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Special Feature Article

Assessment of the Psychiatric System of W. Griesinger Rethinking Contemporary Psychiatry

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Abstract

A recent series of genetic analyses have demonstrated many common susceptibility genes between schizophrenic disorder and bipolar disorder. Furthermore, in pharmacotherapy, the same antipsychotic agents, particularly atypical neuroleptics are effective not only for schizophrenic disorder but also for affective disorder including depressive disorder. These findings support the notion of "primary affective disorders", which was proposed by W. Griesinger in the textbook "Mental pathology and therapeutics" (1845, 1861) referring to acute psychosis, including acute schizophrenia and early psychosis from a transdisorder viewpoint with therapeutic implications. Considering the dynamic framework proposed by W. Janzarik, the classification system of W. Griesinger should be reevaluated. The concept of schizophrenic disorder in the DSM-5 is as outdated as "dementia praecox", taking into account that the DSM-5 tries to capture the essential features of schizophrenic disorder in a coherent manner only as the cognitive disorder lacking therapeutic perspective. On the other hand, Kraepelin was correct to have proposed the concept of "dementia praecox" as this disorder is based fundamentally on the pathology of personality structure according to W. Janzarik. In deconstructing the transdisorder viewpoint of Griesinger and the dichotomic viewpoint of Kraepelin, the author proposed the core pathology of schizophrenic disorder to be

characterized by primary language disorder, whereas that of manic-depressive disorder is characterized by primary affective disorder. Therefore, if we think logically, schizophrenic disorder may be an upper level manic-depressive disorder.

Keywords: Griesinger, Kraepelin, DSM-5, schizophrenia, bipolar disorder

Introduction.

In the course of treating many patients in clinical practice and gaining a lot of experience, including long-term follow-up, this author has argued that there is much to be learned not only from Kraepelin's psychiatric system, which led to the disease units of manic-depressive and schizophrenic disorders, but also from Griesinger's psychiatric system, which preceded Kraepelin's system and was the dominant force in Europe and the United States. In addition to these systems, the German psychopathologist Janzarik proposed the structural dynamics theory, which views the pathology of mental disorders in terms of both vital dynamics and personality structures 15). Inspired by these systems, this author has also sought to extend this line of work by including the viewpoints of Freud-Lacan's structural psychoanalysis and proposing neo-Griesingerism 18). With the rise of molecular biology, neo-Kraepelinism, which attempted to support Kraepelin's system biologically, gained power in the United States. However, a considerable number of findings, such as the discovery of cross-disease-related genes, have not supported neo-Kraepelinism, and the demise of the Kraepelin dichotomy has begun. In this regard, it is also important to note that the method is not the only one that can be used in the study of psychiatry 8). In this regard, it would not be meaningless to methodically bracket Kraepelin's system and return to psychiatry systems before the dichotomy of manic-depressive and schizophrenic illnesses. It would also provide an opportunity to review today's psychiatry from a new perspective, and to understand the background that led Kraepelin to develop the disease unit of premature dementia.

Griesinger gained a wealth of clinical experience under Zeller, the director of the Vinental Clinic, who was considered a proponent of the theory of monopsychosis 30)32). In 1845, at the young age of 28, he published "The Pathology and Treatment of Mental Illness", based upon his training 9). The book was groundbreaking in that it

systematized psychiatry, which was still in its infancy, under a scientific guise for the first time, and proposed important paradigms such as distinguishing between acute and chronic conditions in a cross-disease manner.

Pinel, in his "Medical and Philosophical Theory of Mental Illness", made a broad classification of illnesses, such as "melancholy", a type 1 psychosis, "mania without delirium", a type 2 psychosis, "mania with delirium", a type 3 psychosis, and "dementia or extinction of thought", a type 4 psychosis 29). Following on from this, "Pathology and Treatment of Mental Diseases" continued Pinel's classification to a certain extent, but reclassified melancholy and mania as "primary emotional disturbance" and "dementia or extinction of thought" as "secondary mental debility", based upon a new perspective to systematize the classification of mental disorders 9). As a result, German psychiatry gained an advantage over French psychiatry and became the world leader. The second edition of Kraepelin's system was published in 1861 and went through many reprints, followed by a French translation in 1865 10) and an English translation in 1882 14). After this, Griesinger's theory appeared to be completely forgotten due to the fact that Kraepelin's system had dominated for a long time. Perhaps because of this, the Japanese translation (second edition) 11) was first published in 2008. In this paper, I would like to re-assess the Japanese translation, referring when necessary to the original sources to confirm and examine some of Griesinger's interests and discuss their significance to psychiatry today. Some of the quotations are supplementary to the original and the author's translations have been used where necessary. In principle, pages are based on the Japanese translation. The same is true for other citations.

