urges, for example throwing oneself under a moving train, for the most part completely defy understanding. These events, however, which are sometimes difficult to see as compulsion, mostly go beyond the basis of the insecure personality and therefore, an understanding of the occurrence of such urges is impossible from this perspective. From a psychopathological perspective, compulsion will be treated in conceptual terms later.

Fanatical psychopaths are governed by excessive personal or ideological thought complexes and in fact, the actual fanatic is an extremely active, expansive personality. The personal fanatic, such as the grouser, fights for his actual or supposed rights; the ideological fanatic fights or demonstrates for his programme. There are, however, also quiet, eccentric, unrealistic, purely fantastic fanatics who are hardly combative if at all, such as many sectarians. We call them tame fanatics. Expansive fanatics are of particular psychiatric interest as grousers, particularly those seeking compensation. At the same time they also usually have paranoid processes that go beyond the usual mistrust, for example founded in jealousy; however, these are not simply expansive, but more complexly constructed personalities, as shown by Kretschmer.

We describe as attention-seeking psychopaths those personalities who wish to appear more than they actually are, by which Jaspers characterises the essence of the hysteric, a term which we never use. These therefore are ungenuine, vain personalities. This seeking for attention can be seen, on the one hand, in an eccentric existence: in order to draw attention to themselves, the most unusual views are expressed and things done and also a striking external appearance is often adopted. Another possibility here is self-satisfied boasting and finally, in order to increase the importance of their own self, fairy-tales are recounted or played out which requires a considerable degree of imagination. This is then referred to as pseudologia fantastica, a somewhat antiquated expression. In his obsession with the idea that he should play a role which real life refuses him, the pseudologist puts on an act to himself and to others. For the pure pseudologist, the classic confidence trickster, it is not a matter of material gain, but the role itself. At any rate, the two often coincide. It should not be thought that the pseudologist is unaware that he is exceeding the bounds of reality. In the extreme and far from common cases, his game should be viewed in the way one might view that of children playing teachers or soldiers. Obviously these children do not 'believe' they are teachers or soldiers and yet they abandon themselves completely to their role. Self-conscious assurance in their appearance, sociable manners and a likeable nature are important in this. Sympathy trickster appear as silent sufferers. The ungenuine nature of these attention-seeking characters makes human relations difficult. Adoration is often rapidly replaced by indifference and even slander. If these people no longer believe themselves to be admired, they soon find others boring.

Labile psychopaths are people with unexpected irritable depressive moods. It is often very difficult to say whether these depressive moods are reactive, i.e. psychogenic. Such people, however, have days on which they are more likely to react depressively and more persistently than on others. This involves an increased and intensified depressive reactivity based on a disposition that is itself not reactively determined. A variety of responses are engendered by these depressive moods, such as running away or excessive drinking. 'Instinctive people' are mostly such labile personalities: here,

the depressive mood is the primary factor. There are, however, also similar instinctive actions in which this is at least not comprehensible. A prostitute said about giving up again a steady job: "Then I had one of those days when I just had to; an undefined urge as if it had got into the blood." Sometimes labile psychopaths are described as 'epileptoid'. We caution against the use of this term. There are certainly epileptics who also have labile crises, but there is not the slightest reason to count labile psychopaths as epileptics.

Explosive psychopaths are easier to describe. They are those people who react to the slightest provocation, in other words externally excitable, irritable and hot-tempered people. Their reactions are primitive reactions in Kretschmer's sense. A word is said to them and before its value and significance are correctly assimilated and processed by the personality, a reaction follows in the explosive form of a furious contradiction or an act of violence.

We call affectionless psychopaths those people without or almost without sympathy, shame, a sense of honour, remorse or conscience. By nature, they are often dark, cold, sullen, in their actions often impulsive and brutal. At any rate we should not call this moral imbecility, because imbecility implies intellectual deficiency and this does not necessarily have to be present, even though it often is the case. Affectionless people are fundamentally incorrigible and untrainable because in extreme cases there is a lack of any structure on which to base any influence that might be exerted. In addition to the criminal affectionless, one should not forget that there are also the completely social affectionless, natures as hard as steel who stick at nothing. In this case, extreme intelligence is often present.

Weak-willed psychopaths cannot resist any influence. They are seducible people who usually respond readily to good influences, for which reason youthful weak-willed personalities are, in most cases, easy to handle when they live in reformatories. However, the good influence exerted upon them does not persist. Discharged, they are open to the first person whom they meet and who suggests something to them. The social picture is one of instability.

With asthenic psychopaths, we are not thinking of people with an asthenic, leptosomal body type. We use the expression characterologically and in fact we distinguish two subforms here, which

moreover often occur together. The first involves certain people who find themselves mentally inadequate. Their complaints are in the first place quite general: poor performance, inability to concentrate, declining memory. Furthermore, they sometimes suffer depersonalisation experiences: the whole perceptual world, their own actions, all feeling appears distant, unreal, ungenuine. All these states are not always, but often, aroused or at least sustained by self-observation. Frequently some trivial failure makes them anxious and their fearful self-control then results in persistence or repetition. Mental achievements and actions require a certain naïvety for their natural completion and for this completion to be perceived as genuine. The second subform is represented by those who easily fail physically because of their psychological disposition. Minor discomforts that occur hourly, small functional disorders, normally pass unnoticed and rapidly disappear again. The asthenic focuses his attention as a matter of habit on his body and thus, function and the interaction of organ systems suffer. These only proceed normally when they are far removed from conscious control. Actual functional disorders are psychogenically enhanced and perpetuated. These self-observers do not live in the outside world, but constantly look inwards upon themselves and as far as their physical processes are concerned, these lose the harmlessness that is necessary for their unimpaired functioning. They complain of rapid fatigue, insomnia, headache, or heart, vessel, bladder, menstrual and other disorders. There is no question that these asthenic psychopaths very often also suffer from physical problems which are not psychologically caused, so that the significance of their self-observation in the aetiology of the disorders is again limited. Often the self-observation is not obviously to blame for this, but a diversion as a result of some other distraction causes the disorders to disappear. It would be an unjustified assumption to suggest disorders of the nervous system, vegetative mobility or 'neur'asthenia, so that we refer more cautiously and very unspecifically to somatically labiles, to somatopaths. We exclude here actual diseases, although these may to some extent play a similar role in the process. Between the somatopathic and the psychopathic pole, a whole variety of possibilities may be imagined. 1. There is a somatic lability, a somatopathy without mental

abnormalities, without experiences playing any causal role at all. That something like this exists is also shown by the fact that even newborn children can be 'neuropaths'. 2. A personality which in itself cannot be described as psychopathic reacts to the disorders of a somatopathic constitution with hypochondriasis, insecurity about life, anxiety and depressive moods. 3. If the reactive personality is a psychopathic one, these reactions will also be abnormal in degree and nature. 4. The primary factor is the psychic, in the form of intrinsically normal responses to experiences but which result in psychogenic physical disorders. The more labile the physical regulations are, the more likely this is to happen. 5. The primary factor is a psychopathic personality. If we can express it so crudely, as a result of its hypochondriacal control and self-observation, it creates disorder in an intrinsically not at all labile body and thus all sorts of psychogenic physical disorders are produced. It is this type we mean by the pure asthenic psychopaths of this group, but the asthenic is all the more likely to practice self-observation and be encouraged in it, the more somatopathic lability is actually present in him. It is not always anxiety, but often the wish that is the driving force, and often no motive is visible at all. Somatopathy and psychopathy are indeed frequently expressions of the same abnormal general constitution, although psychopathy cannot be held responsible for the somatic disorders. Such psychogenic somatic disorders can certainly not always be viewed as a result of of experiences, tensions and conflicts. An explanation in purely psychological terms comes up against its limits at a much earlier point than is often assumed today. The usually non-somatopathic person can also become the victim of such disorders even in the absence of any psychological cause. (Constructive interpretations are, however, irrefutable.) Sometimes, such physical disorders may have arisen psychically, but they then become automated, so that the event, which to some extent has faded away, no longer plays any role.

III.

Even outside of psycho-analytical circles, which for the most part reject the concept of the psychopathic anyway, typological classifications of psychopaths have often been criticised, for example

by Klages, Liebold, Schröder and Heinze. Approaching it from a different angle, Kretschmer objected fundamentally to purely psychological listings, which he views essentially as being merely sociological. This objection certainly applies to many such typological classifications, such as those of Kraepelin to some extent but not to our own. Kretschmer's idea, in principle, goes beyond the purely psychological and seeks constitutional psychopathic types and even a universal anthropology. Certainly his system does encompass some important psychopathic forms, but not others. This therefore leaves a neutral residue in relation to his biologically based classification system. Clinically important and common forms remain outside his lines of intersection, including those which even he cannot reject, indeed forms which he himself considered in very specific detail such as his sensitives or hysterics.

In fact, the criticism of psychopathic types, whether with or without an underlying systematic structure, is correct in some respects. There are risks associated with such an approach which on both theoretical and practical grounds should be recognised and noted.

Psychopathic types look like diagnoses. However, that is a totally unjustified analogy. A depressive psychopath, for example, is simply 'that sort of person'. People and personalities cannot be labelled diagnostically like diseases and the mental consequences of diseases. At most it is possible to demonstrate, underline or highlight features in them that are strikingly characteristic, but without having anything comparable to disease symptoms. This emphasis is always coloured by a specific point of view, particularly that of a subjective feeling, an approach to existence and life, or that of the difficulties which the environment and society encounter with these people as a result of their characteristics. In addition to the characteristics that are important in these respects, the same person has an infinite number of other characteristics that are often no less important from different, e.g. ethical, viewpoints and that are not covered by the diagnosis-like designation, thus remaining in the dark and hidden. The diagnosis of disease also indicates only a certain aspect of the person, indeed of the body, but here that is self-evident. The typological designation of psychopaths, however, can

readily give rise to the impression that it relates to the whole or at least to the absolute essence of the mental aspect of a human being. It is understandable from a historical viewpoint that psychopathology began with these typologies along the lines of diagnoses and thus made it easier for the doctor practised in thinking in terms of medical categories to adopt them. It is therefore also understandable that these forms should be willingly and tenaciously retained; by so doing one apparently remains within the usual medico-clinical lines of thought.

As we have just seen, labels apply only to individual and in some respects, critically important characteristics in individual people. (Not everything, moreover, that is designated by the same name is psychologically 'the same'. For example, it is possible to be a depressive in very different ways.) It should also now be realised that the characteristics highlighted are to be found at very different depths. The level to which they relate may in one case be central, in another more superficial. One might, adapting the concepts of J. H. Schulz, refer to 'core psychopaths' and 'marginal psychopaths', without, however, being certain about how to distinguish them in each case. The level in insecure personalities is a deep one. Pronounced insecurity is in fact a very central, deep-lying character trait that profoundly characterises a person's nature. This applies also to a great extent to the affectionless, the attention-seekers and perhaps also the extreme fanatics. Other forms, however, are based on very peripheral traits and are far from saying anything essential about the 'core' of the personality. They are therefore superficial, 'façade' terms, often apply only to behavioural aspects. How infinitely varied in their deeper being are those humans we call hypothymic, depressive, labile, explosive, weak-willed, asthenic psychopaths. These terms say nothing essential and decisive about the person as a whole. However, even terms which say something more fundamental about the whole person remain formal and therefore, never provide satisfactory knowledge of human nature. In what areas is an insecure person insecure? What sort of compulsions do they have? What attention-seeking pretensions and targets does an attention-seeker have? What is their particular ambition, where do they want more than what they are and what they can

do? What does the fanatic do fanatically? It is in fact evident that such characteristics are rarely total. At most, this might apply to the case of a completely primitive affectionless personality, but even they have small reservoirs of emotional warmth, even if it is only concern about a cat. Research into people and personalities, even psychopathic personalities, follows a totally different path from that of psychoses. In psychoses, one attempts to look beyond the substance, the theme, the individual configuration and to find a way through to the form. In most psychopaths, however, the substance is what is essential and if this is left aside then only a shell remains. This substance – the what – however, can only be demonstrated in individual cases, in other words on a case study basis, in the same way as the why insofar as it is fathomable.

Because the characteristics elicited as designations are in fact only a few among many and because they are relative to the meaning and purpose of the approach adopted, it is so difficult to illustrate what is meant by specific psychopathic types. It should be said that it is possible to furnish a richer description than the one provided above, which reflected deliberate restraint. But in this case, we are immediately deflected from our path, do not focus on what belongs to the type and describe the individual, the specific, the portrait. Traits are included in the description that are not in the slightest necessary and are always associated with the characteristics selected for the designation. If, for example in the case of the depressive psychopath, we do not confine ourselves to the underlying depressive mood, but describe him further as an introspective, religious person or as a quiet humanist or as an active person of duty, then already this constitutes a substantial deviation because the majority of depressive psychopaths do not have such characteristics. These excursions are unavoidable if we wish to illustrate our definitions, but fundamentally they are deviations and lead on to the arbitrary, the fantasising, the poetic vision and the poetic creation. Certainly, it should not be forgotten that not every type can have any old characteristic and that certain characteristics are preferentially found as 'secondary traits'. Many characteristics simply exclude one another, while many frequently occur together: a balanced, true, as opposed to pretend, hyperthymic cannot be insecure, an expansive fanatic

cannot be weak-willed. Conversely, hyperthymics are frequently explosive, depressives often asthenic. There are therefore indeed certain regularly recurring pairings, combinations or associations of characteristics, but illustrative descriptions almost always go well beyond what is to some extent regular and thus lose their purpose. And at the same time they immediately deviate from the pure type by looking at the associations between characteristics.

Precisely because of the wealth of individual configurations and associations, it is rare that any one characteristic should so entirely dominate and characterise the person to the extent that they can be appropriately designated by it. Even if several type designations including the subforms are combined, often in multiple ways, and even if reference is often made to mere traits of this or that type, this is rarely sufficient. The consequence is that it is not in fact possible to work properly with these types. It is rare that we can be satisfied to any degree with the description of a person as a 'depressive psychopath' or a "weak-willed psychopath with traits of affectionlessness" and mostly because of the variability or the typological vagueness, all that can be said is they are a 'psychopath'. It would be extremely difficult, for example, to list and classify psychopaths from a clinical year by type. Only in a very few cases would it be possible to apply one of the common definitions or combinations of these without to some extent forcing them to fit. Even in the case of its abnormal variants it is not possible to provide a comprehensive classification of the immense field of mental being which would parallel the system used for clinical diagnosis and disease definitions.

If we use a type designation for a psychopath, then we are thinking of something permanent, a habitual 'constitutional' variant. Also in this case it is necessary to proceed with great restraint. A severe hyperthymic will certainly usually remain so for the whole of his life, although even here changes may occur, whether episodic or permanent. And a truly affectionless personality, not one just pretending to be so under a series of masks, will always be such. With other types, however, it is different. Someone can be insecure or attention-seeking in his youth and then later lose this entirely or only minor residual traits remain. Or at a particular age someone

may have a tendency to asthenic failure and at other times not at all. There are certainly almost no adult weak-willed personalities at all, other than those with impaired intelligence. Such variations and changes can in fact be founded in the background that acts as a vehicle for the unfolding and development of a personality, the often alternating emergence and regression of one or other characteristic. With other characteristics, however, the alternating presentations are clearly due to experiences, events and fate. Far too little attention has been paid here to which personality traits can be formed, enhanced, attenuated or trained by experiences and which not. Hyperthymic temperament or coldness of feeling will hardly be affected, if at all, but insecurity, a depressive underlying mood, asthenic self-observation and hypochondria may very well be influenced. However, even with these traits this is only the case up to a certain point: where there is a very strong innate disposition, experiences will produce no change or to a lesser extent or only for a short time. With a weaker innate disposition, however, there is a very great malleability. There are also psychopathic episodes, as has already been observed by Kahn, whether these arise endogenously from the background in our sense or whether they are reactive.

Certainly, no clinician using the typological definitions of psychopaths will be satisfied with the label and then regard the description of the personality of the individual who just received the label as being complete. However trainees, whether future doctors or carers, will be readily seduced by typologies to continue to use these designations and no longer see any problem in the individual 'psychopath'. It is certainly totally wrong to accuse the psychiatrist generally of 'labelling' people by using such designations and thus of degenerating into a resigned fatalism: 'just a psychopath'. In many hands, however, a typology will in fact produce something like this. Above all, there is the risk that the individual is confused with the typological template: the substance is ignored, the causes and mental reasons for variations and failure, the biographical, and hence the possibilities for psychotherapeutic influence. There is in fact room for an extremely wide range of movement within a psychopathic personality, even within the typologically comprehensible and definable. However, one must not fall into the opposite trap

either and, by focussing on conflicts between instincts, events and fate, overlook the innate, predisposed characteristics, weaknesses, danger points and obstacles of a personality and the variations in the background, and certainly not by focussing on one's own interpretative phantasies. In this context a greater differentiation between the concepts of innate, predisposed and constitutional are irrelevant. We simply mean something that predates experiences, something that the person has inherited in terms of characteristics. An entelechy develops, there is a disposition, a potential for the unfolding and realisation of a personality, independently of experiences and at most partly conditioned by them. 'Neuroses', apart perhaps from crude acute psychogenic physical disorders following lively affects, always develop from abnormally predisposed, psychopathic personalities and find at least one of their preconditions here. It is astonishing enough how this can be overlooked. In the case of intellect and weak-mindedness, which is merely a variation of intellectual capacity, no-one questions predisposition. Why then should this not apply to personality and its abnormal variants? That there is something inherent in the psychopathic personality, in other words: that there are psychopaths, is beyond any doubt. To conceive what we consider to be a predisposition as the consequences of early childhood conflict and therefore to try to understand it again results in an impenetrable darkness that can usually only be illuminated by imagination. By keeping the types elastic and by viewing the concept of what is permanent in relative terms, there is still enough room to take experiences, fate and life history into account, and allow for successful psychotherapy, while at the same time accepting the existence of predispositions. Certainly, for psychotherapists and for any teacher, it is useful not to value predisposition too highly but to rate mental influences greatly. Without such optimism, their profession cannot breathe. However, the critical eye should also see the other side: the personality constituted in a particular way and the non-reactive, the endogenous variations in the background. Otherwise there will be many disappointments and also, conversely, a naïve over-estimation of one's own actions. We often believe we have achieved something by our own efforts, whereas in fact this was produced by a psychologically unaccountable fluctuation in

the state of the background. However, it is possible to deceive ourselves in the psychological sphere as well: an experience that is independent of the psychotherapist, such as the meeting of the treated person with someone else, may have helped.

Distinguishing predisposition and responses to experience in the abnormal development of a personality is hardly an unimportant question. It is, however, a key idea that is difficult to verify empirically. It is one, therefore, that can be asked, indeed must be asked – but often an unambiguous and clear answer is not possible in individual cases. Predisposition and the experienced environment (as must be said with humans) are not two blind forces colliding with one another. Together, predisposition and the experienced environment form a circle of causation. (One might also refer to a 'Gestalt circle' with V. v. Weizsäcker, but actual analogies are in fact difficult to demonstrate.) The predisposed personality develops from its experiences. The experiences are selected, grasped, included, incorporated by the personality according to their particular value and meaning for that personality. On the basis of the personality, they become fortune or misfortune, encouragement or torment for that personality itself, or at the same time for others, or even just for others. The personality does not collide with its experiences like the spider with a stone which blocks its path and deflects it.

Despite this fundamental insight into the interaction of predisposition and experience, greater emphasis can usually be laid clinically on one side or the other: therefore, it is also right to distinguish psychopathic personalities from abnormal developments in response to experiences.

Many long-used clinical concepts are now being superseded. 'Neurasthenia' has disappeared; 'hysteria' is now used only here and there in certain limited areas. 'Psychopath' also is already waning and its time will probably pass; but only the name, not the condition. For the time being also, the designation is clearly still not dispensable. This somewhat casual abbreviation for 'psychopathic personality' is already used in everyday clinical practice as a brief differential diagnosis for psychosis. The other, superordinate term, 'abnormal personality', is certainly more correct in a scientific context and indeed, the only proper term to be used in this context,

but it is too long for everyday speech and also somewhat open to misunderstanding without further characterisation. A paralytically or schizophrenically defective person can also in a certain sense be referred to as an 'abnormal personality' because the mere difference in intensity, the variant, the variation in personalities is not clearly expressed in this term. Linguistically this is even less the case with the term 'psychopath', indeed it is simply not the case at all, but it is by now much more established what we mean when we use the term 'psychopath', although the term is still not established completely. And this is also a reason why it is better to leave the term 'psychopath' to in-house clinical use and to employ it externally as sparsely as possible and never without further description. It seems that the term implies something ethically or socially negative. It is a similar process to that which occurred with 'hysteria': an increasingly clearer lapse into value judgement, into moralising. Others again still associate 'psychopath' with a form of minor psychosis, a precursor to it, a milder form of it. In this case, decades of effort appear to have been in vain. It is therefore recommended to be reticent with the use of the term 'psychopath' in reports to doctors, youth officers and expert reports of all kinds. One should describe as vividly and as clearly as possible and without using 'specialist terms' the type of person concerned and where appropriate, also the conflicts with which they are confronted. Occasionally it might be possible to state afterwards: "one could, if one wanted, refer here to a psychopathic personality." This is in fact often the case: one can use the term, but only if one wants to.

Typological designations of psychopathic personalities should be viewed with all the reservations expressed here and bearing in mind the problems that arise with each of these type designations. If this is done, then such a typology can still be useful even now, despite its limited, superficial epistemological value. At any rate, it can be used to show much that is human.

The Assessment of Criminal Responsibility*

This lecture, more precisely than the title states, will be about the relationship between various types of mental abnormality and the question of criminal responsibility. Assent to or denial of criminal responsibility is very closely linked to understanding of the essence of mental abnormalities. A generally accepted common property in psychiatry hardly exists anywhere; nearly everything that can be said is also disputed somewhere with more or less justification. I intend to set up before you the framework on which I stand, without much apology, which would here lead into infinity, but I shall not hide weak areas either. From this framework, from the development of a psychiatric system, a position with regard to paragraph 51 of the StGB [Criminal Code] will then be adopted. At the same time, however, the necessity ensues of understanding it in its psychological content and meaning.

I.

One hears it said so often, even by lawyers: "But that can't be normal…" and then the corresponding conclusions are drawn regarding soundness of mind. However, a considerable refinement of the enquiry and a clear insight into the kinds of mentally 'not normal' are needed straightaway. To quote Goethe: "If you miss the first buttonhole, you will not button up all the way to the edge."

Mental abnormality exists, firstly as a result of disease and secondly as a mere variety of mental existence.

By way of illustration, consider the following briefly: if a man in the prime of a hitherto unremarkable life becomes careless, forget-

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*Reference: K. Schneider. *Die Beurteilung der Zurechnungsfähigkeit*. Georg Thieme Verlag, Stuttgart, 1948.

ful, tactless, rude, indifferent and antisocial as a result of a paralytic brain disease, this is a mental abnormality as a result of disease. If a man attracts attention even in his schooldays because of difficulties such as playing truant, mendacity and disorderliness and soon afterwards commits his first major robbery and from then on, until age moderates his activity, receives one conviction after another, that is a mental abnormality as a variety of human essence and in particular an abnormal (psychopathic) personality.

We recognise many mental abnormalities as a result of diseases. By that we always mean only that the disease causes the existence of the mental disorder as this does not encompass its essence, its particular appearance – here a different and much deeper area of psychiatry opens up. Ultimately they are always brain diseases. Even if the disorder, for instance in the case of an infection, has its primary location elsewhere in the body, the 'successful organ', the organ through whose disease the mental abnormality results, is always the brain. Among such acute diseases we can list drug or alcohol intoxication, among acute episodes of chronic diseases the clouded consciousness and twilight state of some epileptics, and among chronic diseases the paralysis referred to above along with senile, arteriosclerotic and atrophic brain diseases. These are generally familiar and easily understood facts, even if the how of the connection remains empirically unfathomable because this question strikes at the metaphysical problem of the 'connection' between body and mind. We speak in the language of 'empirical dualism', indeed of 'empirical interaction', which is meant with all metaphysical reservations. We find in the world the physical and the mental way of being which cannot be compared with one another and can hardly express our experiences otherwise than as dualistic, depending on the kind of interaction or at least correspondence between the two. That is all that is meant here, that is, nothing metaphysical is intended.

Now it must be admitted that we do not recognise this disease wherever we are forced to assume, on the basis of the structure of a mental abnormality, that disease is the cause. It is an embarrassing and almost shameful confession that, in the majority of inmates of mental asylums, we do not recognise the diseases underlying these

mental abnormalities and only postulate them even in the case of the quite definitely and severely 'mentally ill'. These forms are today subdivided nearly everywhere into two overlapping types: cyclothymia and schizophrenia. For cyclothymia, the term 'manic depression' is often employed, a quite inappropriate term, as only relatively few of these patients have both manic, that is cheerful, excited and energetic and also depressive moods, and the name 'manic' is hardly ever appropriate for these states. These patients are burdened with this quite unjustifiably. For a long time, the second type was called 'dementia praecox', but it was neither dementia, i.e. an actual destruction of the intelligence itself, nor was it always an early disease.

Thus, we still do not know the diseases underlying cyclothymia and schizophrenia. We can identify neither a certain brain finding in them nor a condition elsewhere in the body that affects the brain secondarily, thereby producing the psychosis. We also know of no neurological syndrome, such as the seizures in epilepsy, which we can regard for this purpose as a known disease with regard to the mental disorders, although it is not the disease itself. The fact that cyclothymia and schizophrenia are sometimes but by no means always hereditary does not mean that we know the diseases that cause them. These things are confused again and again, even by experts. One can find that a psychosis is inherited and still not know what kind of disease is hereditary and causing it. A recognised hereditary occurrence must not be mistaken for a recognised disease.

The assumption that cyclothymia and schizophrenia are due to diseases is thus purely a postulate, even if a very well, indeed almost cogently justified one. Only the most important reasons will be listed. Apart from the very frequent inheritance just mentioned, disease is suggested by the fact that these states are often triggered in biologically critical periods, in puberty, in pregnancy, in the puerperium and in the degenerative years and furthermore, by the fact that general physical changes are not infrequently found, such as weight fluctuation, cessation of menstruation and vegetative disorders of various kinds.

However, all of this is not as weighty and convincing as the purely psychological facts. These states occur completely without

motivation; they are not mentally based and they tear apart the meaningful continuity of life's development that is characteristic of non-diseased mental life even when this is of an abnormal variety. Mental life essentially develops as the resultant of two factors; it develops according to its constitution, which includes the general tinge that comes with age, in interplay with the destinies acting upon it, experiences, events in the widest sense (Karl Jaspers). In the cyclothymic and schizophrenic states, something now happens that cannot be deduced from this interplay: a break, a crack, something that cannot be comprehended from these two factors, whether it is episodic and reversible or a chronic process. This is now exactly as in the mental disorders that are a result of comprehensible diseases and otherwise only in such diseases, which is why the conclusion that cyclothymia and schizophrenia have causative (physical) disease processes is very well founded. However, the special symptoms are very different in the one and in the other. (This is very strange: whether we recognise a physical cause of disease or do not recognise it cannot possibly be the essence of these causes. How does it then happen that diseases familiar to us throw up certain symptoms and unfamiliar ones throw up others, almost, if not completely, without overlapping? There is no satisfactory answer to this, not even a speculative one.)

