

Schizophrenia: The Sacred Symbol of Psychiatry*

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I

Let us try to project ourselves back into the places and minds of physicians and psychiatrists in, say, 1900. When they spoke of disease, what did they mean? They meant, typically, something like syphilis. 'Know syphilis in all its manifestations and relations,' declared Sir William Osler (1849-1919), 'and all things clinical will be added unto you.' (1). Obviously, this is no longer true. Indeed, how many cases of syphilis do modern medical students see between the time they enroll in school and the time they graduate? In the United States, Osler's maxim has been replaced by another which asserts that 'mental illness is our number one health problem'. This would make schizophrenia—the most common and most disabling of the so-called mental diseases—the successor of Osler's syphilis, showing us immediately what a gulf separates us from him. For, clearly, a physician may know all there is to know about schizophrenia, and yet be totally ignorant of medicine.

Still, the fascination which this medical image has exercised on the minds of psychiatrists, and hence its power over them, can hardly be exaggerated. At a 1974 international symposium on schizophrenia, Marvin Herz, Associate Professor of Clinical Psychiatry at Columbia University, is quoted as having alluded to 'the observation of Chicago psychiatrist Roy Grinker, who recalled at a recent meeting on schizophrenia that, as a young man, he had been told that if he knew schizophrenia, he would know psychiatry. "Well, the fact is that today I still don't know psychiatry," he confessed somewhat ruefully' (2).

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The Oslerian image thus points to a lesson we forget at our own peril. That lesson is the agreement among modern physicians *qua* medical scientists that they must distinguish between complaints and lesions, between being a patient and having a disease; and the resolution to regard as diseases only those processes occurring in the body (human or animal) which they can identify, measure, and demonstrate in an objective, physico-chemical manner. This was one of the reasons why syphilis was the turn-of-the-century medical paradigm of disease. Another was that it was common. And a third was that the syphilitic infection could affect countless organs and body parts, causing discrete lesions which could be appropriately named, all of which were, nevertheless, due to, and were manifestations of, the general systemic disease called 'syphilis'. Thanks to the work of numerous medical investigators around the turn of the century, physicians finally grasped that such totally dissimilar biological phenomena as the genital chancre of primary syphilis, the dermatitis of secondary syphilis, and the general paralysis of the insane of tertiary syphilis were actually all different manifestations of the same disease process, called 'syphilis'.

What made these monumental medical discoveries important, besides the prophylactic and therapeutic benefits for which they were essential, was that they paved the way toward establishing the empirical and epistemological criteria for judging whether or not a person had syphilis (or any other disease). In other words, with the development of clear-cut anatomical, histological, biochemical, immunological, and clinical criteria for syphilis, it was possible to say not only that certain persons hitherto unsuspected of this disease were in fact syphilitics, but that others, suspected of it, were not.

These developments were of the most far-reaching importance for physicians, including

psychiatrists, working at that time. By about 1900, European psychiatry was a well-established medical specialty. Its respectability, both scientifically and politically, thus depended on the medical perspective—perhaps we ought to say medical premise—that the psychiatrist's patients, like those of the surgeon or internist, suffered from diseases. The difference, in this view, between the non-psychiatric and the psychiatric patients was that whereas the diseases of the former caused them to have fevers and pains, those of the latter caused them to have hallucinations and delusions (3). 'Mental diseases are brain diseases,' is the way Theodor Meynert (1833–1892), Freud's professor at the Medical School in Vienna, had put it. To Meynert it was clear that disease meant anatomical abnormality, and accordingly he searched for and postulated such abnormalities to account for all so-called mental diseases (4). His 'vasomotor theory,' writes Zilboorg, '. . . permitted Meynert to offer a classification of mental diseases on a purely anatomical basis' (5). Meynert thus sought to reduce psychiatry to neurology; revealingly, he objected not only to psychological explanations of so-called psychiatric illnesses but even to the term 'psychiatry' itself.

