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The notion of unitary psychosis: a conceptual history

G. E. BERRIOS* and D. BEER

'Unitary psychosis' is the collective name for a set of disparate doctrines whose common denominator is the view that there is only one form of psychosis and that its diverse clinical presentations can be explained in terms of endogenous and exogenous factors. This paper examines the history of these doctrines since the eighteenth century in the work of their main sponsors and extricates their conceptual assumptions. It is shown that the nature of the debate between 'unitarians' and those who believed in the existence of separate diseases has changed throughout time, and that to these changes national differences have been important. Earlier discussions made use of conceptual and ontological argument; latter ones of clinical analysis; and the latest debate, that occurred during the 1970s, over-relied on statistical techniques and genetic analysis. The outcome of this long debate remains inconclusive.

The term 'unitary psychosis', a rendition of the German *Einheitspsychose*,¹ is the name for a collection of views which have in common the assertion that there is only one psychosis.² To reach this conclusion, it is variously assumed: (a) that clinical differences between traditional 'psychoses' are due to either pathoplastic effect of personality, life events or observer bias; and (b) that the single psychosis is the clinical expression of an underlying *invariant* (conceived as 'organic' (e.g. Neumann), 'psychological' (e.g. Freud) or 'structural' (e.g. Ey or Llopis)). Cross-sectional versions of the doctrine

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¹ The term has been translated into Spanish as *psicosis única* or *psicosis unitaria*, and into French as *Monopsychose* and *Psychose unique*.

² During the nineteenth century, the term 'insanity' (*folie*, *pazzia*, *locura*, or *Wahnsinn*) was replaced by 'psychosis' (Berrios, G. E., 'Historical aspects of psychoses: 19th century issues'. *British Medical Bulletin*, xliii (1987), 484–98). This was more than a terminological change and reflected a shift in the conception of mental disorder (i.e. the abandonment of pre-nineteenth-century views of insanity as states of total irrationality).

must explain why, given that personal and environmental factors change, psychoses tend to remain the same from episode to episode; longitudinal versions (as per Griesinger) must offer a mechanism by means of which the 'invariant' may change clinical presentation within the same individual.

During the 'pre-statistical' period, 'unitarians' (the name given here to the sponsors of the doctrine) favoured arguments such as that the mind can not be split into faculties or that 'intermediate cases' were common or that all diagnoses are longitudinally unstable. After the statistical revolution of the 1930s, factor analysis, cluster analysis and discriminant function analysis have been increasingly used to show that boundaries between the psychoses are unreliable; mathematical naïvety, unfortunately, led many to assume that failures to obtain bimodal distributions were tantamount to proving their case.³

Historiographic pitfalls

Writing the history of the unitary psychosis doctrine is not easy. Unitarians have rarely made their assumptions explicit, or have changed their mind, or have contradicted themselves; furthermore, there is little continuity in the unitarian doctrine itself, and the assumptions made by Reil, Neumann, Griesinger, Hoche, Bonhoeffer or Crow are closely tied up with the science and ideology of their time.

There is also the question of the object referred to by the doctrine. If anachronistic reading is to be avoided, one must not readily assume the existence of an 'invariant' or 'trans-epistemic' object (whether a neurobiological lesion or a psychological archetype) which unitarians endeavour to capture. Even concepts such as 'ruling ideas' (used by Vliegen in his important book⁴) must be avoided, as must, indeed, be the assumption that unitarians are necessarily anti-nosological: Menninger probably was so, but not Griesinger, Llopis, or Ey who *believed* in the medical model but disagreed with the idea that there could be many psychoses. The best work on the unitary psychosis doctrine is still to be found in the German and Spanish languages.⁵

³ During the 1970s, a debate erupted in the UK on the usefulness and power of these statistical techniques; its inconclusive outcome encouraged a return to a search for reliable and valid 'markers' of disease (for an analysis and list of the 1970s references see excellent paper by Grayson, D. A., 'Can categorical and dimensional views of psychiatric illness be distinguished?' *British Journal of Psychiatry*, cli (1987), 355–61).

⁴ Vliegen, J. *Die Einheitspsychose* (Stuttgart: Enke, 1980).

⁵ Mundt, C. and Saß, H. (eds), *Für und wider die Einheitspsychose* (Stuttgart: Thieme, 1992); Vliegen, 1980, *op. cit.*; Wyrsh, J., *Zur Geschichte und Deutung der endogenen Psychosen* (Stuttgart: Thieme, 1956); Pauleikhoff, B., *Endogenen Psychosen als Zeitstörungen* (Stuttgart: Pressler, 1986); Masi, C., 'Histoire des psychoses "endogènes"'. *L'Information psychiatrique*, lvii (1981), 57–72; Lanczik, M., 'Heinrich Neumann und seine Lehre von der Einheitspsychose'. *Fundamenta Psychiatrica*, iii (1989), 49–54; Llopis, B., 'La psicosis única'. *Archivos de Neurobiología*, xvii (1954), 3–39; Rennert, H., 'Wilhelm Griesinger und die Einheitspsychose'. *Wiss. Z. Humboldt-Universität Berlin. Math. Nat.R.*, xvii (1968), 15–16; Valenciano, L., 'La Tesis de la Psicosis única en la Actualidad'. In Llopis, B., *Introducción Dialéctica a la Psicopatología* (Morata: Madrid, 1970), 113–59.

Medical nosology and taxonomy

Classifications of insanity entail a taxonomic theory and a concept of disease.⁶ Classical medical taxonomy included strategies for the description and *grouping* of symptoms, syndromes, diseases and lesions.⁷ So-called *natural* classifications, particularly in psychiatry, depend on description, so rules for symptom-recognition are needed, and indeed they were developed during the nineteenth century. But symptom-description is also influenced by 'non-cognitive' forces so that the older a psychiatric discourse, the harder it is fully to grasp its real meaning. The nineteenth century *feels* more 'accessible', but this may be because the clinician still shares in the same 'discourse'.

Periods of taxonomic change offer privileged windows; one such was opened during the early nineteenth century when the anatomo-clinical model of disease was introduced.⁸ According to this view, signs and symptoms were to be considered as 'signals' emitted by biological lesions (localizable in the internal space of the body).

Pre-1800 psychiatric taxonomy

The eighteenth century witnessed the apotheosis of one type of medical

⁶ Aschaffenburg, G., *Die Einteilung der Psychosen* (Leipzig: Deuticke, 1915); Temkin, O., 'The history of classification in the medical science'. In Katz, M. M., Cole, J. O. and Barton, W. E. (eds), *The Role of Methodology of Classification in Psychiatry and Psychopathology* (Washington: US Department of Health, 1965), 11–125; Sartorius, N., Jablensky, A., Regier, D. A., Burke, J. D. and Hirschfeld, R. M. A. (eds), *Sources and Traditions of Classification in Psychiatry* (Toronto: Hogrefe & Huber, 1990).

⁷ On historical work on classification see: Pichot, P. J., 'The French approach to psychiatric classification'. *British Journal of Psychiatry*, cxliv (1984), 113–18; Verga, D., 'Projet d'une classification uniforme des maladies mentales, au point de vue de la statistique'. *Annales médico-psychologiques*, xxiv (1876), 140–4; Riese, W., 'History and principles of classification of nervous diseases'. *Bulletin of the History of Medicine*, xviii (1945), 465–512; Guiraud, P., 'Évolution de la nosographie clinique'. In *Psychiatrie générale* (Paris: Le François, 1950), 17–34; Rémond, M., 'Essai sur la classification en psychiatrie'. *Gazette des Hôpitaux*, lxxv (1902), 973–6; 983–7; Desruelles, M., Leculier, P. and Gardien, M. P., 'Contribution à l'histoire des classifications psychiatriques'. *Annales médico-psychologiques*, xcii (1934), 637–75; Lewes, F. M. M., 'Marc d'Espine's statistical nosology'. *Medical History*, xxxii (1988), 301–13.