Mental abnormalities as mere varieties of mental essence are not due to diseases. They are not something abnormal in quality but only in intensity, deviations from what is average, customary, usual. Here there are no sharp boundaries compared to the 'normal' states and in milder cases it is therefore often arbitrary, 'a matter of taste', whether it is described as an abnormality or not.

The forms of this are:

1. Abnormal intellectual constitution, merely a variation of intellectual endowment. Although there are upward variations just as often, only the downward ones are of interest here: limited intelligence, congenital feeble-mindedness. This also exists as a result of disease; indeed, the more severe congenital forms of feeble-mindedness can always be understood thus. However, it is beyond question that weak intellectual endowment occurs merely as a variation.

2. Abnormal physical (vital) instinctual urges, amongst which almost only the sexual ones are of practical importance.
3. Abnormal personalities, certain types of which tend to be called psychopathic: unusual, peculiar personalities, falling outside the boundaries of what is usual. To comprehend the essence of the abnormal personality, it is quite irrelevant whether it is assessed as socially positive or negative. We have an average norm in view, not a value. 'The saint', seen from this aspect, is just as abnormal as many a criminal. The designation 'psychopathy', which tends to be used as a kind of shorthand, must on no account be used only for disturbing, asocial, abnormal personalities.
4. Abnormal reactions to experience: one might think of the suicide of a distressed person, reactions of jealousy, reaction to arrest, custody and conviction, to reactions of fright and fear. All such strong acute affects can lead to clouding of consciousness, to twilight states, even if this is very rare on the whole. These are all variations, not consequences of disease. If one in some way imagines a physical 'correlative' to them, it would be imagined only as a variation of a morphological or functional nature. This may be thoroughly acceptable in the case of congenital abnormalities of intellect, physical instincts and personality; however, in the case of abnormal reactions to experience, the causes cannot be imagined as physically abnormal, but at most as the 'apparatuses' that absorb the experience and respond to it. We know nothing of all of this.

We arrive at the following outline:

1 Mental abnormalities as the result of diseases.
  a) Known diseases.
  b) Postulated diseases.
2 Mental abnormalities as variations of mental essence.
  Abnormal intellectual endowment, physical abnormalities of instinct, abnormal (psychopathic) personalities, abnormal reactions to experience.

We make a fundamental distinction between 1 and 2. We speak of 'disease' and 'pathological' only in the case of 1. Our concept of disease is a purely medical concept.

The question of the connections between 1 and 2 can barely be touched on here. If a 'psychopath', uncontrolled by nature, becomes explosive and violent under the effect of cerebral arteriosclerosis, a connection, indeed a transition, can be seen between 1 and 2. Naturally such transitions exist just as much between normal personality states and group 1a. Many psychiatrists, under Kretschmer's guidance, also assume transitions, not just connections, between 1a and 1b, i.e. cyclothymia and schizophrenia and the abnormal personalities and reactions of group 2. We do not do so but we rather assume that there are sharp boundaries. We ask 'Either – or' and believe that we can also answer this sharply. These are special problems of psychiatry, about which there can be different opinions. We have presented ours in advance and will now consider from this roughly constructed framework the question of criminal responsibility.

II.

We will first give the text of paragraph 51 of the Criminal Code, which is to be expounded.

A criminal offence does not exist if, at the time of the offence, the offender is incapable of understanding the illegality of the offence or acting according to this understanding because of a disturbance of consciousness, because of a pathological disorder of mental activity or because of feeblemindedness.

If the capacity to understand the illegality of the offence or to act according to this understanding was substantially diminished at the time of the offence for one of these reasons, the penalty can be mitigated according to the regulations regarding the punishment of the attempt.

If we now approach the application of this paragraph on the ground of what has been expounded and learned, we will deliberately ignore much that encumbers this task: the history, preliminary stages and legal philosophical premises[1] of this paragraph and also the commentaries and otherwise vast literature to which it has given rise, both for and against it. It usually comes from a

1. See H. Leferenz: "Die rechtsphilosophischen Grundlagen des § 51 StGB". In: *Der Nervenarzt;* in press.

psychological and psychiatric point of view that is no longer ours. And our business is solely to enquire into and expound it from the psychological and psychiatric aspect.

If we consider our psychiatric system as presented above and the text of paragraph 51, this would suggest simply saying that we exculpate among the kinds mentioned under 1, the disease forms, but not in the case of 2 as these are variations of human essence and are therefore subject to the same principles and requirements as human essence generally. However, this would be much too simple even if one were to grant diminished responsibility to milder degrees of group 1 and to more severe degrees of group 2. It would be schematic and would not do justice to reality. Furthermore, this procedure could not be brought into harmony with the wording of the paragraph.

This expressly names three types of psychopathological facts: disturbance of consciousness, pathological disorder of mental activity and feeble-mindedness. This in fact applies exactly to what tends to be exculpated (quite generally and independent of the psychiatric position), namely, all of group 1 and from group 2 the reactive (affective) twilight states and congenital feeble-mindedness. The result is complete congruence and work that is satisfying in practice, especially if only diminished responsibility were to be assumed in certain mild cases of disturbed consciousness and feeble-mindedness from group 2 and perhaps also in certain milder cases from group 1a, also predominantly with disturbed consciousness and feeble-mindedness.

It must not be concealed that this congruence only applies with our clinical views and particularly with our concept of disease. It has often been said that the legislator does not intend this somatic disease concept, that, for example, in the meaning of paragraph 51, expressions of the psychopathic personality can also be understood under 'pathological' disorder of mental activity. However, this does not alter the fact that the expert witness actually keeps to these three facts even when he has a different (or usually no) disease concept: when they are present, he exculpates and generally only then. And we are left with these facts, i.e. we are content with establishing them; if they are present, we do not enquire any further.

But that is not the intention of paragraph 51. It does not state: "A criminal offence does not exist if at the time of the offence the offender is in a state of disordered consciousness, pathological disorder of mental activity or feeble-mindedness." Although this version would be sufficient for us as we do not think or enquire any further, this is not what the wording states. The three listed psychopathological facts must make him incapable of "understanding the illegality of the offence or acting according to this understanding." Only then does the criminal offence 'not exist'. Stated in brief, we are therefore asked about the capacity or incapacity to understand and the capacity or incapacity to act according to this understanding. There is thus a two-storey structure, where one must envisage the three upper designations in each case connected with the two lower ones by arrows pointing to them.

Disordered consciousness – Pathological disorder of mental activity – Feeble-mindedness.

Incapacity to understand – Incapacity to act according to understanding

These latter questions about the capacity to understand and the capacity to act according to this understanding are in fact unanswerable, particularly the second, and we therefore do not answer it directly at all but much more roughly than we are asked. We are left with the clinical (psychopathological) facts of the 'upper storey' and if they are present, we assume silently that the capacity to understand or the capacity to act according to this understanding was not present, though a position is not adopted regarding the 'or'. We hardly ever differentiate between these latter two questions in our answer – to a certain extent, we do not even get that far.

The opinion has also in fact been held that only the 'upper storey' concerns the expert witness somewhat and that the lower storey is a matter for the court. However, the general opinion today is that this is incorrect and that the expert witness has to give his opinion regarding the entire scope of the wording.

The possible special versions of our answers will be considered only briefly. Quite summary statements, which do not refer at all to the wording of the paragraph, will suffice, assuming naturally that in particular the life history, the development of the disease

and the mental findings at the time of the offence and today are clearly apparent from the expert report. We might perhaps say: "From our exposition, it is apparent that N. N. at the time of the offence was suffering from schizophrenia. He is therefore supported by paragraph 51 section 1 of the Criminal Code." That suffices even though it is not really an answer to the question that has been put. A version somewhat closer to the text would be: "N. N., according to our exposition, was suffering from schizophrenia at the time of the offence. There was therefore a pathological disorder of mental activity, which results in the application of paragraph 51 section 1." However, there is practically never any talk of the capacity to understand and the capacity to act according to this understanding, at least it is never considered in detail, because nobody can answer that.

Why not? This must be explained in greater detail. The text of paragraph 51 is based on a psychology of action, which is far from real life and cannot be reconciled with today's psychological perceptions either. It has ancient historical preconditions, which must not detain us here. It divides the action into a rational, intellectual part and into a voluntary decision. It means that the acting person considers beforehand whether the action is right or wrong, permitted or prohibited and the decision to act is then made based on this, that is, on consideration. A 'rational' person should certainly act that way, this is what parents and teachers demand – but in reality hardly anyone acts that way. And if people always wanted to act thus, they would be like compulsive persons who would never make any headway.

To give an example: a post office employee gets a parcel into his hands. He suspects that it contains cigarettes and the urge, the desire to keep them for himself stirs. According to the schema, he should now have the understanding at the ready that this is illegal and accordingly he should not do it. That may well happen but it is extremely rare. The process happens as follows: the sight or feel of the parcel awakes 'in a flash' the urge, the desire, the attempt to keep it. Either the attempt passes directly into action, and then it has happened even if it may still perhaps be reversible for a while, e.g. if he does not finish work for some time

or opposing tendencies arise from the genuine ethical conscience[2] or from the warning of conscience that it would be improper to do it or also only from fear of the consequences, i.e., what would happen if it were 'found out', opposing tendencies that thus do not need to be ethical at all (just as there is mere secondary regret alongside genuine regret for a deed, i.e. if it had not had any deleterious consequences, it would not have been regretted at all despite its badness). These opposing tendencies can now simply be overwhelmed by the urge to possess or can actually lead to a halting, to prevention of the instinctive desire. All of this is a pure power play of the urges. Only in extremely rare cases will there be a weighing up of the pros and cons, the urges and oppos-

2. Whatever weight may be given theologically and philosophically to the conscience and however rightly, for most people at least, it can be said empirically that conscience cannot be absolutely relied on, it can be suspended or it can leave one incomprehensibly in the lurch. This is why morals, laws, prohibitions are needed to which the person can hold on in those weak hours even if he is incapable of meeting these standards with conviction at that moment. This is then, so to speak, a secondary conscience: keeping the commandments, doing the decent and proper thing. If this to a certain extent impersonal conscience also departs, then there is no stopping. However, it leaves one in the lurch less easily than the personal original actual and genuinely ethical conscience. – Decades ago, in a humorous magazine, roughly the following words were written under a picture showing a girl in an awkward situation: "I think I don't have my character with me once again today." – A profound word, whether the actual or the impersonal conscience is meant.

N. Hartmann in chapter 54 of *Ethics* (2nd edition, Berlin and Leipzig 1935) said profound things about 'ethical values' and 'values of behaviour'. Here we mean something different, which will be clear from the fact that we cannot subsume what is meant here under the title 'values of external dealing', which N. Hartmann gives to that chapter. We mean here that ethical values, which lapse in a certain sense at this moment, i.e. which cannot be achieved personally and therefore are not there, not just now, can be replaced by instinctively and conscientiously keeping to 'morals and decency', by which continuity of moral behaviour can be guaranteed despite the ethically basically empty segment. Conscience can therefore call to moral behaviour even when the ethical sense cannot be lived at the moment and perhaps never can be. This is of great importance in criminal psychology. Keeping to this secondary, to a certain extent secularised conscience is something completely different from when a person desists from a wrong action purely from fear of the external consequences.

ing tendencies and finally an elective voluntary decision. Because the action takes place as we have described, it is also absurd to ask: "What were you actually thinking of when you did it?" The answer is 'nothing' – if by thinking we understand rational consideration.

The great difficulties, which encumber the question of the capacity to understand and in particular, the capacity to act according to this understanding, should be described in more detail even if still very roughly in relation to the possibilities of reality.

The 'understanding' of the 'illegality' of the action means not what is ethically permitted but what is illegal. In paragraph 3 of the Juvenile Court Act it says so expressly. According to my feeling for language, however, 'understanding' the illegality sounds thoroughly ethical. With regard to what is illegal, 'knowing', 'knowledge of' would sound more correct to me. What is not permitted ethically and legally are two different things, however hard the criminal codes attempt to make them coincide, i.e. to forbid what is bad – a profound and necessary legal philosophical principle. However, the human being cannot always go along with the ethical content of a legal prohibition. In the first place, he may perhaps not comprehend the meaning of the prohibition purely rationally, particularly in more complicated situations. In other cases he understands rationally and perhaps he also understands the moral sense and nevertheless, the meaning does not become an interiorised value, a value experience. Finally there are also prohibitions without an ethical sense, less in the criminal code than perhaps in police regulations. I am still capable of understanding ethically why I must not walk over an unmown meadow but I cannot interiorise ethically why I must not walk on a forbidden path. At least I would have to know in advance why the path is forbidden, e.g. because it leads across an unsound bridge. However, we are educated in such a manner that we also feel ourselves involved ethically when we discover ourselves on a forbidden path, as what is forbidden by the authorities leads easily to the establishment of ethical norms in general.

However the relationship of what is not permitted ethically and legally may be in the individual case, an understanding of what is not permitted legally is demanded. Now, there is a further very

important difference between whether a man has this understanding (whether rational or normative) in quiet hours, outside the situation of temptation or whether it actually pops up to warn him in the endangering situation, whether he has it 'with him'. Potential, inactive understanding and having this understanding ready to hand at a certain moment are two very different things. Demanding the latter is obviously more. Whether the understanding is currently there does not depend on the rational, on 'knowing about', not even when the prohibition is seen as morally or at least socially correct and necessary, but on the emotional, value-related and instinctive strength of the understanding, on its vitality, whether it has become part of one's 'flesh and blood'. Here it is not so important whether this vitality is one of ethical interiorisation, personal conscientious identification or instinctive compliance with morals and decency or only of training: that is forbidden and if one does it, one will be punished. However, the engagement of the current understanding also depends on the instinctive strength of the temptation, which can be so powerful that nothing emerges beside it.

Potential, i.e. inactive, and present instinctive understanding must be considered separately. The former can even be examined to a certain extent and established by questioning. The person in question will have understood in the meantime in most cases that one 'was not allowed' to do that, but whether he can understand the moral sense still remains to be established. Whether the understanding emerged as an inhibiting urge, in particular as if one could 'demand' this, eludes anyone else's view and judgement. The time factor is of great importance. The more an action is extended in time, the more stages it had, the more it required individual actions and considerations, such as a complicated forgery of documents, the more can one expect and 'demand' that there was room for understanding to be there and this understanding was given an opportunity to speak. This distinguishes ethically affective actions from considered, deliberate ones.

The judgement of whether the capacity existed of acting according to an understanding is even more hopeless. The (presumed) present understanding, whether rational or in some way normative,

is to be the spring, the motive for preventing an illegal action and one should act according to it. That is, something negative, a braking, a renunciation is nearly always demanded. The Criminal Code essentially does not ordain what one should do but forbids what one should not do (paragraph 139 is an exception). Thus, not only the current emergence of a rational or normative understanding is demanded but also that it prevents what is illegal. Whether the man was 'capable' of this eludes every judgement. In fact, every starting point for a response is lacking, even if we assume 'free will'[3] as a precondition of the whole and leave it completely out of play. Without assuming free will, one can safeguard, frighten off generally and individually and also educate, which would be impossible with total indeterminism, but one cannot punish. A 'criminal' law without the foundation of responsibility would not be a criminal law at all.

However, assuming free will and assuming that its existence or indeed the capacity for it can be judged from the outside in the individual case, is something else entirely. One can only say that an 'ability to do otherwise' is assumed in the 'normal' person but not in certain kinds of abnormality. This does not have to be thus by any means, either with regard to the understanding or with regard to the capacity to act in accordance with it. It is not stated, indeed it is obviously wrong that both would always be denied even in the clearly severely ill patient. However, we are virtually unable to answer these concrete questions. We therefore answer only approximately, summarily, roughly clinically, we keep to the three psychopathological facts, to the 'upper storey', and conclude silently from its existence the incapacity for understanding or the incapacity to act according to it.

In our task of assessing criminal responsibility, the demand emphasised by N. Hartmann[4] that the person himself must recognise the responsibility, "that all responsibility that is not recognised by the person him-/herself remains deeply doubtful", cannot help

3. On this subject recently: E. Mezger: "Über Willensfreiheit". Sitz.-Ber. der Bayer. Ak. d. Wissensch. Phil.-histor. Kl. 1944/46; 9.

4. *Ethik*. 2nd edition, Berlin and Leipzig 1935, chapter 77.

us further either. N. Hartmann himself acknowledges deceptions on this point. In fact, persons of diminished responsibility and psychotic persons undoubtedly defend their criminal responsibility to us, usually fanatically, and non-patients, whom we declare to be criminally responsible, deny it just as often. On this point, it must indeed be said that this is not always founded in the inner consciousness of criminal responsibility but in the tendency to escape punishment this time or else in a need for self-defence and saving one's self-worth. Nevertheless, it will be admitted that these persons hardly ever deny their criminal responsibility in general but only for the deed in question and not always because of the consequences, e.g. from fear of indefinite imprisonment, but also because they actually perceive the denial of soundness of mind as a kind of 'incapacitation and debasement', as a denial of the "moral being as a person". N. Hartmann is correct about this, even if he has a very high quality of the person in view overall from our point of view. Deep down, even the simple person makes a "claim to soundness of mind", however often his intellectual tendencies in the specific case appear to argue against it. That the 'judge of human nature' might decide casuistic questions, i.e. whether freedom existed in the individual case, is, however, expecting too much of him – he cannot do that.

Overall we get on well with paragraph 51, as we did with the old version that was in force for over half a century, but only because we do not answer its questions directly at all, but infer the answer clinically. The crime itself is also rarely considered more closely, although in paragraph 51 everything is aimed at the concrete action. We conclude the state generally when the offence was committed from the overall clinical state. It is different in the case of disorders of consciousness because we gauge from the offence the features of the disorder of consciousness. We also look at the offence in the case of feeble-mindedness, particularly when it is of milder degree. It is often important whether it is a matter of a simple offence or one that is difficult to overlook and judge. Otherwise, however, we give a roughly summary answer in the described manner. It is also not asked whether the content of a psychotic disorder, for instance, mania, has a connection as regards its

content with the nature of the offence. We exculpate a delusional patient for every murder, not only that of his persecutor. Psychosis suffices us here.

A few comments, by no means exhaustive, about diminished responsiblity. When it finally became law, it was again unwelcome on the whole to the then upcoming generation of psychiatrists. The pros and cons cannot be the topic here. It is there and we must deal with it and avoid or diminish its dangers.

The worst thing is when an expert witness conceals his clinical diagnostic uncertainty and embarrassment with it and chooses this middle way out of it 'for all cases' – "expert witnesses of diminished responsibility" have been mentioned, not without reason. It is also bad when the expert witness adopts this compromise in cases that with the best will he cannot solve.

Regarding the question of the capacity "to understand the illegality of the offence or to act according to this capacity", a more detailed position will not be adopted here further. If the positive and negative decisions are already difficult and virtually impossible in the second part of the question, this certainly applies for estimation of the degree of diminution, and in particular, 'substantial' diminution of these capacities. Here, too, one is reduced to one of the three clinical facts and indeed the degree of their intensity is a roughly estimated starting point. An – in short – substantial diminution of responsibility is assumed in only mild degrees of disordered consciousness, pathological disorder of mental activity and feeble-mindedness. This would not be done in a pathological disorder of mental activity in the clinical form of cyclothymia and schizophrenia. Even in milder cases they represent such an incalculable and immense intrusion in the essence and action of the human being that application of paragraph 51 section 1 is always justified.

One would hesitate greatly to approach the application of paragraph 51 section 2 to psychopathic personalities. If that became the rule, an unhealthy situation would arise, at least crimino-politically. Strictly speaking, this must not influence the question of guilt, but does influence it because we cannot answer the question of guilt at all, especially not in group 2. It would have to be demanded at least

that the special variety of psychopathy is connected with the nature of the crime. Paragraph 51 section 2 could thus, for instance, perhaps be imposed on an 'explosive psychopath' for an affront but not for robbery. One might say that he found it more difficult because of his particular personality to control himself than a person who was not so easily excited. But that is a delicate point. Sexual offenders would then all fall beneath this mitigation. The sexual offender is generally not criminal outside his compulsive sphere and he only does illegal things that correspond to his particular, abnormal sex urge. Nearly all serious offenders would also be judged more mildly. The characterological essence of many persons who are 'devoid of feeling' includes the inability to remain social. Their criminality derives directly from their ethical defects. The result would be that only the harmless person, the opportunistic offender, would be punished fully. Rauch[5] is of the opinion that, in this sense, if it is granted that a congenitally feeble-minded person has a poor capacity for thought and judgement, by right the psychopath should be granted his defects of feeling, instinct and will. In this regard it should be said that there are in fact differences. On the one hand, with the feeble-minded person it is essentially a matter of the lack of understanding, but in the psychopath it is more a question of the capacity to follow this understanding. Furthermore, one cannot demand of a stupid person that he should be cleverer than he is, but it can be demanded of a person with dangerous tendencies that he should suppress them, that he does not act on them. Can one demand this? In any case, this is demanded and this is the foundation of the whole. This cannot be explained 'scientifically' but the administration of justice is not an empirical science without preconditions either and criminal law is not orientated only to the question of guilt. Here we must stop. The direct logical and practical difficulties that arise everywhere here are outside the responsibility of the expert witness. However, he senses them constantly when he

5. H. Leferenz and H-J. Rauch: *Über die Beurteilung der Zurechnungsfähigkeit. Arbeiten zur Psychiatrie, Neurologie und ihren Grenzgebieten.* Willsbach and Heidelberg, 1947.

thinks about them more deeply, which is why his task and his work so often leave him unsatisfied.

I have shown you how we 'do' it, what we can and cannot answer and how we answer. Distrust an expert witness who can answer too much, especially when he is all too willing to adapt himself to the formulations presented, often with supra-judicial ambition. If everything 'is resolved', this is not always a praise for the expert report. What cannot be concluded without violence must be left open. Reports that one can 'do something with' are comfortable but they often distort and compress the reality in the effort to be useful. It is not our ambition to answer all of your questions but to assist honestly and clearly in discovering justice with our means, which, like those of every empirical science, are limited.

Psychiatry Today*

Preface to the 3rd edition

I gave this lecture on 22nd November 1951 on the 565th anniversary of Ruprecht Karl University Heidelberg as rector of the university. I therefore had to try to make it generally understandable.

One can justifiably ask whether a lecture given in 1951 can still be called "Psychiatry today". As I see things, I can accept that responsibility. And after all, this work has become known under that title.

The lecture itself has remained as it was delivered. Of the three commentaries added to the 2nd edition, only that on the psychotherapy of the endogenous psychoses was able to remain. It was preceded by a digression on meaningfulness and understanding. It has been taken from "The assessment of soundness of mind", where it was out of place. These two parts, both essentially revised, belong closely together. They now form a single commentary, which forms part of the whole lecture.

Heidelberg, December 1959

Kurt Schneider

*Reference: K. Schneider. "Eine Rede mit einer Anmerkung zu Psychiatrie heute". In: *Psychiatrie heute.* Georg Thieme Verlag, Stuttgart, 1960; 3rd edition: 1–37.

It is an old custom that on this day, the birthday of Karl Friedrich, who revived the University in 1803, the rector gives a lecture on his speciality. My speciality is psychiatry and I intend to give you a brief outline of a few of the problems, which concern psychiatry at present. I shall not deal with problems of practical psychiatry, although there are enough of them, but rather with problems of science.

I.

The question of the object of psychiatry suggests a simple answer, which I am sure most of you will have ready. Psychiatry is simply the diagnosis and treatment of mental illnesses. But the expression 'mental illness' is already the first problem and in fact only habit can still somewhat justify this popular term. Let us look at it more closely. It assumes firstly that the mind is something being and existing in itself, an *ens in se*, an independent substance, an *ens per se existens,* as Leibniz says. Secondly, the term mental illness assumes that there can be disease in this mind, as in the body. If 'illness' is then taken, not metaphorically but strictly medically, it can exist only in something that exists in space, in something material, and so by no means in the mind, if this can still be said to be mind. There is therefore no such thing as 'mental illness' and one might at most speak metaphorically of such a thing.

So does disease here concern the bodily 'substrate' of the mind? Does it especially involve the nervous system and the brain in particular? Are diseases of the brain the object of psychiatry? In fact this has been thought for about a hundred years. Even in antiquity (Hippocrates, Galen) and also in the period of scholasticism, people thought so here and there alongside the demonological interpretations. As a principle, indeed as an axiom, it has been said that "mental illnesses are brain diseases" but only since Griesinger, since the middle of the last century. While this sentence, despite the naïve 'are', may also have a certain accuracy for a group of mental disorders, it is far too narrow to describe the object of psychiatry. Certainly, the psychiatrists are also occupied most intensively with brain diseases, that is, with neurology, and every well-planned psychiatric clinic, indeed many an asylum, has laboratories and spe-

cialists in macroscopic and microscopic histo-pathological examination of the brain. But the object of psychiatry goes far beyond the consequences of brain diseases – quite apart from the fact that until today no direct and no indirect brain disease has been found in the great majority of asylum inmates especially with the forms that first come to mind when we use the term 'mental illness'. It is a pure postulate, even if a well-founded one, to accept it nevertheless. This will be discussed later in detail. The object of psychiatry must be outlined from the psychological aspect. And that is also natural; if one speaks of a mental disorder, then a mental disorder is what it is. Seen that way, psychiatry is the science of the mentally abnormal, of its ways of manifesting itself, its physical and mental causes, its possibilities of physical and mental treatment.

This determination of concepts leads to something fundamental: psychiatry obviously includes very heterogeneous areas. It rests on the two pillars of somatology (particularly neuropathology) and psychopathology. Psychiatry seeks to unite these two so-different sciences. One could therefore say that there is no uniform science of psychiatry but only the psychiatrist. This may be regarded as exaggerated but it cannot basically be contradicted. That is, it is a science that wants to unite the physical and the mental under one roof. But is this whole approach not a philosophical one? For it includes the problem of body and mind. This is certainly the case and every step that the psychiatrist takes in this effort to unite physical and mental facts is a metaphysical one. We tend to speak in the language of 'empirical dualism'. Leaving aside all epistemological considerations, we find in experience the physical and the mental order unmistakably together. Indeed, we also speak without hesitation of a causal classification, of an interaction. That is the natural view for us, so very natural that the relationship of the physical and the mental can hardly be expressed otherwise in ordinary speech. If somebody becomes confused and drowsy after taking a poison, how else should that be expressed than in the sense of cause and effect? If someone has the intention of standing up and walking around, how else should that be expressed in natural language than that here a mental process sets the body in motion? But certainly, we go beyond the empirical as soon as we establish

more than classifications. This is what positivism and materialism have done at all times. However, if a brain researcher were to think that he could find a foothold on a straight path in the mental sphere, he would be like a man who throws a rope towards the moon in the hope that it would loop around a post up there.

