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Bleuler and Schizophrenia

By DAVID E. RASKIN

Eugen Bleuler has had a major influence on American psychiatry. His theory of schizophrenia, linking descriptive psychiatry to Freud's psychoanalytic concepts, has had an important influence on diagnosis and treatment, especially in America. This paper will summarize first some textbook descriptions of Bleuler's contribution and then some major issues which Bleuler discusses in his book *Dementia Praecox, or the Group of Schizophrenias*. I hope to demonstrate that the textbook accounts do not adequately describe the complexity and ambiguity of Bleuler's approach.

Textbooks on Bleuler

Mayer-Gross, Slater and Roth (1) state that Bleuler thought that loosening of the associations was the primary and fundamental disturbance. Other primary symptoms were weakening of the will, emotional stiffness, and ambivalence. Delusions, hallucinations and catatonic symptoms are considered to be secondary or accessory symptoms. 'Autism is placed somewhere between those two groups in Bleuler's system, and freely used to explain other symptoms.' 'Bleuler was on the search for a fundamental disturbance, hoping that the symptoms could then be explained as the reaction to it of the patient's mind.' (1) (p. 243).

Detre and Jerecki (2) interpret Bleuler as stating that splitting or fragmentation is the characteristic feature of schizophrenia. Fundamental symptoms are association disturbances, affectivity disturbance, morbid ambivalence, and a predilection for fantasy and autism. These symptoms, they state, are also called basic or primary symptoms.

Kolb (3) also mentions the importance of splitting. Primary symptoms are direct manifestations of a hypothetical somatic morbid process. They are listed as association difficulties, affective disturbance, ambitendence and ambivalence, and autism. Secondary symptoms are psychically determined. They include delusions, hallucinations, mannerisms, catatonic symptoms, and deterioration. Secondary symptoms represent an adaptation to the primary disturbance.

According to Redlich and Freedman (4), Bleuler felt schizophrenia to be essentially an organic disease, although he described it in psychological terms. Primary symptoms cannot be observed directly; the familiar observable symptoms are secondary. These are either direct consequences of the primary symptoms or attempts at restitution. Bleuler divided secondary symptoms into fundamental symptoms, which only occur in schizophrenia, and accessory symptoms, which are found in other diseases in addition to schizophrenia.

Lehmann, in Freedman and Kaplan (5), says that Bleuler described three primary symptoms of schizophrenia: disturbances of associations, affectivity, and initiative. Lehmann refers to the '4 A's': associations, affect, autism and ambivalence.

It is clear that each major textbook presents its own interpretation of Bleuler. The terms fundamental-accessory, and primary-secondary are used differently in each. In addition, there is confusion as to the method by which Bleuler would diagnose schizophrenia and distinguish it from other psychiatric disturbances. The task of this paper will be to clarify the meaning of these terms. Most of the data will be taken from Bleuler's work mentioned above (6).

Fundamental-Accessory Distinction

Fundamental or basic symptoms are only found in schizophrenia. (Symptoms include both observational and subjective data.) Accessory disturbances may be seen in other illnesses. They may or may not be present in schizophrenia. Fundamental symptoms are

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divided into simple and complex functions. Simple functions include: (1) a loss of the continuity of associations; (2) affective disturbances, which include indifference, lack of depth and modulation, moodiness, and a paramimia-parathymia defect (inappropriate affect). The capacity to produce affects does not disappear, even in chronic patients; (3) Ambivalence of the affects, the will and the intellect. 'Ambivalence is the tendency to endow the most diverse psychisms with both a positive and a negative indicator at one and the same time.' (p. 53); (4) Sensation, memory, consciousness, and motility are not disturbed.