On modern work on classification see: Overall, J. E. and Woodward, J. A., 'Conceptual validity of a phenomenological classification of psychiatric patients'. *Journal of Psychiatric Research*, xii (1975), 215–30; Schwartz, M. A. and Wiggins, O. P., 'Diagnosis and ideal types: a contribution to psychiatric classification'. *Comprehensive Psychiatry*, xxviii (1987), 277–91; Schwartz, M. A. and Wiggins, O. P., 'Logical empiricism and psychiatric classification'. *Comprehensive Psychiatry*, xxvii (1986), 101–14; Reuchlin, M., 'Contribution to the theoretical problems of classification in the observational sciences'. *Psychopathology*, xvii (1984), 149–57; Andreasen, N. C. and Spitzer, R. L., 'Classification of psychiatric disorders'. In Van Praag, H. M. (ed.), *Handbook of Biological Psychiatry*, Part 1 (New York: Dekker, 1980), 378–95; Corning, W. C. and Steffy, R. A., 'Taximetric strategies applied to psychiatric classification'. *Schizophrenia Bulletin*, v (1979), 294–305;

⁸ Ackerknecht, E., *Medicine at the Paris Hospital 1794-1848* (Baltimore: Johns Hopkins Press, 1967).

taxonomy and the stirrings of another. Following Sydenham's injunction,⁹ physicians classified diseases 'in the manner of botanists',¹⁰ indeed, many were both.¹¹ Diseases, like plants, were classified in terms of privileged features,¹² i.e. according to a 'top-to-bottom' or 'downwards' mode. Two assumptions were then made: (a) the object to be classified (whether plant or disease) was considered as a 'complete' and immutable entity, and (b) privileged features had semantic reality, i.e. were part of a universal design. (In pre-Darwinian periods such design was believed to result from a divine hand; afterwards, from evolution). 'Natural' classifications reflected the natural order; 'artificial' ones, practical needs.¹³

During the latter part of the eighteenth century a second view was suggested by Adanson,¹⁴ the great French botanist of Scottish descent. Influenced by Aristotelian ideas, he believed that more 'natural' groupings might be identified if no 'feature' was privileged or 'weighted' in any way.¹⁵ For example, plants (or diseases) might be exhaustively described and patterns sought out. This 'bottom-to-top' or 'upwards' approach assumed that clusters are determined by feature density. For reasons which are beyond the scope of this paper, Adanson was not influential, although it has been claimed that his ideas led to the development of numerical taxonomy.¹⁶

Cullen

Cullen¹⁷ suggested that mental disorders might be classified on the basis of anatomical, functional, symptomatic and outcome features. Cullen, a downward taxonomist, used principles already present in Sauvages, Linné,

⁹ Sydenham, T., *The Works of Thomas Sydenham MD* (translated by R G Latham). Vol. 1 (London: Sydenham Society, 1848).

¹⁰ López Piñero, J. M., *Historical Origins of the Concept of Neurosis*, translated by D. Berrios (Cambridge: Cambridge University Press, 1983).

¹¹ Berg, F., 'Linné et Sauvages. Les rapports entre leurs systèmes nosologiques'. *Lychnos*, xvi (1956), 31–54; Faber, K., *Nosography in Modern Internal Medicine* (London: Oxford University Press, 1923); Fischer-Homberger, E., 'Eighteenth-century nosology and its survivors'. *Medical History*, xiv (1970), 397–403.

¹² Larson, J. L., *Reason and Experience. The Representation of Natural Order in the Work of Carl von Linné* (Berkeley: University of California Press, 1971).

¹³ Hoppe, B., 'Der Ursprung der Diagnosen in der botanischen und zoologischen Systematik'. *Sudhoffs Archiv*, lxii (1978), 105–30; Raven, H., Berlin, B. and Breedlove, D. E., 'The origins of taxonomy'. *Science*, clxxiv (1971), 1210–13; Stevens, P. F., 'Metaphors and typology in the development of botanical systematics 1690–1960'. *Taxon*, xxxiii (1984), 169–211

¹⁴ Baillon, T., 'Adanson'. In Dechambre, A. and Lereboullet, L. (eds), *Dictionnaire Encyclopédique des Sciences Médicales*, Vol. 1 (Paris: Masson, 1864), 689–91.

¹⁵ Baillon, 1864, *op. cit.*

¹⁶ Adams, J. N., 'A critical evaluation of Adansonian taxonomy'. *Develop. Ind. Microbiol.*, v (1964), 173–9; Vernon, K., 'The founding of numerical taxonomy'. *British Journal of History of Science*, xxi (1988), 143–59.

¹⁷ Cullen, W., *The Works of William Cullen*. Edited by J. Thomson. Vol. 1 (London: Blackwood, 1827).

Vogel, Sagar and McBride.¹⁸ In regard to anatomical criteria he wrote: 'there have occurred so many instances of this kind, that I believe physicians are generally disposed to suspect organic lesion of the brain to exist in almost every case of insanity [. . .] this, however, is probably a mistake; for we know that there have been many instances of insanity from which the persons have entirely recovered'.¹⁹ 'Such transitory cases, indeed, render it probable, that a state of excitement, changeable by various causes, had been the cause of such instances of insanity.'²⁰ Cullen believed, therefore, that 'physiological lesions' might be important.

In regard to classifications, he stated: 'having thus endeavoured to investigate the cause of insanity in general, it were to be wished that I could apply the doctrine to distinguishing the several species of it, according as they depend upon the different state and circumstances of the brain, and thereby to the establishing of scientific and accurately adapted method of cure. These purposes, however, appear to me to be extremely difficult to be attained.' Thus, only symptomatic classifications seemed possible.

Cullen criticized classifiers: 'The ingenious Dr Arnold has been commendably employed in distinguishing the different species of insanity as they appear with respect to the mind; and his labours may hereafter prove useful, when we shall come to know something more of the different states of the brain corresponding to these different states of the mind; but at present I can make little application of his numerous distinctions'. And then stated a 'unitarian' view: 'It appears to me that he [Dr Arnold] has chiefly pointed out and enumerated distinctions, that are mere varieties, which can lead to little or no variety of practice: and I am specially led to form the latter conclusion, because these varieties appear to me to be often combined together, and to be often changed into one another, in the same person; in whom we must therefore suppose a general cause of the disease.'²¹

Pinel

There is less elegance and insight in Pinel's nosography. He identified three stages in the formulation of a new disease: (a) recognition of symptoms;²² (b) observation of clusters and symptom-covariance, particularly during the acute stage of the disease; and (c) distinction between simple and complex

¹⁸ Cullen, W., *Synopsis nosologiae methodicae*. 6th Edition (Edinburgh: W. Creech, 1803); Bowman, I. A. 'William Cullen (1710-1790) and the Primacy of the Nervous System'. PhD Dissertation, Indiana University (History of Science), 1975.

¹⁹ Cullen, 1827, *op. cit.*, 175.

²⁰ *Ibid.*, 176.

²¹ *Ibid.*, 76-77.

²² Pinel was influenced by and quoted Landre-Beauvais, A. J., *Séméiotique, ou traité des signes des maladies*, 2nd Edition (Paris: Brosson, 1813).

diseases, the latter showing (and in this he followed Cullen) 'in their course two or three different symptom-clusters'.²³

Pinel espoused a less organic view of insanity than Cullen. His experience at *Bicêtre* had 'convinced him that the common sources of mental alienation related to sadness and loss'²⁴ and that 'non-febrile insanity, far from resulting from brain lesions, [may be] triggered by unbridled passions.' Pinel had no difficulty in accepting symptomatic classifications. It must be kept in mind, however, that his use of terms such as mania, melancholia and dementia is different from the present, and unless case-notes are studied, it is not possible always to determine what sort of patient he was talking about.

Kant

Kant is a typical example of late eighteenth-century armchair classifier.²⁵ His writings on mental disorder are surprisingly little known, in spite of the fact that it has been suggested that they were influential in German psychiatry.²⁶ Reference will only be made here to the classification included in his *Anthropologie*²⁷ where Kant attempted a downwards classification.

Kant assumed that mental disorders result from impairment of the brain, but believed that classification had to be based on what 'faculty of the mind is involved'.²⁸ Dysfunction of the mental faculties dealing with reality-unreality, judgment, and reason, led to different mental disorders: 'I should like to classify all [diseases of the mind] according to the three following categories: perturbation of experience which I want to call confusion (*Verrückung*); dysfunction of judgment which I call delusion (*Wahnsinn*); and impairment of reason which I call mania (*Wahnwitz*). All other manifestations of brain disease may be, it seems to me, classified as variations in degree or as combinations of these three [basic] disorders or as their combination with emotions.'²⁹ Kant's classification is a good example of a botanical top-to-bottom approach, uncomplicated by clinical experience.

Battie

Battie's top-to-bottom classification combined clinical and aetiological criteria. His theoretical position is likely to have caused embarrassment to the then fashionable 'sensationalist' hypothesis of perception. Battie started with

²³ Pinel, Ph. *Nosographie philosophique*, 6th Edition (Paris: Brosson, 1818), xxxviii-xxxix.

²⁴ *Ibid.*, 53.