The discovery of the syphilitic origin of paresis was a brilliant scientific confirmation of this organic-psychiatric hypothesis—namely, that persons whose brains are abnormal are likely to exhibit behaviour commonly judged to be abnormal. With paresis as its paradigm, psychiatry became the diagnosis, study, and treatment of 'mental diseases'—that is, of abnormal biological processes within the patient's head manifested by the psychological and social 'symptoms' of his illness. Psychiatry—whether organic or not, as Freud and his followers have subscribed to this model as slavishly as their organic opponents—thus became fatefully tied to medicine and its core concepts of illness and treatment. It is necessary that we should understand exactly how this happened.

II

There are experiences we may read about and know about intellectually, but cannot,

without going through them personally, appreciate in their full human impact. People who are well cannot, in this sense, grasp what it is to be desperately ill; or those who are rich, what it is to be desperately poor.

In the same way, people—physicians and non-physicians alike—cannot now grasp the impact which neurosyphilis had exerted on modern institutional psychiatry during the crucial first four decades of its existence, that is, between 1900 and 1940. Most psychiatrists now practising in the major industrial societies never see a patient with neurosyphilis. Many physicians have never seen one in their whole lives. For medical students, the disease has already become as legendary—in the sense of esoteric and extinct—as leprosy had been generations ago.

It is against this contemporary background that we must re-inspect the frequency and reconsider the role of neurosyphilis during the formative decades of modern psychiatry. Until the advent of penicillin in the 1940s, a large proportion of patients admitted to mental institutions, throughout the world, suffered from general paresis. Here are some illustrative figures. In the mental hospital Dalldorf, in Berlin, between 1892 and 1902, from 22 to 32 per cent of the patients, both men and women, had paresis. At the Central State Hospital, in Indianapolis, Indiana, between 1927 and 1931, from 20 to 25 per cent of the newly-admitted patients were paretics. At the Tokyo Insane Hospital in 1930, 30 per cent of the patients admitted were paretics (6). And so it went throughout the world.

Is it any wonder, then, that in 1917 the great Kraepelin asserted, and no psychiatrist or psychoanalyst doubted, that:

The nature of most mental disorders is now obscured. But no one will deny that further research will uncover new facts in so young a science as ours; in this respect the diseases produced by syphilis are an object lesson. It is logical to assume that we shall succeed in uncovering the causes of many other types of insanity that can be prevented—perhaps even cured—though at present we have not the slightest clue . . . (7).

And is it any wonder, also, that the paradigm of paresis was deeply imprinted into the mind

and memory of psychiatry? And that psychiatry still speaks with the accents of neurosyphilis on its lips? Or, to vary the metaphor, it is as if paresis had been a traumatic event, or indeed a series of such events, in the childhood of psychiatry. Now, while asleep, psychiatry still dreams about it; and while awake, it sees the world as if the spectre of paresis lurked behind every foolish face or troubled thought. Thus has the image of the crooked spirochaete making people mad been replaced, in the minds of many psychiatrists, by the image of the crooked molecule making them mad.

III

Viewed against this historical background, the story of the origin of the modern concepts of dementia praecox and schizophrenia appears, to me at least, in a quite different light from that in which it is usually presented.

The officially accepted form of this story is, briefly, that in the second half of the nineteenth century medical scientists began to be able to identify the precise morphological character and the material causes of many diseases; and that this led quickly to effective methods of prevention, treatment, and cure for some of these diseases. For example, physicians learned to identify many of the infectious diseases and their causes: puerperal fever, tuberculosis, syphilis, gonorrhoea, diphtheria, and so forth; they also learned to prevent and treat some of them. According to this version of the history of psychiatry, as some medical investigators discovered and identified diphtheria, so others—in particular, Bleuler—discovered and identified schizophrenia.

As I see it, this is not what happened at all. It is true, of course, that around the turn of the last century many medical investigators discovered and identified a host of diseases—in particular, the major infectious diseases of that age. But it is not true that psychiatric investigators discovered and identified certain other diseases—in particular, dementia praecox, schizophrenia, or other so-called functional psychoses (or neuroses). Psychiatrists made no discoveries according to which the people allegedly suffering from these diseases would have qualified by Virchow's

criteria—which were then the only ones that counted—as having a disease.

