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H.-J. HAASE and P.A.J. JANSSEN

revised and enlarged
2nd edition

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with an Introduction

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M. BLEULER

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INTRODUCTION*

by

M. BLEULER

When discussing the treatment of schizophrenics one has to explain what is understood by schizophrenia and with what type of patients and under what conditions one has gained one's experience. If this is omitted there is a danger of talking at cross-purposes.

Among psychiatrists it is probably clear which conception of schizophrenia I am referring to, if I define this controversial conception in a few (only four) terms:

Together with most clinicians I always understand by schizophrenia nothing other than a mental disease which corresponded in severity and social impact to the notion of mental illness, psychosis or insanity in the popular, social, and forensic sense of the word at least once in the patient's life. I don't have to explain to you how this term has evolved in the course of centuries from personal experience and experience with other people, and why it has become a useful word not only in popular language but also in legislation and has been more or less clearly defined. By no means do I include here patients who might also be termed psychopaths, neurotics, or eccentrics. To me it seems that the psychopathology of schizophrenics is primarily characterized by the coexistence of a sane and an insane psychic life. This insane life is seen above all in the diffusion of intellectual processes together with the disorder of emotional life; and both together (seen from a different angle) form the depersonalization in its subjective and objective meaning. Hallucinations, delusions,

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*This introduction corresponds to a lecture on "The treatment of schizophrenics": from the 2nd Psychiatric Symposium in Landeck, edited by H.-J. Haase (1978). The lecture was made available with kind permission of Prof. Dr. Med. M. Bleuler, CH-8702 Zellikon, Zurich, March 17, 1983.

catatonic symptoms are particular signs of a more elementary alteration. However, I do not wish to dwell on this in detail today either. Incompatible with the assumption of schizophrenia, in my opinion are psychoses with amnesic psychosyndrome or other signs of cerebral illness, furthermore psychoses closely linked to a physical disease, such as temporal lobe epilepsy or an intoxication. Nor do I include here short-term illness following severe psychic trauma and with preoccupation with this trauma, even if the symptoms are for a while hardly discernible from those of schizophrenia.

Our University Clinic Burghölzli at Zurich received the assignment for a more intensive treatment of schizophrenics more than a hundred years ago, expressed in clear and exacting terms by the rural population of the area. Until 1830 several generations of these rural people living outside the gates of Zurich had had practically only a glimpse of the academic and intellectual life of the city, while academic education and the access to academic professions was denied to them by the urban aristocracy. In this situation they experienced a burning desire for education, and fostered exaggerated hopes that their sons, once they had been admitted to university, would become better theologians, teachers and doctors than the unreceptive and hidebound aristocrats. Such high hopes were bound to be shattered after the people had obtained full freedom and a university of their own, open to everybody. Disappointments in the field of theology were the cause of the revolution of 1839.

In psychiatry, however, they bore fruit; as a result of these disillusions it was demanded and achieved that in Burghölzli the doctors' main interest shifted from cerebral anatomy and cerebral pathology and from an impersonal nosology to the hopes and worries and concerns of the individual schizophrenic, we might say today, and that research was aided less by the microscope and more by contact with the patient. At the Zurich University Clinic, newly founded in 1870 and planned by Griesinger, researchers of international renown were one by one called to the chair, first of all von Gudden and Hitzig. Rightly or wrongly, the people complained that the professors, unknown to them, did not look after the patients, they were only interested in the laboratory and in writing books, one never saw them with the patients, to whom, moreover, they could not even talk in their mother-tongue. The convictions expressed in his native village became a lifelong assignment for Eugen Bleuler, my father. He was the first in his rural district to study psychiatry — and as a psychiatrist he spent most of his time with his patients and discussed their problems with them in their own language.

He took up his actual research work in psychopathology and the therapy of schizophrenics in the year 1886. He was an assistant to Forel at

Burghölzli at the time, and was appointed director of the rural clinic of Rheinau. He brought eight young schizophrenics from Burghölzli along with him, and wanted to try an intensive environmental and psychological treatment in close communication with them at Rheinau. Being unmarried he devoted every hour of the day to these and his other patients in strict seclusion at Rheinau. From 1898 to 1927 he continued his work at Burghölzli. His personal acquaintance with Freud and his teachings led him — in cooperation with Jung, who was then his senior physician — to add, carefully and critically, psychoanalytical aspects to the understanding and treatment of schizophrenics. Through him I became acquainted with schizophrenics in my early childhood, since we grew up in his official apartment at Burghölzli, where we were continuously running into schizophrenics in yards and on staircases, and he even brought some of them home to meals. Except for several years in hospitals for the physically ill and my military service I lived in psychiatric hospitals, from my childhood until my retirement as a hospital director, and the treatment of schizophrenics, above all the severe cases, has always been one of my main tasks, at first in various hospitals in Switzerland and the United States, and then for 28 years as a director at Burghölzli. Often assisted by my colleagues, I studied above all the long courses of disease in schizophrenics and the factors influencing them, also the significance of different methods of treatment. At the hospital, Benedetti, Christian Müller and others employed new psychoanalytic methods in schizophrenics, that had been introduced in many places after the last war.