Compound functions are derived from simple ones. Attention, intelligence, will and action are all disturbed to the extent that they are derived from simple functions. Autism is a compound, fundamental symptom representing a detachment from reality with relative or absolute predominance of inner life. Dementia in schizophrenia represents the effect of the association disturbance, the affective disturbance, and the autism, and is unlike dementia as the word is used in relation to organic brain diseases like senile dementia. Behavioural and activity disturbances reflect an absence of initiative, a lack of goal directedness, and inadequate adaptation to the environment.

Accessory symptoms lead to admission to hospital, and may or may not be present. They include hallucinations, illusions, and delusions. Hypermnesias and memory lacunae are also accessory symptoms. Bleuler lists a number of disturbances as accessory disturbances of speech and writing, poverty of ideas, condensations, word salad, neologisms, agrammatisms, and speech disturbances based on the similarity of two concepts or two words. It is not clear how he distinguishes these accessory disturbances from fundamental association disturbance. 'Be so kind and come and get my sister washed for me and we must to the kitchen' is given as an example of an accessory speech disturbance.

Somatic symptoms, catatonic symptoms and twilight states are other accessory symptoms.

The fundamental-accessory distinction is based on a *descriptive* approach where symptoms *peculiar* to schizophrenia are differentiated from those found in other psychoses. 'Once the affective disturbance or the disturbances in association have been shown, the diagnosis is proven.' (p. 283.) Yet, 'Just how prominent the various symptoms have to be in order to permit a diagnosis of schizophrenia can hardly be described.' (p. 298.) Clearly it is puzzling to state that these symptoms are always there, yet at the same time to state that one may not be able to observe them. How long do we need to study a patient before we conclude 'no fundamental disturbance, hence no schizophrenia'? In addition, the description of some of the fundamental symptoms does not adequately demarcate them from certain accessory symptoms.

Diagnosis of the Disease

In fully developed cases diagnosis is no problem; in less advanced ones it becomes more difficult. Bleuler feels that the diagnostic threshold of schizophrenia is higher than that of any other disease, and that the individual symptom is less important than its intensity and extensiveness, and above all its relation to the psychological setting. The clearer the patient's state of consciousness, and the fewer reasons for the presence of affects, the milder the symptoms may be which permit a diagnosis of schizophrenia. Bleuler disagrees, however, with Kraepelin's idea that there is no single sign of the disease that is decisive for diagnosis. 'The previously described disturbance of associations, and also probably the type of hallucinations, are characteristic and sufficient for a positive diagnosis; in addition a flattening of affect may serve this purpose.' (6) (p. 297.)

Bleuler lists a number of clinical observations which he feels aid in the diagnosis of schizophrenia. These include: (a) splitting of psychic functions in a clear state of consciousness; (b) thoughts being heard aloud (Gedankenlautwerden) which occurs *rarely in other psychoses*; (c) delusions, which are poorly developed in strong contrast to reality, and are expressed during periods of clear consciousness; (d) the delusion that everyone knows what the patient is thinking is *pathognomonic*; (e) affectless laughter; (f) adamant and unreasonable negativism; (g) exaggerated and inappropriate

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mannerisms; (h) stupor in clear consciousness; (i) widely dilated pupils in the absence of a detectable cause such as agitation; (j) improvement in nutritional status without corresponding psychic improvement indicates the probability of schizophrenia; (k) lack of attention and interest, but registration of events; (l) different persons or things being identified with one another.

Bleuler's clinical approach to diagnosis utilizes *some fundamental* symptoms (association and affect) plus *many accessory* symptoms which he states to be pathognomonic or highly suggestive of the diagnosis (thoughts being read, thoughts being heard). In addition, some fundamental symptoms are not diagnostic (autism and ambivalence).

Bleuler's system, when examined from the framework of the fundamental-accessory distinction and its application in diagnosis, becomes logically contradictory. Symptoms unique to schizophrenia are not considered diagnostic of schizophrenia. Some accessory symptoms are considered to be pathognomonic of the disturbance.