It cannot be emphasized enough, in this connection, that until Rudolf Virchow's (1821–1902) great work, *Die Cellularpathologie* (1858), the concept of disease was abstract and theoretical, rather than concrete and empirical; and that it became abstract and theoretical again with the introduction of psychopathological, psychoanalytic, psychosomatic, and psychodynamic concepts and terms into nosology (8).

Before Virchow, the model of disease was 'humoral pathology'; since him, it has been 'cellular pathology'. More precisely, until about 1800, diseases were supposed to be due to an imbalance of the four fluid humours of the body—that is, blood, phlegm, yellow bile and black bile. This concept dated back to the ancient Greeks. In 1761, Giovanni Morgagni, an Italian anatomist, showed that diseases were due not to an imbalance of humours but to lesions in organs. Around 1800, Xavier Bichat, a French anatomist, demonstrated that the human body was composed of 21 different kinds of tissues, and suggested that in a diseased organ only some of its tissues might be affected. It was, however, not until 1858, when Virchow delivered his famous twenty lectures, published as *Die Cellularpathologie in ihrer Begründung auf physiologische und pathologische Gewebelehre* (*Cellular Pathology Based on Physiological and Pathological Histology*), that the model of disease as cellular pathology was firmly established. According to this view, 'disease of the body is a disease of cells. The cure of the body may be effected by curing the cells. The real question which the modern scientific physician puts to himself when called to treat a case is: what cells are out of order and what can be done for them?' (9). This has been, and remains still, the basic concept and model of disease in Western countries and in scientific discourse throughout the world.

In short, Kraepelin and Bleuler discovered no histopathological lesions or pathophysiological processes in their patients. Instead, they acted *as if* they had discovered such lesions or processes; named their 'patients' accordingly; and committed themselves and their followers to the goal of establishing a precise identification

of the 'organic' nature and cause of these diseases. In other words, Kraepelin and Bleuler did not discover the diseases for which they are famous; they invented them.

IV

Because of the dominating role and importance of schizophrenia in modern psychiatry, it is easy to fall into the trap of believing that schizophrenia has always been an important problem in this field, and in the world. This is simply not so.

Actually, the concept of dementia praecox, as we now know it, was invented by Emil Kraepelin (1855–1926) in 1898. He has since been hailed as a great medical scientist, as if he had discovered a new disease or developed a new treatment; in fact, he did neither. What he did, according to Arieti—who is very respectful of his achievement—was this: 'Kraepelin's insight consisted in including three conditions under one syndrome' (10). The three 'conditions' were catatonia, originally described by Karl Ludwig Kahlbaum (1828–1899); hebephrenia, partially described by Ewald Hecker (1843–1909); and 'vesania typica', or hallucinations and delusions, also previously described by Kahlbaum. The point I want to emphasize here is that each of these terms refers to behaviour, not disease; to disapproved conduct, not to histopathological change; hence, they may loosely be called 'conditions', but they are not, strictly speaking, medical conditions. If none of these three items is a disease, putting them together still does not add up to a disease. Nevertheless, the unpleasantness of the persons who displayed such 'psychotic' behaviour, the actual or seeming social incapacity of the 'patients', and the academic-scientific prestige of physicians such as Kraepelin sufficed to establish dementia praecox as a disease whose histopathology, aetiology, and treatment now awaited only the further flowering of medical science.

Before such developments could occur, the disease was put on even firmer footing. Its name was changed from Latin to Greek, that is, from 'dementia praecox' to 'schizophrenia'. And its incidence—that is, its epidemiological significance—was increased with the stroke of

a pen. All this was done by Eugen Bleuler (1857–1939) who, again according to Arieti,

... accepted the fundamental nosologic concept of Kraepelin but enlarged it to a great extent, because he considered as related to dementia praecox many other conditions such as psychosis with psychopathic personalities, alcoholic hallucinoses, etc. Furthermore, he thought that the largest number of patients are never hospitalized because their symptoms are not severe enough; that is, they are latent cases (11).

The imagery and vocabulary of syphilology are unmistakable here: 'severe cases' requiring confinement, and 'latent cases' lurking about without the patient realizing that he is ill. Since Bleuler, too, neither discovered a new disease nor developed a new treatment, his fame rests, in my opinion, on having invented a new disease—and, through it, a new justification for regarding the psychiatrist as a physician, the schizophrenic as a patient, and the place where the former confines the latter as a hospital.