The unity of mind and body is something that is simply there and does not by any means need only to be discovered. But this unity of psychophysical essence in the human being is nevertheless an irrational, a thoroughly metaphysical fact. We use the expression 'metaphysical' not in the sense of territorial metaphysics but in Nicolai Hartmann's sense: all problems, in which there is an insoluble residue, something impenetrable and irrational, whether in philosophy in the narrower sense or in the area of the empirical sciences, are metaphysical. Now, the psychophysical problem is of a 'unique irrationality' – and this is at the core of psychiatry, for what makes psychiatry precisely into psychiatry is the connection of physical and mental facts. All sciences, including somatology and psychopathology, have their own irrational problem contents, that is, their metaphysical elements. However, such sciences can halt outside these walls and work without disquiet over the broadest stretches. However, the situation is different in psychiatry, which seeks to unite these two sciences. Here the metaphysical is to a certain extent right in the middle. It is absolutely crucial for every actual psychiatric step and for every interpretation of the connection of physical and mental findings. Thus, psychiatry in fact ultimately becomes metaphysics.

II.

We have outlined the object of psychiatry in general and we now turn to more special considerations. In doing so we use this language of empirical dualism, indeed of interaction, that is natural to us. The metaphysical problem is therefore left aside. However, it is inevitable that it will be exposed again at the end. We will now talk about the three groups of mental abnormalities, which are generally recognised today (while more or less unspoken). However, there are very different views about the nature of their relationships, connections and overlapping. Here there are a few crucial differ-

ences in psychiatric opinions, for instance between Kretschmer and ourselves.

1. The mentally abnormal as a mere variety, as a variation, is present in all areas of mental life. We would state explicitly that 'abnormal' does not signify an evaluation but only a quantitative deviation, a deviation in intensity, from the average that we have in mind. These forms thus merge everywhere into the normal states without sharp boundaries. If we look away from the varieties of lower intelligence, away from some of the feeble-minded states and away from the abnormal instinctive urges, for psychiatry there remain the abnormal personalities and the abnormal reactions to experience. Both groups, by the way otherwise deeply linked to one another, can only be grasped psychologically. We know nothing at all of any physical substrate in this entire group. If such a thing were to be conceived, it could again be thought of only as a variation of bodily organs, systems and their functions. There can be no talk of 'pathological' mental disorders, of diseases, in this group unless we want to resort to metaphor. The theory of the abnormal personality, which is often also called 'psychopathy', is part of characterology, the science of personality: it is patho-characterology. It describes the abnormal, out of the ordinary, unusual varieties of personality. And the theory of the abnormal reactions to experience is again nothing but a representation of the abnormal variations in processing experience. They can extend far into the physical sphere as psychogenic physical disorders. We just spoke about the deep connection between personality and experience processing. It exists if only because personalities can often only be grasped in their reactions to experiences, destiny, situations. Whether the weight is more on the personality or more on the experience as such is controversial, not only in the specific case but also fundamentally. In the case of abnormal reactions to experience, the psychiatrist is inclined to place great weight on the personality, indeed on the innate personality. By this he does not mean something that is always hereditary but simply understands it as something given to the human being, provided prior to life. Psychiatry (including myself) has never overlooked the fact that many kinds of abnormal personalities can be extensively moulded and changed by experiences, by destiny. It is

also not possible to overlook the fact that it occasionally happens that a person whose personality can by no means be described as somehow deviant, abnormal or psychopathic gets involved in severe abnormal reactions because of an experience, because of a mental shock. Some profound motivated reactive depression, some fear and anxiety reactions with confusion and impairment of consciousness, some mentally induced physical disorders could be listed here. However, 'neurosis' (a name that means linguistically exactly the opposite of what is meant by it) generally grows on the soil of an abnormal personality, which is constitutionally inclined to all sorts of difficulties with itself and with the world around it. This is an annoyance for psychoanalysis and psychosomatics. They dispute the 'psychopaths' more or less and believe that these forms are stamped by life, by destiny, and particularly by early childhood experiences. One can arrive at such interpretations only if one submits to the psychology of the unconscious that leads completely into the dark. If it is assumed without contradiction that there is something innate in the (negative) variations of intellect, in intellectual under-endowment, it is not apparent why there should not be such innate variations in the area of the personality also.

'Depth psychology' began by using its methods to research psychogenic (at that time 'hysterical') physical disorders, that is disorders of physical function that had arisen mentally and were maintained mentally, which are not pathological in our sense. Psychosomatics goes one step further. For it, genuine diseases are completely or partially mental in origin. Their development derives from some situation of the life history and in it some purpose, some intention. The diseases are there when one needs them, they have a biographical meaning. Thus a difference between a psychogenic physical disorder and genuine disease is lacking after all. If paralysis during life was assumed to be psychogenic and a brain tumour was then found at autopsy, this is fundamentally not an objection to psychogenesis. The entire problem of psychosomatics, which exists in a moderate and a radical form, can understandably not be expounded here. The mere fact that veterinary medicine exists, that hens and cows can also get sick, might convincingly restrain us from exaggerating psychosomatic opinions. But there are very

serious problems. It would be highly important and meaningful to conduct statistical psychological research into how often depressing or stimulating experiences are effective in a stomach ulcer or asthma attack. This might perhaps be assumed with certainty in some cases but only with a degree of probability in others. However, because of the connection with psychoanalysis, with the psychology of the unconscious, because it departs from what is immediately tangible intellectually, psychosomatics from the start has trodden a very uncertain and uncontrollable path and missed the right direction. In detail it might be stated thus: physical functions, such as gastric secretion, intestinal activity, heart and blood vessel regulation and breathing, which are assigned to the emotions as expressive phenomena, are more susceptible to mental influences than others. Mental influences will therefore be seen much sooner in diseases in these areas than, for instance, in acute infectious diseases or cancer. This second group also includes the known or unknown diseases underlying the 'mental illnesses'. Here the possibilities for mental influence are obviously extremely small, although the symptoms are of a mental nature. A further deeper reason for psychologising disease lies in the need to make diseases subject to the will of the human being by classifying them in associations of motives. We do not want to accept anything because we would like to control it ourselves – a titanic rebellion against fate and its transcendent origin.

In this entire first group, in the abnormal personalities and abnormal processing of experiences, the only treatment is psychotherapeutic, whether in the form of a more educating guidance or whether in a form that helps to deal with a certain life conflict. Some forms, such as the psychogenic physical disorders or perhaps compulsive and anxiety states, often require systematic, revealing psychotherapy. Psychotherapy of any kind can be successful. The success is not proof of the correctness of the theoretical path. Anything somatic, for instance medication, can only occasionally be incorporated here cautiously and sparingly for support.

2. We now come to the mental abnormalities that are clearly recognised as the results of disease, which is why the treatment is medical. If we disregard malformations and brain damage of

some kind before or during birth, which often leads to feeblemindedness, this is something that has developed in the course of life. There are acute forms, such as the mental disturbances in intoxications, infections, head injuries, and there are chronic forms, which sometimes derive from the acute ones. The psychological picture of these results of disease is as follows: in all such acute disorders, the cardinal symptom is clouding of consciousness or loss of consciousness. Often this is not a matter of simple drowsiness but excitational states or hallucinations are often seen, states that are quite generally called delirium. The chronic states have as their cardinal symptom the breakdown, the loss of differentiation, the loss of the personality and intellectual breakdown, idiocy and dementia. These chronic conditions are, in many cases, not only chronic but the breakdown proceeds as a process. In this entire group the special physical cause can never be deduced purely on the basis of the psychological picture, i.e. the diagnosis of the underlying disease. It was Karl Bonhoeffer, director of our clinic in the summer semester of 1904, who recognised that these pictures are nonspecific 'exogenous reaction types', by which, however, he meant only the acute states. The diseases underlying these typical conditions can thus not be diagnosed psychologically but only medically. The entire modern diagnostic apparatus of internal medicine, particularly neurology, is applied here. Simple examination of the patient will not always, indeed will seldom lead to the goal; for this, one needs laboratory tests, such as blood or spinal fluid tests or radiography of the brain after filling the cavities with air or electroencephalography, the non-operative recording of the brain's electromotor forces. In most cases, when the disease has a fatal outcome or the patient otherwise has an autopsy, the autopsy findings fit the clinical findings and sometimes there is a surprising autopsy result.

Because of its great fundamental and historical importance, we will say something about one chronic disease in this group, namely, general paralysis. Here we know the cause: syphilitic infection. Here the same neurological findings recur again and again. Here there are characteristic serologic findings when the blood and spinal fluid are examined. And here as the cardinal mental symptom we find

the personality breakdown and dementia mentioned above. Only for a few decades has it been possible to treat and arrest this disease successfully with Wagner v. Jauregg's fever treatment. Previously it was regarded as fatal without exception. If it is not treated, physical decay goes hand in hand with the increase in mental destruction, leading to death after a few years. That this is a uniform disease was already suspected in the first third of the last century but this was generally accepted only in the last third. General paralysis was the first psychiatric disease entity to be found; with the same cause, the same physical findings, on the whole the same mental disorders and finally the same brain findings on macroscopic and histopathological examination. Paralysis became the model for forming disease entities. It was thought it would continue thus, it was hoped that with time more and more such disease entities would emerge from the multifarious conditions of the mentally ill. In fact, however, this did not happen and things have basically remained the same with this one disease entity. As before, by far the great majority of asylum inmates cannot be included in some disease entity and certainly not in such diseases that combine the physical and the mental in the described manner.

3. This leads to the third and last group, the mental abnormalities that we call 'endogenous psychoses', although this customary name cannot tell you anything initially. After all the attempts to grasp a physical disease here and find genuine major disease entities according to the general paralysis type had failed, the epoch-making psychiatrist Emil Kraepelin, director of our clinic from 1891 to 1903, set up minor disease entities provisionally, disease entities that remain purely in the psychological sphere and can be so expressed: the same psychological picture, the same psychological course. More specifically, with certain psychological symptoms the disease heals without residue and with certain other psychological symptoms the disease is incurable; indeed it is often progressive. He thus created the two forms that we today call cyclothymia and schizophrenia. They have not been regarded as entities that are sharply distinct from one another; they are only types that allow all transitions between one another. These two forms are recognised throughout the world wherever psychiatry is practised.

All attempts, as still undertaken today, to tailor other entities from the great sphere of the endogenous psychoses have not been convincing and have found little acceptance. Although attempts were made histopathologically and also physiologically, though so far unfortunately only in fits and starts, to discover the physical basis of these psychoses, nothing has come out up to now. There has been no lack of investigations and publications of supposed discoveries, but right up to very recently, one disappointment followed another. This may be less surprising in the temporary cyclothymic phases although they provide favourable conditions for pathophysiological investigation because findings could be recorded in the same healthy and sick person in relatively short periods of time. However, there is no hint of the pathophysiology of the cyclothymic phase. The lack of all physical findings in the schizophrenias, which not infrequently end in a severe mental deficiency state lasting years and decades without any threat to physical health and life, is much more astonishing. However, even in these endogenous psychoses, there is no known physical cause nor are there regular concomitant physical manifestations as symptoms of an underlying disease nor specific laboratory or autopsy findings. If we speak here of diseases, of pathological mental disorders, this is still a pure postulate today, for nobody has ever seen these diseases.

In psychiatry a fine thread of what has been definitely described somatically and psychopathologically and which is therefore valid, loops through the large mass of what has been speculated somatically and psychopathologically. After what has been said, it is no wonder that the speculative blooms particularly richly precisely in the area of the endogenous psychoses. Depending on the spirit of the age, the speculation was theological, natural-philosophical, scientific or psychological and with multifarious connections. In the positivistic materialistic period of the late 19th century, the speculation was understandably a mixture of cerebral anatomy and psychology. Once famous and admired psychiatric works, those of Meynert and Wernicke, are essentially speculative. However, Wernicke, to a certain degree by the way, made a few very important psychopathological and clinical discoveries. Today the somatological speculations about the endogenous psychoses or (to put it more

pleasantly) theories about them, essentially involve the area of the diencephalon, the hypothalamus and thalamus.

Even if in these endogenous psychoses the 'disease' has only been a postulate hitherto, how have we the right to assume that these endogenous psychoses are diseases anyway? Numerous circumstances can be demonstrated, which make it highly likely, indeed almost certain, that diseases are involved here. One argument in favour of this is the heredity that is frequently present. One should guard against accepting heredity roughly as a cause, which happens even in widely available textbooks of psychiatry. Heredity is not a cause in the nosological sense, as the disease itself has not been identified with the hereditary occurrence. One would first have to know the disease that is being inherited, which is actually the case in a few hereditary neurological diseases. In favour of disease there is also the fact that endogenous psychoses not infrequently are triggered by comprehensible diseases and that, in contrast, psychological elements appear to play a triggering role only in very rare cases. Furthermore, they often occur at biologically critical times; also, in some forms certain general nonspecific physical changes are not uncommon either. Moreover, all psychotherapeutic efforts achieve nothing decisive, while modern physical treatment methods at least appear to be able to change these states and can even cure phases of cyclothymia. What finally, almost conclusively, argues for disease is the following: in the endogenous psychoses, life's meaningfulness is destroyed temporarily or permanently in a way that otherwise occurs only in mental disorders as a result of recognised diseases. Very strangely, however, the appearance of the endogenous psychoses is usually completely different from that of psychosis with a known physical cause. I cannot go into more detail here about this so important shredding of meaningfulness. The problem derives from Dilthey with his distinction between explaining and understanding and then leads through the causal and intellectual associations of Jaspers (at our clinic at that time) and ourselves, and it has been amply elucidated up to the present. In criminal jurisprudence also, on the question of soundness of mind, meaningfulness or understandability has gained great importance through E. Mezger. Although we recognise this destruction of meaningfulness as an

extremely important sign of every psychosis, it is not always possible diagnostically to work with this criterion. For a long time we have supplemented this, so to speak, methodological diagnosis of the endogenous psychoses by elaborating concrete symptoms. Together with evaluation of their further course and expression, both allow a fundamentally sharp separation without transition of all abnormal personalities and reactions to experience. We know no 'cycloid' and no 'schizoid' and no 'borderline states'.

If despite all the arguments presented, a sceptic did not want to believe in the underlying disease in the case of the endogenous psychoses, what solutions would be provided? To interpret them as 'neuroses', as psychoanalysis does, is completely out of the question. As we said already, life conflicts, which might perhaps be held responsible, are very rarely found when they are grasped with ordinary understanding. Furthermore, the picture is completely different from reactions to experience, from the 'neuroses'. Certainly, everything is conceivable by means of a psychology of the unconscious.

Perhaps one might be tempted to resort to a third possibility, to something that was no longer supported for over a hundred years, since the somatologists triumphed over the psychologists. Would it be conceivable that the mind could go astray of itself? Would the endogenous psychoses or at least parts of them perhaps be 'mental diseases' or more correctly 'dis'-orders of the mind? What we said at the start should be recalled though it remained deliberately covered up by the empirical dualism during our subsequent remarks: psychiatry is ultimately metaphysics, because it everywhere deals with the body-mind problem, which is an irrational and insoluble problem. Depending on how the body-mind problem is interpreted, the answer to the question of what psychosis, particularly endogenous psychosis, ultimately is, will be answered differently. One can speculate, for instance, from the Cartesian or monadological or Aristotelian-scholastic standpoint, about what psychosis is – none of these speculations can be contradicted and none, indeed, can be proven either.

Psychiatry as an empirical science does well to keep to the 'postulate' of disease in the endogenous psychoses as a working hypoth-

esis. This assumption has only the possibility of verification, while this remains denied to all possibilities of metaphysical speculative thought. It is not as if the endogenous psychosis as a metaphysical problem would be abolished with the discovery of the disease as interpretation of the somatic findings can be included in the speculation. But it would then become incorporated in our central thought of empirical dualism and we could then leave the metaphysical more confidently to itself.

We do not intend on any account to resign ourselves and assume that underlying diseases will never be found with the endogenous psychoses. Otherwise the same would happen to us as happened to that philosophy lecturer in Jena in 1801. In his habilitation thesis, he explained the assumption that no further planet would be found between Mars and Jupiter without knowing that Ceres had been discovered a few months previously. This philosophy lecturer was Hegel, probably the greatest name in our university, where he was a professor from 1816 to 1818. It is not my job to judge whether this error was a mathematical astronomical hypothesis or a purely natural philosophical speculation. In any case, the speculating thinker certainly errs more than the empiricist, but he errs 'more importantly'.

Our path is at an end. Every psychiatrist would have given you a different answer to the question of "Psychiatry today". This is because of the ambiguity of our subject, which I hope became obvious to you. Naturally I gave my answer, honestly but certainly 'one-sidedly'. As Goethe says: "I can promise to be honest, but not to be unpartisan."

Commentary

In the strictest use of the term, a psychological state makes sense when its existence is understandable (comprehensible) or, stated more precisely, is genetically understandable (Jaspers). Understanding is the method of grasping such meaning. Seen like that, one cannot speak of a thorough meaningfulness or continuity of meaning, of uninterrupted associations of meaning in the development of mental life. On the one hand, very much is simply given, for instance innate intelligence, the vital instinctual life and the features of the

personality. Although the vital instinctual life and personality can be largely formed by destiny, experiences and events, something of it is given. The particular shadings of instinctual life and personality due to age are also incomprehensible in the above sense. If one therefore says somewhat vaguely that normal mental life follows a meaningful course, this means only that there is a certain unity, that no major cracks and breaks occur despite the shadings of age and other meaningless elements (this cannot be expressed otherwise than metaphorically). Within this unity and because of this given, the person now reacts meaningfully to environment and events. If one wants to understand this, however, the given must be taken into account; the actions of a person can often only be understood if a certain variety of intellectual endowment and his personality are taken into account. "When I have studied the person's core, then I know his will and action" (Wallenstein's Death II, 3). Strong reactions to experience can divert the line of development, can act as inroads, indeed invasions, which crucially determine further life; nevertheless, the unity described above remains.

Not only what is innately given and the shading given to it by age are incomprehensible but also the unexperienceable underground on which everything mental is based. By underground we mean neither a psychological unconscious or subconscious on which light can be shed nor unconscious physical events, but we here encounter a metaphysical borderline concept. How one imagines this underground is thus unanswerable empirically. One can certainly imagine it physically, which seems reasonable and sometimes appears convincing. If someone were to appreciate an unexplainedly happy day as a grace, it could not be disputed either although it might be thought (translating) that grace 'was making use of' the physical. Here nothing is provable and nothing is disprovable as experience does not extend into these depths. The unexperienced and unexperienceable underground also modifies the reactions to experience. Certainly, for instance, acute sorrow about some misfortune is initially a pure reaction to experience, but when it is processed, the underground elements are of the greatest importance along with rational efforts and aids. They see to it that the same facts are borne more easily on one day for no reason and with more

difficulty on another and that there can be relapses after the whole already appeared to be overcome. Such relapses can certainly have meaningful reasons and causes but they are often outside any meaningfulness. The interlocking of the reactive and the underground is commonplace. This is the experience of normal life; an experience upsets one more if one is depressed for no reason than on a good day just as, conversely, an oppressive experience can also disturb the underground for a shorter or longer period even after it has been completely rectified. However, the underground throws up moods especially downwards (or upwards) even without any connections with the reactive. The existence of these states is no less endogenous and meaningless than the existence of an endogenous psychosis. However, there are not only such underground depressions but there are also incomprehensible times of asthenic failure, meaningless anxiety states, alienation experiences, compulsions. If such states are extreme, they will be called psychopathic. Thus, no separate clinical group is necessary for the abnormalities of the underground. It is today almost a general custom to psychologise all such states, i.e. to attribute them to biographical reasons and tendencies. Psychologising may often be correct and this type of enquiry will always be made seriously initially; however, we regard it as a mistake to elevate it to an axiom. A person can be overwhelmed by such states without psychological reasons and without difficulties in his life history and without intentions either. And accordingly, such disorders often disappear just as meaninglessly without any treatment. Sometimes it is also an impact coming from without that floats the boat again: a happy or painful experience, an encounter with some person, a task. To the extent that such states thrown up from the underground have a thematic content, such as this kind of depression or that kind of urge, these themes will always have meaningful associations with personal affairs, worries, anxieties, unmastered experiences that reawaken. However, that these states are there is meaningless. Thorough psychologising of everything mentally abnormal and mental in general that is not psychotic can only take place with constructive interpretations. These are unassailable by criticism and experience but are also not provable. The more or less evident acceptance of the interpretation

by the interpreted person himself also does not have any decisive weight. Someone who credulously entered an interpretation group will not often preserve his own judgement. As the underground, in itself something self-evident, was never expressly contrasted competitively with the experience-reactive and the psychotic, this had to be dealt with at somewhat greater length.

The opinion that one can understand the described psychological states thoroughly has a parallel in the view that all functional physical disorders (we will not even speak of real diseases) have a meaningful psychological cause, are a reaction to experience. We do not share this opinion. Not only the definite somatopath but more or less everybody can be afflicted by such disorders without a psychological cause. Constructive interpretations are indeed incontrovertible here also. While such functional physical disorders have sometimes arisen mentally, they then became automatic without the, so to speak, dead experience still playing a part. There are two kinds of interpretation of meaning: the fact that someone in a certain situation has some physical disorder can have a biographical meaning, though the 'how' of the disorder does not have to have any meaning. For instance, a child can react to suspected tension between his parents with stammering without the nature of the difficulties being associated meaningfully with the form of the disorder, namely with stammering. However, the special picture of the disorder can also sometimes be associated meaningfully with the experience. For instance, it can happen that in a scene between child and father, the speech of the bawled at child failed and a stammering remained. Here the special picture is therefore associated meaningfully with the experience. Such physical disorders also often disappear quite according to the nature of the underground disorders. They are also often overrun by current reactions to experience and abolished, even where they themselves had not arisen reactively.

What is underground fits in and disrupts the mentioned unity of mental development as little as reaction to experience. However, what is psychotic does this, whether temporarily, episodically or as a process and irreparably. The degrees of these invasions and their consequences are different. Both the underground and the psychotic are meaningless with regard to the existence (the being)

of the state, both of these in contrast to the reactive. The essence of the state is always rationally understandable in all these three forms with regard to its content, its subject matter, if these are there at all. In this regard, even in psychosis what kind of a madness a person has and what kind of hallucinations may be meaningful and also often comprehensible for the observer but never that the psychotic person has a madness and that he hallucinates. The comprehensibility of the 'what' tempts us again and again to find the 'that' of a psychosis meaningful and understandable. Psychoses, whether episodic or a continuous process, are then mistaken for reactions to experience. This question of the probably well preserved meaningfulness of the subject matter, i.e. its associations with previous experiences, with the world of the personality's feelings and values, in short, with what has been experienced, sought and desired, is not the same as the question of the meaningfulness of the existence of a state. Finally, with the essence it must also be asked whether the subject matter is present in a meaningful mode of being. It would be meaningful if a disappointment in love were there in the mode of mourning or homesickness as with a reaction to experience. It would be meaningless if this subject matter occurred as a sexual influence as in some psychoses. As with the reactive, if there is a subject matter at all in the case of the underground, this is usually present in a mode of being that is also meaningful to the observer. In the psychoses it is often meaningless. However, here, this does not mean anything more than unnatural, alienating, inappropriate and unempathisable.

We thus already have three different kinds of 'meaning': the meaning of the existence of a state and the meaning of its essence. In the case of its essence, the association between the meaning of the subject matter with what has been experienced, sought and desired must be distinguished from the meaningful association between the subject matter and its mode of being. A fourth that could be added would be the understanding of the meaning of the expression that we touched on with the functional and psychogenic physical disorders. There are many other meanings. There is also a transcendent meaning, which will not be denied even to a psychosis. Thus

and only thus can one call the existence of Hölderlin's schizophrenia and Nietzsche's paralytic breakdown meaningful.

In recent years the interest in the psychotherapy of the endogenous psychoses has increased greatly in Germany also. This is very closely connected with the psychologising of the endogenous psychoses that I have sketched. We do not mean here that the contents, the subject matter of a psychosis can be derived understandably from the biography, an undertaking that is immensely correct; rather, we mean the view that the very existence of an endogenous psychosis is causally attributable to the biographical, to experiences, conflicts and situations. One can also express it thus: endogenous psychosis is understood as 'neurosis'. Psychologistical positivism, which followed materialistic positivism, has also reached the psychoses.

In the psychotherapy of the endogenous psychoses, one must also distinguish the actual causal therapy from the more modest attempts to steer, to guide, to educate a psychotic person, to teach him work, order, sociable behaviour. No more will be said here about this kind of psychotherapy. Psychiatry has always known in any case how highly malleable many schizophrenics are. We only have to recall work therapy. However, today it depends on something different, the psychotherapy of the endogenous psychoses is making a much greater claim: it claims to be a causal therapy, a genuine, a real psychotherapy, which is directed at the cause of the psychosis, which is believed to be mental. We decline decisively the reinterpretation of endogenous psychosis as 'neurosis', above all the overvaluing of childhood conflicts and their significance as the cause of subsequent psychosis. Infinitely many people have had the most severe childhood conflicts and have grown up without any love and do not become psychotic (and not 'neurotic' either, by the way). In the case of infinitely many psychotics also, with the best will in the world one can find no defect in childhood and the family environment unless one wants to write creatively. How would it happen, moreover, that the same unfavourable home circumstances should lead on one occasion to a 'neurosis' and on another to a psychosis? How does it happen that the psychoses in fact differ so completely from the body of reactions to experience and abnormal reactions to experience ('neuroses')? It is in fact necessary to assume that

there is something given, something innate both in the psychoses and in the 'neuroses' – the constitution that is today so often and so arrogantly mocked, though one does not have to think of it as hereditary or as ineluctable destiny. Nobody will dispute that conflicts of every kind not only shape the 'neuroses' but to a large extent produce them as a *"Conditio sine qua non"*. However, their causal role is extremely doubtful in the case of the endogenous psychoses or at any rate is not unequivocal. Otherwise, the question of whether experiences can manifest an endogenous psychosis at a certain time coincides with the old problem: triggering by mental causes. This sometimes exists, even when considered critically. An interpretation cannot be attempted here.

In order to avoid difficult and ultimately unfruitful explanations, we appear to speak of 'cause' and 'causal' somewhat roughly. In the concrete case, a cluster of causes will always be assumed: each of these actually innumerable and unassessable partial factors is therefore equally important for the achievement of a result. Clinically, however, the factors without which the state would not exist do not matter, but what matters is that without which it *could* not exist – what cannot be thought away, what cannot be changed. That is how 'cause' and 'causal' are meant here. Just think through this in the admittedly very simple model of paralytic psychosis.

If one considers the malleability of endogenous psychoses by mental influences more closely, one cannot simply regard the cyclothymic and schizophrenic psychoses as equivalent; we must distinguish them as types in any case, and we can also distinguish them in the great majority of cases. Schizophrenia is incomparably more accessible in this respect. The great dependence of its symptoms on the situation must warn us against assuming that these states are simply due to brain and bodily causes. How often we find that a schizophrenic, when he comes to the clinic, simply gives up his symptoms, whether it is that hallucinations just stop or that there is a dissociation from madness. It can also be found that schizophrenics, shortly before their death, lay aside and give up their psychosis and also the schizophrenic expression. This malleability showed itself extremely compellingly during air raid alarms and attacks. Those with disordered consciousness, demented and cyclothymic

patients are somehow capable of reaction within the framework of their possibilities, but neither one or the other is able simply to leave aside their psychosis in a certain situation. Cyclothymics cannot interrupt their condition for an hour, as some schizophrenics can, at any rate as regards its expression. (It is something entirely different that some cyclothymics can dissemble or pull themselves together). Cyclothymia is just much more 'intimate'. Its rigidity and incapacity to be shaped by experiences should also warn us against letting cyclothymic depression merge into reactive and underground depression.