²⁵ For example, he was triggered into psychopathological speculation by the neuroanatomical work of Sömmering who dedicated to Kant his book on the 'Organ of the Soul' (see Kant, I., *Anthropologie*, translated by J. Tissot (Paris: Ladrangé, 1863), 441-6.

²⁶ Dörner, K., *Bürger und Irre* (Frankfurt am Main: Europäische Verlagsanstalt, 1969).

²⁷ Kant, I., *Anthropology from a Pragmatic Point of View*, translated by M. J. Gregor (The Hague: Martinus Nijhoff, 1974 (first edition 1797)).

²⁸ *Ibid.*, 220.

²⁹ *Ibid.*, 220-21.

the assumption that the 'medullary' substance of the brain was the seat of 'sensation', and that sensations were produced by stimuli (pressure) impinging upon it. Imaginary sensations are caused 'by an internal disorder of the nervous substance'³⁰ or by the 'nervous substance being, indeed, in like manner disordered, but disordered *ab extra*; and therefore chiefly to be attributed to some remote and accidental cause'.³¹ Each mechanism gave rise to a different madness: 'the first species, until a better name can be found, may be called original, the second may be called consequential madness.'³²

It would be anachronistic, however, to interpret Battie as offering an early version of the late nineteenth-century dichotomy of endogenous-exogenous or of the twentieth-century ones of functional-organic and primary-secondary. He was just applying to abnormal sensations a model taken from Hartley³³ and Condillac.³⁴

Battie said little about the mechanism involved in 'original madness'³⁵ and concentrated on 'consequential' madness where the problem was to explain why only some external (*ab extra*) stimuli managed to give rise to 'delusive' (insightless) sensations. Battie suggested a way around this problem based on the 'quality' of the sensation, i.e. a delusive sensation occurred when *per chance* the stimulus was identical with the one causing a real sensation: 'which force necessarily implies impulse and pressure in delusive sensation in the same manner and order as it does in the perception of objects really corresponding thereto'.³⁶ But do all subjects thus duped develop delusions? Apparently not, indeed Battie realized that explanations only based on the 'quality' of the sensation were not adequate. So he resorted to personality characteristics and concurrent factors: 'What this particular sort and degree of pressure is, which is capable of creating delusive sensation, we are not able to ascertain; because the different circumstances of the unknown subject acted upon will make the nervous effects variable and oftentimes contrary, notwithstanding the action of the known cause considered *per se* is in all respects the same.'³⁷

³⁰ In Battie, W., *A Treatise on Madness* (London: J. Whiston, 1758), 43.

³¹ *Ibid.*, 43-4.

³² *Ibid.*, 44.

³³ Hartley, D., *Observations on Man, his Frame, his Duty, and his Expectations* (London: Tegg, 1834 (first edition 1749)); Oberg, B. B., 'David Hartley and the association of ideas'. *Journal of the History of Ideas*, xxxvii (1976), 441-54; Smith, C. U. M., 'David Hartley's Newtonian Neuropsychology'. *Journal of the History of the Behavioral Sciences*, xxiii (1987), 123-36

³⁴ Riese, W., 'La Méthode analytique de Condillac et ses rapports avec l'oeuvre de Pinel'. *Revue philosophique*, clviii (1968), 321-336; Le Roy, G., *La Psychologie de Condillac* (Paris: Boivin & Cie, 1937).

³⁵ Battie divided all forms of madness into original and consequential.

³⁶ In Battie, 1758, *op. cit.*, 44.

³⁷ *Ibid.*, 45-6.

Classification and nosology during the nineteenth century

Nineteenth-century alienists were confronted with the task of classifying objects whose definition was in a state of flux. There were changes at all levels: symptom description (including for the first time subjective information), temporal context (acute *versus* chronic disease), outcome (reversible *versus* irreversible), causality (psychological *versus* physical), lesion type (anatomical *versus* physiological) and localization (brain sites *versus* diffuse location).³⁸ In the wake of these changes, the insanities were gradually transformed from monolithic entities to multiple categories defined as symptom-clusters.³⁹

The anatomo-clinical model

The single most important factor was, perhaps, the development of the 'anatomo-clinical' view according to which disease was a collection of signals resulting from lesioned sites.⁴⁰ When, towards the second half of the nineteenth century, the quest for anatomical lesions failed, the same model encouraged the search for 'physiological' and later for 'psychological' lesions (à la Freud). The anatomo-clinical model also encouraged the refinement of surface descriptors (i.e. of 'semiology').

Clinical descriptors

'Symptom and sign' are categories already present in Hippocratic medicine. During the eighteenth century 'signs' (of a disease) and 'features' (of a plant) played the same role in classification. The rules governing their combination, however, were clearer for plants than for diseases. Medical classifications at the time often consist in mere lists of 'symptoms' reified as diseases. After the 1820s, rules of combination were created based on new anatomical and physiological knowledge. The old insanities were broken up and the resulting fragments became veritable 'units of analysis' or building blocks which could partake in the definition of more than one disease. There is no better illustration of this than Landre-Beauvais's semiological views: 'it is not sufficient faithfully to list the signs of disease, it is also required to offer them in the sort of order that shows up their relationship to physiology and

³⁸ For a full account of these changes and how they affected individual symptoms see Berrios, G. E., *The History of Mental Symptoms. Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, in press).

³⁹ Berrios, G. E., 'Descriptive psychopathology: conceptual and historical aspects'. *Psychological Medicine*, xiv (1984), 303–313.

⁴⁰ Ackerknecht, 1967, *op. cit.*, (Note 8); López Piñero, 1983; *op. cit.*, (Note 10); Lain Entralgo P., *Historia de la Medicina* (Barcelona: Salvat, 1978).

nosography.⁴¹ He considered *sémiotique* as a new science dealing with the language of medical description: 'as sciences progress, terms to name more objects multiply in number and its language becomes more appropriate.'⁴² He distinguished between phenomenon, symptom and sign and saw the latter as carrying information on occult changes (lesions) in the body (in this paper to be called biological signal).

Changes in the concept of insanity

Before 1750, insanity tended to be considered as an all-or-none metaphysical state relating to the body in an abstract way. The mind was alienated in its entirety and the concept of partial insanity could not be really countenanced, in spite of the fact that such states had occasionally been suggested by lawyers.⁴³ The acceptance of this 'holistic' view is hidden by the fact that pre-1800 views on insanity were conceived (since John Locke) as exclusive disorders of intellect. For example, although forms of partial madness seem to be included in Kant's classification (see above), in real life the insane were considered as having 'lost their reason'. It seems also clear that there were no concepts to distinguish 'remission', 'improvement' and 'cure'. Thus, the concept of 'lucid interval'⁴⁴ was created to preserve the belief in a continuous state of insanity.

The nineteenth century and after

The collapse of eighteenth-century classifications was due less to theoretical failure than lack of clear symptom- and disease-description; both these elements were sharpened during the nineteenth century.⁴⁵ To start off with, psychiatric taxonomy benefited little from these advances, and up to the time of Esquirol mental disorders continued being classified on theoretical principles (such as faculty psychology). It is not by chance, therefore, that the zenith of the 'unitarian' doctrine occurred in a period when in Germany both Cartesianism and faculty psychology were being resisted by *Naturphilosophie* and other holistic notions that demanded that body, mind and spirit be studied in conjunction or as a unity. For example, the 'ganglion system' (the white matter of the nervous system) featured centrally in Reil's views. He conceived of the body as a hollow sphere with one surface facing the outside world and the other closeting the soul. The body contained the

⁴¹ In Landre-Beauvais, 1813, *op. cit.*, (Note 22), xx.

⁴² *Ibid.*, xxiii–xiv.

⁴³ Walker, N., *Crime and Insanity in England. Vol 1: The Historical Perspective* (Edinburgh: Edinburgh University Press, 1968).

⁴⁴ In Haslam, J., *Observations on Madness and Melancholy* (London: Callow, 1809), 45–9.

⁴⁵ King, L. S., *Medical Thinking* (Princeton: Princeton University Press, 1982), 105–27.

nerves or ganglia; there was no real centre to this system which resembled a *monarch-less Republic*.⁴⁶

German-speaking psychiatry prior to Kraepelin

German unitarians agreed on the view that classifications of insanity were neither feasible nor useful, but on little else. It must not be forgotten that they lived in a pre-Kraepelinian universe in which there could be no preoccupation about whether dementia praecox and manic depressive insanity were the same disease!