Still, the question remained: just what was schizophrenia? Eugen Bleuler answered this question—at least to the satisfaction of most psychiatrists, past and present.

V

Before 1900, psychiatrists believed that paresis was due to bad heredity, alcoholism, smoking and masturbation. These beliefs are now only of historical interest, like the belief in demonic possession or exorcism. We celebrate and credit with discoveries the physicians—Alzheimer, Schaudinn, Wassermann, Noguchi and Moore—whose work demonstrated irrefutably that paresis was due to syphilis.

Today, psychiatrists believe that schizophrenia is similarly due to an organic disease of the brain. Batchelor's phrasing is illustrative: 'Both Kraepelin and Bleuler believed that schizophrenia was the outcome of a pathological, anatomical, or chemical disturbance of the brain' (12). But why, we might ask, should we care about what Kraepelin and Bleuler *believed*? Bleuler also believed in abstaining from alcohol and in the symbolic rather than literal interpretation of the Eucharist. These beliefs of Bleuler's are of no more consequence for the

histology of schizophrenia than are Fleming's religious beliefs or disbeliefs for the therapeutic powers of penicillin. Why, then, do psychiatrists continue to record Kraepelin's and Bleuler's *beliefs* regarding the nature of schizophrenia? Why do they not emphasize instead Kraepelin's and Bleuler's utter inability to support their beliefs with a shred of relevant—that is, medical, histo-pathological—*evidence*?

Actually, Kraepelin and Bleuler were psychiatric clinicians, not medical investigators. Hence, they were not in a favourable position to generate any truly relevant evidence in support of their beliefs regarding the aetiology or pathology of schizophrenia. Instead, what they, and especially Bleuler, did was subtly to redefine the criterion of disease, from histopathology to psychopathology—that is, from abnormal bodily structure to abnormal personal behaviour. Since it was unquestionably true that most people confined in mental hospitals 'misbehaved', this opened the road toward charting the maps of psychopathology, thus identifying 'existing' mental diseases and 'discovering' new ones. It will repay us to review exactly how Bleuler achieved this scientific sleight of hand. My following quotations are from *Dementia Praecox or the Group of Schizophrenias*, published in 1911 (13). Here is the definition of schizophrenia in Bleuler's original words:

By the term 'dementia praecox' or 'schizophrenia' we designate a group of psychoses whose course is at times chronic, at times marked by intermittent attacks, and which can stop or retrograde at any stage, but does not permit a full *restitutio ad integrum*. The disease is characterized by a specific type of alteration of thinking . . . (14).

But 'alteration of thinking' is, from a strictly medical or physico-chemical, point of view, an irrelevant event. The fact that paresis is a brain disease could never have been established by studying the paretic's thinking. Then why study the schizophrenic's? Not, it seems to me, in order to prove that he is sick; that has already been established by the *presumption* of psychiatric authority whose power neither patient nor layman can match, and which no colleague dares to challenge. The schizophrenic's thinking is thus anatomized and pathologized in order to

create a science of psychopathology, and then of psychoanalysis and psychodynamics, all of which serve to legitimize the madman as a medical (psychiatric) patient, and the alienist as a medical (psychiatric) doctor.

Throughout his book, Bleuler emphasizes that the schizophrenic patient suffers from a 'thinking disorder' manifested by a 'language disorder'. His book is full of illustrations of the remarks, pleas, letters, and other linguistic productions of so-called schizophrenic patients. He offers many comments about language, of which the following is typical:

Blocking, poverty of ideas, incoherence, clouding, delusions, and emotional anomalies are expressed in the language of the patients. However, the abnormality does not lie in the language itself, but rather in its content (15).

Here, and elsewhere, Bleuler goes to great lengths to protect himself against creating the impression that in describing a schizophrenic patient he is merely describing someone who speaks oddly or differently from the way he does, and with whom he disagrees. He never ceases to emphasize that this is not the case, that, on the contrary, the 'patient' is sick and his linguistic behaviour is only a 'symptom' of his 'illness'.