From this great situational malleability of schizophrenic psychoses, it can also be understood how effective psychotherapy can have access to them. It can also be understood how in the case of cyclothymics psychotherapy can at most succeed briefly and superficially in calming them; perhaps it may also have an influence on aspects of the symptoms but even that is only in mild cases. When successful psychotherapy of cyclothymics is reported, we would doubt it in all seriousness. Either it was not cyclothymia or the natural course of cure met the psychotherapist half-way.

When evaluating the success of a psychotherapeutic treatment of endogenous psychoses, the following critical aspects should be noted.

Firstly, the diagnosis of endogenous psychosis must be really established. Otherwise one will not know what one has achieved. Where one thinks that transitional states and 'borderline cases' should be assumed, those cases should be selected for psychotherapeutic treatment which undoubtedly are regarded as such wherever endogenous psychoses are diagnosed at all, if it is to demonstrate success. It is not possible to study in 'transitional states' whether psychotherapy is successful in endogenous psychoses. Here what is important is only that an endogenous psychosis is present at all, but not what it is called. It is therefore irrelevant how the line between cyclothymia and schizophrenia is drawn or whether the endogenous psychoses are divided into a few or many subgroups.

Secondly, the spontaneous course should be considered. Psychotherapeutic success in cyclothymics can probably never be achieved on account of the episodic course, unless the psychosis collapses in

or perhaps immediately after a therapeutic session. Does this exist with a 'typical' cyclothymic phase definitely confirmed diagnostically from every aspect? We do not regard that as possible, as said before. In the case of the schizophrenias, besides the often major reactive situational malleability, one should also consider the often completely surprising spontaneous course. Psychotherapeutic success in schizophrenia is somewhat convincing only when it has occurred during a short period and to a certain extent as a crisis. But a therapy affecting the cause is not proven then either. All other improvements are completely without evidential value for a genuine causal psychotherapy. One should further consider that 'cure' here is very relative. One can be satisfied with less or even with more.

Kraepelin and Present-Day Psychiatry*

On his centenary on 15th February 1956

Today we commemorate the 100th birthday of Emil Kraepelin. It falls on the 15th February 1956. It could, therefore, be objected that this commemoration is a bit premature, but our undertaking is justified by the circumstance that you are here before the gates of Heidelberg. Here he worked from 1891 to 1903. Here his 'classical' theory was developed, as set down first in the 5th edition (1895) and then in the 6th edition (1899) of his textbook. The 7th, which was the last 'classical' edition (1903 and 1904) still grew on Heidelberg soil. The Kraepelin whose psychiatry conquered the world is the Heidelberg Kraepelin.

I can give you neither a sketch of his life nor a presentation of his development and clinical mission. The stress is on 'present-day'. I must limit myself greatly. The topic is basically synonymous with a presentation of the change in psychiatry in the last 30 or even 50 years. In the short time, I can only single out a few points and treat even them only aphoristically.

Like no German psychiatrist, indeed, like no other psychiatrist anywhere, Kraepelin founded an era. Today he has unquestionably lost much importance. In the USA, if he is spoken of at all, it is with contempt. Here, too, he is regarded more and more as a grandfather, indeed as a great-grandfather, whose time is just over.

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*Reference: K. Schneider. "Kraepelin und die gegenwärtige Psychiatrie". In: *Fortschritte der Neurologie, Psychiatrie und ihrer Grenzgebiete.* 1956; 24, no. 1: 1–7.

Based on a paper given at the Conference of the Baden-Wurttemberg Hospital Psychiatrists, on 2nd July 1955 in Wiesloch, Germany.

A lot is past. Kraepelin understandably had a picture of the human being that is no longer ours: that of the positivistic science of the 19th century. The problem of the human-ness of the psychotic was there only as a human consideration from without. The philosophical contemplation, without which there can be no psychiatry, had sunk to an epistemological minimum. However, Kraepelin always respected this, for which we give him much credit. Griesinger's proposition that "mental diseases are brain diseases" (with the so naïve 'are'), he called an "inaccurate formulation of the psychophysical problem of our science". The overestimation, indeed estimation at all of experimental psychology as he practised it, is past. He himself made hardly any use of it within psychiatry and was also hardly able to do so. Still, he is the founder of industrial psychology. Much is disconcerting today. I single out the excessive use of 'madness', even where it does not fit at all stylistically. This corresponds to the coldness and severity of this psychiatry, which is laden with negative evaluations. It had no sense for the otherness, for instance of schizophrenics or odd personalities – only for the inferiority with regard to life fulfilment, indeed achievement and 'society'. What was different and incomprehensibly other was all too quickly stamped as 'mad'. I cannot list all of these many 'madnesses'. There is manic-depressive madness, induced and impulsive madness, and until the 7th edition inclusive, there was also hysterical madness, compulsive madness, an exhaustion madness, under which astonishingly acquired neurasthenia, certainly no 'madness', is treated. That is past. Besides, clinical systematology followed a path to simplicity. Where is induced or impulsive madness still diagnosed today? Manic-depressive madness unfortunately has not yet disappeared fully although it is a quite uncalled-for burden on cyclothymic patients. If manic-depressives are 'mad', they are no longer manic-depressive. But these are trivialities, like the whole untenable grouping of the non-psychotic mental aberrations. Who has ever made use of the ponopathies, homilopathies or symbantopathies of the 4th volume (1915) of the last complete edition?

The work, however, is the diagnostic classification of the 'endogenous psychoses'. I do not wish to argue with this term here (note 1). An older classification spoke of 'simple mental disorder' – without

subdivisions, which was not at all bad with regard to the decisions for one or another form which are so subjective. Kahlbaum, following Guislain, had demanded that states of disease forms must be distinguished. Kraepelin described dementia praecox (the name comes from Morel) from the 4th edition (1893) onwards and manic-depressive madness from the 6th edition (1899) onwards from this standpoint. This had predecessors extending far back in the cyclothymic and manic-depressive area. Paralysis became more and more the model for a disease unity: the same cause, the same somatic and mental findings, the same somatic and mental course, the same autopsy findings. This would be a 'large' disease unity. If in psychopathology one looks only at the axial syndromes of personality disintegration and dementia and disregards the pathoplastic details, one will acknowledge this disease unity. But it also stayed at that. Kraepelin posited 'small' disease units provisionally (without expressing it thus) from the standpoint of the same mental findings, the same mental course. How is this today and thus what is the position of Kraepelin's actual work?

Until the end he held firm to the sharp division between his two forms. The essay about the manifestations of madness (1920), alarming at the time, was widely misunderstood. Outwardly it looked like a breakdown into Bonhoeffer's non-specific reaction types, Birnbaum's structural analysis, and even Hoche's so fought-over syndrome theory. Although Kraepelin in fact took over a surprising amount of this, he kept 'unconditionally' to the "fundamental difference of the disease processes themselves". There were 'no real transitions'. He was only interested here in how it happens that the symptoms of the two forms so often overlap: the 'atypical cases'.

Nobody today will still make a sharp differential diagnosis between cyclothymia and schizophrenia (as we say). There is only a differential typology, that is, there are transitions. The borderline forms continue to exist and the majority of cases can still be included with them without constraint. From the great material of disease stories one could certainly extract evenly distributed links and use them to demonstrate this. However, this would not correspond to the actual case numbers in the daily clinical. Most

atypical cases can be placed close to one or the other pole and counted with that. Rarely there are also intermediate cases, which can be regarded equally correctly as atypical cyclothymia or atypical schizophrenia. Whether in making the diagnosis more weight is placed on the condition or more on the course will often be important for the diagnostic naming of atypical cases. However, it should be considered that with the first-time patient one has to rely purely on the condition. This is equally the case when a previous history is lacking. Today one should really no longer argue about an atypical case of endogenous psychosis: that is cyclothymia, no, that is schizophrenia. One can fight thus about possible paralysis or brain tumour. There the 'is' is verifiable. Compared to endogenous psychoses, that is, purely psychological forms, one measures only against one's own concepts. One can only say, that is for me, or, that is what I call cyclothymia or schizophrenia. Here it was fundamentally only a matter of making clear that Kraepelin's forms are still standing in such descriptive psychopathology.

This is also the case with Kretschmer. Here, however, the two forms become constitutional and hereditary cycles which can mingle. Atypical cases are mixed psychoses and are explained thus. (We do not have something like this in mind with our intermediate cases. They are only intended descriptively.) Kretschmer is fond of Kraepelin completely even if he loosens the individual case multidimensionally. He expands Kraepelin's two endogenous forms to a universal anthropology. He thus includes, with dilutions of diseases and the mixtures of such dilutions, all human varieties including their cultural achievements and philosophical, ethical and religious attitudes. Truly, one cannot do greater honour to Kraepelin's clinical forms.

There has never been a lack of attempts to propose separate names for the atypical cases, indeed separate disease forms. None has become accepted. Even Kleist rattled Kraepelin's chains in vain. He too classifies his roughly 40 diagnoses (within the endogenous psychoses) among the main groups of 'phasic diseases' and 'disintegration diseases (schizophrenias)'. Leonhard is even closer to Kraepelin with about 10 forms. There is no limit to the possible typological subgroups and names. Everything is there: 'motility

psychosis', 'fear psychosis', 'submission psychosis', 'happiness psychosis', 'progressive hallucinosis' etc., etc. By the way, this psychiatry not only wants to create typological subgroups, but it intends its own disease forms each with its particular course and particular hereditary behaviour. Even acknowledging the careful clinical effort, particularly Leonhard's, I see nothing convincing and no gain in all of this, quite apart from the practical unwieldiness of these forms that are often so difficult to distinguish from one another. They are therefore a too uncertain foundation for exact prognosis and genetic research. Here, only one thing is important to us: here, too, Kraepelin's forms stand as the foundations (note 2).

They are everywhere where diagnoses are made. Today it has become uninteresting here and there after the North American pattern. The all too objectifying psychopathology of Kraepelin was already overcome by the 'Phenomenology' presented methodically and programmatically by Jaspers; this was directed at experience and ways of experiencing. But it did this for diagnostic purposes so no opposition to clinical psychiatry resulted. This is completely different from the tendencies of the present. It can indeed be said that the phenomenological direction has carved Kraepelin's rough diagnostic blocks very discriminatingly. This is how the cyclothymia of today coincides only partially with 'manic-depressive madness'.

Diagnosis looks to the 'How?' (form), not on the 'What?' (subject, content). If I find withdrawal of thoughts, this is important for me as a way of experiencing and diagnostic evidence, but it does not interest me diagnostically whether the devil or the beloved or a political leader is withdrawing the thoughts. Where one looks at such contents, diagnosis disappears; only the biographical or interpretable existence is then seen. It is thus in psychoanalysis and more recent extreme varieties of existential psychopathology. However, this is where diagnosis stops and thus Kraepelin's legacy also.

One is almost ashamed to say that we need diagnosis. Not only for the acute question of 'psychosis or not?' – we also need differential typology within the endogenous psychoses. We need diagnosis for prognosis, therapy, reporting. If one assents to the need for diagnosis, it can be found quite simply: Kraepelin's era is not yet over. The stakes driven in by him are standing. If they wobble,

as we showed, they wobble not because they might be fragile but because they are elastic.

Notes

1. Before we enter into explanations of the dialectic of 'exogenous' and 'endogenous', it should be recalled that by 'exogenous' we always understand something physically exogenous and never use the expression in the sense of the experience-reactive, psychogenic, motivated, which unfortunately still often happens. The descriptions 'exogenous' and 'endogenous' have become descriptions of psychotic conditions, i.e. of the psychopathological appearance of psychoses. (Exactly as 'organic' and 'symptomatic'.) These descriptions have hardly anything to do with exogenous or endogenous origin. From its appearance, uraemic delirium is an exogenous psychosis, but it is an endogenous and not an exogenous disease. This also applies for psychoses associated with most brain tumours. Only traumatic, infectious, toxic and parasitic psychoses are 'exogenous' in both respects. If one wanted to justify the description of 'endogenous' as genetic, this could only be done negatively: these are psychoses that visibly have no exogenous cause. However, that is still not enough: uraemic psychosis also does not have an exogenous cause; seen that way it is also endogenous. One can thus only say of the 'endogenous psychoses' that no physical cause for them is known. However, this hardly justifies the positive description of 'endogenous'. The sole clear distinction is between psychoses with a physical basis and (till today) without a physical basis. The former show an 'exogenous', the latter 'endogenous' psychopathological appearance, even if not entirely without overlapping.
   Kleist also saw these difficulties and believed, if I understand him correctly, that he could solve them; 'allogenic' diseases come from the external world. Example: paralysis. 'Somatogenic' diseases are "internal with regard to the whole body but external with regard to the nervous system". Example: psychosis in Graves disease. 'Neurogenic' conditions have 'neural causes'. Example: manic-depressive mood disorders. The latter is hardly making sense.

2. Among the 'endogenous psychoses', cyclothymic depression has become by far the most delimitable and also the prognostically most reliable form. This applies both for the bodily type with disease insight and for the type with uncritical delusion. (Weitbrecht has contrasted these two forms.) Cyclothymic depression is fundamentally the pole from which the schizophrenic forms can be rejected fairly reliably in daily diagnosis. This does not hold for cyclothymic mania to anything like the same degree. Here, too, the otherwise so dubious similarity fails. Cyclothymic depression and mania contrast with each other not as types but as species. (After all, we no longer believe in Weygandt's manic-depressive 'mixed states'. What might at best look like that is change or conversion, insofar as it still fits at all into cyclothymia.) Within these species there are then types. This is different from the schizophrenias, which can only be classified typologically. And there are occasionally transitions from these schizophrenic types to the cyclothymic depressive and cyclothymic manic types, much more often to the latter.
It hardly makes greater sense today to classify the schizophrenias typologically. Nevertheless, this is necessary for mutual understanding and for clinical teaching. We will consider briefly the usual names. The type of the simple, catatonic and paranoid forms is still useful. Hebephrenia does not belong in the same series. One cannot say with Kolle that hebephrenia is an insidious petering out of the personality "usually with its onset in youth". Hebephrenia is a term referring to the age. The picture outlined by Kolle he would not employ to call a 50-year old 'hebephrenic' even if the same patient had shown roughly the same picture at the age of 18 years. We include hebephrenia in the simple form. If it occurs in youth, it often has the pathoplastic features of this age: 'awkward adolescent', 'snotty little upstart', 'teenager', 'little goose'. This can certainly be called hebephrenia, but this is then on a different level of definition than the simple, catatonic, paranoid form.
With the type of catatonia, we mean the more or less acute hyperkinetic or hypokinetic psychoses. It is often common that schizophrenic defects with motor and also speech eccentricities

are called 'old catatonics'. These forms have little to do with catatonia as meant here. They are probably not catatonias in the sense meant here that have become chronic. However, investigations about the question of whether these 'old catatonics' were originally 'young catatonics' are lacking.

It would probably be practically justified to accept schizophrenic hallucinosis (including hallucinosis in the area of bodily sensations) as a separate fourth type, for it does not have a clear place either in the simple or in the catatonic or in the paranoid form and not infrequently occurs in isolation. However, the schizophrenic defects can now be included satisfactorily with the listed four types only with difficulty if one understands the simple form very widely, calls those old eccentrics 'catatonics' and otherwise works with combinations of the four types, which very often has to be the case. However, it does not appear very fruitful to set up further types for this. The forms of the Kleist school and also of the later Kraepelin would be able to provide a good service here.

The schizophrenias are slowly but steadily losing areas to the physically explainable psychoses. We are not thinking of the question of whether and how far one can hold definite cerebral artery sclerosis responsible for the existence of schizophrenic paranoid psychosis – that is an ancient and undecidable problem, of which there are many in this area. We also touch only briefly on the surprising fact that cerebral atrophic processes were found to an increasing degree in schizophrenics (Huber). (Incidentally also in cyclothymias: Weitbrecht.) This matter is not yet definite, probably for somatological reasons and, in any case, is extraordinarily ambiguous (cf. Klinische Psychopathologie, 4th edition, pp. 92 et sqq.).

Another recent question is the position of catatonia. For a long time even outside Kleist's school, separation of the hyperkinetic psychoses from the schizophrenias has been attempted. This applies especially to the fatal and the psychopathologically fully healing (phasic but often periodic) catatonias and also to such conditions in the puerperium. These catatonias, in contrast to the other schizophrenic conditions, appear much more elementary,

more intimate, 'organic'. The most recent histopathological investigations of catatonia by Huber have shown that many of these states must now be regarded positively as (different) physically explainable psychoses. Nevertheless the time has not yet come to exclude catatonia completely from the circle of the schizophrenias. From the clinical aspect, all the transitions lead from them to the other forms that can be called schizophrenic. Everything that we have said applies only to the hyperkinetic but not to the hypokinetic (stuporous) catatonias. It is highly doubtful whether these two forms can, as customary, be compared with one another clinically at all.

Ernst Kretschmer (1888–1964)

Ernst Kretschmer was born in 1888 in Wüstenrot near Heilbronn. Under the influence of the Württemberg manse and supported by the Tübingen protestant foundation, he first studied philosophy, followed by medicine in Munich and Hamburg. He worked in the ambulance service during the First World War in the Department of War Neurology in Bad Mergentheim. There he developed the "protreptic" method for the treatment of shell shock, which occurred frequently during this period. He qualified as university lecturer under Gaupp in Tübingen (1919) and then was awarded the chair in psychiatry in Marburg in 1926. From 1946, he worked at Tübingen University.

His post-doctoral thesis dealt with the sensitive relational delusion. Even today, this attempt to explain the development of delusion from the close interaction between sensitive character features and specific experiences of being offended or hurt remains both conceptually and linguistically impressive. Psychological delusion research in Tübingen (centred on Gaupp and Kretschmer) differed dramatically from the views of the Heidelberg school (influenced by Jaspers and K. Schneider), especially with respect to the "somatosis postulate" and the concept of the process character of schizophrenic psychosis. Kretschmer's multidimensional approach was based on a comprehensive view of biology as the science of life, seen as the "continuous interlocking of psychological and physical" and not just as a physical phenomenon. His main works are "The Sensitive Relational Delusion" (1918), "Constitution and Character" (1921), "Medical Psychology" (1922), "Hysteria, Reflex and Instinct" (1923), "Geniuses" (1929) and "Psychotherapeutic Studies"

(1949). Kretschmer's constitutional theory ascribed specific types of character and proneness to specific diseases to the specific body types but without clear dividing lines. Thus the pyknic subject tended to have a cyclothymic temperament, with cycloid character or manic depressive disease, and the leptosome subject tended to have a schizothymic temperament, with schizoid character or schizophrenia. Although regular relationships between physical build, character and psychosis could not be confirmed empirically, Kretschmer's ideas, his clinical observations and his characterological descriptions have had an essential influence on the medical psychology of the 20th century. Ernst Kretschmer died in Tübingen of cancer in 1964 after a short illness.

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Types of Constitution*

Progress in endocrine research has been so rapid and dazzling that it has hitherto been able to give only a few of the roughest clues with regard to habitus. Questions that would be of the greatest importance for our present investigations, such as the associations between acromegaly and muscle growth, are barely mentioned even in the most comprehensive presentations. Nevertheless, in the *types of constitution* in *cretinism*, *acromegaly* and *eunuchism* (to name the most important), we have at least some of the rough features of what has already been worked out comprehensibly and which is of great benefit to us.

There has been much less preliminary work with regard to the general theory of constitution in the sense of individual types of constitution than in the special field of endocrine dysplasias. We owe most of what was initiated and collected previously from the internal medicine aspect to the indefatigable work of J. Bauer, which must be warmly acknowledged. What has been said especially from the paediatric aspect about the exudative, lymphatic and arthritic type of constitution, while clinically valuable, is so unclear and uncertain with regard to habitus that it is useless for our purposes.

Recently, the French nomenclature of the type *cérébral*, *respiratoire*, *musculaire* and *digestif* has begun to become established in Germany also. There is much good intuition behind these French types. We suspect that the type musculaire and the type digestif are based on a core of real observation, which will be described below in more detail with the athletic and pyknic type of constitution. The

*Reference: E. Kretschmer. "Die Körperbautypen". In: *Körperbau und Charakter.* Springer Verlag, Berlin, 1921; 23rd and 24th edition, chapter 2: 17–37.

weakness of the French classification, however, is that these partially correct individual observations are now forced into a speculatively constructed schema, which is based roughly on the following idea, if we may express it somewhat naively for the sake of clarity: these are: 1. rational persons, who must have a big head, 2. eaters who must have a fine abdomen, 3. athletes who must have powerful muscles and 4. runners who must have long lungs. These deductions are now pursued consistently to their conclusion: in the type respiratoire not only the lungs but also the entire respiratory tract, the nose and even the maxillary and frontal sinuses have to be overdeveloped while the digestive type naturally requires a jaw to correspond with his abdomen. I fear that here there lurks at the same time an idea which has taken in the physiognomists and popular race biologists since the times of Lavater, namely, that a highly developed lower jaw so to speak might represent a small embarrassing inheritance from the gorilla and thus would be a badge of those people in whom defective development of their higher moral cerebrum is compensated by a corresponding excessive endowment with vegetative apparatus and so would be particularly destined by nature to animal-like wildness and criminality (this is in the older physiognomic literature) or in our case to a gentler material ethos. In contrast, the type cérébral is quite consistently illustrated by the advanced person who is almost only spirit or mind, in whom the remaining material hangs from an unusually large head like a small atavistic appendix.

It is also disturbing that the entire classification (already partially more or less implicit in the names) is based on a naïve association between physical and mental characteristics, which strikes the doctor trained in psychiatry as oversimplified.

MacAuliffe gives a very valuable historical overview of the traditions of French research into constitution, which, starting with Hallé in the 18th century, have continued in an uninterrupted conceptual tradition until modern times with the familiar concepts of Sigaud. I have developed its fundamental ideas, particularly the idea of the predominance of certain organ systems, more precisely elsewhere and have also listed the connections between modern German popular physiognomy and the older French theory of con-

stitution. Von Rutkowski has shown using the example of the physiognomist Huter how the latter's 'feeling', 'movement' and 'nutrition' natures coincide essentially with the types of the older French authors. These articles can be referred to here.

It cannot be our task here to discuss all the biotypological systems presented since the appearance of this book, of which Sheldon's system and Martiny's system, which continues the French traditions of biotypology, should be noted. The fundamental original articles of the former were not available to me for a long time; nevertheless, even extracts show that there are numerous analogies with and confirmations of our results, which are valuable because they often lead to similar results by different routes. This extensive similarity in results is also emphasised by Rohracher in the characterology chapter of the Katz Handbook of Psychology and is, therefore, valued particularly highly by him because Sheldon originally set out from methodological viewpoints that were the opposite of the typological method. Sheldon also employs comparative anthroposcopic and anthropometric (see and measure) methods. He, too, arrives at 3 main types on the basis of his analyses of characteristics, of which endomorphism with rounding of the outlines and predominance of the intestines corresponds roughly to the pyknic type, mesomorphism with the emphasis on the bones and muscles corresponds roughly to the athletic type and ectomorphism with a delicate slender figure corresponds roughly to the leptosome type. The dysplasias, as in the present book, are assessed separately. The degree to which the components of the individual constitutions are expressed in a given individual is described with the use of a numerical scale which ranges from 1–7 so that e.g. the number 711 would correspond to the most extreme endomorphism and 117 to the most extreme ectomorphism, while 444 would correspond to the middle of the 3 classifications. As regards the psychophysical correlations, the descriptions which Sheldon makes of the often 'ectomorph' (delicate, slender) 'cerebrotonic' types correspond largely to the characteristics of the leptosome schizothymic in the present book. They are described psychologically as tense, withdrawn, unsociable ('sociophobic'), with a lack of spontaneity and difficulties in accustoming themselves to the elementary business of life. In viscerotony,

roughly corresponding to the pyknic-cyclothymic type, the relaxed, comfortable and unforced nature of the movements is completely in agreement with our earlier investigations and also the sense for comfort and comfortable enjoyment of life and the extroverted and social manner capable of sympathy and contact in human intercourse. On the other hand, as far as I can establish, the periodic phenomena and the central factors in the temperament of the cyclothymics associated with the diathetic proportion could not be documented with Sheldon's methods. The dichotomous structure of the individual temperaments (hypomanic-melancholy, hyperaesthetic-anaesthetic etc.) is a quite central basic law, which becomes apparent only with the addition of the extreme psychopathological variants, but cannot be found in ordinary persons with summary group statistics.

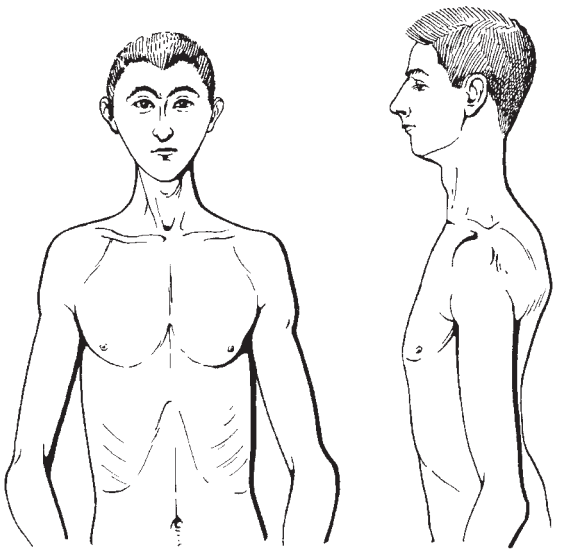

Fig. 1. Leptosome (asthenic) type (schematic)

While Sheldon's descriptions of psychological temperament in the leptosome and pyknic types are essentially in the same direction as our results with the schizothymic and cyclothymic types, the interpretation of the temperament form which he called 'somatotonia' is somewhat more difficult. Features of those variants of the

leptosome schizothymic types, who are strong, are bordering on the athletic types with their firm and 'wiry' body build and their cool but energetic nature have been included in Sheldon's description, but are described quite accurately by us in the experimental chapters where we present the 'leptosome record achievers'. The values which, particularly in American life, dominate the athletic education and evaluation might also play a certain role in the character formation of the athletes.

The athletes who work intellectually and the shaping of the athletic temperament under the influence of intellectual professions are hardly apparent in Sheldon's statistics while they are contained in abundance in our material.

In contrast, the more primitive and explosive variation of the athletic temperament is well documented in his work and his descriptions here match our experiences when he emphasises their enthusiasm for sport, erect posture, mental robustness and pugnacity, low alcohol tolerance, aggressiveness and torpid pain tolerance, amongst other things. In the chapter on the athletic types we have shown these syndromes in association with boxing, which is a real treasure trove of variants of the athletic constitution and forms of the athletic temperament, and then on the explosive epileptoids.

If, as it appears to me, Sheldon is in good agreement with our previous investigations in many points, on the other hand I cannot understand the theoretic derivation from the 3 blastemas. In the leptosome types, all the tissues are thin and delicate, they have the smallest head circumferences – there is no type in which especially the brain and the skin are hypertrophic or functionally dominant. In the pyknic types (this applies to the 'type digestif' just as much as to endomorphy), all the large body cavities are equally spacious and show peak values with respect to their volumes, although the brain and cranial cavity have nothing to do with the internal blastema. The proportions of the pyknic types – Conrad pointed this out correctly – with large body cavities and relatively short limbs with delicate bones have certain analogies ontogenetically with the proportions of the infant growth phase, but they cannot be constructed from predominance of one blastema.