In the fifth edition of Psychiatry, Kraepelin identified dementia praecox as a serious personality disorder that leads to personality disintegration through an endogenous slowing process. More than 100 years later, although some cases of schizophrenia have a severe course, the number of schizophrenia cases with a favorable course is increasing, and we cannot help but feel that this rigid way of thinking is no longer clinically appropriate. In addition to social and cultural changes, advances in pharmacotherapy and social therapy can be cited as factors contributing to the decline of the disease. Therefore, the author's basic proposal is to methodically bracket Kraepelin's system and to return to Griesinger's flexible understanding of the pathogenesis. It should be added, however, that Kraepelin's final insight

in his 1920 article entitled "Die Erscheinungsformen des Irreseins" (The Phenomenal Forms of Mental Abnormality)*1 presents a broader view that relativizes the disease unit of premature dementia.

I. Advocacy of scientific psychiatry (organic brain theory)

It has been said that Griesinger was the first scholar to explain the scientific methodology of modern psychiatry, which he passionately explains in the beginning of "Pathology and Treatment of Mental Illness" as follows 11).

"Since mental abnormality (Irresein) is a disease, especially a disease of the brain (Erkrankungen des Gehirns), only medicine can properly investigate it" (p. 13).

"If the facts of physiology and pathology show that the organ in question is none other than the brain, then in psychosis (Die psychischen Krankheiten) we must always recognize a disease of the brain" (p. 3).

As you can see from a careful reading of this argument, according to Austin's (British linguist) 2) classification of speech, Griesinger's formulation that mental illness is a disease of the brain 11) is not yet sufficiently grounded in physiology and pathology, and so it is not possible to say that mental illness is a disease of the brain. It is clear that Griesinger's formulation that mental illness is a brain disease 11) is not a constative utterance, but rather a performative utterance with reservations, saying "I think this way".

The DSM-5 1) lists neurodevelopmental disorders in the first group, schizophrenia and other psychotic disorders in the second group, and bipolar disorders in the third group, suggesting an intention to classify mental disorders as neurological disorders. It is striking that the basic guidelines of psychiatry, which were advocated in Germany more than 160 years ago, are being pushed forward and embodied in the diagnostic classification in a clear manner. However, the current achievements in molecular biology are still lacking in evidence to support the validity of the classification, and there is still a lot of action-oriented speech that says, "We now classify mental disorders in this way".

II. Advocacy of university hospital psychiatry and general hospital psychiatry

The most distinctive feature of Griesinger's classification of mental illnesses is their cross-disorder division into two broad categories: "curable acute conditions" (primary emotional disturbances) and "treatment-resistant chronic conditions" (secondary or secondary mental debilitations)*2. The word "treatment" in the title of his work,

Pathology and Treatment of Mental Illness, suggests that he was thinking of treatment as the ultimate goal. In this paper, I would like to discuss the dichotomy of Griesinger's system, which is based on a completely different way of thinking than Kraepelin's major classification, which also dichotomizes schizophrenia and manic-depression. The key to diagnosis in psychiatry is to be measured by how far into the future one can look with certainty. The "practical demands" of psychiatry are to "judge the future prospects", that is, to judge the prognosis, and this emphasizes the idea that this is the mission of psychiatry 23). The assertion that the "practical requirement" is not treatment, but prognosis, is backed up by the pessimism that psychosis cannot be cured. When the author was a resident, he read this article and felt uncomfortable.