Reil (1759–1813)

Reil subscribed to a philosophy of integration.⁴⁷ For example, in regard to brain function, he took an anti-localizationist position. He believed, however, that insanity had an organic basis: 'the nervous system, more precisely the brain, is diseased in madness.'⁴⁸ Although a 'disease of the nerves',⁴⁹ madness was different 'from other nervous diseases, i.e. those of the imagination, memory, attention, or consciousness.'⁵⁰ Reil was writing before the anatomical view had become predominant, and hence had no real 'lesional' language in which to express his organic view: 'classification is impossible for the pathologist and the psychologist can classify only according to phenomena.'⁵¹

Nonetheless, and perhaps due to his great interest in 'psychological treatments',⁵² Reil contributed little to descriptive psychopathology. He believed that mental illness was caused by 'irritation' of the brain, a theory also sponsored by Autenrieth who himself believed that mental disorders were related to each other as the links in a morbid chain (*transmotio morborum*). Hypochondriasis and melancholia might lead to idiocy or dementia.⁵³

Reil's unitarian views were expressed in two ways. In regard to 'activation' levels, he wrote: 'In mania (*Tobsucht*), rage (*Raserei*), insanity (*Wahnsinn*),

⁴⁶ Vliegen, 1980, *op. cit.*, (Note 4), 4.

⁴⁷ Lewis, A. J. C., 'Reil's concepts of brain function'. In *The State of Psychiatry* (London: Routledge & Kegan Paul, 1967), 18–28; Lewis A., 'J. C. Reil: innovator and battler'. *Journal of the History of the Behavioral Sciences*, i (1965), 178–90; Harms, E., 'Johann Christian Reil'. *American Journal of Psychiatry*, lxxvi (1960), 1037–1039; Heller, R., 'J. C. Reil's training scheme for medical auxiliaries'. *Medical History*, xix (1975), 321–32.

⁴⁸ In Reil, J. C., *Über die Erkenntnis und Kur der Fieber*, Vol 4, *Nervenkrankheiten* (Halle, 1805), 470.

⁴⁹ *Ibid.*, 365.

⁵⁰ *Ibid.*, 288.

⁵¹ *Ibid.*, 365.

⁵² Harms, 1960, *op. cit.*, (Note 47).

⁵³ At the time, this term meant 'psychological dilapidation' and had no necessary relationship to old age, cognitive status, or irreversibility (for a history of dementia see: Berrios, G. E. and Freeman, H., *Alzheimer and the Dementias* (London: Royal Society of Medicine, 1991).

and melancholia (*Melancholie*), brain irritability is increased; in Idiocy (*Narrheit*) reduced. Dementia (*Blödsinn*) results from a paralysis (*Lahmung*) of the brain.⁵⁴ Thus, different mental disorders resulted from changes in the level of brain energy. This view was developed by Griesinger, and was to influence Janet. But Reil also expressed his unitarianism in the abstract psychological language of the late eighteenth century by claiming that mental disorders resulted from pathological splits in *Gemeingefühl*.⁵⁵

Zeller (1804–1877)

Zeller learned of Reil's Ganglion Theory from Esquirol in France and Autenrieth in Germany, and subscribed to the Romantic belief that 'Man is body and soul at the same time.'⁵⁶ In 1834, Zeller was confident enough to claim that the insanities were but stages of a common disease: 'in the course of one case all the main forms of mental disorder may occur.'⁵⁷ Organic and psychological aetiologies of mental disorder unworriedly combined in his work. In regard to the former, he wrote 'the organic basis of all mental disorders is indicated by the physical illness which antedates the mental disorder';⁵⁸ as to the latter or 'moral' causes, he believed that 'pain' was the universal source of morbidity. Under 'pain' he included experiences induced by remorse, guilty conscience, failures in friendship, and poverty. He believed that 'cases are rare in which the mental disorder is caused by purely organic problems of the central nervous system.' Thus, 'adverse circumstances and physical disease may conspire to produce mental disorder after mood, mind and soul have been affected . . . possibly by hereditary factors. . . .'⁵⁹ Psychological causes, pain and organic changes combined to cause melancholia. Irritations and aggravations led to mania, paranoia, and finally dementia. All four types of madness were but stages in the same pathological process.

Jacobi (1775-1858)

Karl Wigand Maximilian Jacobi, the son of the great spiritualist philosopher

⁵⁴ In Reil, 1805, *op. cit.*, (Note 48), 477.

⁵⁵ This term referred to the general bodily sensation of commonality and integration serving as background to all other experiences (see Harms, 1960, *op. cit.*; Starobinski, J., 'Brève histoire de la conscience du corps'. *Revue française de psychanalyse*, ii (1981), 261–79; also, Reil, J. C., *Rhapsodien über die Anwendung der psychischen Curmethode auf Geisteszerrüttungen* (Halle, 1803 (1968 re-impression, Amsterdam: Bonset)), 254–61.

⁵⁶ In Vliegen, 1980, *op. cit.*, (Note 4).

⁵⁷ In Zeller, A., *Beilage zum medizinischen Correspondenzblatt des Württembergischen ärztlichen Vereins*, Vol 7, N°30 (1837), 344.

⁵⁸ In Zeller, A., *Beilage zum medizinischen Correspondenzblatt des Württembergischen ärztlichen Vereins*, Vol 10, N°17 (1840), 135.

⁵⁹ In Zeller, A., *Beilage zum medizinischen Correspondenzblatt des Württembergischen ärztlichen Vereins*, Vol 13, N°38 (1843), 300.

F. H. Jacobi,⁶⁰ held a *somatic* view of insanity.⁶¹ He was involved in hospital organization, and showed interest in the English administrative system. Kraepelin noticed his support for neuropathology,⁶² but Zilboorg was wrong in exaggerating Jacobi's anti-psychological stance.⁶³ He did not deny the existence of mental symptoms but considered them as non-specific, changeable in time and space, and as providing a poor basis for classification: 'the signs which are given such weight by others (e.g. Esquirol) as being indicative of mental illness are deceptive.'⁶⁴ 'the symptoms of melancholia are found in more than twenty diseases'⁶⁵ . . . 'the form of the mental illness changes without the underlying disease lifting. It can come and go quickly because the latter undergoes a modification.'⁶⁶

Jacobi proposed a unitary view of mental illness based on the belief that the resolution power of neuropathology and psychology was limited: 'in my view, there are no mental illnesses which are independent ... all are caused by an organic disturbance and should be seen as organic illnesses inasmuch as the psychic manifestations are determined by the organism.'⁶⁷ 'Mental illnesses are merely symptoms of the illnesses which cause them. Their manifestations and course depend upon them.'⁶⁸

Griesinger (1817–1868)

In 1840, Griesinger criticized the 'ganglion system' view, and rejected the notion that physical disease not affecting the brain might lead to madness. Mental diseases were brain diseases which *were caused themselves by psychological factors*. Levels of nervous or psychological energy were central to his theory. Mania was the *mental* counterpart of the convulsive state; dementia, of the lameness caused by brain and spinal palsy.

Like Zeller, Griesinger considered melancholy to be the fundamental disorder leading in due course to disturbances of thought and of will (mania,

⁶⁰ Focke, Dr., 'Obituary Notice'. *Journal of Mental Science*, v (1859), 289–97.

⁶¹ For an account of the so-called somaticist position see: Marx, O., 'German romantic psychiatry: parts 1 and 2'. *History of Psychiatry*, i and ii (1990–1991), i: 351–82; ii: 1–26; for an account of the somatic view see: Kirkby, K. C., 'Proving the somaticist position: J. B. Friedreich on the nature and seat of mental disease'. *History of Psychiatry*, iii (1992), 237–52; Hagner, M., 'The soul and the brain between anatomy and Naturphilosophie in the early nineteenth century'. *Medical History*, xxxvi (1992), 1–33.

⁶² In Kraepelin, E., *One Hundred Years of Psychiatry* (London: Owen, 1962 (First Edition, 1918)), 42–3.

⁶³ Zilboorg, G. W., *A History of Medical Psychology* (New York: Norton, 1941).

⁶⁴ In Jacobi, M., *Sammlungen für die Heilkunde der Gemüthskrankheiten*. 1st Edition (Bonn: Elberfeld, 1830), 131.

⁶⁵ *Ibid.*, 107. Griesinger repeated this 35 years later without acknowledging its source. In Griesinger, W., 'La Pathologie mentale au point de vue de l'école somatique allemande'. *Annales médico-psychologiques*, xxiii (1865), 1–31.

⁶⁶ In Jacobi, 1830, *op. cit.*, 129.