Naturally, we will analyse step-by-step the genetic and developmental contributions to the individual components of constitution described by us as 'stature tendencies'[1] and research them exactly; and we have also already tackled this for certain growth problems of the base of the skull initially. However, this is extremely tedious, time-consuming and strictly empirical work. Only when this has been done will we comment on the genesis of types of constitution with the exceedingly complicated interlocking of primarily blastemic, central nervous and endocrine controls and exogenous modifications.

Meanwhile, it is more important for us to emphasise the valuable work achieved e.g. by Sheldon or by French biotypology than to enter into an individual critique that exceeds the scope and purpose of this book.

It appears remarkable to us that, in the wake of our research, Sheldon has arrived by quite different methods essentially at the same empirical results from the aspect of forms of constitution and temperament as those we had earlier elaborated.

If we compare with these theoretical problems the few empirical types of constitution that endocrine research has already provided (cretinism, acromegaly, eunuchoid etc.) we do not see a single organ system (respiratory tract, digestive tract, cerebrum) hypertrophying on its own, but we see quite the opposite: a confusing mixture of various effects stemming from one single cause, which however seems to defy any attempt of logical reconstruction. We see the intermingling of trophic drive and trophic inhibition which becomes apparent in the most varied organ systems at the same time, now in the skeleton, now in the skin, now in the muscles, now in the fat and then often only in circumscribed parts of an organ system; the physical results of this are not associated with the mental signs produced at the same time in any conceivable way, but can only be accepted empirically.

We, therefore, take the following view: we can accept as found constitution types that involve the entire person according to soma

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1. cf. in detail Kretschmer: Körperbau und Charakter. In Just's Handbuch der Erbbiologie, Springer Verlag, Berlin, 1940; 2.

and psyche and that affect the real biological associations, particularly when we have uncovered regular connections between complex types of constitution that have been worked out purely empirically and equally complex endogenous psychological types (as in cyclothymic and schizophrenic disorders). We will then have a sure test in that the actual identity of the mental syndrome can be checked from its somatic foundations and the somatic symptom grouping can be checked from its psychological effects. The following grouping should be interpreted in the light of such a test. We note that the description of constitution and the calculation of the tabular averages uses exclusively schizophrenic and cyclothymic material while the illustrations also show individual patients from other groups. This is always noted separately.

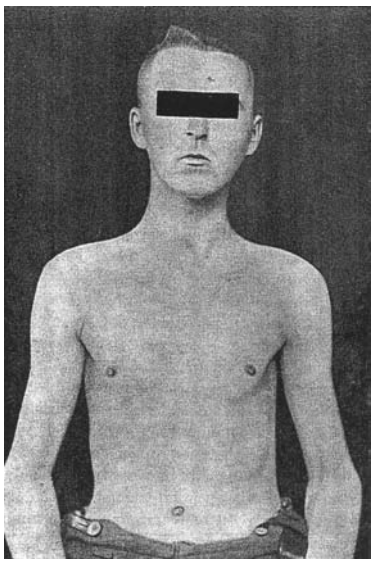

Fig. 2. Asthenic type. Frontal

The types as described below are not 'ideal types' that would have arisen arbitrarily through certain leading ideas or scales of values. Rather, they are obtained empirically in the following manner: where a rather large number of morphological similarities is consistently found in a large number of individuals, we start to

measure. If we then calculate the averages from this, the predominantly shared characteristics emerge clearly while the features that are different in the individual case become blurred in the average. We proceed quite similarly in the case of other characteristics that can only be described visually. This would correspond to the exact methodology created by Katz as a development of Galton's train of thought, which he calls 'image statistics' and which, as already mentioned, is based on the physiological principle of 'optic integration' (for more details see chapter 20). We proceed as if we had copied the pictures of 100 persons of a group conspicuous for shared characteristics on top of one another onto a single screen, where the coinciding features are again reinforced intensively but those that do not match become blurred. We describe as 'typical' only the features that are reinforced in the average picture. We must not now believe that we would only need to look to discover such a type in our material on a large scale and without prolonged practice by the eye; rather, in the individual concrete case we always find the type veiled by heterogeneous 'individual' features and blurred in some places. This is similar to clinical medicine or botany and zoology. The 'classical' cases, the almost admixture-free representatives, well provided with all the main symptoms of a syndrome or zoological racial type, are almost lucky finds which we cannot expect to see every day. This means that our description of types as presented below is guided not by the most frequent but by the best cases, those that demonstrate most clearly the shared feature that is seen only hazily in the main mass but is nevertheless demonstrable empirically. The same also applies to the descriptions of psychological type in the second part.

With the described methods our clinical material has initially yielded three recurring main types of constitution, which we will call *leptosome (asthenic)*, *athletic* and *pyknic*. They are found in men and women; however, women in general show less morphological differentiation, therefore clear and extreme cases are rarer. However, the way that these 3 types are associated with the schizophrenic and cyclothymic disorders is very different and quite remarkable. Even in healthy life we encounter these 3 types everywhere; they do not in themselves involve anything patho-

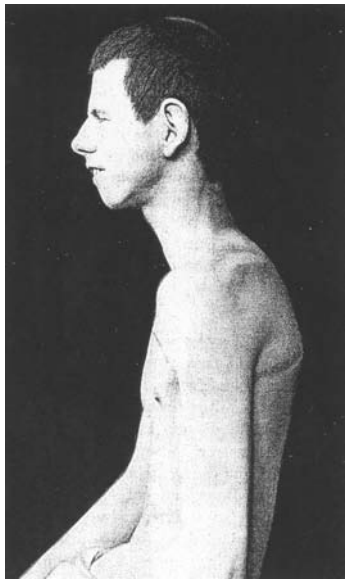

Fig. 3. Asthenic type. Profile

logical but designate certain normal biological predispositions of which only a fairly small fraction reaches a pathological peak, whether in the psychiatric area or in certain disorders in the area of internal medicine. Besides these large main types, we also found various small groups, which we would like to group together as dysplastic special types insofar as they represent major deviations from the average and insofar as their morphological connections are sometimes very close to the roughly dysglandular syndromes of endocrine pathology.

We will first give only an outline of the most general features of the 3 main types and postpone the finer morphology of constitution, particularly facial and cranial structure and body surface, to the following chapters for the sake of clarity. In general, we again emphasise that the morphology of constitution must always be studied first in men and not in women. The female constitution is less distinct particularly in facial structure, muscle and fat development on average. We, therefore, find far more indistinct and atypical images of these types among women.

a) Leptosome (asthenic) type

The concept of asthenic habitus[2] has been characterised by Stiller and corrected and qualified by J. Bauer in a welcome manner. The asthenic type obtained from our psychiatric material might essentially coincide with the same type which Bauer developed in the domain of internal medicine. Of the individual points that Bauer's short description mentions, most are also fairly accurate according to our investigations. We are only unable to confirm the statement that the asthenics are usually dolichocephalic; according to our calculations (see below), the asthenic skulls, compared with those of the other types, are of smaller circumference on average, of medium width but short and low. All of the figures of subsequent investigators published since then also confirm that our clinical asthenics do not have particularly elongated skulls (cf. the critical summary by von Rohden and Gründler).

The essential aspect of the habitus of the male asthenic is, stated briefly, in the rough overall impression: *low expansive growth with undiminished average growth in length.* This sparse expansive growth involves all the parts of the body, face, neck, trunk, limbs, and all forms of tissue, skin, fat, muscle, bone and the vascular system. Consequently, we find the average weight, like all the measurements of circumference and width, reduced compared to the general male average.

In severe cases we receive the following general impression (figs. 1, 2 and 3): a lean and lanky person who appears taller than he is, with sapless and anaemic skin, the skinny non-muscular arms with thin bony hands hanging from narrow shoulders, a long, slender, flat chest in which the ribs can be counted, with an acute costal

2. We adopt the expression 'asthenic' as clinically established although it contains a biological value judgement, which seems inappropriate for type descriptions which serve not only a clinical but also a more general biological purpose. 'Asthenic', thus for us, designates only a graphic expression and has nothing to do with diseased or healthy, adequate or inadequate.

angle[3], a thin fatless abdomen and the lower limbs like the upper ones. The lag in body weight compared to body length (50.5:168.4) and in the chest measurement compared to the hip measurement (84.1:84.7) becomes quite obvious when looking at the average male body measures.

Table 2. Main body measurements of the leptosome (asthenic) type calculated as average

	Men	**Women**
Height	168.4	153.8
Weight (in kilograms)	50.5	44.4
Width of shoulders	35.5	32.8
Chest circumference*	84.1	77.7
Girth	74.1	67.7
Hip circumference	84.7	82.2
Forearm circumference	23.5	20.4
Hand circumference	19.7	18.0
Calf circumference	30.0	27.7
Leg length	89.4	79.2

* Average of inhalation and exhalation.

One variant of the type shows broader shoulders, but with a board-like flat chest and very delicate shoulder bones. Instead of the thin abdomen, there is a slack, small, enteroptotic pendulous abdomen in individual cases or the fat is in an eunuchoid or female distribution, which must not be mistaken for the pyknic fat belly. Often variants of the asthenic type are suggested more or less by the characteristics of the constitution of the *dysgenital group*, such as infantilism (acromicria), feminism (waist formation, increased pelvic circumference, increased hip curves, female pubic hair line) and particularly by elements of *eunuchoid height* with excessively long limbs. We shall return to this later.

3. Stiller places great weight on the free 10th rib. With Bauer, I should like to warn against overestimation of such details. If anywhere, in the theory of constitution the general diagnostic rule applies not to press the individual symptoms but always to look at the entire picture.

The asthenic type tends very much to form variants and mixtures with the athletic type, in that either asthenic and athletic characteristics occur directly side by side (e.g. long narrow chest with strong limbs, incongruence between face and constitution etc.) or a *middle type of sinewy slim figure* occurs, which again can verge more towards the delicate lean type or towards the powerful muscular side.

These lean, sinewy slim figures still come under the wider concept of 'leptosome' but no longer under the narrower concept of 'asthenic', which includes only the more extreme degrees of the slender constitution and, particularly, also the actual hyposomatic forms.

If we consider the *longitudinal life development* of the asthenic type, he appears fairly constant in his basic features at all ages. Already as children, these persons are often represented as puny and delicate; they often shoot up rapidly and thinly during puberty and even in adult and old age show not the least tendency to put on normal muscle and fat. They can do strong physical work as farmers and yet they do not train their muscles much to judge from their circumference. They can be very well nourished and even eat greedily like some old institutional residents in peace time and still remain as skinny as they are. Their age alters the hair pattern in some of the asthenics (q.v.). The facial structure often achieves its characteristic form, which will be described later, only from about the age of 18 and can become sharper and sharper with the progressive thinning of advanced age.

In some of the asthenics, we are struck by their *premature ageing* as an important biological characteristic. In severe cases I found men aged between 35 and 40 who already had quite senile involution with wrinkled, sagging skin that was completely dry, loose and faded, and snaking, prominent temporal vessels (cf. figs. 15 and 16, which show a 39-year old patient). In such cases despite a normal lifestyle, quite astonishing degrees of general wastage of fat and muscle are often found, indicating severe chronic metabolic disorders. Even patients who constantly eat a lot are subject to this and the muscles, without becoming paretic, can also reach such a degree of atrophy, even with constant field work, that a diastasis of

the femoral adductors occurs, such as that seen otherwise only in extremely wasted cachectics; the inside contours of the thighs no longer run together towards the perineum in a single line as normal, but join the perineum separately so that a gap remains between the two thighs.

With regard to the *development in puberty* of the asthenic constitution in men, in our cases growth in length usually occurred normally, sometimes strongly and prematurely. A 16-year old hebephrenic boy in our material is already 165 cm tall (which decidedly exceeds the age average in the Swabian population) and an 18-year old is 176 tall. However, this cannot be called a rule. Individual asthenics remain small permanently among the men also. The smallest of our adult male asthenics measures 158, the tallest 178 cm; but people of extremely small stature are not common amongst them. The one just mentioned is the only one amongst 50 cases with a height below 160 cm. Strikingly childlike underdeveloped facial features are still found in individual asthenics between the ages of 20 and 25 years and later, particularly amongst women; however, with their sharp and thin facial shape, many asthenics already look older at this age than they are. Sex drive and hair pattern will be discussed below.

The *asthenic women*, insofar as the type emerges clearly, resemble the asthenic men in their habitus apart from one important point: they are not only thin but are also often *small in stature*. The normal and even increased growth in height/length of the men also occurs in asthenic women, but is more often absent in them. Amongst 20 female cases I have only one of 169 cm and one of 161 cm; the others are all 160 cm or less, the smallest 145 cm. This group of women is, therefore, not simply asthenic but *asthenic-hypoplastic*, where throughout this entire study asthenic signifies only the inhibited expansive growth, but hypoplastic means the general underdevelopment of the body and body parts, in particular the diminished growth in height. Thus with the asthenic women we come to the very low average height of 153.8 while the average height of the asthenic men at 168.4 corresponds roughly to the average of the Swabian male population. Consequently the discrepancy between height and weight in asthenic men is very sharp, but is much less in

women (cf. table). It is about 18 in the men (the weight subtracted from the last two figures of the height), but only about 9 in the women.

Leptosome. In the further course of research it became apparent that something derogatory attaches permanently to the expression 'asthenic' because the purely linguistic value judgement of powerless, sickly and biologically inferior cannot be removed fully from it despite all reservations. In particular, the expression is always somewhat disturbing in psychological research in healthy subjects or in racial investigations. I was, therefore, unable to avoid coining a further new concept, which has also become widely established. We thus designate as *leptosome* (leptos = thin) the large overall group of forms of constitution which are generally distinguished by slim growth, a thin face and sharp nose and to which those constitution characteristics are ascribed in detail that we have just described as 'asthenic' in their most extreme expression. The clinically established expression 'asthenic' remains as a narrower subgroup of the overall leptosome type, especially for the more extreme and hyposomatic types. Leptosome in contrast is the further generic term, which besides the narrower asthenics includes especially all the large number of those sinewy, thin or scrawny figures, who are sometimes distinguished by very good general vitality, robustness and also a particular inclination to athletic achievements. There is naturally no sharp boundary between this subtype of the leptosomes and the athletic types.

b) Athletic type

The male athletic type (figs. 4, 5 and 6) is characterised by strong development of the skeleton, muscle and also of the skin.

The rough impression of the best examples of this type is as follows:

A man of medium to tall height with particularly *broad prominent shoulders*, a powerful chest, taut abdomen and a torso that tapers somewhat downwards so that the pelvis and the still powerful legs at times appear almost delicate in comparison with the upper limbs and particularly the hypertrophic shoul-

der girdle[4]. The *massive high* head is carried erect on a free neck, where the oblique outline of the taut trapezius seen from in front gives the neck and shoulder area its particular stamp.

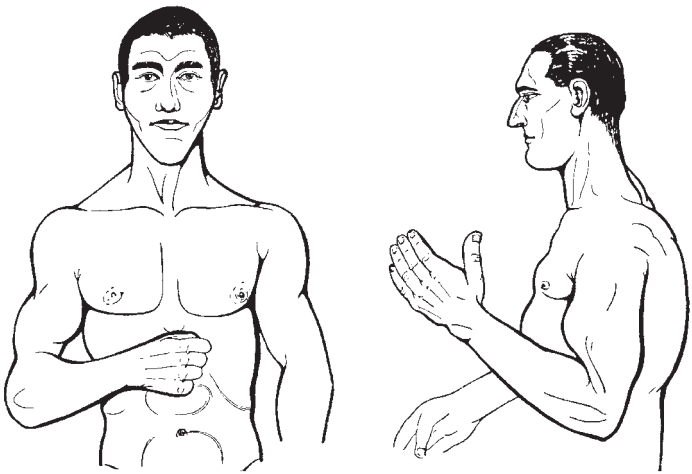

Fig. 4. Athletic type (schematic)

The outlines and shading of the body are dominated by the muscle bellies of the good or hypertrophic musculature, which stands out three-dimensionally as *muscle relief*. The *bone relief* is particularly prominent in the facial structure. The generally *coarse bone structure* can be seen particularly in the clavicles, the wrists and ankles and the hands. Besides the shoulder girdle, the *trophic accent* is *often on the ends of the limbs*, which in isolated cases can almost resemble acromegaly. The greatest hand circumference in our material reaches the very remarkable figure of 25 cm, i.e. a figure that exceeds by 5 cm the male average of about 20 cm. A hand circumference of 23 cm is very common. Apart from the hand circumference, the shoulder width in particular is remarkable in this type; it reaches the extraordinary figure of 42.5 cm in 2 cases, which exceeds by nearly 5 cm the male average value of our population which is an estimated 37.5–38 cm. The limbs tend to be long rather than short.

4. The expression 'hypertrophy' should be understood here not as a pathological disorder but only as a development that exceeds the average.

Besides bone and muscles, the skin also participates in the hypertrophy. It has good taut elastic turgor and appears coarse, thick, and sometimes doughy particularly in the face. In contrast to all these tissues, the fat is relatively only moderate, and in absolute terms is of roughly normal development. The precise muscle relief is primarily due to this in that the overdeveloped musculature projects strongly through a very thin layer of fat.

The mean height is above average; heights over 180 cm are not rare and the tallest athlete in our material measures 186 cm. The lower limit cannot be established, because there are seamless morphological transitions between the athletic type and the hypoplastic broad shouldered type (see below). It is worth noting that there are also upward transitions to certain gigantic growth types, which will be discussed later.

Table 3. Main body measurements of the athletic type calculated as average

	Men	**Women**
Height	170.0	163.1
Weight (in kilograms)	62.9	61.7
Width of shoulders	39.1	37.4
Chest circumference	91.7	86.0
Girth	79.6	75.1
Hip circumference	91.5	95.8
Forearm circumference	26.2	24.2
Hand circumference	21.7	20.0
Calf circumference	33.1	31.7
Leg length	90.9	85.0

Otherwise *variants* within the athletic type are apparent mainly in the facial structure. In the constitution, besides the type described above with the relatively slender lower body and the well-sculptured body structure, we find a variant that is distinguished by *general plumpness*. The difference between shoulder and pelvic development is not remarkable here; everything is unpleasantly solid, huge, the facial skin doughy, the muscle relief obliterated by somewhat more diffuse fat development. Whether this is a variant, a combination,

a different stage of development or, which is more likely, a separate type with an essentially different biological basis, cannot be decided purely morphologically. The cases of this type are less numerous in my material; besides severe catatonic imbecility, one of them also had epileptic seizures. Another patient along with an infantile fat distribution showed deformed genitals with bilateral cryptorchidism. Amongst these doughy plump athletic types in the asylum I also encountered isolated examples of those in whom a solid upper body sat on a not merely slender but hypoplastic thin lower body, an infantile narrow pelvis and asthenically thin legs.

The morphological connections between the dysgenital group and the athletic type are also numerous. Mixtures of athletic elements with eunuchoid tall stature are not unusual, e.g. excessive length of the limbs with large hands, partially coarse bones, muscular shoulder girdle etc. Strong feminisation is also observed. Recently I saw a schizoid psychopath with an otherwise quite athletic constitution but narrowly sloping rounded shoulders, a waist and a very curved feminine pelvis of large circumference. Whether the type to be described later of broad-shouldered short stature with acromicria is based on an interference of infantilistic and athletic structural principles, which would be entirely conceivable, or whether it is something independent, will have to be left aside initially.

The development of the athletic type through *different ages* offers little of note. In our material the type is clearly apparent even at puberty, roughly from the age of 18; with the maturing of the body after the age of 25 years it becomes even more prominent and distinct. I have seen it still unchanged in several cases in their 50s. Cases with an age beyond the early 60s are not available to me, which is probably due only to chance as the athletic group is much smaller than the asthenic and men and women combined form a group of only about 30 cases. It is unlikely that the changes occurring with advanced age are so drastic that the type could no longer be identified at least on the basis of head and skeletal structure. In contrast, among middle-aged imbecilic asylum catatonics, who lie there or stand around dully on every day of the year, the musculature was often considerably slackened and no longer so bulky while the coarse bone structure and the entire dimensions of

the body appeared to indicate an earlier much more athletic build. This can be explained easily as inactivity atrophy, but the question of whether endogenous trophic moments can lead to muscle atrophy as in the asthenics should be investigated carefully in such patients where the inactivity moment is lacking.

The athletic type in *women*, where it can be identified here, corresponds to that in men, with certain characteristic differences. In particular, fat development is often not inhibited in athletic women but is abundant; however it is in correct ratio to the other tissues, especially the bones and muscles, and is, at least in the cases of our material, not selectively increased as in the pyknics. Besides these athletic women with female rounded forms, however, we also find some with marked masculinism in facial structure and constitution. Several such cases, which are quite masculine in muscle relief and shoulder-pelvis proportion, will be discussed in chapter 5. It should be noted generally that the trophic accentuation of the shoulder girdle can often be observed in the female athletic also (up to 39 cm shoulder width), where it is opposed rather than in line with the secondary sex characteristics. This indicates that it does not represent something casual but derives from characteristically directed special growth impulses. Apart from the chest and shoulder girdle, the pelvis also is often very powerfully developed in the athletic women.

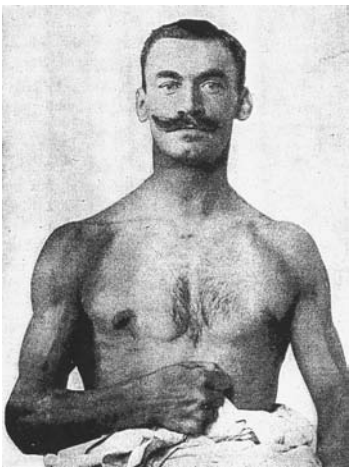

Fig. 5. Athletic type. Frontal

The constitution of the athletic women on average gives us a greater impression of the abnormal, the excessive, unpleasantly crude and solid than that of the athletic men and that is because these men sometimes come very close to our ideal of artistic beauty while our ideal of feminine beauty is considerably exceeded by the athletic women. This is the place to warn against bringing the layperson's subjective assessments into the diagnosis of constitution. We do not achieve much with regard to our three main types with the judgement of 'normal' or 'abnormal'. All three are found everywhere in both healthy persons and patients with psychiatric or other medical disorders. All three are normal in that they belong to the commonest anthropological appearances and abnormal in that they harbour the predisposition to certain diseases, each in a different direction. It is also not appropriate to claim that any of the 3 types is, because of their body habitus, better suited for life's struggle.

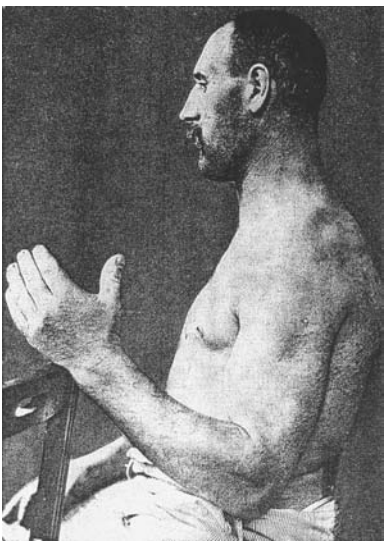

Fig. 6. Athletic type. Profile

The athlete is better built for wrestling and the asthenic for flying, but in many occupations it is quite indifferent whether they are performed by one or the other. Many asthenics are healthy all their lives and grow old when their more robust contemporaries have long

succumbed to a heart attack. That is why it is quite inappropriate (and here, too, I am quite in agreement with Bauer) to speak of the asthenic disease *(Morbus asthenicus)*. Terms such as 'arthritic habitus' or 'phthisic habitus' should only be used in a strictly clinical context, while they cannot be used for a fully objective scientific theory of constitution as they imply too strongly a certain disease tendency. If the asthenic has a greater predisposition to tuberculosis, he is perhaps on the other hand more immune to rheumatism, diabetes and arteriosclerosis than the pyknic and vice versa. One can thus not declare one of the large constitution classes to be fundamentally healthier or sicker than the other.

c) Pyknic type

The pyknic type at the level reached in middle age is characterised by the *great development in circumference of the visceral cavities (head, chest, abdomen)* and the *tendency to deposit fat on the trunk*, with *more delicate development of the locomotor apparatus (shoulder girdle and limbs)*.

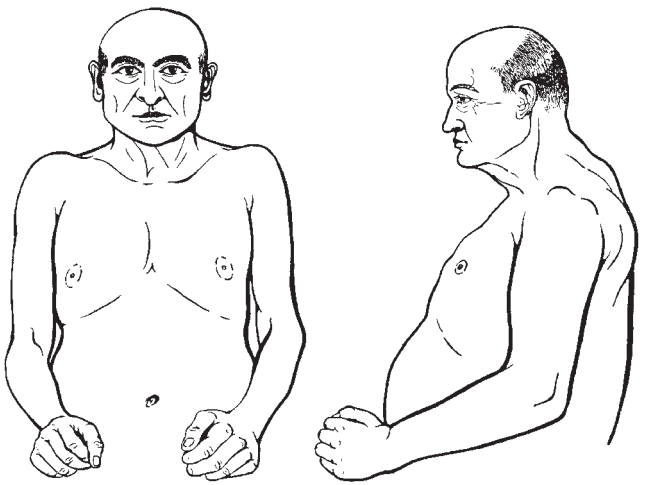

Fig. 7. Pyknic type (schematic)

The rough impression is very characteristic in marked cases: a *stocky figure* of medium stature, a *soft broad face on a short solid neck*

sitting between the shoulders; an imposing *paunch* grows out of the broadening *low arched ribcage.*

Table 4. Main body measurements of the pyknic type

	Men	**Women**
Height	167.8	156.5
Weight (in kilograms)	68.0	56.3
Width of shoulders	36.9	34.3
Chest circumference	94.5	86.0
Girth	88.8	78.7
Hip circumference	92.0	94.2
Forearm circumference	25.5	22.4
Hand circumference	20.7	18.6
Calf circumference	33.2	31.3
Leg length	87.4	80.5

If we consider the limbs, they are soft, plump, shaped with little muscle and bone relief, often quite dainty, the hands soft, more short and broad. The wrists and clavicles, in particular, are often of a slender and almost delicate structure. The shoulders are not broad as in the athletic types but (mainly in elderly people) more round, somewhat elevated and pushed forwards, often offset against the chest with a characteristic sharp kink on the inner border of the deltoid. It then seems as if the entire shoulder girdle is sliding upwards and forwards over the expanding ribcage; the head too participates in this static shift: it drops forward between the shoulders so that the short thick neck gradually seems almost to disappear and the upper thoracic spine assumes a slightly kyphotic curve. Seen in profile the neck then no longer appears, as in the other types, as a slender round column that carries the chin like a sharply offset broadly projecting capital, but in the marked cases of middle and advanced age the tip of the chin is connected directly with the upper end of the sternum by an oblique line without much of an indentation for the throat (fig. 21).

The *chest-shoulder-neck proportion* is, apart from the head and face structure and the pattern of fat distribution, the most character-

istic feature in the pyknic constitution. The ratio of the moderate shoulder width to the large chest circumference such as 36.9: 94.5 distinguishes it in a precise manner from the corresponding proportions in the athletic types, where the chest circumference is subordinate to the powerfully dominating shoulder width (39.1: 91.7). If the athletic torso appears broad above all, the pyknic one appears deep above all; where the trophic accent in the former is on the shoulder girdle and the ends of the limbs, in the latter it is on the middle of the torso, on the barrel-like widening of the lower thorax and the fat abdomen. The limbs are on average short rather than long.

