Case histories
Schizophrenia

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For more on **Case histories** see **Comment** *Lancet* 2016; **387:** 211 and **Perspectives** *Lancet* 2018; **391:** 195

For more on **schizophrenia** see http://www.thelancet.com/clinical/diseases/schizophrenia

Dementia praecox, dementia paranoides, catatonia, hebephrenia, stupefaction—just the terms historically associated with schizophrenia could fill up a short essay on the subject. The contentious and surprisingly short history of this diagnosis draws out some of the most difficult questions in psychiatry. Is schizophrenia a natural entity, awaiting objective description, or does it emerge from a shifting intersection of contexts? Is good practice a matter of grouping disorders into broad categories based on underlying resemblances, or does accurate diagnosis depend on breaking these generalisations down into lists of specific symptoms?

For all these complexities, the origins of the word itself are clear. Schizophrenia—"split mind" in Greek—first appeared in a 1908 paper by the Swiss psychiatrist Eugen Bleuler. He characterised schizophrenia in terms of four As—ambivalence, autism, affective disturbance, and impaired association. Historians continue to disagree over whether he aimed to replace or enhance the concept of dementia praecox put forward by the German psychiatrist Emil Kraepelin in 1893. For Kraepelin, dementia praecox—an untimely loss of mental function—was one of a group of degenerative conditions characterised by "the unusually rapid development of a lasting state of psychic weakness".

Kraepelin's work in turn emerged at the conjunction of three late-19th-century psychiatric contexts. He was the acknowledged leader of a new nosological psychiatry, aiming to place the comparatively junior discipline on a firm footing of empirical symptomatic classification. His work and that of his contemporaries took place in the setting of state-funded asylums—both a professional powerbase and a necessary resource for Kraepelin's project. And his concept of dementia drew on wider cultural concerns around degeneration—initially rooted in a Catholic notion of original sin but transformed by evolutionary theory and fears over the effect of industrialisation and social disorder on minds and bodies. Kraepelin's vision of nosology was strongly influenced by his German elder Karl Ludwig Kahlbaum, who argued that observations made over the course and outcome of an illness were the only way to generate a stable psychiatric nosology.

Bleuler's concept of schizophrenia drew on Kraepelin's dementia praecox, but with two differences. Rather than observing and recording symptoms, Bleuler theorised an underlying disease process in the brain; and, drawing on his conversations with the psychoanalyst Carl Jung, he sought to interpret the meaning of schizophrenic symptoms and the disease as a whole. His reframing sparked controversy, but by the late 1930s schizophrenia was, in the words of the psychiatrist and historian Trevor Turner, "a dominant motif of professional descriptions of psychosis". Insulin coma therapy, developed between 1927 and 1933 by the Austrian neurophysiologist Manfred Sakel, is usually lumped in with pentylenetetrazol (then known as metrazol) and frontal lobotomy as a misguided response to the failure of asylum psychiatry, but the historian Deborah Doroshow has argued that it gave psychiatrists and patients at least some sense of agency in the treatment of schizophrenia.

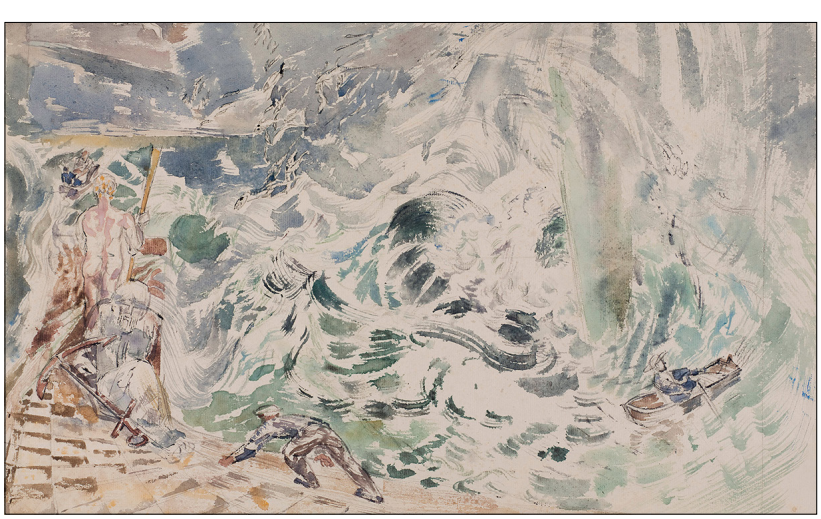
The appearance of antipsychotic drugs like chlorpromazine in the early 1950s ran in parallel with new debates over the cause of schizophrenia. Psychoanalysts interpreted it as a failure of ego development; followers of the radical Scottish psychiatrist R D Laing pointed to familial tensions and the "schizophrenogenic mother"; and the British psychiatrist Edward Hare wondered whether the steady increase in records of schizophrenic behaviour since the early 19th century indicated a viral origin. In Germany, Kurt Schneider, drawing on the work of Karl Jaspers, developed a neo-Kraepelinian framework of "first rank" and "second rank" symptoms, and this approach found international (though not unconditional) favour in DSM-III and its successors.

Over the last generation, a broad biological consensus has emerged: schizophrenia is understood as a neurodevelopmental disorder, related in some way to dopamine neurochemistry. Even in wealthier nations, however, quality of care remains low, and schizophrenia continues to be a stigmatised and poorly understood condition, still widely confused with multiple personality disorder. People diagnosed with schizophrenia experience high rates of unemployment and reduced life expectancy. "Living with schizophrenia", as Turner has said, "remains hard work".

Further reading

Turner T. Schizophrenia: social section. In: German Berrios G, Porter R, eds. A history of clinical psychiatry: the origin and history of psychiatric disorders. London: Athlone Press, 1995: 349–59

Scull A. Madness in civilisation: from the Bible to Freud, from the madhouse to modern medicine. London: Thames & Hudson/Princeton University Press, 2015



Wellcome Collection

***Visions of a schizophrenic* watercolour by Thomas Hennell (*c.* 1935)**

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