VI

Thus, slowly and subtly, but surely indeed, Bleuler, Freud and Jung—and the other pioneer psychopathologists and psychoanalysts—brought about the great epistemological transformation of our medical age: from histopathology to psychopathology. It is now all too unappreciated how closely these three men worked together, in the crucial few years before the outbreak of the First World War, and how intimately intertwined were the earliest developments of psychoanalysis and psychopathology. The first psychoanalytic journal, published in 1909, bore the title: *Jahrbuch für Psychoanalytische und Psychopathologische Forschungen* (*Yearbook for Psychoanalytic and Psychopathologic Investigations*). Its publishers were Eugen Bleuler and Sigmund Freud, and its editor was Carl Jung. Bleuler was then the professor of psychiatry, and Jung a *Privatdozent*, at the Univer-

sity of Zürich Medical School. The lead article in that issue was Freud's 'Analysis of a phobia in a five-year-old boy', which became known as the case of 'Little Hans' (16).

Freud's fondness for pathologizing psychology—that is, life itself—had, of course, been clearly revealed eight years earlier, in his popular work *The Psychopathology of Everyday Life* (1901) (17). It was there that Freud developed, first and most fully, in James Strachey's words, 'his [Freud's] belief in the universal application of determinism to mental events. This is the truth which he insists upon in the final chapter of the book . . .' (18). Concepts such as 'idea', 'choice', and 'decision' all become, in Freud's hands, 'events', and all are 'determined'. 'I believe', he writes, 'in external (real) chance, it is true, but not in internal (psychical) accidental events.' (19). Thus have Bleuler and Freud transformed our image and idea of illness, and our vocabulary for describing and defining it: they had displaced lesion by language, disease by disagreement, pathophysiology by psycho-history—and, generally, histopathology by psychopathology.

Modern psychiatry began with the study of paresis and the efforts to cure it. It soon turned into the study of psychopathology and the efforts to control it. It has now become, the world over, the study of misbehaviour and the efforts to manage it. And schizophrenia is its sacred symbol—the largest grab-bag of all the misbehaviours which psychiatrists, coerced by society or convinced by their own zeal, are now ready to diagnose, prognose, and therapize. This ceremonial role of schizophrenia in psychiatry, indeed in the world at large, is illustrated by the publication, and the contents, of the prestigious *International Pilot Study of Schizophrenia* (20) conducted under the auspices of the World Health Organization.

The authors of this study list the following four characteristics—they call them 'inclusion criteria'—which, when observed about, or attributed to, a person by a psychiatrist, qualify that person as a schizophrenic: (1) Delusions. (2) Definitely inappropriate or unusual behaviour. (3) Hallucinations. (4) Gross psychomotor disorder; over- and under-activity. . . . Inclusion criteria 1–4 automatically qualified the patient

for inclusion, regardless of the severity of the symptomatology.' (21).

We had better laugh at this, lest we weep. The briefest critical scrutiny of this list makes its scientific and medical pretensions vanish—like the frightened child's ghost dispelled by flicking on the light in the bedroom.

Delusions. We know what they are: believing that you are one of the Chosen People; or that Jesus is the son of God, who died, but is still alive; or that gold will always be worth \$35 (US) an ounce.

Inappropriate or unusual behaviour. Well, we know that, too, when we see it: attacking Pearl Harbour, or invading Vietnam; having long hair or short hair or no hair; setting yourself on fire, committing hara-kiri, or jumping off the Golden Gate Bridge.

Hallucinations. No problem here, either: communicating with deities or dead people (and being unsuccessful at claiming a 'divine calling' or being a spiritualist); or seeing one's childhood or other long-past events (in one's mind's eye and relating it to someone who insists that the speaker 'actually' sees them).

Over- and under-activity. This is the easiest. Travelling half-way across the world to attend a psychiatric meeting; falling asleep while listening to the papers.

I hope I will be excused for my levity. I am using it, at this point, deliberately in an effort to dramatize the degree and the depth to which psychiatry has been debauched by physicians who prefer to be detectives rather than doctors.