The pyknic types tend definitely to put on fat. The nature of the fat distribution is characteristic and quite different from that of the asthenic and athletic types, who do not have a substantial tendency to fatness generally, but it must nevertheless be described quite accurately in the following to allow a clear differentiation between the pyknic type and some forms of roughly dysplastic special types (see below). The *obesity* of the pyknics usually remains within moderate limits and is primarily truncal obesity; the fat deposition in men occurs mainly as a compact paunch. All the other body shapes are soft and rounded through diffuse fat deposition but are not concealed and deformed. Thus the face is characterised by its round soft lines and the hips and the calves also frequently (though not always) take part in the increased fat deposition. In contrast, the forearms and hands and also the lateral parts of the shoulders are often only moderately involved. The legs, too, can be astonishingly thin in elderly pyknic men.

The skin is neither slack as in the asthenic nor taut as in the athletic type, but soft and close-fitting, of medium thickness, and also full over strongly contoured curves such as over the cheekbones and on the outside of the upper arms. The muscles are of medium strength but of soft consistency.

On average pyknic men are of medium stature (167.8). The average level of fat deposition is expressed in that the weight of the pyknics somewhat exceeds the last two digits of the height (68.0) in contrast to the others including to the athletic type. Weights of over 100 kg occur in isolation in single periods of life; in our mate-

rial, the highest weight we find is 107 kg with a height of 171 cm. However, we also sometimes find considerable underweight, particularly in elderly persons (in one case 163:49) as a consequence of marked degeneration. Pyknics often demonstrate *profound and sometimes abrupt fluctuations in body weight, particularly in association with transitions between different stages of life and with psychotic phase transitions*. In the case mentioned above, a rapid increase in weight began around the age of 30 years, which reached the level of 107 kg in middle age with repeated major fluctuations, only to fall rapidly to 76 kg at the age of 60 years which coincided with the onset of a psychological depression, and it did not rise again afterwards even after the depression was successfully treated. Small short-set figures are very common among the pyknics in our population but only one of our patients remains below 160 cm at 154 cm. Markedly tall stature is also rare. Only 2 cases, which both also show numerous features of the athletic type, exceed the limit of 180 cm with heights of 181 and 182 cm.

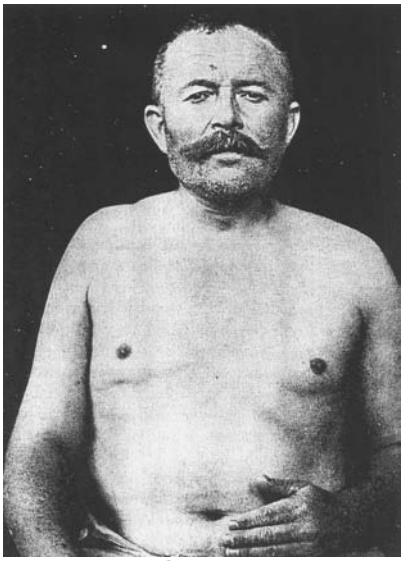

Fig. 8. Pyknic type. Frontal

The class of the pyknic type is fairly distinct and does not comprise many variants. It should be emphasised that it is often char-

acterised by the skeletal structure, particularly the dimensions of the cranial, facial and hand skeleton, which are independent of fat deposition, and also by the chest, shoulder and neck proportion and *that major fat deposition is not required for its diagnosis*. The rough outline of the body is very different externally depending on how much it is marked by the paunch and the thick neck. If it is considered that the majority of heavy labourers and also the majority of young persons below the age of 30–35 years do not have the compact pyknic fat distribution, it will be realised how many wrong diagnoses would arise if this impressive and important but inconstant single symptom were relied on. Completely strong combinations can at the first glance be not at all reminiscent of the average pyknic appearance and yet on careful observation and measurement, they demonstrate marked pyknic components. Mingling with athletic elements is not rare, when the shoulders are broader and the limbs are more robust and bonier. Asthenic-pyknic structural interferences are seen e.g. in the pattern of a small paunch, long thorax, long slender limbs, and additionally in the facial and cranial structure: slight turricephaly (i.e. long, pyramidal skull) over a soft and broad pyknic cheek and jaw structure. Innumerable similar mixtures could be listed here and in the other types; there is no single symptom that could not be varied and recombined with characteristics of another type.

The morphological difference between the *different periods of life* is decidedly greater in the pyknics than in the other types. The pyknic type usually reaches its most characteristic form at a more mature age, after 30 and towards the age of 40 years, and can be blurred again somewhat after the age of 60 due to strong degenerational processes. These differences are associated primarily with fat deposition and with probably secondary shifts in chest shape. There are cases where the pyknic paunch and the parallel widening of the lower thoracic aperture appears shortly after the age of 20. However, these are exceptions. Usually we find roughly the following habitus in the *young pyknic* between 20 and 30 (figs. 22 and 23). The wide soft facial shape with the good medium height proportions and the characteristic lower jaw is already fairly obvious, the neck is short, rather thick but still not strikingly stocky and still sharply offset

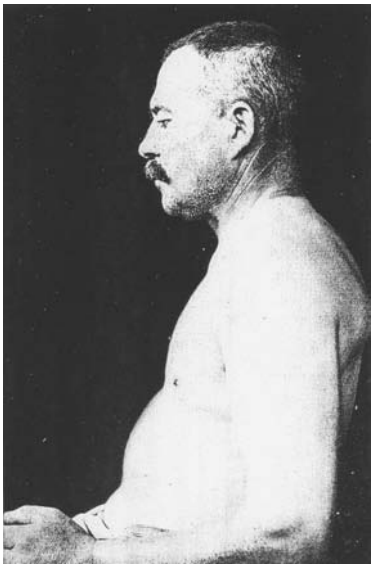

Fig. 9. Pyknic type. Profile

against the undersurface of the chin. The neck-shoulder proportion has not yet been pushed together over the distended thorax, so that kyphosis and drooping of the head forward between the raised shoulders are not found. Thus the young pyknic at the first glance can easily be mistaken for the athletic type. Nevertheless, the extent to which the essential measurement ratios already approach the later ones is shown by the following small table in which the average values in question here of the 3 main groups are calculated separately for the age between 18 and 30. The values for the youthful pyknic habitus are obtained from our young cyclothymic patients, who constitute the major part.

Table 5. Male average values in the age between 18 and 30 years

	Pyknic	**Athletic**	**Asthenic**
Head circumference	57.7	56.3	55.6
Shoulder width	37.9	39.4	35.9
Chest circumference	95.7	90.9	83.9
Girth	84.4	78.8	70.6

We thus see clearly here the characteristic pyknic dimensions in that even the young pyknics are clearly at the top with head, chest and abdominal circumference and so already show a disposition for a broad and round constitution. In particular, we again see the relation between shoulder width and chest circumference that is so important in differential diagnosis in that the pyknic on average remains behind the athletic type in shoulder width, while he exceeds him in chest circumference. The bend of the shoulder at the inner border of the deltoid is also sometimes found even in quite young pyknics.

The tendency to fat deposition is still more diffuse in the young pyknic; it can be identified above all in the face and in the soft modelling of the trunk and limbs where there is little muscle relief.

In our overall graphs and tables of the most important body measurements of the cyclothymics and schizophrenics (see figs. 10–13 and table 12) we have shown the young ones under the age of 30 separately; it is incontrovertibly apparent from these precise figures that the mass proportions characterising the pyknic habitus already give the entire mass of young cyclothymics their stamp: in weight, in chest circumference, in the Pignet index of body fullness, the young cyclothymics are displaced relative to the young schizophrenics quite clearly and to a similar degree as is the case in the corresponding older age groups; for head circumference and for the characteristic cranial shape of the 3 types generally, this is a matter of course anyway as they form a quantity that is as good as constant in the ages in question.

However, it is correct that the pyknic habitus reaches its fullest maturity in middle age, at the same age where manic depressive madness breaks out most commonly; this fact too makes it striking that the two predispositions go closely hand-in-hand.

In *old age*, the paunch is usually still obvious, but it has often collapsed to a certain extent and so the thorax is no longer pushed upwards as much. The skin becomes lax and withered. However, the essential characteristics of the constitution are preserved.

The pyknic constitution in women is slightly modified according to the sex characters. Here the main fat deposition is also on the trunk but is more concentrated on the chest and hips. The chest-

shoulder ratio is similar to that in men. In chest and hip circumference the pyknic *women* on average exceed the athletic women, not absolutely but relatively to their height. This is thus associated, on the one hand, with the greater fat deposition of the athletic women and also with the fact that the pyknic women are relatively smaller than the pyknic men. Markedly short stature below 150 cm is not at all rare among them. The smallest in our material measures 145 cm. Very young pyknic women, who sometimes do not yet demonstrate greater fat deposition, might be mistaken at a brief glance for leptosome women because of their petite constitution. Exact consideration of the measurement ratios, facial structure, vasomotor system (see below) and the fuller and rounder shapes already will protect against this. Young pyknic men can look very athletic at first glance with good musculature and fresh skin turgor. Where the facial shape and chest-shoulder ratio are typical, they will not be mistaken. On the other hand, the differential diagnosis can become very uncertain in individual cases.

When youthful photographs of elderly cyclothymics are compared, it is generally striking that individual men and women in their twenties still have quite atypical body shapes, an elongated face and slender constitution, who later developed quite pyknically. With the young cyclothymics one, therefore, has to be very cautious in one's judgement towards the negative side in that it cannot be asserted with certainty from the status below the age of 40 that they did not contain at least pyknic components in their constitution. The question of the change in appearance (see chapter 7) is of particular relevance for these episodically occurring pyknic components.

There are only 2 quite young cyclothymics below the age of 17 in my material; they both appear markedly behind in age development though their constitution is well-formed and plump. Whether this constitutes some law cannot yet be said in the absence of adequate observation series.

Klaus Conrad (1905–1961)

Klaus Conrad was born on 19 June 1905 in Reichenberg in the Sudetenland. His father taught national economics at the Technical College in Vienna and his mother came from a family that had produced many scientists. After optaining his secondary school diploma, Conrad studied medicine in Vienna from 1923 to 1929, with one term each in Leipzig and in London. During his period as registrar, he first worked at the Magdeburg City Asylum. He wrote two articles there in which there were already references to what later became his main theme, the holistic psychological gestalt analysis of neuropsychiatric syndromes. In 1933, he went to Paris for about a year to study French neurology at the Salpétrière. With the support of a Rockefeller Foundation Scholarship, he worked under Ernst Rüdin at the German Research Institute for Psychiatry in Munich (now the Max Planck Institute) from 1934 to 1938, where he carried out research on the hereditary biology of epilepsy. After habilitation (qualification as university lecturer) in 1938, he applied for a job as consultant under E. Kretschmer in Marburg an der Lahn. Stimulated by Kretschmer's constitutional teachings, he wrote a monograph there entitled "Constitutional Type as Genetic Problem", which appeared in 1942. He was then already working as military doctor in Russia. In 1943, he took over responsibility for the special military hospital in Marburg for the brain injured. He made valuable findings during this period, which later served as the basis for his aphasia studies. In 1948, Conrad was appointed Professor of Psychiatry and Neurology in the new Department of Psychiatry and Neurology at the International University of the Saarland in Homburg/Saar. In 1958, he moved to an appointment

in the Department of Neurology in Göttingen (founded in 1955). In the same year, he was offered the post of Director of the German Research Institute for Psychiatry in Munich, which was being rebuilt. Conrad died before the rebuilding was complete.

Conrad's "Early Schizophrenia", subtitled "An Attempt at a Gestalt Analysis of Delusion" (1958) is one of the most important psychiatric works of the last century. Conrad summarised here the observations of a study performed in 1941–1942 on 107 schizophrenic soldiers and described the development of full schizophrenic psychosis, employing the basic concept of a protopathic gestalt conversion. Conrad's subtle phenomenological recording of the early stages of the disease is particularly impressive. The first stage is the 'trema', a state which precedes delusion and is accompanied by affective tension, in which the environment is perceived as strange. This is followed by the 'apophanic phase', in which an abnormal consciousness of significance develops together with the experience of being at the centre of world events. Conrad explains this with the increasing inability of the patient to change his reference point. He can no longer manage to leave his own coordinates and to place himself next to others or in the role of others. There is no longer the possibility of transition, either in relation to the external world, or in relation to the internal world, his own thoughts and feelings. The borders between the environment and the self are dissolved. In the final 'apocalyptic' phase, the intellectual and voluntary order of the patient's experience is completely lost. Because of his early death, Klaus Conrad could no longer participate in the search for the pathophysiological substrate of the changes he described. He was also missing from the psychopathological discussion of the personal background for schizophrenic disease.

He died on 5 May 1961 at the age of 55 of myeloma.

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Gestalt Analysis in Psychiatry*

One of the main reasons why psychopathological research has barely progressed at all since Jaspers, whose seminal work appeared as long ago as 1913, lies in the barrier to further development, pointed out many years ago by Köhler, Metzger and others, constituted by its strict methodological distinction between causal and understandable relationships in psychopathology, which to some extent constitutes the underlying theme of the whole work. According to Jaspers, we can either attempt to '*explain*' the individual phenomenon with which we are confronted in psychopathology 'causally'; but then we are immediately confronted with the change in organic substrate, transpose the problem into the realm of the extra-psychic, in other words the physical, and transform the psychopathological problem into a *pathophysiological* problem, which thus becomes accessible to scientific investigation. Or, on the other hand, by referring the psychic aspect back to some other psychic aspect, we can attempt to '*understand*' the phenomenon, in other words apply what has since been described as 'understanding psychology'; in which case, we move towards a humanistic search for relationships of meaning and purpose similar to the historical sciences and transform the psychopathological problem into a *hermeneutical* problem by undertaking a sort of scientific interpretation of the psychic with a non-empirical scientific approach. *There is obviously no third way with Jaspers.* Consequently, the development of psychopathology has diverged along two different lines. One development abandoned the area of the psychic in order to advance our knowledge of brain diseases, cerebral physiology, endocrinology and genetic biology. A patient's

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*Reference: K. Conrad. "Die Gestaltanalyse in der Psychiatrie". In: *Studium Generale*. Sept. 1952; vol. 5, no. 8: 503–514.

hallucinatory experience is then nothing more than the expression of an electro-encephalographic finding in certain cortical regions and a psychopathic characteristic nothing other than the expression of a certain constitutional glandular formula. The other development investigated the area of hermeneutical relations in the psychic field in humanistic terms in such a way that the phenomena of mythologies and religions founded in mankind's history, became interwoven into the psychopathological problem so that ultimately the psychopathological phenomenon can be understood as the expression of the unconscious or in terms of a prototype or metaphor. The hallucinatory experience then becomes comprehensible as a development from the primaeval origins of the psychic and is nothing other than an 'archetype' that has risen from the deep. Likewise, an abnormal personality trait can be deduced comprehensibly from the individual's life history by interpreting his history in terms of that of a mythological figure, such as King Oedipus.

Nowadays, we can only *explain* in terms of cerebral physiology or *understand* or interpret humanistically; *a third way no longer appears to exist in current psychopathology*.

I consider this development to be hugely detrimental. It seems to me that the psychopathological once again needs to be tackled psychologically to begin with. To believe that one has explained the essence of a hallucination by recording its somatic correlate on an electro-encephalogram appears to me just as mistaken as the view that clarity about it has been achieved if its archetypical meaning has been understood. Both paths lead away from the actual psychic, in the one case into the infrapsychic, in other words the physical, and in the other into the ultrapsychic, in other words the metaphysical. Psychopathology, however, is first and foremost applied psychology, it is, therefore, a *subdiscipline of psychology* and what I discover in terms of features and phenomena I must first of all analyse psychologically. This obvious approach was naturally also attempted in the classical period of psychopathological research (Wernicke and many others), but was increasingly abandoned as fruitless because the psychological tools available, namely association psychology, proved inadequate. In this respect also, Jaspers' work has, to my mind, not served the progress of

research since not only did it fail to acknowledge sufficiently the fundamental re-orientation of psychology in the last five decades, but in many respects differentiated only vaguely between the old and new viewpoints and essentially professed greater loyalty to the old classical psychology.

Now, however, psychological research over the past few decades has developed completely new ideas that are in the process of being collated into an all-encompassing *Gestalt theory of the psychic*. Metzger has summarised clearly the material already published in this field.[1] What needs now to be done is to re-analyse from this new perspective the extensive wealth of experiences in psychopathology that has been built up by psychiatry. I should like to call this *analysis of psychopathological findings from the perspective of Gestalt theory 'Gestalt analysis'*.

By 'Gestalt' in the psychological sense, we mean first of all that structured and transposable whole that stands out against a background as a phenomenal given, an experiential fact. On the basis of the Gestalt nature of the spoken word or sentence, I have presented a series of Gestalt analyses in the field of aphasia.[2] The same would be possible in the area of agnostic or apraxic disorders. However,

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1. Metzger, Psychologie. Dresden 1941.

2. Über den Begriff der Vorgestalt und seine Bedeutung für die Hirnpathologie, Nervenarzt, 1947; 18: 189. – Über differentiale und integrale Gestaltfunktion und den Begriff der Protopathie, Nervenarzt *19*, 314 (1948). – Strukturanalysen hirnpathologischer Fälle. I. Über Struktur- und Gestaltwandel. Dtsch. Z. Nervenhk. *158*, 344 (1947). – II. Über Gestalt- und Funktionswandel bei einem Fall von transcorticaler motorischer Aphasie. Dtsch. Z. Nervenhk. *518*, 372 (1947). – III. Über den Gestaltwandel der Sprachleistung bei einem Fall von corticaler motorischer Aphasie. Arch. f. Psych. *179*, 502 (1948). – IV. Über subcorticale motorische Aphasie. Arch. Psychiatr. *180*, 54 (1948). – V. Über die Broca'sche motorische Aphasie. Dtsch. Z. Nervenhk. *158*, 132 (1948). VI. Zum Problem der Leitungsaphasie. Dtsch. Z. Nervenhk. *159*, 188 (1948). – VII. Über Gestalt- und Funktionswandel bei der sensorischen Aphasie. Arch. Psychiatr. *181*, 53 (1948). – VIII. Das Problem der gestörten Wortfindung in gestalttheoretischer Betrachtung. Schweiz. Arch. Neur. *63*, 141 (1949). – IX. Beitrag zum Problem der parietalen Alexie. Arch. Psychiatr. *181*, 398 (1948). – Über aphasische Sprachstörungen bei hirnverletzten Linkshändern. Nervenarzt *20*, 147 (1949). – Über den Abbau der differentialen und integralen Gestaltfunktion durch Gehirnläsion. Psyche, 3. Jg. 26 (1949). Über den Begriff der Vorgestalt. Entgegnung auf die Arbeit von Weinschenk. Nervenarzt *21*, 58 (1950).

the transformation of the perceptual world in delusional experiences can also be examined by Gestalt analysis, and likewise the changes in the global field in states of confused, amnesic or delirious consciousness, the restructuring of the global field in paranoia, the different forms of disintegration of the Gestalt in dementia and in Korsakov's disease, and finally the whole transformation of Gestalt in the schizophrenic field of experience. All this has almost never been attempted. Isolated attempts of this kind, such as the study of the world of the patient with compulsive disorder by E. Strauß[3] or von Gebsattel,[4] attracted almost no followers. The first large-scale trial of this nature is the existential analysis by Binswanger,[5] which from our perspective might also be termed the Gestalt analysis of existence. However, it seems important to us not just to make the ultimate overall whole an object of the analytical process, but also to subject subordinate parts, Gestalts in the narrower sense, to analysis at all times.

We wish therefore, on the basis of a few examples, to attempt to show below in what way and in what direction psychopathological analysis can be advanced. In the first part, we deal with very detailed individual cases of disorders of the Gestalt formation process, while in the second part we attempt a short analysis of a more comprehensive situational Gestalt, although our analysis in this case will still be quite different from an existential analysis in Binswanger's sense and will consider only the Gestalt analysis of an individual abnormal response.

I.
a) A phenomenon of impaired word-finding

We are all acquainted with the phenomenon of the temporary inability to recall a well-known name. This is still within the

3. E. Strauß, Ein Beitrag zur Pathologie der Zwangserscheinungen. Monatsschr. f. Psych. Neur. *98*, 61 (1938).

4. v. Gebsattel, Die Welt des Zwangskranken. Monatsschr. f. Psych. Neur. *99*, 10 (1938).

5. Binswanger, Grundformen und Erkenntnis menschlichen Daseins, Zürich 1942.

normal range, but the transition to the pathological is a fluid one; there are mental states in which almost no names can be recalled at all and the reproduction process follows very similar laws to those in the normal state. One such example will be examined here from the perspective of Gestalt analysis. It comes from a collection of similar examples by A. Wenzl.[6]

In a discussion about Thomas Mann, the author searches for the name of the second husband of the principal female character in Buddenbrooks (Permaneder). He comes up with: 'an Italian name', then: 'Pembaur'… 'Peano'... (obviously not, definitely not!). The author's son contradicts: "it's a typical Bavarian name, almost like -inger, it might be four-syllabic, full of consonants." The author's wife: '-eder', then after a pause: 'Permaneder'.

Previous approaches to this phenomenon went no further than, on the one hand, the idea that this involved a loss of word disposition, physiological inhibition, interrupted facilitation, etc., or, on the other hand, the attempt to seek in this 'dysfunction' certain intentions or tendencies of the unconscious that had 'suppressed' the name for reasons associated with the individual's life history. Neither of these approaches showed any interest in the fact that a specific mental process following certain obviously very specific laws was unfolding here and that this should be studied first of all. Only when the laws of this mental process are understood is there any hope to recognise the underlying physical or metaphysical aspects.

It is apparent to begin with that, although the name being sought does not appear to be accessible, nevertheless there is 'something' there. We can describe this 'something' as a quality and, in fact, it is apparently the Gestalt quality 'Italian'. It is a quality without the associated object of which it is the quality, a free-floating qualitative to some extent. The mere fact that we have some sort of physiognomy in front of us, the physiognomy of the 'Italian' or 'Bavarian', in relation to a name that we do not have to mind at that precise moment, is psychologically extremely important; it is a type of 'inkling', a 'primaeval mist' to use a phrase from Sander's school. In a second act in the formation process, two erroneous

6. Wenzl, Empirische und theoretische Beiträge zur Erinnerungsarbeit bei erschwerter Wortbindung. Arch. f. Psychol., 1932; 85: 181.

solutions (Fehlgestalten) suddenly emerge: Pembaur… Peano. It is certainly no coincidence that in both these Fehlgestalten the initials match those of the name that is being sought. The Gestalt begins to crystallise around this characteristic position of the initial letter. From this fixed point, the process then tails off into uncertainty, vagueness. However, both Fehlgestalten also show something else: they are both to some extent embodiments of those general qualities 'Bavarian' (Pembaur) and 'Italian' (Peano) which formed the first seed of experience.[7] The quality 'Bavarian' deriving from the ending of the word that is being sought (-eder) obviously conflicts with that of the quality 'Italian' deriving from the beginning of the word (Perman-). However, both qualities are in fact *Gestalt qualities of the word being sought*. From this it can be seen: the experienced qualities of 'Italian' or 'Bavarian' are definitely not errors, are not something meaningless or randomly occurring, but they are to a large extent determined by the Gestalt that is being sought. Why then the Fehlgestalten Pembaur occurs specifically for the quality 'Bavarian' or the nonsense word Peano for the quality 'Italian' we do not know. Nevertheless, these formation processes are certainly strictly deterministic, i.e. they emerged inevitably from the global field. In terms of Gestalt analysis, a considerable amount could still have been established experimentally through free association, but a barrier always arises at some point since we can never entirely elucidate the whole psychic field of an individual. The formation process now unfolds in a lawful manner: with the discovery of the ending -eder, a fixed contour has now been established, P---eder, while the interior of the structure remains diffuse. In line with Sander, we describe this phenomenon as internal diffuseness. A fixed contour surrounds a diffuse interior 'full of flickering life'. This unique, albeit provisional, structure with a fixed contour surrounding a diffuse interior is now an extremely characteristic transitional phase of a Gestalt in the process of formation which, using an expression of Sander's, we term a *pre-Gestalt*.[8]

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7. to use an expression of Wellek's

8. I do not wish here to go into the discussion with Weinschenk about the definition of pre-Gestalt. Cf. Weinschenk, Der Begriff der Vorgestalt und die

It is then that certain structural properties make their appearance, above all the recognition of the four-syllabic nature of the word, although it seems important that in chronological terms the *physiognomic* quality 'Italian' occurred earlier than the *structural* quality 'four-syllabic'. And then the final Gestalt bursts forth, ultimately without transition and, at the same time, the whole tone of uncertainty that accompanied the process disappears with it, the element of tension, the sense of a lack of finality, the hint of something not quite right in the Fehlgestalten; the final Gestalt appears 'cool and distant' and free from any tension. Now, for the first time, the Gestalt becomes freely available. During the Gestalt formation process, there was a sense of being tied down, of not being able to grasp the image voluntarily, but rather of having to wait until it revealed itself, of being dependent on inspiration, a flash of illumination, a revelation. It descends from above or emerges from below, 'comes' to us or 'illuminates' us from within, but always seems to emanate from some other area of existence, although the location of this 'other area' can be identified only negatively. There is also no sense of awareness that the ultimate success is the consequence of an action, but instead the feeling of being a victim persists throughout the whole process despite the strenuous efforts that are being made. At the same time, however, these search efforts interfere with the process of finding, which is often more successful if our attention is distracted elsewhere. Although we view ourselves as active participants, we remain bound to a passive form of existence and do not possess the degrees of freedom of conscious action.

A large number of other questions are raised by this example, including references to similar processes in other areas of the psychic, such as the produc-

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Hirnpathologie, Nervenarzt, 1949; 20: 355. – Conrad, Über den Begriff der Vorgestalt. Bemerkung zu dem Aufsatz von Weinschenk, Nervenarzt 21, 58 (1950). – Weinschenk, Der neue Begriff der Vorgestalt und die Hirnpathologie. Eine Erwiderung auf die Arbeit von Conrad: "Über den Begriff der Vorgestalt." Nervenarzt 21, 452 (1950). – Conrad, Schlußbemerkung der Diskussion über den Begriff der Vorgestalt. Nervenarzt 21, 454 (1950).- Weinschenk, Conrads neuer Begriff der Vorgestalt und die Hirnpathologie. Schweiz. Arch. Neurol. 67, 101 (1951). – Conrad, Über das Prinzip der Vorgestaltung. Schweiz. Arch. 67, 119 (1951).

tion process of artistic creation which in many respects follows similar laws and also becomes bogged down in Fehlgestalten that certainly have the nature of a pre-Gestalt, from which certain trends in modern art have sought to establish a doctrine. Above all, this yields the close relationship between what we term the *pre-Gestalt* and what current psychiatry describes as the *unconscious*. All this however is beyond the scope of this discussion.

Our aim in this was to show that a phenomenon such as that described here can be further elucidated by Gestalt analysis, in other words it follows certain laws that appear to have general validity for the psychic field.