⁶⁷ *Ibid.*, 24–5.

⁶⁸ *Ibid.*, 118.

partial madness, confusion) and then dementia. He went further than Zeller in the belief that mood disorder was an entity *per se*, and in this respect he prepared the ground for the Kraepelinian view. Although his earlier writings suggested that he believed in unitary psychosis, later views go against this. In 1845, he wrote 'From our observations there are two groups of insanities: firstly, the affective ones, secondly the primary disturbances of perception and will, arising not from a problem of mood but from false thinking and will.'⁶⁹ But in 1864, in his superb inaugural lecture at the University of Zurich, he starting developing a new classification based on both organic and psychological criteria. By then, he had read Kahlbaum's book on classification⁷⁰ and took advantage of the Lecture to let his views be known: 'This excellent work must be received with favour as witness of the current tendency to try new classifications and abandon the old ones. The simple classification I am proposing today is in keeping with clinical observation, responds to different needs and has only few points of coincidence with the ideas exposed by my honourable friend.'⁷¹ Three years after this publication Griesinger was dead, and never was to develop these ideas in any depth.

Neumann (1814-1884)

Heinrich Neumann joined the unitarians with his notion of the *Einheit der Psychosen*.⁷² His anti-taxonomic position was the expression of idiosyncratic views on mental illness: 'Insanity [*Wahnsinn*] is a state of lack of productivity in which the sufferer creates a world which is in contradiction to that of other human beings, and which is not amenable to correction. He gets less and less intellectual pabulum so that his capacity is exhausted and his creativity diminishes.'⁷³ Herbartian echoes⁷⁴ can be heard in his pathogenetic ideas: 'confusion is to be defined as a loosening of associations, and dementia as a disintegration of conscious intellectual life and dissolution of mental elements.'⁷⁵ And again: 'in health, there is a ready differentiation between sensation, thought and wish. In mental illness, there is confusion, the subject may have sensations without the corresponding nerves being stimulated, this is called a hallucination.'⁷⁶ The pathogenic mechanism in operation Neumann called *metamorphosis* and defined as a *disturbance of consciousness*

⁶⁹ Griesinger, W., *Die Pathologie und Therapie der psychischen Krankheiten*, 2nd edition (Stuttgart: Krabbe, 1861).

⁷⁰ Kahlbaum K. *Die Gruppierung der psychischen Krankheiten und die Eintheilung der Seelenstörungen* (Danzig: Kafemann, 1863).

⁷¹ In Griesinger, 1865, *op. cit.*, 14.

⁷² See Lanczik, 1989, *op. cit.*, (Note 5).

⁷³ In Neumann, H., *Lehrbuch der Psychiatrie* (Erlangen, 1859), 168.

⁷⁴ Ribot, Th., 'La Psychologie de Herbart'. *Revue philosophique*, ii (1876), 68-85; Stout, G. F., 'The Herbartian Psychology'. *Mind*, xiii (1888), 321-38; 473-98

⁷⁵ In Neumann, 1859, *op. cit.*, 168.

⁷⁶ *Ibid.*, 111. These claims are redolent of Battie's (see below).

causing a misinterpretation of sensations. Excesses of stimulation caused irritation and mania, and led to drops in psychic energy and to an increased likelihood of hallucinations.

His views on taxonomy and diagnosis, at odds with the growing medicalization of insanity in his time, reflect a late hour acquaintance with *Naturphilosophie*: 'true diagnosis has nothing to do with nomenclature. The former is concerned with the individual case, the latter is a product of abstraction . . . it may be comforting to classify by external symptoms but it does not provide true knowledge [of the phenomena] . . . diagnosis has to do with understanding, not with a group of signs.'⁷⁷ Neumann dispensed with Zeller's 'primary form' of mental illness in favour of a continuum from health to disease.

This very view was later to be taken up by twentieth century unitarians such as Menninger (see below). Neumann's continuum ranged thus: health – sleeplessness – illusions – exaggerated sensitivity – illness – madness – confusion – and terminal dementia. He wrote: 'every classification of mental illness is artificial. We should throw it all overboard . . . there is only one form of mental illness, that is insanity [*Wahnsinn*], which does not have different forms but different stages.'⁷⁸

Neumann, however, left open the possibility of classifying according to causes: 'classification is only possible when there are *genera*, but these do not exist in the absence of 'generation' [aetiology]. The only diseases with generation are those characterized by contagiousness. Thus, as far as mental illness is concerned, there are only individual diseases';⁷⁹ 'one cannot classify except on the basis of physical disease . . . fever, delirium, and mental illness can [therefore] be considered different from each other.'⁸⁰

Kahlbaum (1828–1899)

The principle that differences in symptoms reflect differences in causes and hence provide the foundation for a classification was developed by Kahlbaum, one of the greatest alienists of the nineteenth century,⁸¹ and the strongest influence on Kraepelin.⁸² Initially taken by the idea that all insanities were stages of one disease, he progressed on to offer a classification which included many. Kahlbaum divided mental illness into four categories of *vesania*: 'an idiopathic mental disorder with the whole range of mental life clearly affected to some degree', i.e. *vesaniae acuta, typica* (which included

⁷⁷ In Neumann, 1859, *op. cit.*, 75–6.

⁷⁸ *Ibid.*, 167.

⁷⁹ *Ibid.*, 75.

⁸⁰ *Ibid.*, 181.

⁸¹ Lanczik, M., 'Karl Ludwig Kahlbaum (1828–1899) and the emergence of psychopathological and nosological research in German Psychiatry'. *History of Psychiatry*, iii (1992), 53–8.

⁸² Berrios, G. E. and Hauser, R., 'The early development of Kraepelin's ideas on classification: a conceptual history'. *Psychological Medicine*, xviii (1988), 813–21.

Neumann's four stages), *progressiva and catatonica*.⁸³ He believed in the separation of clinical pictures (which he called the 'Elementary forms of the disease process') but as emerging from only one (unitary) *vesania*.

French-speaking psychiatry

At the beginning of the nineteenth century, Pinel⁸⁴ set the pattern for psychiatric classifications in France. Georget and Esquirol⁸⁵ modified his views somewhat, but the real challenge came in 1853 with Baillarger's classical *Essai sur une classification des différents genres de folie*.⁸⁶ Like his predecessors, he opted for a symptomatic taxonomy, but chose as his criterion the presence or absence of insight. Baillarger believed it to be nonsense to talk of partial and total delusions (*délires partiels et généraux*) (as Esquirol and Georget had done before)⁸⁷

Although by this period the frondous pre-1800 nosologies had been left behind, some of its principles were still in operation, namely those of categorical groupings and privileged symptoms.⁸⁸ It is not surprising, therefore, that when, as late as 1860, the *Société Médico-Psychologique* of Paris held its debate on classification, some of the discussants appealed to the old principles (see below).

Guislain (1797–1860)

It has been claimed that Joseph Guislain, the Belgian alienist, was a 'unitarian', and that he influenced Zeller.⁸⁹ Guislain entertained a psychological view of the causation of mental illness. In 1852 he wrote: 'all the phenomenology⁹⁰ of the mental diseases, all their forms of presentation may be found combined . . . or they change into each other with some symptoms disappearing and others reappearing.'⁹¹ Guislain's terminology was quaint. He suggested that at the basis of mental illness there was 'phrenalgia' (pain of the mind) which could range from melancholia to simple suffering. Given the right 'irritants', melancholia could be

⁸³ Kahlbaum, 1863, *op. cit.*, (Note 70).

⁸⁴ Pinel, 1818, *op. cit.*, (Note 23); also Pinel, Ph., *Traité médico-philosophique sur l'aliénation mentale ou la manie*, 1st edition (Paris: Richard, Caille et Ravier) (An IX), 1801 (second edition, 1809 by Brosson).

⁸⁵ Caprariis, E. de., 'La Scuola psichiatrica parigina del primo ottocento e la nosografia di Esquirol'. *Minerva Medica*, lxii (1971), 1439–48.

⁸⁶ Baillarger, J. G. F., 'Essai sur une classification des différents genres de folie'. *Annales médico-psychologiques*, v (1853), 545–66.

⁸⁷ *Ibid.*, 549.

⁸⁸ Renouard, P. V., *Histoire de la médecine*, Vol. 2 (Paris: Baillièrre, 1846).

⁸⁹ Vliegen, 1980, *op. cit.*, (Note 4), 9.

⁹⁰ Guislain was fond of neologisms, for example, he introduced into French (and World) psychiatry the term 'phenomenology' to refer to the symptomatic presentation of the psychosis.