VII

Medicine had been pregnant with psychiatry for a long time—for almost two-hundred and fifty years, from the middle of the seventeenth century, when it was impregnated by the founding of madhouses, until the end of the nineteenth century, when Kraepelin and Bleuler gave birth to the living medical specialty of psychiatry. This birth was duly celebrated by a christening: the baby's last name was, of course, a double one, as befits a noble offspring: medicine, from the father, and psychiatry, from the mother. Hence the specialty of 'psychiatric medicine'. In addition, the child had to be

identified by given names as well: these were bestowed upon it by its two great accoucheurs, Kraepelin and Bleuler, to whom we owe the names 'dementia praecox' and 'schizophrenia'. Their authoritative legitimization of all sorts of medically healthy (or non-sick) persons as sick—that is, as mentally sick—was the crucial event signifying the birth of modern psychiatry. This, briefly, is how it all happened.

When Kraepelin, Bleuler, and their contemporaries became psychiatrists, psychiatry was already an established form of medical and medico-legal practice. Moreover, the real locus of psychiatric practice was the insane asylum or mental hospital, just as the real locus of surgical practice was the operating room. What distinguished the important psychiatrist from his less important psychiatric colleagues and from his colleagues in other medical specialties was that he was the director or superintendent of an insane asylum or mental hospital. This meant that he had the authority, at once medical and legal, to keep innocent men and women—often thousands of them—under lock and key.

In addition, the medical and social definitions of madness being what they were (and still are), the majority of the patients brought to the attention of physicians like Kraepelin and Bleuler were considered to be mentally ill before, often long before, they reached these psychiatrists. The upshot was that these men reigned over hospitals full of people who were regarded—by their relatives, by other physicians, by the law—as *bona fide* patients. The pressure—both scientific and social—on them was therefore all one way: define the madman as sick and discover how he is sick!

Still, could these institutional psychiatrists have not taken a more independent, more scientifically honest position? Could they have not told themselves that, as medical scientists, one of their foremost duties was to ascertain what was, and what was not, a disease? Which persons complaining or suspected of disease were, and were not, sick? And could they have not acted accordingly?

Had those physicians taken such a position, they could have also asked themselves whether it was not their first duty toward the inmates of

their hospitals to examine them medically; and to declare, on the basis of their examination, whether they found them to be suffering from an illness or not? Actually, given the Virchowian criteria of disease which then prevailed, and given the social facts of psychiatry which also prevailed, I do not believe that Kraepelin, Bleuler, or the psychiatrists of that period could have assumed such a role, and got away with it. The reason is simple. Had they done that, they would have had to conclude that most of the 'patients' in their hospitals were not sick: at least they could not have found anything demonstrably wrong with the anatomical structure or physiological functioning of their bodies. But this would have dangerously undermined the justification for the patients' confinement.

It is, in fact, overwhelmingly clear that the institutional psychiatrists in the days of Kraepelin and Bleuler could not have declared their 'patients' as 'medically well', and have survived as professionals, as physicians and psychiatrists. Indeed, they still cannot do so. The 'patients' relatives, physicians, and society generally, wanted to segregate certain disturbing persons and had done so in madhouses. This was a *fait accompli*—on a massive scale, at that—by the time Kraepelin and Bleuler arrived on the psychiatric scene. Had they said that their so-called patients (or many of them) were not sick, they would have cut the ground from under what was then the accepted justification for confining them. The medical profession, the legal profession, and society as a whole would not have stood for it. They would have got rid of such psychiatrists and would have replaced them with men who did what was expected of them. And they would have richly rewarded those who so fulfilled society's needs for social control and scapegoating—just as they had rewarded Kraepelin and Bleuler.

Accordingly, I regard Kraepelin, Bleuler and Freud as the conquistadors and colonizers of the mind of man. Society, their society, wanted them to extend the boundaries of medicine over morals and law—and they did so; it wanted them to extend the boundaries of illness from the body to behaviour—and they did so; it wanted them to conceal conflict as psycho-

pathology, and confinement as psychiatric therapy—and they did so.

VIII

Schizophrenia, I have suggested, is the core concept of modern institutional psychiatry. This concept, and the problems it now poses for us, cannot be understood and unravelled except by a careful historical and epistemological re-examination of the origin and development of psychiatry.