The phenomenon thus fits into the series of other phenomena, relationships are established between previously unrelated manifestations; in short, we have taken a step forward in analysing the phenomenon. In so doing we have not tried to explain the phenomenon by means of *causal analysis*, *nor* have we tried to understand it *psychoanalytically*. We have simply gained a better hold on it, in other words 'grasped' it, by the fact that we have used Gestaltanalysis to study the principles of its formation. We do not believe that in so doing the epistemological gain is greater than that achieved with the other epistemological methods, but we are convinced that our method has *chronological primacy* over the others: it must precede the other methods. Only when we have *grasped* a phenomenon by Gestalt analysis can we start to *explain* it causally or *interpret* it hermeneutically.

b) A phenomenon of paraphasia or paragraphia

Following damage to certain regions of the brain, it is known that speech disorders occur which we describe as aphasias; the corresponding speech abnormalities are called paraphasias. An actual analysis of the errors in paraphasia has as yet barely been attempted since the phenomenon appeared to be 'explained' by the destruction of the relevant brain region, with the result that this all too rapid resort to the physical has tended to close off certain paths to knowledge rather than open them up. The relationship between the dysfunction and the physical change, moreover, was so clearcut in aphasia that the psycho-analytical school has not yet attempted to explain aphasic 'dysfunctions' psycho-analytically.

In a case of severe motor aphasia following a war-related brain injury, the patient pronounces the name of his birthplace (Niendorf) as 'iembhorf', forming the structure of the word very laboriously and slowly with exaggerated movements of his mouth. When he is asked to spell out the name with letter tiles, he finally spells out, again after considerable searching and deliberations, Nidrof. Although, neither attempt is improved upon further, they do not appear to have a sense of finality and, instead, the impression of a certain dissonance still persists.

If we first look at the paraphasic mistakes, it is immediately apparent that in both halves of the word (Nien- and -dorf) the vowels and also the word endings are formed correctly, but the initial letters of both halves are changed. In the first half, the initial was entirely lost and its place taken by an unclear aspirate, while in the second half a similarly semi-aspirated B sound occurs. The structure now undoubtedly exhibits considerable similarity to the way in which we might mishear such a name under adverse acoustic conditions (e.g. on the telephone). It is well known that in such circumstances it is the initial consonant in particular that is lost first of all. For a similar reason, we can only make individual consonants recognisable on the telephone by giving them a rhythmic vowel structure with a known meaning in order to define the sound. We would, therefore, in this case say: N – as in Napoleon, D – as in Dora. The kinetic execution of the word, therefore, appears here to follow similar laws to those we find under adverse acoustic conditions. The factor common to the acoustic and the kinetic performance is that both cases involve Gestalts that unfold over time, in other words, not simultaneously but *successively*. Without going into a more detailed justification here since the space for this is lacking, we believe we are justified in maintaining that the motor Fehlgestalt of the discussed paraphasia is due to the insufficient configuration of the kinetic blueprint, which we might interpret as an acoustic-kinetic pre-Gestalt formation or as the prototype of the pre-Gestalt of successively generated Gestalts. In this case the initial letter is the weakest and most unstable point of the whole structure.

If we now look at how our patient spells the same word with letter tiles, a totally different picture emerges. Here he suddenly finds

the correct initial letters and the vowels also are again correctly put in place, but in both halves of the word the structure then fades into vagueness. In the first half, the ending is lost completely, while in the second half the correct ending is found, but again we see that characteristic internal diffuseness to which we have already referred in the previous analysis. The fact also that the first half is less well constructed than the second is a consequence of that internal diffuseness, since the ending of the first half represents the interior of the whole unit, while the ending of the second half again acquires somewhat greater definition by the fact that it is the ending of the whole unit. Here we find all those changes, to which an optical Gestalt presented simultaneously is subjected during its pre-formation. In the optical domain, the initial letter is almost always the most firmly fixed and, therefore, the first structural element, whereas the internal structures are usually the most unstable.

The *degradation of function* thus takes place differently according to the type of function required, but always in such a way *that it follows the principles of formation or Gestalt disintegration* known to us from experimental psychology. For this reason, the degradation of successive Gestalts must result in different Fehlgestalts from those resulting from the degradation of simultaneous Gestalts. The kinetic-acoustic paraphasia must, therefore, be constituted somewhat differently from the optic-graphic paragraphia. The understanding of these structural laws should make it possible to some extent to predict the nature of the dysfunctions if we have learnt all the preconditions for their occurrence in this way.

It is also clear here that the analysis of the phenomenon has definitely remained in *the realm of the psychic*, without referring to the physical or anticipating the metaphysical.

c) The phenomenon of delusional misidentification

By misidentification we mean in psychiatry the phenomenon whereby a delusional patient considers those in his immediate environment, even if they are unknown to him, to be acquaintances and relatives and often persists in this for a long time, even when he himself is aware of discrepancies. Early psychiatry was already

concerned with this phenomenon and even now certain questions are discussed as to whether it involves an abnormality of perception or judgement, whether it is a trick of memory, a disorder of understanding, etc. W. Scheid is the most recent author to have presented the problem in detail.[9]

Twenty-year-old schizophrenic. The disease began during his military service with a typical delusion of reference. When he was brought to the military hospital, he thought he recognised his cousin in the nurse, while other people around him were also known to him. The cousin was admittedly taller and blonde in reality, but had, therefore, probably dyed her hair here to deceive him. There was no doubt that it was her, although he knew that she had never been a nurse in France and had married in Germany. Later he was examined by a doctor who looked like his uncle. This similarity petrified him. The voice also was the same kind voice of his uncle. Comrades from his previous company were also there, but made up in such a way that it was not certain whether it really was them. This had probably been done to test him. Later: in his home hospital there were former comrades from the National Labour Service. One looked extraordinarily similar to G., his beard was totally typical. It was so striking that he thought for one moment he had gone mad. In reality it was not him, only very cleverly 'made up'.

Within the global setting of a florid delusional experience in the context of a delusion of reference, the patient considers complete strangers to be acquaintances or – during the recovery phase of the delusion – so strikingly similar to acquaintances that he is constantly irritated by this. Previous psychopathological research was confined to the systematics of the phenomenon, in other words, the question of whether the phenomenon should be attributed to disorders of comprehension, delusional perception or delusional ideas, distorted memories leading to mistaken identifications or déjà-vu experiences, the phenomenon of an abnormal familiarity or the primarily illusional misidentification. The structure of the experience itself has barely been touched upon by research.

In Gestalt analysis, we try to analyse the phenomenon as such, initially without asking about its systematic classification. Since

9. W. Scheid, Über Personenverkennung. Z. Neur., 1937, 157: 1.

however it is not possible to experiment psychologically with delusional patients – (which would be by far the best method of clarifying the phenomenon) –, we study first of all which laws apply to the recognition of physiognomies. The recognition of physiognomy has always been a highly significant problem in Gestalt theory. In each separate Gestalt, we distinguish its 'structure' from its 'essence', structural qualities from physiognomic qualities (Metzger). The human physiognomy provides only the most striking example to show that Gestalts not only have a structure, but also a physiognomy. This is in fact a very general rule: each structure has its physiognomy and for each physiognomy, insofar as it is expressed at all in a structure, there is a very specific structure within which it is most clearly and most convincingly embodied, the 'distinct' structure.

Let us first of all turn the problem on its head and ask: why do we not constantly misidentify and confuse people? Every human face is constructed according to the same laws and the structural differences are often barely measurable. This is in fact what happens with a foreign race: with Chinese or Negroes, our epicritical capacity for differentiation often fails, *they all look the same*. Here we have the first situation in which misidentification might occur in the normal sphere and that possibly shares features with delusional misidentification. However, within our own racial sphere we normally have an astonishing capacity for differentiation and can recognise people, who we may have met only once, again after many years. Our vision is extraordinarily acute in relation to the human physiognomy, i.e. we have formed an extraordinarily *rich system of levels of distinctness* by means of which each structure possesses its quite specific essence – its physiognomy.

This is different under conditions of 'loosened stimulus binding', when for example the observation is made following too short a period of presentation (tachistoscopy), with too narrow an angle of incidence (diminution), with insufficient definition against a background (darkening) or in areas where the elemental organs are less densely distributed (peripheral vision). Under such conditions misidentifications may also happen to the normal observer, as anyone knows who passed by a strange person at great speed or saw this

person at great distance, in the twilight or in the peripheral visual field, and mistook this stranger for an acquaintance. The dedifferentiated structure changes from a particular stage of dedifferentiation its appearance. It is precisely in this transitional zone that it can then happen that a stranger is considered to be known, whereas a few stages further on in the reduction of differentiation the opposite occurs: the known physiognomy is no longer recognised. Here also a model can be constructed – which, moreover, would also be amenable to experiment – where a normal person might experience a misidentification along the lines of our patient.

We find a third model from the psychology of the normal in the case of affective misidentification: when we are 'focussed' on a particular person in a state of increased affect, e.g. in pleasurable and anxious expectation, it can easily happen that we seem to recognise the person in a complete stranger for a brief moment, particularly if factors of loosened stimulus binding are also effective. The high affective tension also dedifferentiates the whole psychic field, so that this dedifferentiation aspect must probably also be used here to explain the phenomenon.

In all these models, one physiognomic feature dominates, one of many physiognomic features stands out from all the others and temporarily takes precedence over all the others. This need not be a purely morphological feature, but can also equally well be a motor factor, a certain movement of the head or mouth, a posture, a physiognomic trait of the voice, etc. At any rate, however, it is always something on which a 'similarity' with the original is based. The similarity aspect is also a highly significant problem that has been very thoroughly studied in Gestalt psychology. It is always based on the concordance of certain physiognomic Gestalt qualities, i.e. on the embodiment of the essence in certain Gestalt qualities.

The defective formation of levels of distinctness (1st model), the degeneration of the levels of distinctness due to loosened stimulus binding (2nd model) and the impairment of distinctness as a result of the affective tension of the subject (3rd model) all have one thing in common, namely a *degeneration of the distinctness relationships* in the sense that two previously physiognomically distinguishable structures prove temporarily to be indistinguishable.

This then gives rise to the following obvious conclusions for delusional misidentification:

1. Delusional misidentification is always based on *similarities* in the persons confused, i.e. on the concordance of certain physiognomic qualities.
2. Delusional misidentification is based on a *change in the distinctness relationships* in the global psychic field of the delusional patient, i.e. on a depletion of levels of distinctness in the area of physiognomies.
3. Delusional misidentification is based also on the fact that one '*essential feature*' of a physiognomy becomes *dominant*, causing all other 'features' to fade into the background so that the whole being appears to be embodied in this one Gestalt quality.
4. This then gives rise to the following possibilities which are often observed in clinical practice in a patient in the course of a psychosis:

a) The patient considers X., who is actually unknown to him, without any reservation to be a specific acquaintance A.
b) The patient considers X. to be the acquaintance A., but observes certain inconsistencies: A. must have dyed his hair or "made himself up" in some way.
c) The patient considers X. to be the acquaintance A., then in the next moment explains that it is not A. but someone strikingly similar to him, only to address him again in the next moment as A. This stage of constant switching has associations with competition phenomena (competition of visual fields).
d) The patient admits that X. is unknown, but is so struck by the extraordinary similarity to A. that he can find no natural explanation for it.
e) The patient has the vague feeling of having already seen X. but without being able to say where that was. There is, therefore, only a vague feeling of familiarity.

Obviously these are only gradations in one and the same psychological change, leading to a further important conclusion whereby the *change of Gestalt* resulting in delusional misidentification can occur *in gradations* and can also resolve via these same intermediate stages. According to the approach of psychiatric textbooks that is

still current, however, all these highly related forms would have to be split up and classified in very different systematic groups.

5. Delusional misidentification is an expression of a major change in the optical field of perception. What models 1) to 3) exhibit in a very fleeting form, to some extent lasting only seconds, becomes a permanent form in the delusional experience: *the relationship of structural properties to essential properties has been altered in some strange way*. At the same time as the destructuring – just as in the experiment with the loosened stimulus binding – physiognomic qualities become dominant so that 'similarities' now appear extraordinarily more striking than normal. I have defined this phenomenon generally as *physiognomisation*. Since the patient cannot be conscious of this structural transformation, at a specific point in the destructuring these 'striking similarities' finally become genuine misidentifications. At some point the realisation that "it's not A., he just looks exactly like A." switches to the realisation: "it is A., he just looks slightly different." From the perspective of Gestalt psychology this switch is extremely significant and prompts the question which general conditions in the field trigger it. This also could possibly be tested experimentally. It is to some extent reminiscent of the change-over that occurs when we imagine a series of white cows with black spots and allow these spots to become gradually larger: somewhere along the line we reach a transition point beyond which we suddenly have black cows with white spots.

6. Misidentification of people is only a *particular example of delusional misidentifications of other kinds* in which the same principles apply, whether the patient mistakes the physiognomies of voices in the acoustic field (and believes he hears the voices of his relatives in those of strangers), whether in the overall perceptual field he mistakes the physiognomy of the localisation in which he finds himself, or finally whether he mistakes the physiognomy of his own global situation. In all these areas, the same phenomena can be observed as have been described here in the misidentification of people, typical transitional effects, change-over experiences, physiognomisation events, etc.

Once again it can be seen here, possibly even more clearly than in the previous examples, that as well as the possibilities of ascribing

the phenomenon *pathophysiologically* to changes in brain function or of interpreting it as a psychodynamical dysfunction due to unconscious desires, there is a third possibility, which brings us closer to the essence of the phenomenon when we subject it to Gestalt analysis. Only when we have understood it from the perspective of Gestalt analysis can we begin to ask about its pathophysiology or its meaning.

II.
An abnormal response to events (Impulsive act)

The 22-year old labour service conscript Wihelm Haase[10] was admitted to the Neurological Clinic M. on 21 June 1938 for assessment. Using his lockable pocket knife, he had stabbed in the neck a fellow conscript who, together with another colleague, had crept up on his bed in the belief that he was sleeping in order to smear him with shoe polish as a joke; the victim died 8 days later from the pneumonia which developed as a consequence of the extensive injury exposing the pleural cavity. The charge against H. was of causing bodily harm with fatal consequences. The question posed by the court was that of the degree of responsibility.

The investigation yielded the following findings in brief: H. had reported to the National Labour Service camp only 10 days previously. A number of others had come with him and had been divided between the conscripts who had already been present in the camp for half a year and still had several months to serve. H. thus found himself as one such newcomer in a group of colleagues who had already known one another for several months. To begin with he kept to himself, was shy and not particularly friendly. The 'old hands' included a number of loud-mouths. In the 10 days prior to the incident, he had not stood out for any reason. He himself also stated that he was just beginning to settle in. On the day before the incident, they were sitting together during their leisure time in the camp's communal room. He himself was sitting at a table and writing a letter to his bride, while some other fellow conscripts were sitting to one side and telling jokes. These included one colleague who had been 'placed on silence' but who was ignoring the order. As the troop leader came in and started remonstrating with the colleagues who had been conversing with the subject

10. Pseudonym

of the order, our patient remarked from his table that he had not taken part in the conversation because it disrupted his letter writing. When the troop leader left the room, H. was taken vigorously to task for this remark. It was deemed uncomradely and an attempt to endear with the leader.

He did not allow this to disturb his letter writing and continued to write, apparently calmly, but noted that the others, including one in particular known as O. who had already stood out the whole time because of his unfriendly attitude towards the 'newcomer', put their heads together and whispered, during the course of which he caught the word 'tonight'. He did not say anything, but was convinced that he would be beaten up that night. As a result he became extremely agitated and anxious. Several years previously in a camp which he had attended for a short while he had seen a colleague particularly badly treated during one such 'visit'.

The evening came and his fear of the night-time increased, particularly as he found his suspicions that 'something was going on' confirmed by certain looks and gestures. As he went to bed, he took his pocket knife with him. He had considered using something less dangerous as a weapon, but did not have anything else. He also simply wanted to use the knife as a weapon to ward off any assailant.

When the lights were turned out, H. lay in tense expectation and great anxiety, starting at the slightest sound; of sleep there was no question. Other comrades had long been asleep when he heard the door open softly and someone enter. A match was struck and he again recognised his fellow labour service conscript O., who appeared to be in discussion with someone else. His fear now exceeded all bounds. Everything then became clear and he could think only of one thing: selling his life as dearly as possible. He opened the knife which had a fixed blade and held it tightly in his right hand. He also now heard someone approaching his bed in the darkness and at the same time noticed a sweetish smell. At that precise moment he realised that he was going to be chloroformed and then somehow horribly mistreated or mutilated while unconscious. During the investigation, he said that he had no precise idea of what was intended with him; he thought only that something might be done to his genital organs. When he was then seized by the arm he struck out blindly with the knife. Immediately a great tumult arose, the light was turned on and at that point he saw that he had stabbed O., who was holding a tin of shoe polish, in the neck. He himself was still agitated, but the fear had disappeared. In the investigation conducted on the arrival of the troop leader, he was able to give clear and sensible information.

In the Gestalt analysis of this explosive reaction, we begin with a consideration of the *topology of the situation and its field forces* (Lewin). What is important, first of all in this respect is that H. had joined the camp only shortly beforehand and that he had, therefore, been catapulted as a newcomer into a circle of colleagues who already knew each other well. This situation has very characteristic features. The group of 'old hands' who are known to one another appears as a compact, relatively undivided mass that is master of the field, a *block* against which the individual is more or less powerless. In fact, all one can do is subordinate oneself to it. Thus, from the outset, the assertion of the ego is severely weakened. Assertion against the 'block' requires considerable mental strength, even in normal, unstressed everyday life. From the outset, the 'block' assumes the nature of a major barrier, it is something that must somehow be overcome, a barrier in the field which we, therefore, describe using an expression of Lewin's as an *internal barrier*. The process of overcoming this barrier normally follows a path in which the newcomer first of all splits off so to speak part of the block – in most cases it is only a loosely adhering part in the form of one or more colleagues who are themselves not so firmly established in the 'block' – and attaches himself to it. This then creates a certain communication with the 'block'. Depending on the personality structure, integration progresses more or less rapidly. Often it never completely succeeds and sometimes a sort of 'counterblock' forms. In groups of old military comrades also, a regular group knits together increasingly closely, often against latecomers. Naturally these interesting processes in the emergence of social groups, which are of considerable interest in the area of animal societies as well, cannot be examined in further detail here.

The psychic field of our patient is further characterised by the strict *external barrier* of the quasi-military environment. One cannot simply 'leave the field' just as one wants. One cannot 'give notice', one cannot 'go home', 'run away', 'divorce oneself', not even 'abstain' or 'remain behind' or 'turn back' or 'abandon the attempt', all expressions of possibilities of resolving certain situations in civilian life. Here, all one can do is to put up with it, one simply has to play along, and in any case the possibilities of 'leaving the field'

are extremely small. 'Desertion' is a crime punishable by death. However, this deadly seriousness is not engendered solely by the threatened penalties, but to a very large extent also by the military ethic: it is not just a 'may not' but also a 'must not' and, therefore, a 'cannot'. This engages the deepest psychological areas that are closely associated with the core of personality.

Thus, our patient finds himself in a situational structure surrounded by an impenetrable external barrier in which we may suspect from the outset a certain level of tension, a 'baseline affectivity',[11] as a result of the existence of that internal barrier we described as a 'block'. The patient obviously did not progress very far in breaking down this 'block' in the 10 days. This is due to the personality structure, which will be discussed briefly later on.

On the afternoon in question, this fundamental situation, which is provisionally entirely within tolerable limits, undergoes a substantial structural shift. To begin with, as far as the unfortunate comment is concerned which became the trigger event, it appears psychologically to be fairly clear in its nature: it is an action against the 'block', in other words *against the internal barrier*, an aggressive action, an attack under the cover of the leader whose social force field at that moment rules the field and, therefore, to a large extent eliminates the influence of the 'block'. At this moment of neutralisation of the strong forces governing the situation, the individual's own small force field can come to bear. It is naturally directed against the internal barrier. It was however an attempt with inappropriate resources. This is immediately apparent when the leader's force field no longer governs the situation. If it had been possible to break through the internal barrier once and for all, then long-term success would have been achieved. As such, however, the counterblow from the block was soon to follow, since in each systemic whole any action against one of the barriers must necessarily result in a counteraction, provided naturally that the barrier is functional, i.e. it is capable of action.

The response is also commensurate with the greater quantity of energy which the 'block' embodies. Thus, H. experiences the

11. to use an expression of Lewin

situation at this moment as an enormous added pressure on the limits of the psychological field. This pressure necessarily results in a sudden and marked increase in the *tension in the field.* The field becomes a battlefield, the actions acquire the characteristics of attack and defence.

As regards the tone of the enhanced affect, in our case *anxiety* developed. This does not necessarily follow from the fact of the increase in tension. Indeed, a great variety of different affect qualities might develop, i.e. tension coloured merely by disinclination, a sensation similar to the *butterflies* of the actor before going on stage, or neutral tension in the sense of *curiosity* about what is to happen or even *pleasant anticipation* of the battle, similar to the excitement before a competition. The tone of affect that develops depends on the relationship of the field forces, one's own and those of the opponent. If one's own forces are perceived to be more powerful than those of the opponent, the awareness of superiority will then create a positive feeling of tension, but if one's own forces are viewed as inferior, then anxiety is generated, while in between there is a whole range of differing intermediate tones. The fact that in this case anxiety developed shows that the field forces were perceived as being strongly in favour of the opponent's pole.

What is also essential for the topology of the situation is that it is focussed on a specific point in the chronological process: it is to happen 'tonight'. In this way, the field acquires a fixed endpoint in its temporal horizon which, like any new barrier, has the effect of increasing the tension so that *the tension increases as it were as a square function of the reduction in distance to the fixed endpoint.*

Then comes the night and with it a still greater tension in the state of affect. In our opinion, much too little has been established about the *structural change of our experiences in the dark*. In fact, a study of this would also be of the greatest possible importance for the psychotic experience. I cannot however go into this in greater detail here.

The first added pressure occurs when his fellow conscript O. enters the room in the dark and prepares something. We can assume that the suspense has now reached a level where the boundaries between

the intra-psychic systems are loosening and breaking down. The intrinsically harmless and comical situation has now become a *struggle for life and death*. Very early on, the tension had spread from a small part to considerably broader areas, had to some extent broken through the intrapsychic walls and now takes over the whole person in its entirety. It is that characteristic transitional point when a 'game' suddenly becomes 'serious', a moment of extremely characteristic topological restructuring which can be very clearly observed in puppies playing together and better still even in young boys scrapping with one another. Now, all of a sudden, any change in the situation as a whole, any action in the field, is perceived in a totally different light and can at any moment become the trigger for a serious confrontation with the barriers. The emotion of rage here corresponds to an act of aggression, i.e. action against the internal barrier; the emotion of anxiety to the act of flight from the field, i.e. action against the external barrier. Psychopathology in particular is acquainted with the fatal outcomes represented by anxiety or panic attacks, terrible self-mutilations, leaps from windows, etc.

It is fundamental to these states that even areas which are relatively unrelated to the ego, e.g. perception, are drawn into the whole field of tension and become completely subordinated to the whole field of experience. Thus, the smell of shoe polish at that precise moment is perceived as an odour of chloroform which is associated momentarily with ideas of anaesthetisation and – very significantly for the psycho-analyst – *of castration*. It is a state in which all fine structures are completely abolished and there is a regression to a state of extreme primitiveness in the global field that is surrounded by a rigid and now extremely overloaded external barrier in which only the motor layer acts as a border between the homogeneous intra-psychic system and the outer world. The slightest added pressure can now result in a fracture of that boundary line, i.e. in a 'blind' act governed purely by affect. *In its nature, this action is one of flight in this case*. It barely has the character of aggression any longer. At first sight this may appear paradoxical in view of the nature of the crime, the stabbing, which costs another person's life. However, analysis of the situation shows that the action is entirely unintended, that

it is clearly directed towards 'escaping from the field' and that only the narrowness of the confines led to this affect. This action can best be compared to the reactions of hunted animals driven into a corner which suddenly turn on the oncoming hunters. In psychological terms also this is purely, as it were, a perverted flight reaction, 'flight' in the sense of the tendency to 'escape from the field', whereas genuine aggression has the tendency to dominate the field.

The nature of the action is also characteristic. It has the nature of something unconditional and massive that is specific to each affect process, but at the same time also has the nature of something irrational and senseless, indicating the disintegration of the situation into individual elements. The action has become an end in itself and does not in any way possess the characteristic of rational defence, nor is it in the slightest way appropriate to the overall situation.

The disintegration of unities of meaning that is occurring here is an expression of the affective loosening of all the field structures and boundaries.

The action here in fact resulted in a complete structural transformation of the situation. This was not in any way 'intended' in the narrower sense of the term. It is however an essential aspect of an outbreak of affect that it can result in a complete restructuring. This is also the case here: at the same moment, the global psychic field was free from barriers, unenclosed, relaxed.

If we also cast a look at the personality structure, this shows the following: the patient is the youngest of several siblings who were so much older that essentially he grew up as an only child since the next oldest sister had already left home when he was born. At school he had learnt well, but thought that he always took somewhat longer than others to grasp something. After school he was apprenticed to a decorator, but wanted to have an office job to ensure he was cared for and had a guaranteed pension in his old age. At about the age of 17 he suffered an epileptic seizure for the first time. Subsequently such attacks recurred in isolation at lengthy intervals. A general dilatation of the cerebral ventricles was diagnosed in a neurological clinic (internal hydrocephalus). He himself thinks that he was pampered by his mother. He was intrinsically anxious, hid himself behind his mother, had little social contact with other children

and was frightened of thunderstorms and strangers. He was also a loner at school and not very popular. Later he was anxious and uncertain in his dealings with girls. Only in the last year had he developed a deeper friendship with a girl. In psychological tests he showed a lack of imagination and a tendency to perseveration. Physically he was a leptomorph with slightly hyperplastic stigmata.

This brief overview shows that this is not a balanced personality with which we are dealing here. The constant thread that runs through his childhood, his later development, his attitude to a career, to the female sex, to the future, is that of uncertainty, anxiety, timidity and reticence and a lack of self-confidence.

In terms of affect, he is dull, somewhat shiftless, often filled with a certain degree of resentment and constantly reproachful towards the world. He is one of those born losers who, without doing much towards it, always manage to get on the wrong side of people, draw attention to themselves and manage with particular adroitness to make themselves unpopular.