In fact, early-onset dementia (schizophrenia) is understood as an endogenous slowing down in which the internal associations of the mental personality are uniquely disrupted, and damage to the emotional life and will is predominant, and is clearly defined as a disease with a poor prognosis 24). It is a highly regarded view, even today, that early-onset dementia is a disorder specific to a deep level of personality. However, the diagnosis of early-onset dementia implies that the patient's future is unlikely, and Kraepelin is conspicuously psychoanalytical and lacks a therapeutic perspective.

With the development of many new antipsychotics, psychiatric pharmacotherapy has shown some success, especially in the treatment of schizophrenia, bipolar disorder, and acute depression. Kraepelin did not distinguish between the acute and chronic phases of early-onset dementia, and the concept of Kraepelinism seems to be problematic in terms of pharmacotherapy treatment. As Janzarik explains many times in "Structural Dynamic Basis of Psychiatry" (hereinafter referred to as "Structural Dynamics Theory") 15), antipsychotic drugs are effective in correcting deviations in the dynamik*3, and in this respect, antipsychotic drugs should be used not only in the acute phase of schizophrenia and manic-depression, but also in the chronic phase. Additionally, antipsychotics are effective not only for treatment of schizophrenia and manic-depressive illness, but also for postpartum psychosis and alcohol psychosis.

Griesinger was a theorist who proposed a system that included a therapeutic perspective on mental illness. He was also a practitioner who tried to realize his system. In a paper written in his later years, he made a pioneering proposal for psychiatric

treatment 12). He argued against the tradition of building psychiatric facilities in remote areas, and called for the creation of acute beds in cities to treat acute patients, in other words, urban psychiatric hospitals (Stadt-Anstalt). He pointed out that this would make it easier for family members to visit the patients and for them to stay overnight. He also argued for the establishment of a 24-hour observation room in the hospital. He proposed the establishment of a university hospital psychiatric ward (Klinik). The target conditions include postpartum psychosis (puerperal mania, postpartum mania), acute alcoholism, and delirium tremens (drinking mania). In "Pathology and Treatment of Mental Illness", the authors suggest that psychiatric hospitals in large cities should be equipped to admit such short-term patients, and, citing hospital statistics in New York, they state that urban psychiatric hospitals attract patients with good prognoses (pp. 332-333) 11).

He also proposed the establishment of a department of psychiatry in university hospitals, which would enable cooperation with other departments and contribute to education. In fact, Griesinger, who was invited to the University of Berlin, established an acute psychiatric ward in Charité Hospital. Griesinger's proposal, which emphasizes the significance of establishing acute psychiatric wards in urban areas and even in university hospitals, explains the need to treat potentially curable acute patients in a high-quality medical environment. It is a concept that anticipates modern psychiatric treatment.

III. Griesinger's major classification

In "Pathology and Treatment of Psychosis", psychosis is broadly divided into two groups: Group 1, "pathological states related to emotional and affective states", and Group 2, "mental abnormalities based on abnormalities of thought and will". In the first group, the basis of the pathology is "primary (emotional) abnormality", and it is considered curable (p. 245-246) 11). Depression and mania, which have been regarded as emotional disturbances in the Anglo-American world, are good examples. In addition, it is thought that early schizophrenia and acute schizophrenia are included in the group of primary (emotional) abnormalities in this system.

In fact, even in modern clinical practice, early schizophrenia and acute schizophrenia often present as emotional disturbances in a broad sense. In his famous book, The Beginning of Schizophrenia, Conrad documented the fact that in the acute course of schizophrenia, there is an "increase in

basal emotions" from the beginning, and depressive and manic mood swings are observed (p. 224).

In addition, Ciompi, a Swiss psychopathologist who focuses on the treatment of schizophrenia, clearly stated that the chronic phase of schizophrenia is an artificial product, that schizophrenia is an emotional disturbance, and that the acute phase is the basis of the pathogenesis of schizophrenia 5)6). This idea is in line with Griesinger's view that schizophrenia is also a primary emotional disorder. The view that the chronic phase of schizophrenia is an artificial product of the secondary phase is valuable, and it can be taken to mean that how well the acute phase is concluded depends on the skill of the physician. Unfortunately, the DSM-5, which focuses on cognitive impairment as the basis of schizophrenia, does not include the perspective of emotional disturbance, nor does it include the therapeutic perspective of leading patients into remission.