⁹¹ In Guislain, J., *Leçons orales sur les phrénopathies*. Vol. 1 (Hebbelynk: Gand, 1852), 96.

transformed into other brain diseases (*phrénopathies*) such as mania, paraphrenia, epilepsy, delirium and dementia (*Noasthénie*).

Morel (1809–1873)

A few years later, symptomatic taxonomy itself came under attack when Morel suggested the first aetiological classification.⁹² This led to a famous debate at the *Société Médico-Psychologique* where Delasiauve⁹³ together with Falret, Briere, and the non-alienists Maury⁹⁴ and Bouchez,⁹⁵ defended the symptomatic approach. Morel, who had not planned to intervene, made a spirited defense of the aetiological criterion. A third course was chosen by Garnier who put forward a unitarian view, based on the observation (made already by Cullen and Pinel), that the insanities changed one into another.⁹⁶

Morel proposed six groups: hereditary (four classes), by intoxication (alcoholism, pellagra, etc.), neuroses (hysterical, hypochondriacal and epileptic insanity), idiopathic, sympathetic, and dementia. At the time, his classification was criticized by Foville for being a taxonomy 'of [putative] causes of insanity but not of its clinical pictures.'⁹⁷ In 1872, Foville (fils) himself proposed his own nomenclature and classification; in this important paper he identified the 1860s as the time when the shift from symptomatic to causal taxonomy had started. He mentioned Skae and Batty Tuke as two British alienists supporting a causal taxonomy, and noticed that Morel's (aetiological) classification did, in fact, depend on symptoms and pathogenic mechanisms.⁹⁸

Degeneration theory and classification

After 1857, degeneration theory⁹⁹ became an important factor in the reorganization of French psychiatric classifications. Although hereditary taint had been mentioned in relation to insanity before that time, it was Morel's work that made it fashionable. Overtly Lamarckian (not Darwinian), and inspired in the concept of the original sin, his notion of degeneration included the

⁹² Morel, B. A., *Traité des maladies mentales* (Paris: Masson, 1860).

⁹³ Delasiauve, like Forbes Winslow in England, edited his own Journal and mostly kept aloof from his national Society.

⁹⁴ Dowbiggin, I., 'Alfred Maury and the politics of the Unconscious in nineteenth-century France'. *History of Psychiatry*, i (1990), 255–87.

⁹⁵ Bouchez was medically qualified but was not practising at the time. See: Bieder, J., 'Un précurseur de la démocratie chrétienne et de l'Europe à la Société Médico-Psychologique: Philippe-Joseph-Benjamin Buchez'. *Annales médico-psychologiques*, cxliv (1986), 109–15.

⁹⁶ P.327 in SMP Debate on Classification. *Annales médico-psychologiques*, vii (1861), 128–77; 316–32; 456–500; 648–57.

⁹⁷ In Foville, Ach (fils), 'Nomenclature et classification des maladies mentales'. *Annales médico-psychologiques*, xxx (1871), 5–35, p.17.

⁹⁸ In Foville, 1872, *op. cit.*, 17.

⁹⁹ Genil-Perrin, G., *L'Idée de dégénérescence en médecine mentale* (Paris: Leclerc, 1913); Pick, D., *Faces of Degeneration* (Cambridge: Cambridge University Press, 1989).

claim that mental illness affecting one generation could visit successive generations in an ever worsening spiral. Thus, melancholia or mania may lead to dementia and eventually idiocy. Two mechanisms were involved: transmission and degradation of the tainted seed.

Anachronistically interpreted, degeneration theory offered alienists a credible 'genetic' hypothesis. Since the expression of the hereditary taint was not only behavioural but physical, 'stigmata' (signs) of degeneration could also be recognized such as deformed teeth, ears, head, etc.¹⁰⁰ Mechanisms for initiating and maintaining the process of degeneration were searched, and alcoholism and masturbation were found to play a prominent role. After few generations, sterility ended the deteriorating chain.

Degeneration theory seemed to entail a longitudinal form of 'unitary psychosis', i.e. the same 'invariant' was passed on from generation to generation, although on each occasion it caused a 'different' clinical picture. Why did the same metamorphosis not occur within the life span of the same individual (as Griesinger had suggested)? Morel never explained. Furthermore, degeneration theory seem to be in contradiction with the (cross-sectional) taxonomic view put forward by Morel himself in 1860, according to which each disease had a different cause.

Valentin Magnan completed the incorporation of degeneration theory into psychiatry by cleansing it from its religious and moral overtones to render it palatable to the strong anti-religious world of late nineteenth-century France.¹⁰¹ He placed the degeneration process firmly *in the brain*. Towards the end of the century, Roubinovitch compared German and French psychiatric classifications and concluded that, although differences due to diverging intellectual tradition could be found, degeneration theory was rampant in both countries.¹⁰²

British echoes

Monro and Sankey

British psychiatrists were not given to offering new classifications and, in general, echoed continental efforts. Thus, in 1857, Henri Monro¹⁰³ published a paper on the classification and forms of insanity in which he echoed vitalistic and unitarian views then fashionable in the Continent: 'Madness is

¹⁰⁰ Talbot, E. S., *Degeneracy. Its Causes, Signs and Results* (London: Walter Scott, 1898); Saury, H., *Étude clinique sur la folie héréditaire (Les dégénérés)* (Paris: Delahaye et Lecrosnier, 1886).

¹⁰¹ In Bing, F., 'La Théorie de la dégénérescence'. In Postel, J. and Quételet, C. (eds), *Nouvelle histoire de la psychiatrie* (Paris: Privat, 1983), 351–6, p.354.

¹⁰² At the request of his chief, Joffroy, the author wrote this little classic of French psychiatry: Roubinovitch, J., *Des variétés cliniques de la folie en France et en Allemagne* (Paris: Doin, 1896).

¹⁰³ Monro's 1861 views were to be influential in the development of Jackson's notion of positive and negative symptoms (see Berrios, G. E., 'Positive and negative symptoms and Jackson'. *Archives of General Psychiatry*, xlii (1985), 95–7).

to be characterised very much by the results of too much, and too little . . . what is required for cure is to restore this lost equilibrium . . . I believe it is a right thing to esteem emotional insanity rudimentary to notional, and notional to intelligence . . . In laying down this rule, I do not mean to say that all cases of more complete insanity must have passed through the more rudimentary forms.¹⁰⁴ Monro was here using the English names for melancholia, mania and dementia.

In 1866, W. H. O. Sankey published his *Lectures on Mental Disease*. A reviewer noticed that Sankey's views had much in common with Neumann's in that he felt that there were 'no different species of insanity, but that all the phenomena observed are the symptoms of the disease (insanity), which commences with a stage of depression [melancholia] and passes through those of delusion and excitement to mental torpor and decay'.¹⁰⁵ This was also redolent of Griesinger's views.

Kraepelin and the twentieth century

Kraepelin (1856–1926)

Kraepelin dismissed Zeller's unitarian view as 'speculative and clinically unfruitful', and based his nosology on brain lesion, course and symptoms: 'we need facts not theories.' He kept detailed clinical notes and performed genuine 'longitudinal' studies.¹⁰⁶ By 1899, he had reached the conclusion that there were only two forms of insanity: dementia praecox and manic-depressive illness. This view has dominated psychiatry for nearly a century. Griesinger and others had hinted at this, but Kraepelin's originality resided in choosing to base his classification on clinical course and prognosis (and, for the time being, surrendering aetiology).

Kraepelin was aware of the difficulties involved in creating separate diseases and as early as 1887 he noted that mental disorders 'merged into one another'. By 1918, in *Ends and Means of Psychiatric Research*, Kraepelin began to use the word 'syndrome',¹⁰⁷ and in his magnificent 1920 paper on *The Manifestation of Madness*¹⁰⁸ he abandoned his belief in pathognomonic symptoms: 'It is incorrect to attribute signs to specific disease processes . . . symptoms are not limited to a distinct disease process but occur in the same

¹⁰⁴ In Monro, H., 'On the classification and forms of insanity'. *Asylum Journal of Mental Science*, iii (1857), 193–218, p.197.

¹⁰⁵ Review of 'Lectures on Mental Diseases'. *Journal of Mental Science*, vi (1860), 243–6.

¹⁰⁶ Berrios and Hauser, 1988, *op. cit.*

¹⁰⁷ Kraepelin, E., 'Ziele und Wege der psychiatrischen Forschung'. *Zeitschrift für Gesamte Neurologie und Psychiatrie*, xlii (1918), 169–205; also see excellent paper by Hoff, P., 'Zum Krankheitsbegriff bei Emil Kraepelin'. *Nervenarzt*, lvi (1985), 510–13.