Nevertheless, American textbooks continue to emphasize the '4 A's' in diagnosing schizophrenia, even though: (1) there are more than four 'A's'; (2) there are no criteria for identifying these '4 A's' in mild cases; and (3) Eugen Bleuler *did not* emphasize fundamental disturbances in *diagnosing* schizophrenia.

Primary-Secondary-Distinction—These terms are used in developing a theory about schizophrenic symptoms.

Primary symptoms are produced by the disease process. They are necessary partial phenomena of the disease. Secondary symptoms reflect the normal psychic processes or attempts at adaptation to the primary disturbance. Secondary symptoms may be absent or may change without the disease process having to change.

'We assume the presence of a process, which directly produces the primary symptoms; the secondary symptoms are partly psychic functions operating under altered conditions and partly the results of more or less successful attempts at adaptation to the primary disturbances.' (p. 461.)

Primary symptoms include: a diminution or levelling of the affinities between words (association disturbance), clouded states, non-psychic oscillations of affect, the tendency to stereotype, certain kinds of pupillary disturbance, tremors and fibrillary twitches, headache and vertigo, vasomotor anomalies, and oedema. Secondary symptoms are a consequence of the primary symptom of loosening of the associations. In his book Bleuler states: 'Currently I am considering the disturbances of affect as secondary symptoms, but in doing so I am well aware that I am in disagreement with the usual conception of schizophrenic deterioration.' (p. 353.) In a later paper Bleuler (7) places affective disturbance in the primary symptom group. 'The disorder in affectivity is the tendency of the feelings to work independently of each other, instead of working together, which becomes evident, for instance, in the ambivalence, in inadequate affective reactions, simultaneous crying and laughing, and many other observations which occur very frequently with schizophrenics.'

Secondary symptoms include blocking, autism, splitting, blocking negativism, delusions, catatonic symptoms, and deterioration. Bleuler utilizes psychoanalytic concepts to explain secondary symptoms. According to Manfred Bleuler (8), 'The explanation of the secondary signs forms the major part of my father's study of schizophrenia.'

Conclusion

English-language textbook descriptions of Bleuler's ideas about schizophrenia have muddled the meanings of fundamental-accessory, and primary-secondary.

The fundamental-accessory distinction is a descriptive approach attempting to separate symptoms (and signs) peculiar to schizophrenia from those found in other disorders. This distinction is unclear, since (1) there are no criteria described to detect 'mild' cases; (2) there is a fuzziness to the use of the terms fundamental-accessory. It is especially puzzling in reference to the distinction between fundamental-association disturbances and accessory speech disturbances; (3) Bleuler's approach to diagnosis ignores this distinction between fundamental and accessory.

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The primary-secondary distinction is an approach to aetiology. It assumes being able to distinguish psychic symptoms which are organically determined from those representing normal psychological functions or attempts at adaptation to the primary disturbance. The distinction between organically derived psychic process and non-organically derived psychic process provides an artificial mind-body dichotomy. How is it possible to identify a *primary* psychic response to an organic insult, especially when different organic insults can lead to identically appearing psychotic pictures? In addition, quite different clinical pictures can arise from a specific brain disease. The search for a *primary* psychic symptom seems as hopeless as the search for a *single* aetiology of schizophrenia.

In contrast to these complicated yet ambiguous descriptive and aetiological notions, we have Bleuler's rich ideas about diagnosis and differential diagnosis. This approach, based on years of clinical experience, represents an artistic, intuitive labelling process. Patients are followed for long periods of time and the labels are more akin to determining 'family resemblances', rather than diagnosing via necessary and sufficient criteria. The clinical descriptions, the capacity to bring psychoanalytic theory to schizophrenia, are all enduring contributions.

The tension between Bleuler's theory and his practice is felt throughout his book. Over the years the theory has survived with all its encumbrances. The rich clinical descriptions and the wise approach to diagnosis and treatment have been omitted in references to Bleuler. It is time to correct the mistaken impression that Bleuler's major contribution to psychiatry was the '4 A's'.

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