It was Janzarik who evaluated Griesinger's major categories and developed a theory of psychopathology in the modern age. His work, Structural Dynamic Foundations of Psychiatry, is quite difficult to understand, but in the introduction, he clearly states the genealogical relationship with Griesinger as follows: 15) "In the realm of essential psychological syndromes, the principle-recoverable affective disturbances, stated by Griesinger to be primary, have been extended to Emotion and Antrieb and re-adopted as 'deviations of dynamics'" (Entgleisungen der Dynamik) (p. 170). The "residue", understood to be secondary, is reproduced due to the insufficiency of the personality structure (strukturelle Insuffizienz) and the insufficiency of the life force dynamics (dynamische Insuffizienz) (p.4)*3, *5.

In light of Janzarik's structural dynamics theory 15), the first group of emotional and affective pathological states, which encompasses the acute phase of manic-depressive and schizophrenic illnesses, is characterized by deviations from the intrinsically rhythmic life force dynamics. The cross-disease efficacy of antipsychotics can be attributed to their ability to correct vital dynamics. Furthermore, mood stabilizers, which are supposed to be applied to manic-depressive illness, are also effective in the acute phase of schizophrenia. Since mood stabilizers originally have the function of correcting deviations in vital dynamics, the fact that these drugs also have a certain effect on schizophrenia proves that the pathology of the acute stage of schizophrenia is a clear deviation in the level of vital dynamics.

The second group of "mental abnormalities based on abnormalities of thought and will", which Janzarik describes as "remnants", can be understood as "secondary states of mental debility", secondary to acute emotional and affective disturbances. It is a chronic condition that "exists independently of emotional states", is marked by faulty thinking and will disturbances, and is not curable (p. 245-246) 11). From the viewpoint of Janzarik's structural dynamics theory, the basis of the pathology is not the change of vital dynamics, but the change of personality structure, which is required to be transformed and dismantled in a broad sense. Therefore, medication is not expected to bring about significant improvement, but non-pharmacological therapies, such as supportive psychotherapy and occupational therapy, are effective to a certain extent.

Primarily, early-onset dementia can be regarded as a descriptive concept proposed by Griesinger's system, based on the fact that there are a series of cases in which secondary mental debility is prominent after the acute phase. It is true that schizophrenia, because of its deep roots, is prone to secondary mental deterioration, which is often severe.

Another way of looking at the establishment of early-onset dementia is to consider that it was derived from the recognition that there is a group of cases in which the state of mental decline and dementia that Griesinger considered to be secondary appears early, before the onset of emotional disturbance or without emotional disturbance. If this is the case, Kraepelin's standpoint is that Griesinger's state of mental debility and dementia is not necessarily secondary, but that there are also primary states of mental debility and dementia. It is true that there are many such cases. In this respect, Kraepelin's concept of early-onset dementia was derived from his criticism of Griesinger's system.

Kraepelin's derivation of the concept of paranoia is a corollary. However, it was not until the work of Snell, Westphal, and Zander that "primary paranoia" came to be generally recognized as a special type of paranoia (underlined author), a primary paranoia 21).

In short, Griesinger considers the emergence of fixed delusions to follow primary emotional disturbance, whereas Kraepelin takes the view that there are cases of primary fixed delusions without emotional disturbance. Similarly, Kraepelin may have derived the concept of early-onset dementia from the fact that there are cases in which a primary state of mental debility, so to speak, emerges without being preceded by emotional

disturbance. It should be added that at least some of the early paranoia concepts included many cases that were later incorporated into early-onset dementia. Additionally, it should be noted that Griesinger accepted Snell's view and acknowledged the existence of primary paranoia (Primäre Verrücktheit) in his last lecture (in 1868, the year of his death) 13). It is a statement of thinking that anticipates Kraepelin's argument and partially overturns his previous system. However, this does not diminish the significance of Griesinger's major classification, which is the focus of this paper.