If we consider how a syntonic cyclothymic person would have behaved in a similar situation, it is clear that the latter would never have found himself in such a 'situation'. Not only would a person with somewhat greater adaptability never have attracted the opprobrium of the whole group upon themselves with so clumsy a comment, but they would also have managed to establish greater contact from the outset, so that it would never have come to the experience of a 'block' in the psychological field. The cyclothymic personality almost never lives in a ring-fenced field; the borders of the field, the internal structure of the field and hence the whole topology are constantly changing. Conversely, the cyclothymic person is also viewed much more neutrally by others; he is as it were incorporated in the social structure. He enters into the situation without exhibiting any fundamental tendency to alter the structure of the situation. Thus, in the position of our patient, he would also never have viewed the initial situation as being closed off without an escape route. He would presumably not experience any 'block' at all, and hence no internal barrier either. Instead of the block, there would be his colleagues A, B, C, D, etc, with whom he got on to a greater or lesser extent, not the closed, compact and hostile unit confronting him. Consequently, he would have succeeded very

easily in the process of splitting off parts of the 'block', which was mentioned previously. Without much effort, he would have established the necessary contact with his neighbour and then from one neighbour to the next. In this way, the field surrounding him appears completely different from the very outset, it exhibits a different distribution of field forces and borders, in short it exhibits a different topology and above all a much reduced rigidity in all the existing borders. Were he to find himself in a similar situation for external reasons, however, this high level of tension would never have developed because that part which this situation represents in the experience as a whole would not so easily lose its relationship to the comprehensive whole. He would never forget that in the end it could only be a practical joke. In order not to forget this, the momentary experience must be viewed in its correct dynamic relationship to the whole, i.e. it must not be allowed to assume an 'independent existence'. In this way, the tension has the constant possibility of draining away, neither the walls separating the adjoining areas nor those with the more comprehensive systems are hermetically sealed. The result would be that he would allow the joke to be played on him if he could not defend himself against a superiority and in fact might even laugh along with it.

The personality structure of our patient is thus shown to be predominantly that of a schizothymic. The particular feature here, however, is the abnormally high degree of tension of the affect which develops extremely rapidly without finding any possibility of discharging itself beforehand and in which a markedly sthenic component comes to the fore in the discharge itself. The hyperaesthetic schizothymic for his part would react differently again. He would suffer the punitive action passively, registering the whole experience as a severe blow to his self-esteem, but without finding any possibility for discharge. The rigidity of the intrapsychic systems would be too great to allow an inner state of tension to result in the dissolution and breach of the walls and boundaries.

From the perspective of Gestalt analysis, this shows that the personality structure exhibits traits which indicate that the explosive reaction analysed is as much situation- as personality-related. Personality type already implies typical situations. *The structure of*

the personality involves specific situational structures and vice versa. In this, we recognize von Uexkülls' idea of the subject-dependent surrounding field structure which to date has never been consistently thought through as regards body and character types (so-called 'Konstitutionstypen').

Gestalt analysis of the abnormal response once again shows here that in chronological terms it must precede the traditional approaches. Although, both the *attribution of the response to the physical*, in other words, the predisposition of the brain to epilepsy in the presence of mild hydrocephalus and the associated psychological explosiveness, on the one hand, and *the psycho-analytical consideration* of the case with its low self-esteem, castration anxieties and latent aggression on the other contribute to an explanation of the abnormal response, this says no more than that, in the first place, a brain must have the predisposition to explosive discharges for an explosive reaction to occur in the brain's owner and, on the other hand, that if an explosive reaction occurs, drive mechanisms, etc, founded in the individual's life history will manifest themselves in this reaction. However, what is required above all is an investigation of the *precise psychological laws according to which such a reaction can occur at all*. This includes, for example, the emergence of barriers in the psychological field and hence of directed field forces, the increase in tensions in subsystems with the tendency to extend to the whole system, etc. Attempting to explain the irrational response of our epileptic patient in causal terms through the physical anomaly of his hydrocephalus appears as unsatisfactory to us as the attempt to understand it psycho-analytically through his castration anxiety. However, we can very well attempt to grasp it psychologically if we study the psychological conditions of the emergence of a high-tension affect, the mechanisms of charging and discharging, of tension and release, the development of vectors, i.e. directed forces in the psychological field, the specific features and possibilities of the topology of the situation, the effects of dynamic actions in the entire field, in short, if we study the psychological process in similar fashion to the way in which physicists study the processes in the physical field. We must simply remain aware that we are not dealing with physical forces and force fields, but specifically with psychological

forces in psychological fields. This opens up a further area for psychopathology which at present is virtually undeveloped. However, modern animal psychology (Lorenz, Tinbergen, von Holst, etc.) has already preceded us and made significant inroads in this area and it seems important to me that the field of psychopathology is not left behind.

Summary

We have attempted to show that in psychopathology the path of psychological research has wrongly been almost completely abandoned. If we follow Jaspers by acknowledging only two paths to knowledge, namely the path of the causal explanation of the individual manifestation through the physical and the path of the psycho-analytical understanding of the phenomenon through the historical, then we ignore the third possibility of grasping psychopathological phenomena though Gestalt analysis. Individual psychopathological phenomena – the case of impaired word finding, a paraphasic dysfunction, the phenomenon of delusional misidentification and an abnormal response to events – have been examined from the perspective of Gestalt analysis to show by means of arbitrary examples how it is possible to explain psychopathological experiences along psychological lines, while at the same time linking with other branches of applied psychology, particularly modern animal psychology.

Henricus Cornelius Rümke (1893–1967)

Henricus Cornelius Rümke was born in Leiden (Holland) in 1893 and died in 1967 in Zurich (Switzerland). After secondary school in Leiden and the Hague, he became a medical student at Amsterdam University in 1911. He also studied theoretical biology under Bouman and trained as a psychiatrist and neurologist. He was awarded his doctorate in Utrecht in 1923 with a clinical psychiatric study on the feeling of happiness. He studied the phenomenological method in psychiatry and also underwent training analysis in Zurich. Starting in 1928, he worked in the Department of Psychiatry in Amsterdam University, first as assistant and then as head of department. In 1929, he published "Introduction to Character Study". In 1933, he was appointed head of the Department of Psychiatry and Neurology in Utrecht University. In 1936, this was split up into departments of neurology and psychiatry. Between 1954 and 1967, his three-volume handbook "Psychiatry" was published. On the side, he published poems under the pseudonym H. Cornelius. He later held offices in the "World Federation for Mental Health" and made Dutch psychiatry internationally known. After his formal retirement in 1963, he worked as guest professor in Ann Arbor in the USA. He died in Zurich in 1967 during a lecture tour through Germany and Switzerland.

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Clinical Differentiation within the Group of Schizophrenias*

Discussions about the problem of schizophrenia are becoming increasingly chaotic, with the only way forward appearing to lie in renewed attempts at exact description, renewed interest in clinical differentiation and renewed interest in nosology, as initiated by Kraepelin.

Unfortunately, this approach requires energetic defence these days. The value of description is described disparagingly. The whole of European psychiatry is rejected, as if it were too descriptive and not dynamic. For this reason, Kraepelin's psychiatry is condemned and abandoned. A mildly ironic tone is permitted when speaking of clinical differentiation. Many American and even some European psychiatrists regard it as a waste of time, rigid and sterile stamp collecting. In their opinion, it would be better to try at once to see what can be achieved with the available means – with psychotherapy, sociotherapy, pharmacology or surgery. One can often read that these differences are slight and that it would be of no import if nosology were abandoned. How often one reads that nosology is the pursuit of a phantom! I suddenly feel that, in view of all these arguments, courage is needed to hold on to the values of description, differentiation and nosology. It almost seems a pity to spoil the others' fun. And nevertheless, I, for one, ascribe enormous significance to description, differentiation and nosology. There is no visible risk of hyperdifferentiation. The end of description is far from being in sight; in contrast, it has just started. Genuine and realistic descrip-

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*Reference: H. C. Rümke. "Die klinische Differenzierung innerhalb der Gruppe der Schizophrenien". In: *Der Nervenarzt*. Febr. 1958; 29, no. 2: 49–53.

tion is one of the most demanding tasks in psychiatry. Not a single science can dispense with description; it is the starting point for all sciences. How can we learn to distinguish, if we are incapable of exact description? How can we propose theories, if we do not know of what we are speaking? Description is so important because we always allow ourselves to be influenced by what our predecessors saw – whether we want to or not – and because of the fact that there is always some theory in each description. Description is so difficult, as we psychiatrists are simply not professional writers. Unfortunately we feel this intensely during our work and this applies to even the best of all psychiatrists and psychologists. Our deficient choice of words is almost always just a little inaccurate. We need to achieve detachment if we are to make progress, to imagine that we were seeing subjects with psychiatric disorders – in this case, the schizophrenics – for the first time. This difficulty in description in psychiatry leads to a really odd phenomenon, which, to my knowledge, is not manifest so strongly in any other science than in psychiatry – namely double orientation. We perceive what we perceive, even if we are incapable of describing it exactly! It is not rare for us to base a diagnosis on something that we perceive with certainty without being able to communicate it to others in the form of words. We are incapable of verbalising it. In my opinion, description should make every possible effort to describe what has not been described. Without any further words in defence, I wish to state the following: *Description and differentiation or distinction on the basis of this description must be the foundation of our views on schizophrenia.*

Is it really necessary to defend nosological efforts? This must, unfortunately, be indubitably affirmed. I have done this in detail in my contribution to the 'Villingerschrift'. I will mention some factors. The most important reference system in Kraepelin's nosology is the neuroanatomic, physiological and biochemical reference system. Sometimes this is known and sometimes it is presumed. If we survey the history of psychiatry, it is more than probable that this will remain the most important reference system for the medical science of psychiatry. We have observed how this approach in psychiatry has won repeated victories since the time of Hippocrates.

It lived a covert existence during the Middle Ages; in later years, somatobiology overcame all demonological attempts at explanation. This school of thought was never abandoned in France. As a consequence of Heinroth's work, it was forced into the background in Germany, but then began a triumphal march from about the 1850s, with Griesinger as its leader. Kraepelin's work is a continuation of this approach – indeed not only a continuation, but an enrichment, as the clinical course is regarded as being of the greatest importance and, particularly, the question of what is primary in the patient's state or what can be understood as 'presentation'.

Kraepelin speaks of 'nosological entities'. A nosological entity or unit includes a group of diseases with common unexchangeable characteristics. I will first state this in Kraepelin's own words and then in a modern transcription: "In a nosological entity, we find the same causes, the same physical and psychological presentation, the same clinical course, the same findings in pathological anatomy". And in modern language: "We find the same system of preconditions, the same physical and psychological abnormalities in the sense of Jackson's negative symptoms, the same *formal* psychological abnormalities, the same clinical course if no treatment is given and the same findings in pathological anatomy". I cannot repeat often enough that the fact that so few diseases can be completely described in this manner does not detract from Kraepelin's method to the least extent. The cause of much of the confusion in scientific terminology is that classification according to the 'positive symptoms' is now attempted and that the types of 'presentation' are taken as the principle basis of classification. The 'presentation', not the disease, is treated. This is comprehensible. It is really no minor achievement to bring someone nearer to reality than he or she was by modifying the 'presentation'.

There is a group of schizophrenias for which no-one disputes that the diagnosis of schizophrenia is correct. This is called 'real schizophrenia'. In addition, precise scrutiny of clinical experience shows that there is a wide variety of psychoses which appear similar to the first group and which produce inexpressibly many difficulties in diagnosis. The so-called primary symptoms are always present in 'real schizophrenia'. Kraepelin's classical symptoms are: poor

judgement, loss of mental ability, mental dullness, loss of energy. When I list these characteristics, it is striking that they all occur in 'real schizophrenia', but that *they all need revision and addition, if they are really to be valid characteristics of schizophrenia.* If they are taken literally, they can be perceived in many different psychiatric abnormalities. These criteria are thus totally inadequate. If, however, the words 'a certain' are placed before each of these symptoms, it becomes clear what Kraepelin intended. However, it is impossible *even today* to state what 'a certain' actually is. This reminds us again how inadequate our description is. E. Bleuler added the following to these primary symptoms: "The personality loses its unity, there is some abnormality to thought and a changed relationship to reality": These criteria too are important. He borrowed the term 'loss of unity' from the word schizophrenia; in my opinion, it is erroneous. There is no psychological splitting or anything similar. Abnormal thought is the best described of these criteria. 'A changed relationship to reality' must once again be prefixed by 'a certain'. The words 'a certain' should really be replaced by 'a schizophrenic'. This is apparently scientific nonsense. Nevertheless, is it not the case that every research worker knows exactly what the word 'schizophrenic' implies? However, he is incapable of verbalising it. It is also essential that the clinician be always aware of this 'a certain' or 'schizophrenic'. If he does not do this, there is always the totally realistic danger that he will make the diagnosis of schizophrenia for non-schizophrenics. This happens again and again.

There are also some important criteria, namely the feeling that one's own activity has been eliminated (Kronfeld). I have only met this myself in 'schizophrenics'. This is characterised by Minkowski's abnormal vital contact – which should actually be prefixed again by 'a certain' or 'a schizophrenic'. The revivification of the archetypal world (Jung) is a really important characteristic, although this criterion is often impermissible. Gruhle's symbolic experiences, Kurt Schneider's symptoms of the first rank and C. Schneider's and Arnold's disturbances in the consummation of experience should also be mentioned. Wyrsch's 'schizophrenic underlying mood' is also important. All these so-called primary symptoms are only primary if the adjective 'schizophrenic' is added. I myself ascribe

great value to abnormalities in psychological 'closing and opening oneself'. A certain feeling of 'lying open' can be pathognomic (see too the reports of van der Drift).

The following has been of greatest clinical help to *me*. In practice, I let myself be guided by the 'feeling of praecox' arising in the investigator. Perhaps it would be better to say 'praecox experience', as it is not a real feeling. Only a very experienced investigator can employ this compass. If this feeling is not awoken in me – the above criteria are lacking 'a certain' or 'schizophrenic' – then I resist the diagnosis of 'real schizophrenia' for as long as possible.

I also consider that the following is important for the concept of real schizophrenia. *The secret of schizophrenia is a secret of 'form'.* That real schizophrenia is a problem of form is evident in the fact that we can often diagnose schizophrenia with absolute reliability, without knowing the least of the content of the experience, for example, because we do not understand the language or that the mimicry (or pantomimicry) and psychomotor ability of schizophrenics is seriously disturbed. The 'real schizophrenic' is *unindividual*. This is the clearest indication that this is a nosological entity. We see the same 'real schizophrenics' in Athens, Helsinki, Paris, London, Mexico City or Toronto and they can often be recognised at a glance. Thus, clinical experience shows us that there is quite definitely a group of psychoses which form a unit. We call these 'dementia praecox' or 'real schizophrenia'. I agree on this point with Claude, particularly with Langfeld and with Bellak, if I have understood him properly. If the phenomena described above are absent, we are dealing with another disease, however many similarities it may exhibit with the symptoms of schizophrenia patients. This view is also supported by the observation that, once we have made the diagnosis of 'real schizophrenia' in our clinic, the disease never becomes better and even remissions are rare. Insulin, electroshock, largactil and reserpine are a little help, but not much. Insulin makes the schizophrenia somewhat less florid. The patients cannot be immediately recognised as schizophrenics. My statistics for the cure of schizophrenia are worse than in practically all other clinics. My enthusiasm for new therapies for schizophrenia has therefore never been great. If I include the diseases which I would not designate as schizophrenia

myself, although I am convinced that others would do this, my statistics improve until they are similar to those from other clinics. I would like to emphasise expressly that this is not the converse situation – such as cured, therefore not schizophrenia. Sometimes I comment to my assistants: "If this patient is cured, I still think that he is a schizophrenic". I will repeat it once more with every emphasis: If the criteria are strictly applied, the prognosis of dementia praecox is always poor. *Complete cure* does not take place.

However, the task I have selected for myself is the differentiation within the group of 'schizophrenias'. The first differentiation is:

A. *Real schizophrenia*, 'schizophrenia' for short.

All others are:

B: *Pseudoschizophrenias.*

To A: The first question I put is the following: Is there any justification for the differentiation between simple dementia simplex, hebephrenia, catatonia and paranoid dementia? And if so: What is its value? I consider it quite possible that most of the difficulties leading to such a chaotic discussion today are connected with this classification, even though I admit that there is some justification to this classification. I must honestly admit that I have never, or hardly ever, made this distinction in my clinic for years. If I make the diagnosis of 'real schizophrenia' for the disease which has been correctly designated as 'catatonia' or 'paranoid dementia', I do not do this because of the catatonic or paranoid symptoms, but because of the essential schizophrenic symptoms, which were recognisable *as a consequence of* the catatonic or paranoid characteristics. It is easy to forget that this classification is not of equal weight. Hebephrenia does not prescribe a syndrome, although catatonia and paranoid dementia do so. *The danger of errors arose from the fact that catatonia and paranoid dementia were named after accessory symptoms.*

Catatonia and paranoia are almost ubiquitous. Catatonia occurs in many diseases and delusions are possible almost everywhere. I might dare to suggest the following: If catatonic symptoms or delusions – however complicated they are – occur without schizophrenic colouring, if they do not awake the 'praecox feeling' in an experienced investigator, they are *nothing* to do with real schizophre-

nia. This is why I still believe in real 'paranoia', which is not a type of schizophrenia – referred to as 'délire chronique' by the French. (Why is it no longer mentioned that Kraepelin was unsure whether 'délire chronique' was to be identified with paranoid dementia or not? He never overcame his doubts. If he had, he would certainly have reported this). Kraepelin's later classification is partially based on accessory symptoms, partially not. This is:

1. Simple dementia; 2. Hebephrenia; 3. Depressive and stuporous dementia; 4. Depressive dementia with delusions; 5. Agitational forms (circular and paranoid); 6. Catatonias; 7. Paranoid forms; 8. Linguistic confusion.

This classification is certainly not a bad clinical aid. We tend far too easily to forget or not to notice that the agitated or depressive forms might be considered to be schizophrenia. This classification could even be extended. There are also almost purely manic forms, almost purely obsessional forms, almost purely neurotic forms (Hoch) – all ubiquitous syndromes – although we must not forget that neurosis is *also* a syndrome. These forms are partially preformed reaction forms, partially defence forms, partially 'manners of failing' (Zutt). Very many modern theories assume that if one identifies these syndromes with 'real schizophrenia' when they are a little bit unusual, the cure rate rises enormously.

One can regard simple dementia as an admittedly rare, but nevertheless identifiable group. Some of the primary symptoms are always recognisable in these cases and the 'praecox feeling' is always elicited in the investigator. It is still an unanswered question why simple dementia does not develop the full clinical presentation.

On the basis of these considerations, I come to the following conclusions:

Within the group of the schizophrenias, there is only one clinical group which may be designated as 'real schizophrenia'. Whether this is a species or a genus remains open. E. Bleuler had done this from the start. I, personally, am of the opinion that 'real schizophrenia' is a unique disease, a nosological entity. This was also the original view of Kraepelin, Claude and several French scientists in earlier years and is currently supported by Bellak and Dide. I essentially agree with Langfeld's opinions.

To B: Is clinical differentiation within the pseudoschizophrenias possible? Although this is very difficult, it is to some extent both possible and fruitful. When preparing the classification, I have been influenced by difficulties in differential diagnosis. These are of more than one type.

1. *Some of these are endogenous pseudoschizophrenias,* including atypical manic degeneration psychoses, paranoid psychoses and obsessional psychoses. The accessory symptoms are perceptible in all these psychoses, but always without the schizophrenic colour, the 'praecox feeling'. These include many of the oneiric presentations described by Mayer-Gross. This group reacts particularly to insulin therapy, electroshock, largactil and reserpine. Some patients react to none of these, but to one or two sleep therapies. Sleep therapy is far from obsolete.

2. Exogenous toxic pseudoschizophrenias. Catatonic symptoms and amentia-type presentations predominate here. Drug-induced 'schizophrenias' belong to this group. It is initially often very difficult to make the correct diagnosis in the group. Although the typical forms of amentia cause a feeling in the investigator which may have few similarities to the 'praecox feeling', this does not prevent the uniqueness of the amential helplessness triggering a feeling in the investigator which can be confused with the 'praecox feeling'. I have made mistakes here myself and drawn the false conclusion that an exogenous presentation would turn out to be real schizophrenia. The therapy of *these* pseudoschizophrenias is namely the same as that of the exogenous psychoses. Patients suffering from extreme agitation are given very low doses of insulin (20–40 U) several times daily. This group includes some of Kahn's schizoform presentations.

3. *Characterogenic pseudoschizophrenias.* These include Kretschmer's marked schizoid personalities. As a consequence of psychogenic difficulties, they can sometimes be psychotic for a period, without exhibiting the characteristics of *real* schizophrenia. If my memory serves me, Mayer-Gross once pointed this out. Maybe this should include specific forms of paranoia, those forms described as development of a personality.

But here there are clear transitions to the following group.

4. *Developmental pseudoschizophrenias.* This group includes the diseases which are now classified in my clinic as *Sechehaye schizophrenia.* I hope the Swiss psychiatrist will forgive me this. I am totally convinced that I would never have diagnosed René as schizophrenic. And this is not only my view. The patient is missing the primary symptoms and the presentation is reminiscent of the severe forms of degenerative hysteria of the introverted type. (Introverted hysteria is fairly rare. Van der Hoop has pointed out the unique presentations this leads to). One of my female patients with Sechehaye schizophrenia has been treated with intensive psychotherapy by one of my staff (Groen). This girl was practically cured after more than a thousand sessions, in which the 'réalisation symbolique' was used intensely. Treatment has not yet been completed.

These developmental pseudoschizophrenias sometimes present transitory symptoms which are designated as 'délires épisodiques des dégénérés' in the French literature and frequently possess the characteristics which used to be called 'dégénérés supérieuers' – a term which may appear old fashioned, but which has not yet been replaced. I would like to include Kanner's childhood autism under the heading of developmental pseudoschizophrenias. Although these patients do not suffer from real schizophrenia, they do not get better. Some other puberty psychoses also belong here, although the final word has not been spoken about these. These groups also include forms with quasi-neurotic structure. If the patients in the fourth group were to be identified as schizophrenics – whom they really do resemble if no attention is paid to the essential symptoms and the occurrence or lack of occurrence of the 'praecox feeling' – (How often we forget that there are very odd individuals who are not schizophrenics!), then, for example, the views of Adolf Meyer and others would apply. It can then be understood why specific 'schizophrenias' can be cured by psychotherapy.

5. *Cerebral organic pseudoschizophrenias.* Encephalitis is the most important here. Very many diagnostic errors can be made without a precise investigation, particularly when there are few neurological symptoms and no lumbar puncture is performed. Catatonic symptoms can be very marked. It is even the case that when I see a really clear case of catatonia with catalepsy and flexibilitas cerea that I now

always first think of encephalitis. However, it is not only catatonic symptoms which remind one of schizophrenia. Some patients with encephalitis exhibit subdelirious or fully delirious symptoms. These are either followed or independently accompanied by protracted paranoid symptoms with hallucinations, which we used to think only occurred in schizophrenia. I have observed a very interesting hallucination of change in sex in a patient with established encephalitis and also observed the cure of this condition. I would not trust myself to suggest what sort of personality structure would permit this hallucination.

I would also like to include those syndromes in organic pseudoschizophrenias which I described in my Paris lecture as 'exogenous paranoid presentations', including patients with meningitis and cerebral syphilis. The error of diagnosing schizophrenia in a patient with a cerebral tumour may be rare, but it does happen.

Finally, I would like to mention psychoses resembling schizophrenia after a serious head injury. I would not dare to suggest how the organic neurological reference system, the physical constitution and the personality structure are related in these psychoses. It is only clear that schizoid features are not at all frequent in these patients. These syndromes could also be described as schizoform presentations (Kahn).

6. *Unclassifiable cases.* I would like to emphasise this section. Even psychiatrists interested in nosology are not of the opinion that we are working with a complete system in psychiatry in which everything has its place. We meet patients for whom we have to admit honestly that they do not belong to any of the above groups, although they exhibit a superficial resemblance to schizophrenia.

I could name other pseudoschizophrenias. I am thinking of really remarkable paranoid presentations in epilepsy and of psychoses in pernicious anaemia.

I hope I have convinced you in this lecture of the value of clinical differentiation in schizophrenia. If you listened to my analysis, you may be thinking that one could never confuse all these pseudoschizophrenias with schizophrenia. I wish to dispute this. Many of the patients I have briefly discussed here were referred to my clinic by doctors (including specialists)

who considered they were suffering from schizophrenia. In my opinion, it is essential to avoid these errors by developing a nosological attitude. *It is of enormous practical importance not to make the diagnosis of schizophrenia in all these cases.* Once one has become used to this diagnostic system, one can readily drop the term 'pseudoschizophrenia' and designate the condition according to the underlying disease. Nosological developments in psychiatry are certainly not complete. It will however only be successful if it remains open to the achievements of workers using a wide variety of approaches – from Adolf Meyer and White to Stack Sullivan, from Freud's psychoanalysis to that of Menninger, from Jasper's phenomenological anthropological views to Binswanger, pharmacological psychopathology and biochemistry from Buscaino to Osmond and the psychotherapy of the psychoses from the still unknown Dutchman Breukink to Rosen and Sechehaye. In particular, the psychiatrist who thinks nosologically can learn a great deal from all this for his patients and for the development of psychiatric theory, if he allows all these approaches to converge into a nosological concept. Depth psychology and psychiatry based on interrelations have increased the comprehensibility of a very large number of symptoms and shown ways of improving the lot of the schizophrenic. Pseudoschizophrenias have benefited most. This is inexpressibly much, but we should have the courage to admit that we have *learnt nothing* about the nature of *'real'* schizophrenia. Just because they have taught us so much about the pseudoschizophrenias, they have put us in the position of being able to see the character of 'pure schizophrenia' clearly – if you have an eye for these matters. Let us express it briefly and clearly: *Everything of which we can understand the psychodynamics is not specifically schizophrenic. Everything which we can explain as the loss of the higher defence psychism is not specifically schizophrenic.* In fact, we see in schizophrenics how the defence barriers fluctuate and observe hallucinations and delusions, withdrawal and wild self-defence after all defences have fallen. This is the explanation for the marked similarity between real schizophrenia and pseudoschizophrenia. However, we cannot explain the symptoms of real schizophrenia by the loss of defences. The kernel guards its

secrets; we see this kernel glowing through all the barriers, which still seem very effective.

The psychoanalysts have every reason to be modest. Psychoanalysis has been in involved in a gigantic withdrawal over the years – from current trauma, to trauma during puberty, from puberty to the oedipal phase. It stayed there for a long time, till it turned out that oedipal trauma was inadequate to explain all phenomena. The withdrawal is continuing – from the oedipal phase through the anal sadistic phase to the first year of life with the central theme of orality, from there to birth. Psychoanalysis has now held these positions for some years, but must admit once again that they cannot explain everything. A further withdrawal is in preparation. What cannot now be explained, can perhaps be explained by events in intrauterine life. But this will probably not provide the ultimate explanations either. The withdrawal will then be continued into the genes. But the anti-analysts should not rub their hands and say it was all meaningless! The analysts have found a great deal during their withdrawals: the knowledge of the life history, greatly intensified knowledge of particularly critical phases in life history and greatly intensified knowledge of the importance of human relationships. The acceptance of this withdrawal and of these achievements will permit totally new collaboration between the geneticists (the proponents of the constitutional viewpoint) and the psychoanalysts.

Neither phenomenology nor anthropology have succeeded in describing the specific qualities of schizophrenia. We have heard about schizophrenic world views, but their specific quality eludes us. Nosological psychiatry, nevertheless, cannot dispense with this approach either, as there is perhaps no approach in psychiatry which has made a greater contribution towards increasing the precision of clinical differentiation. I presented an enthusiastic testimonial for the clinical significance of phenomenology in my Paris lecture and would like to refer you to this.

Ladies and gentlemen, it must be possible to achieve a synthesis of these every different views on schizophrenia. I hope I have demonstrated that one way to achieve this, in my opinion, the best leads through nosology, through renewed interest in what is and should remain our central interest – clinical psychiatry.

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