¹⁰⁸ Kraepelin, E., 'Die Erscheinungsformen des Irreseins'. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, lxii (1920), 1–29. (Translation available: 'The manifestations of insanity', trans. and Intro. by Dominic Beer and with Introductory Remarks by Paul Hoff. *History of Psychiatry*, iii (1992), 499–529.)

form in response to different morbid insults.' Indeed, in this paper Kraepelin did also cast doubt on the distinction between dementia praecox and manic-depressive illness: 'We shall have to get used to the fact that our much used clinical check-list does not permit us to differentiate reliably between manic-depressive illness and dementia praecox.'

As opposed to Kraepelin's dichotomy, and based on his own speculative physiopathology, Wernicke¹⁰⁹ developed a taxonomy of the psychoses that included a number of different entities.¹⁰⁰ His untimely death brought these ideas to an abrupt halt although Kleist, and later Leonhard, attempted to develop his views further.¹¹¹

Twentieth century unitarians

During the 1940s, the unitarian doctrine resurfaced in Europe and the USA. Valenciano¹¹² has identified some of the factors that explain its reappearance: (1) Kraepelin's change of heart in regard to the specificity of symptoms and diseases; (2) the failure to find a specific organic basis, and clear descriptive boundaries, for the psychoses; (3) the long-term effect of Bonhoeffer's views concerning the non-specificity of psychiatric syndromes, and of Hoche's criticism of Kraepelin's dichotomy; (4) Specht's view that the only difference between 'exogenous' and 'endogenous' psychoses related to severity and rapidity of onset (i.e. less severe and slow onset psychoses were likely to be recognized as 'endogenous'); (5) the application of evolutionist, Jacksonian, and psychodynamic view to psychopathology; and (6) the influence of holistic and Gestalt models, particularly in brain localization studies.

Bonhoeffer, Hoche, and Kretschmer

The view that symptom-patterns carried information on aetiology was challenged by Bonhoeffer.¹¹³ He suggested, influenced by the anti-localizationist fashion, that the brain was endowed with a few stereotyped mental reactions, triggered by a variety of noxae.¹¹⁴ Auguste Hoche contributed to

¹⁰⁹ Liepmann, H., 'Über Wernickes Einfluß auf die Klinische Psychiatrie'. *Monatsschrift für Psychiatrie und Neurologie*, vii (1911), 1–32; Lanczik, M., *Der Breslauer Psychiater Carl Wernicke* (Sigmaringen: Thorbecke, 1988); Donalies, C., 'Zur Systematik in der Psychiatrie vor Wernicke, Kraepelin und Bonhoeffer'. *Psychiatrie, Neurologie, medizinische Psychologie (Leipzig)*, xxiii (1971), 411–19.

¹¹⁰ Burckard, E., 'Les Conceptions psychiatriques de Wernicke'. In *Travaux de la Clinique Psychiatrique de la Faculté de Médecine de Strasbourg* (Strasbourg: Universitaire d'Alsace 9, 1931), 45–141.

¹¹¹ Leonhard, K., *Aufteilung der endogenen Psychosen*. 1st edition (Berlin: Akademie-Verlag, 1957); Beckman, H. and Lanczik, M. (eds) 'Leonhard classification of endogenous psychoses'. *Psychopathology*, xxiii (1990), 193–341.

¹¹² In Valenciano, 1960, *op. cit.*, (Note 5), 114.

¹¹³ Jossman, P. B., 'In Memoriam; Professor Karl Bonhoeffer 1868–1948'. *American Journal of Psychiatry*, cvi (1949), 159–60.

¹¹⁴ Bonhoeffer, K., *Die symptomatischen Psychosen* (Leipzig: Deuticke, 1910).

the debate with an important paper on symptom-complexes.¹¹⁵ Although he never expressed a unitarian view, his notion of syndrome emphasized description and dismissed over-searching for causes (whether organic and psychological). Diseases might just be collections of syndromes with no structure to themselves. The search for 'entities', Hoche called 'the hunt after a phantom'. He drew attention, however, to the role of 'cerebral properties' in the modulation of symptom-complexes. Rather unfairly, Jaspers accused Hoche of psychiatric nihilism.

A sort of unitarian view was also implicit in Kretschmer's body-types.¹¹⁶ Character depended on body build and endogenous psychoses were not 'isolated entities' but 'constitutional episodes'. Because environmental triggers (key events) were part of the pathogenic equation, endogenous and psychogenic illness were not independent from one another. Kretschmer rejected off-hand Hoche's notion of symptom-complex in favour of 'living illness pictures'. He believed that dementia praecox and manic-depressive insanity were not really independent: 'they are not separate, but flow into each other.' Kretschmer's views could be seen as a resurrection, during the early twentieth century, of the romantic unity of body and soul.¹¹⁷

Unitarianism after the Second World War

Conrad (1905–1961)

Klaus Conrad¹¹⁸ was an early Kraepelinian whose own clinical observations convinced him that symptoms and diagnosis were unstable. For example, subjects started as manic or depressive might develop delusions and deterioration of personality. He also observed that cyclothymic patients produced children with schizophrenia more often than expected. By 1959, he questioned Kraepelinian dualism and spoke of varied manifestations of one endogenous 'circle of illness'.¹¹⁹ Less severe forms of psychoses would lead to reversible forms; severe forms to deterioration.

In a magnificent lecture before the German Psychiatric Society, Conrad analysed in depth the concept of nosological unity in psychiatry.¹²⁰ He also sought to link the endogenous and exogenous psychoses: 'What connects the

¹¹⁵ Hoche, A., 'Die Bedeutung der Symptomenkomplexe in der Psychiatrie'. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, xii (1912), 540–51 ('The significance of symptom complexes in psychiatry'. Introduction by T. Dening and G. E. Berrios; translation by R. G. Dening and T. Dening. *History of Psychiatry*, ii (1991), 329–43).

¹¹⁶ Kretschmer, E., *Physique and Character* (New York: Harcourt, 1936 (First Edition, 1925)).

¹¹⁷ In Vliegen, 1980, *op. cit.*, (Note 4), 40.

¹¹⁸ Cutting, J., 'Gestalt theory and psychiatry: discussion paper'. *Journal of the Royal Society of Medicine*, lxxxii (1989), 429–31.

¹¹⁹ Conrad, K., *Die beginnende Schizophrenie* (Stuttgart: Thieme, 1958).

¹²⁰ Conrad, K., 'Das problem der "nosologischen Einheit" in der Psychiatrie'. *Nervenarzt*, xxx (1959), 488–94.

exogenous and endogenous? Different noxae attack the same structure, physiological mechanism, biochemical metabolism, or physiochemical relationship' and may include 'physical exhaustion or heightened emotion'.¹²¹ Alteration in emotions led to depression and delusions and madness started. Such observations belong to the heyday of nineteenth century unitarianism.

Llopis (1906–1964)

Observations of pellagra psychosis during the Spanish Civil War led Llopis to formulate his theory of 'The Axial Syndrome common to all psychoses'.¹²² According to this view, there were only quantitative differences between endogenous and exogenous psychoses.¹²³ All mental symptoms resulted from disorders in either the 'content' or 'state' of consciousness. The former were caused by localized brain lesions; the latter by generalized brain 'excitement' and 'irritation'.¹²⁴ Consciousness was a Janus-like structure facing both the external and the internal world. Misinterpreted sensations became pathological 'contents' if there was a degradation of insight: like Zeller and Neumann, Llopis believed in degrees of impairment. On the other hand, pathology of the 'state' of consciousness was determined by (and reflected) the potency of the 'irritant'.

For Llopis, however, changes in mood and affect *per se* were not to be considered as manifestations of disease: the person may say that he or she is happy or sad but as long as *insight* is preserved there is no psychiatric disorder. Illness ensued as insight was lost. Normally, dreaming provided humans with 'as if' experiences, but as long as these were separated from 'real' perceptions there was no psychosis. Psychiatric disturbances appeared as this capacity was lost. Llopis suggested that all syndromes were 'quantitative gradations of a single fundamental disorder'.¹²⁵

Ey (1900–1977)

Ey defined psychosis as a *mouvement de regression* to archaic and primitive forms of mental life,¹²⁶ and based his evolutionary model of illness on Lamarck's 'graded increase in intellectual ability' in the animal kingdom.¹²⁷ Ey supported the existence of a *monopsychose* with all clinical types resulting from variations in the same mechanism (*il y a une certaine unité dans la*

¹²¹ Conrad, 1958, *op. cit.*

¹²² Llopis, B., *La Psicosis Pelagrosa* (Barcelona: Científico Médica, 1946).