Kraepelin does not appear to have mentioned the emergence of mental debility, including what Griesinger calls "dementia", in manic depression. However, even in current clinical practice, there are many cases in which chronic depression leads to a decline in the personality level and a complete change in the former personality. In this regard, Griesinger's view is correct, and it is not uncommon to see the appearance of secondary mental debility in manic depression. Secondary psychotic breakdowns are difficult to treat with medication, whether in schizophrenia or manic-depressive illness. This is because the primary pathology is a change in personality structure.

IV. Griesinger's suggestion about depression and mania

Griesinger's description of depression and mania has many useful implications for modern clinical practice. Here are some of them.

1. "Mental Depression - Depression (Schwermuth) or Melancholy" (p. 247) *6.

According to Griesinger, the term "mental depression" (Die psychischen Depressionszustände) does not mean only a state of immobility or weakness resulting from mental depression and the associated brain processes and seems to be based on a highly active state of brain stimulation and mental excitement ((p.247)11). Griesinger additionally points out that the basis of the pathogenesis of depression is brain stimulation and mental excitement. Indeed, especially in endogenous depression, mental activity is more hyperactive than usual due to various worries being repeated. It seems to make sense that this is the basis for the appearance of inhibition and confusion. In pharmacotherapy, sedative antidepressants (tricyclic antidepressants, amoxapine) and antipsychotics (perphenazine) in small doses have traditionally been effective for the treatment of endogenous depression. Today, a growing number of newer antipsychotics are being

approved for use in depression and have been found to be effective.

Focusing on the characteristic abnormalities of body movement shown by melancholy patients, two, in particular, should be mentioned: one is anxiety, agitation, and restlessness, which are described as follows 11).

Melancholia agitation is a condition in which internal anxiety manifests as physical restlessness. "Melancholia agitans", or agitated depression, is still common today. "The mind is often full of delusional thoughts that are monotonous and of little alternation" (p. 268). This is in contrast to mania's anxiety and delusion, in which the content of speech changes rapidly.

"The patient moves about restlessly, cries and fumbles" and "sometimes shows a tendency to wander, even to distant relatives and friends" (Melancholia Evlander) (p.268) 11).

Melancholia evulanda, or wandering melancholy, may be a name that refers to a condition that is an extension of agitated melancholy. A patient with delusional depression (with delusions of guilt as a theme), whom the author was seeing in an outpatient clinic, suddenly walked alone for 20 minutes to the station and then went to his own mother's house, which was more than two hours away by train. This behavior came as a fresh surprise to the author, but it was carefully described by Griesinger before the concept of depression was proposed. The behavior of "going to distant relatives and friends" was stated to be characteristic of a bipolar or mixed state, and was precisely described in Griesinger's book.

The other characteristic physical movement in melancholy patients is catatonic stupor, which is described as follows: "The movements become slow and sluggish, and the patient tends to lie down". When this progresses, the patient "may remain rigid and motionless as if he were a statue", "the joints are rigid, and there is considerable resistance when other postures are attempted"; however, "the patient may be able to bend or move his limbs without resistance, and yet remain in the posture in which he is moved (catalepsy)" (p. 268) 11). This is a description of catatonic stupor in melancholy. Although the possibility of schizophrenic catatonia cannot be ruled out, Griesinger points out that such changes in body movements in melancholy are "characterized by grievous feelings", and that the changes are consistent with mood. If the author were to characterize melancholy using the specific terminology for depressive disorders in the DSM-5, it would be "mood-congruent" motor changes, and thus catatonia.

As an example of raptus melancholicus, "suicidal impulses may suddenly arise

in a previously healthy person" (p. 293) 11). The concept of sudden melancholy seems to have been forgotten in the current tendency to consider dementia first when sudden suicide attempts occur in the elderly.

The delusion in melancholy is characterized by "passivity, suffering, and overwhelm" (p.265) 11). The characteristics of passivity and suffering describe the transformation by which the subject takes on the "burden of suffering" or the "burden of others" as something imposed on him or her, which is discussed as the core pathology of endogenous depression from the anthropological-phenomenological standpoint 19). In the delusional state, emphasis is placed on the delusion of guilt, and the appearance of paranoia and hallucinations are described as incidental.