The first step in the history of psychiatry was the building of madhouses or insane asylums. This created a population of institutional and institutionalized inmates whose conduct and condition created a demand for their description, and whose confinement cried out for justification.

The second step, generated by the first, was the identification and classification of the conduct and condition of the inmates of insane asylums. These acts of naming and ordering provided both a scientific rationalization for the fictions of the madhouse-keepers and for the fetters in which they confined their victims.

The third step—generated by the two previous steps, taken by Kraepelin, Bleuler and Freud, and heralding the birth of modern psychiatry—consisted of two interrelated moves. One was an ironclad, authoritative literalization of the psychiatric nomenclature built up in the course of the preceding decades. The names of psychiatric diseases were henceforth the unquestioned and unquestionable proofs of the existence of such diseases: because 'schizophrenia' was a disease, it was caused by lesions in the brain whose precise identification required only further refinements in medical science and technology. The second was an ironclad, authoritative justification of psychiatric confinement: because 'schizophrenics' (and other 'psychotics') were confined in nominally medical institutions, they were 'hospitalized', and the nature and function of closed psychiatric institutions became the sacred taboo of 'scientific' psychiatry. Henceforth, physicians and psychiatrists, as well as lawyers and laymen, averted their eyes from the world and fixed their gaze upon heaven: the more obvious it was that schizophrenics were imprisoned, the

less attention psychiatrists, and others, paid to their imprisonment; and the more impossible it became to discover the brain lesions that caused schizophrenia, the more earnestly psychiatrists, and others, searched for them.

The fourth step—taken by so-called organic psychiatrists in our own day—was the systematic use of somatic treatments in schizophrenia. Since after a century of search, psychiatrists could still not demonstrate the characteristic histopathology, much less the organic etiology, of schizophrenia, they now set out to 'prove' that it was a disease by subjecting schizophrenics to certain medical and surgical procedures called 'treatments'.

In all these ways, the development of modern psychiatry has not only differed from, but has been antithetical to, that of modern medicine. With the sole exception of the segregation of lepers (which occurred long before the birth of modern medicine), there has never been—in medicine and surgery—any kind of systematic involuntary institutionalizing of patients; nor has there been a systematic proliferation of disease names created independently of their anatomical, biochemical, microbiological, or physiological correlates. For example, until relatively recent times, physicians spoke of 'venereal diseases' collectively; genuine classification of these diseases occurred only after discoveries in microbiology provided the necessary tools for it. The operation of the same principle is apparent in the identification and classification of all bodily diseases; that is, macroscopic pathological changes in organs, microscopic changes in tissues or cells, microbial invasions, and so forth are observed first; the precise naming of diseases comes next. It is just this sequence which has been systematically reversed and corrupted in psychiatry: the precise, or rather pseudo-precise, naming of alleged diseases came first; the existence of morphological pathology was postulated but never produced.

Hence the ceaseless manufacture of disease names in psychiatry, together with a total lack of evidence that any of them—from agoraphobia to schizophrenia—are caused by demonstrable brain lesions on the model of paresis. It is the greatest scientific scandal of our scientific age.

There is, in short, no such thing as schizophrenia. Schizophrenia is not a disease, but only the name of an alleged disease. Although there is no schizophrenia, there are, of course, individuals who are called 'schizophrenic'. Many (though by no means all) of these persons often behave and speak in ways that differ from the behaviour and speech of many (though by no means all) other people in their environment. These differences in behaviour and speech may, moreover, be gravely disturbing either to the so-called schizophrenic person or to those around him or to all concerned.

In the end, let us remember that physicians could not understand paresis until they accepted it as a disease—like any other, except that it affected the brain instead of the liver or kidney; and that they could not accept it as a disease until medical investigators demonstrated that the brain tissue of paretics, and of paretics only, harboured hordes of *Treponema pallida*. *Mutatis mutandis*, physicians will not understand schizophrenia until the so-called patients reassert themselves as agents, not objects; or until others—for example, politicians, legislators, or jurists—reaffirm that the role of the physician is to cure disease, not to control deviance; or, most generally and perhaps most importantly, until the dominant intellectual, economic, moral, and political institutions of society recognize and publicly acknowledge the differences between disease and disagreement.

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