These remarks are meant to show you that the assertions I am now going to present are not sheer fabrications but are based on long experience, an experience, however, as you may realize, which is one-sided in some respects.

A first assertion: We know at last what can and cannot be achieved with the treatment known to us today; it is a lot compared to former times, but little compared to what we wish to achieve. There is statistical evidence that three important advances have been made in well-managed psychiatric hospitals in the past few decades:

1) We can improve and mitigate schizophrenias in all stages.
2) With good treatment the most dreadful forms of development no longer occur; the catastrophic course — acute onset in adolescence followed by the most severe chronic psychosis without remission — is no longer seen.
3) Many patients who were formerly chronically ill show at least periods of recovery or improvement.

On the other hand there is no statistical evidence that the percentage of

permanent cures has increased with all forms of treatment, and that the number of chronically progressive cases has significantly decreased.

Statistics, however, do not show everything. Based on the immediate observation of the individual, one hopes to have achieved complete cure in one patient or the other, to have put a stop to a chronically progressive course in one case or the other. There is in addition something else, something of importance, which does not emerge from statistics, but very clearly from experience: in the course of every treatment of every schizophrenic one succeeds, at least temporarily, in getting him out of his isolation, in being with him as if he were one of us, in talking to him and feeling with him as with one of sound mind. It seems then as if we have been able to penetrate the wall that he has erected around him in his illness, as if we had been able to visit him in the prison he has built for himself, and spent some time with him in a comforting togetherness. With one patient this moving experience may occur soon and easily, in other cases perhaps only after years of effort. It may occur in the course of the most diverse types of treatment, provided they include personal contact with the patient. The periods of health may be quite short, or they may develop into a permanent improvement or cure. The fact that in the course of treatment we sometimes see the schizophrenic as if he were of sound mind, even if disillusion follows, is one of the experiences which render these efforts so touching.

A second assertion: There is no specific method of treatment for the specific disease of schizophrenia, as there is no method of treatment that could not be replaced by another in the same patient without adverse consequences. And any treatment successful in schizophrenics can also be successfully employed in many other diseases. One experience, however, becomes quite apparent in all these different types of treatment: each of them is much more successful if the therapist takes a personal, enthusiastic interest and is himself intensely involved; any method loses some of its effects if it becomes mere routine.

My third and most important assertion: The therapeutically significant aspect in these essentially diverse techniques may be traced back to three fundamental influences: mainly an active communion, sometimes also a confrontation with responsibility and emotional arousal at the right moment, and — as far as it is necessary — calming down and soothing.

A dialogue with the doctor is already the beginning of an active communion, which can be continued in a hospital ward between patients, nurses and doctors, striving for a common goal. Depending on circumstances this active community can be continued in the patient's

own family, another family, group therapy, in a day or night hospital, a work group. The keyword for practical realization is, of course, occupation, i.e. the right balance between free creative activity with, for instance, paints and clay on the one hand, useful work on the other hand, and recreational activity such as sports, artistic pastimes, gardening etc. We must offer the patient the opportunity to make use of his natural powers and talents, to do what he can do and wants to do, to do something for others and to be socially integrated. It is important, that doctors and their staff use the right tone in the therapeutic community: As one who is scientifically interested, the doctor must not be a distant and cold observer, he must throw his heart and soul into the community — and yet he must learn to control any negative emotions that may arise within him, fear, indignation, disgust and hostility. As long as possible we must treat the patient like a healthy fellow being. If this is made impossible by the unreality of the patient's ideas and desires, he will forgive us if he feels that we respect him as a human being and take him seriously — even though we cannot accept these unreal ideas and desires as real ones.

The second effective factor in the therapy of schizophrenics is surprise and emotional upset at the right moment and in the right way. As far back as in ancient times individual patients were seen to recover during disasters. In epidemics they suddenly assumed the responsibility of nurses, they acted correctly during earthquakes, bombings and evacuations, and after a death in the family they appeared to be healthy all of a sudden.

When they were young many colleagues, who are old now, saw what happened in old institutions when they suddenly took an inmate out of his cell after many years and tried to do something together with him, as if he were a sane friend: many times with him it failed, but sometimes they experienced a surprising change for the better. There are many ways of including unexpected confrontations in therapy: unexpected early discharges, an unexpected overburdening with responsibilities, but also: a sudden and intuitive grasping of the subjective significance of a symptom, so that the patient suddenly feels free from the isolation, which life has forced upon him because of a delusion or pathologic behaviour.