It was mentioned earlier that motor abnormalities in melancholy are consistent with mood. Delusions and hallucinations are also consistent with mood, as they "appear with strong characteristics of grievous emotional changes". In other words, in the DSM-5, psychosis with "psychotic features consistent with mood" is a disease picture.

2.Focusing on intermediate and transitional states between depression and mania

What is interesting about Griesinger's description of primary affective disorder is that it constantly draws attention to an intermediate state between depression and mania, or even a mixed state.

"The course of simple melancholy is sometimes very rapid, preceded by grievous emotional changes with increasing anxiety up to mania, and sometimes interrupted" (p.271) 11).

"It is very common to see a transition to mania or an alternation between depression (Schwermuth) and mania" (p.271) 11).

When describing the pathogenesis of bipolar disorder, "cyclic psychosis", as described by Falret, who proposed the clinical unit of manic-depressive or bipolar affective disorder, is often cited (p. 271) 11). Under the influence of the French school, Griesinger developed a theory of pathogenesis rooted in more precise clinical observations. In my understanding, Griesinger believed that depression or melancholy themselves have intrinsic elements of mania, and that it is in the constant fluctuation of minute movements between depression and mania that the picture of the disease suddenly changes.

A good example is the understanding that when melancholy "produces a blind impulse to destroy everything in sight" it is "clearly a form of mania" (p. 301) 11).

This understanding of the pathogenesis of manic-depressive illness suggests that Griesinger implicitly assumed the clinical unit of manic-depressive illness.

In "Psychiatry", Kraepelin emphasized the transition between manic excitement and depression, saying "A close examination of many cases belonging to the various forms of manic-depressive illness reveals many transitions between the basic types we have distinguished so far, namely manic excitement and depression". It is clear that this diagnosis is a continuation of Griesinger's view.

3. "Dementia" in depression

Griesinger carefully discusses "dementia" (Blödsinn) in depression or melancholy as follows 11).

The author makes the important point that "depression with emotional dullness" is observed, that "depression associated with depression is difficult to distinguish from emotional dullness on the outside", and that "when the depressive state becomes very severe, it is difficult to distinguish from dementia on the outside". Furthermore, "the fact that the disease can progress to mild dementia makes it prone to errors in prognosis and treatment" (p. 286). The "dementia" in the state of secondary mental decline discussed here is first and foremost an impairment of intellect, which appears to refer to a comprehensive failure of personality functions, such as a lack of emotional expression, a lack of will power, and a decline in cognitive ability. Therefore, this differentiation can be taken as an indication that it is difficult to distinguish between depression with rich emotionality due to primary emotional disturbance and mental debility secondary to emotional dullness, which requires careful judgment. Additionally, both may be in a transitional intermediate stage. This insight is clinically important.

It is true that after the acute phase of melancholy, the patient continues to be completely lacking in color, and there are times when it is difficult to decide whether to treat the illness as a mere prolongation or as a secondary chronic personality disorder. In some cases, melancholy and "dementia" with delusions of guilt and paranoia may be more appropriately diagnosed as schizophrenia. For reference, Griesinger used the term "affective blunting" to describe "dementia" in depressive states, but the term that Kraepelin uses to characterize the unique changes in emotional expression in early-onset dementia is affective blunting. In any case, Griesinger hit the nail on the head when he pointed out that both pseudo (secondary) and genuine (secondary) mental decline can occur in melancholy, even in the light of

modern clinical practice.

The point of differentiation between pseudo (secondary) mental decline and genuine (secondary) mental decline in melancholy is that in melancholy "only the eyes are different from those of the 'dementia' patient, but they still express sorrowful feelings, anxiety, and introversion" (p. 286, key brackets added by the author) 11). In melancholy, the author points out that even in pseudo (secondary) mental decline, the characteristic emotions of "grief, anxiety, and introversion" are maintained, which is an accurate clinical observation.

In "Pathology and Treatment of Psychosis", there is no separate section on senile dementia, but senile blödsinn is described together with senile dementia in the section on debilitating mental states (p. 356-357) 11). Therefore, the same approach should be used to differentiate depression from genuine dementia in the elderly. It is true that pseudodementia, which is a "decline" in cognitive function in depression, is easily misdiagnosed as dementia. Based on such clinical observations, the authors proposed the descriptive concept of depression-dementia medius. Griesinger also had this concept.