¹²³ Llopis, 1954, *op. cit.*, (Note 5).

¹²⁴ Llopis, B., *Introducción Dialéctica a la Psychopatología* (Madrid: Morata, 1970).

¹²⁵ Colodrón, A., 'Bartolomé Llopis (1906–1964)'. *History of Psychiatry*, ii (1991), 219–24.

¹²⁶ Ey, H., 'La classification des maladies mentales et le problème des psychoses aiguës. Étude N° 20'. In *Études psychiatriques*, Vol. 3 (Paris: Desclée de Brouwer, 1954), 11–45.

¹²⁷ Lamarck, J. B., *Zoological Philosophy* (Chicago: University of Chicago Press, 1984 (First Edition, 1809)).

désorganisation de l'être psychique).¹²⁸ Categories such as exogenous/endogenous and organic/functional were superfluous as was the notion of mental disease itself. There were only 'reactions' reflecting degrees of functional 'dissolution' (à la Jackson).¹²⁹ Ey was a neo-romantic in the Zeller-Neumann mould who conceived of psychopathology as an evolutionary drama.¹³⁰

Ey was not the only French-speaking psychiatrist to ponder over psychiatric taxonomy. The *Société Médico-Psychologique* debated classifications (once again!) in April 1940 when Vie¹³¹ offered a spirited defence of the need to classify; opposing views were heard from Minkowski, Laignel-Lavastine, Ferdière, Bonhomme, and Delmas. In 1963, Ellenberger mounted a major attack on classifications, drawing attention to 'unconscious and irrational factors influencing classifiers'.¹³²

Menninger

Unitarians found some echo in the USA. After introducing Kraepelinian dualism, the Swiss émigré Adolph Meyer went on to develop an over-inclusive and confused notion of mental 'reaction'.¹³³ The psychoanalyst Karl Menninger, already unsympathetic to medical diagnosis, argued against classification.¹³⁴ He claimed that he did not object to taxonomy *per se* as a 'scientific tool' but worried lest it led to an impersonal approach to patient care. He preferred to see illness as a continuum from health to sickness. Severity of disease he defined in terms of social dysfunction. Although he did not dispense with terms such as manic or schizophrenic, he preferred his own terminology which included four orders of mental problems: nervousness, neurosis, episodic and explosive discharges and syndromes of persistent and severe disorganization. For him 'there were no natural mental disease entities'.¹³⁵

¹²⁸ Albernhe, T. and Roux, J., *La Pensée de Henri Ey* (Paris: Scripta, 1990).

¹²⁹ Ey, H., 'Hughlings Jackson's principles and the organo-dynamic concept of psychiatry'. *American Journal of Psychiatry*, cxviii (1962), 673-82; Evans, P., 'Henry Ey's concepts of the organisation of consciousness and its disorganisation: an extension of Jacksonian Theory'. *Brain*, xcv (1972), 413-40; Berrios, G. E., 'Positive and negative signals: a conceptual history'. In Marneros, A., Andreasen, N. C. and Tsuang, M. T. (eds), *Negative Versus Positive Schizophrenia* (Berlin: Springer, 1991), 8-27.

¹³⁰ Ey, 1954, *op. cit.*

¹³¹ Vie, M. J., 'Sur l'existence d'entités morbides en psychiatrie'. *Annales médico-psychologiques*, xcvi (1940), 347-58.

¹³² In Ellenberger, H., 'Les illusions de la classification psychiatrique'. *L'Évolution psychiatrique*, xxviii (1963), 221-48.

¹³³ Gelder, M., 'Adolf Meyer and his influence on British psychiatry'. In Berrios, G. E. and Freeman, H. (eds), *150 Years of British Psychiatry: 1841-1991* (London: Gaskell, 1991), 419-35.

¹³⁴ Menninger, K., Ellenberger, H., Pruyser, P. and Mayman, M., 'The unitary concept of mental disease'. *Bulletin Menninger Clinic*, xxii (1958), 4-12.

¹³⁵ *Ibid.*

Rennert

In two important articles,¹³⁶ H. Rennert supported the view that a common disease process operated in all psychoses, and that personality factors accounted for the differences.¹³⁷ He also introduced a probabilistic or statistical dimension in favour of unitarianism.¹³⁸ There was only one psychosis but it appeared as if there were many for symptoms had different distribution in the population. Symptom-combinations showing high density would be, understandably, interpreted as being a separate disease. Differential densities were not, however, determined by the brain but by social and pathoplastic factors. Rennert also believed that an endogenous-morbid factor was not necessary.

Janzarik

Janzarik has proposed that the more evolved an organism, the proner it is to insanity.¹³⁹ In man, the 'shackles of instinctive behaviour are loosened' and the emotions freed.¹⁴⁰ 'Psychic dynamics' is released from its biological chains and causes psychosis when mental structures become dismantled. The 'type' of psychosis will be determined by the structure that has been impaired by the flow of the 'dynamics'. (Psychosis is rare in children because this process takes longer.)

'Preconditions' for the psychosis are to be found in the structures themselves. The 'dynamics' goes through stages of 'reduction', 'expansion', 'unsteadiness' and 'emptiness' (more or less corresponding to Griesinger's melancholia, mania, madness and dementia). Human beings carry in them a propensity to insanity. Deviations from normality or the presence of organic illness may release the 'dynamics' and induce insanity. Reductions in the 'dynamics' may cause mood disorder. Psychotic patients treated with neuroleptics may developed post-psychotic depression after their positive symptoms have remitted. For Janzarik the unitarian view is more a *Leitidee* than a nosological reality.¹⁴¹

Kendell and Crow

The views of two recent British writers may be interpreted as unitarian.

¹³⁶ Rennert, H., 'Aufteilung der Psychosen und Einheitspsychose. *Nervenarzt*, xxxv (1964), 263-71.

¹³⁷ Rennert, H., 'Die Universalegenese der endogenen Psychosen'. *Fortschritte der Neurologie und Psychiatrie*, xxxiii (1965), 251-62.

¹³⁸ Masi, C., 'Histoire des psychoses endogènes'. *L'Information psychiatrique*, lvii (1981), 57-72.

¹³⁹ Mundt, Ch., 'The life and work of Professor Werner Janzarik'. *History of Psychiatry*, iii (1992), 1-4.

¹⁴⁰ Janzarik, W., *Strukturdynamische Grundlagen der Psychiatrie* (Stuttgart: Enke, 1988).

¹⁴¹ Janzarik, W., 'Nosographie und Einheitspsychose'. In: Huber, G. (ed.) *Schizophrenie und Zykllothymie. Ergebnisse und Probleme* (Stuttgart: Thieme, 1969).

Kendell used statistical techniques to cast doubt on the existence of clinical boundaries between neurotic and psychotic depression,¹⁴² and later on, on those between schizophrenia and mania.¹⁴³ His arguments relied heavily on the stability of descriptors (reliability and validity), and on the epistemological value of pattern recognition techniques. Crow's interpretation of genetic finding led to temporary unitarian conclusions: 'psychosis is a continuum extending from unipolar, through bipolar affective illness and schizoaffective psychosis, to typical schizophrenia, with increasing degrees of defect.'¹⁴⁴ Crow based his view on three arguments: absence of a convincing bimodal separation between the two psychoses (à la Kendell), evidence for common aetiological determinants, and putative genetic link between the psychoses.

¹⁴² Kendell, R. R., *The Classification of Depressive Illnesses* (Oxford: Oxford University Press, 1968).

¹⁴³ Brockington, I. F., Kendell, R. E., 'The distinction between the affective psychoses and schizophrenia'. *British Journal of Psychiatry*, cxxxv (1979), 243–8; Kendell, R. and Gourlay, J., 'The clinical distinction between the affective psychoses and schizophrenia'. *British Journal of Psychiatry*, cxvii (1970), 261–70; Kendell, R. E. and Brockington, I. F., 'The identification of disease entities and the relationship between schizophrenic and affective psychoses'. *British Journal of Psychiatry*, cxxxvii (1980), 324–31.

¹⁴⁴ Crow, T. J., 'The continuum of psychosis and its implication for the structure of the gene'. *British Journal of Psychiatry*, cxliv (1986), 419–29; Crow, T. J., 'Psychosis as a continuum and the viro-gene concept'. *British Medical Bulletin*, xliii (1987), 754–67.