The third factor in the therapy of schizophrenics is the easiest to apply: calming down, sedation. This is necessary when agitation combined with ranting and clamour renders any attempt at community impossible, or if inner tension renders the patient stuporous and inaccessible. We can calm the agitated patients not only by drugs but also by talking to them in a soothing, determined and yet benevolent tone of voice, often by staying with them and keeping them occupied. A convincing pattern in planning the day and a system of order in their rooms, which schizophrenics

themselves (and also patients suffering from infantile autism) are striving for in an attempt to cure themselves, sometimes helps to calm them.

In all effective methods of treatment we find the impact of one or all of the therapeutic factors. I am now picking out some extremes: first of all the shock therapies that were introduced in the thirties and forties (and also those applied in ancient times) create a community (nurse and doctor give all their care and devotion to the patient); the changes in consciousness are surprising and touching, and all these procedures calm the patient at least temporarily. The frank talk, the understanding of pathologic ideas and the empathy with the patient during psychoanalytical treatment create a close communion; the sudden success with an interpretation, the sudden mutual understanding, the sudden understanding of the patient's cryptic expressions can move and upset him.

Naturally, the treatment of schizophrenics with drugs serves mainly to relax and calm. Professor Haase studied and exposed them excellently. The old sedatives are soporific, tranquilizers and neuroleptics at a dosage below the neuroleptic threshold enable relaxation without creating somnolence, neuroleptic agents at a dosage above the neuroleptic threshold reduce the entire psychoenergetic level by acting on the extrapyramidal system. Drug therapy, however, requires a personal effort by the doctor: its hazards are great, and its advantages are small, if it is applied routinely, without time, devotion, and understanding for the individual patient. — It does not lack an element of surprise, either: drug therapy leads to a surprising change in the patient's emotional life as well as the human environment of the patient.

Although active community, emotional upset, and calming represent the essential elements in the treatment of most schizophrenics, there are individual cases with particular indications: if catatonic agitation develops into an acute delirium and threatens to turn into what used to be called fatal catatonia, the patient's life depends on good physical nursing and treatment, on the avoidance or treatment of aspiration pneumonias, pyelonephritis, bedsores, furuncles and injuries, on control and correction of fluid and ion balance, on the administration of drugs against circulatory insufficiency and of corticosteroids.

Today we are aware of the fact that the so-called fatal catatonia is not caused by a specific catatonic cerebral process, but is the result of the cumulative effects of dehydration, partial undernourishment, exhaustion, respiratory obstruction and various infections. Along with the physical nursing and treatment, staying with the patient and a patiently practised occupational therapy can be effective even in an acute delirium. — We have an entirely different indication for prevention and therapy in episodic psychoses with mixed schizophrenic-manic-depressive symptomatology.

Some of these psychoses respond to the same methods of prevention and therapy as do the manic-depressive ones.

Putting such special indications aside and considering what is essential in the treatment of schizophrenics we may largely regard this treatment as an appeal to the healthy element in the patient. As we know for certain today, this healthy element continues to exist even in those patients who are termed seriously schizophrenically "demented". This healthy element is appealed to in the active community; in the treatment by emotional arousal latent healthy powers are aroused by some biological law. The act of calming helps to develop the healthy element in the patient, where the agitation had rendered life amongst people impossible before.

In the treatment of the schizophrenic which has proved to be effective, in the appeal to the healthy element within him, the same elemental influences are brought to bear that are active from early childhood in everybody when the healthy personality develops: we grow up to be what we are, in active community with others, we grow up confronted with big and vital tasks that mobilize all our strength, and we need quiet and peaceful intervals in between in order to mature. These are the same influences that we make use of when treating schizophrenics, influences that shape the healthy personality, that shape all of us.

We know from immediate observation of the patient that a disintegration of personality occurs in schizophrenia, a disintegration of his own nature, of his own ego. This disintegration may be considered as a transition from a rational inner life to an irrational autistic life, as a transition from a life in which we strive to realize ourselves by adjusting to reality, to a life which is hardly concerned with reality, a life which creates a world of its own corresponding to the inner disintegration. Whether this disintegration, this transition to the autistic world is the solely decisive element in schizophrenia, as I think it is, or whether it is only one important factor among others is open to discussion.

At any rate we may hope today — and even believe until the contrary is proved — that a treatment aimed at the integration of all opposing inner tendencies to an undivided personality, is entirely or largely a causal treatment. Unlike the older generations we do not have to look down on that kind of treatment as "mere" symptomatic treatment, which is only justified for the time being until the sensational finding of a mystic causal treatment.

Based on our understanding of the nature of schizophrenias as well as our experience with the treatment we are entitled to believe that we do not bungle our work when using this type of treatment, and that it comes at least close to the causal treatment longed for by generations of doctors.

From this knowledge we may gather fresh courage and strength and

turn the toilsome and often disillusioning task of treating schizophrenics, exhausting and yet infinitely rewarding, into a significant mission of a lifetime.

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