4. Outcome of melancholy

As for the outcome of melancholy, in the case of long-lasting melancholy, "a state of stupor may appear, or the transition may be to a state of mental debility or to moderate or severe dementia" (p. 273) 11). This point has already been discussed briefly in the issue of "dementia" in (mental) depression, where Griesinger argued that the diagnosis of secondary mental debility should be made with caution because there is a transition between melancholy and secondary mental debility. Nevertheless, the appearance of a genuine secondary mental decline, such as melancholy followed by lassitude, is a condition that occurs in endogenous depression today. Another outcome is "a state similar to paranoia (Verrücktheit)" or "paranoia itself" 11). The following case of paranoia following melancholy has been described.

"The patient talks about delusions such as being poisoned, conspiracies being hatched, being electrified, with little tendency to healing" (p.273) 11). This case should be regarded as schizophrenic. If such paranoia presents in old age, it is appropriate to treat it as old-age first-episode schizophrenia.

5."Die psychischen Exaltationszustände - Manie" (p. 313), mania, in which the "ego periphery" is invaded, and paranoid excitement, in which the "ego depths" are invaded (p. 313).

First we shall explore Griesinger's

perspective of mania. Griesinger's description of mania is divided into two broad categories: (1) motor excitement and mania (Tobsucht), in which "the patient may appear superficially quiet", and (2) delusional excitement (Wahnsinn), in which persistent exaggerated feelings develop, leading to delusion. Nevertheless, it is important to note that there are also transitional and mixed states, as "the two are closely interconnected in a strict sense and frequently alternate or even become fragmented and mixed" (p. 311).

According to Janzarik's theory, this is an expansion of vital energy. He states that the patient is inflicted in a relatively peripheral area of mental life 11). In the case of mania, the periphery of the ego is affected rather than the depths of the ego, which is an important insight into psychopathology.

He also points out that bipolar mood swings occur in mania.

"The mood states of excitement and immobility, contentment and emptiness, change very often", and extreme changes occur, such as "from pleasure to sadness, from defiance to irresolution, from indifference to violent reaction or jealousy, [and] from anxiety to overconfidence". It is stated that "the most important feature" of this condition is "Verworrenheit" 11). In the DSM-5, this would be referred to as "manic episodes with mixed features". Today, a more severe form of mania is considered to be mania, compared to mania in which hyperactivity is the primary sign. The mood swings in such mania "occur without any motive and are generally impossible to interrupt or calm by external mental intervention" (p. 317). The severe mood swings that are no longer under the control of the subject represent an endogenous pathology in manic-depressive illness, or in Janzarik's structural dynamics theory, the autonomy of vital dynamics.

In delusional agitation (Wahnsinn), "delusions dominate the entire mental life" and "deviations from the will in the form of specific delusional ideas" occur, i.e., problematic behavior influenced by delusions. Delusions and hallucinations, such as "having an impossible plan of invention" and "(I am) Napoleon, a billionaire, a great reformer, a god, a hero, a king" (p. 341) 11) appear. Although paranoid delusions are not mentioned, in mania, only "relatively peripheral areas of mental life" are affected, whereas in delusional excitement, the disturbances "extend to the depths of the ego", "alienate and falsify the deepest parts of the psyche" (p. 312), and "thoughts are pathologically altered". Griesinger's understanding of "deep ego disturbance", "alienation and falsification of the innermost recesses of the psyche", and "pathological changes

in thinking", indicates the emergence of a condition in which uncorrectable delusions persist and the original capacity for judgment is severely impaired. This suggests that Griesinger was thinking of a condition that is beyond the level of mania, that is, (paranoid) schizophrenia.

Regarding the course of mania, it is stated that "if the mania does not recover and the psychosis progresses further, a secondary state of mental weakness will develop" and "dementia and sometimes agitation" will follow (p. 327) 11). In mania and manic-depressive psychosis, it is not uncommon for secondary mental decline to occur, such as a persistent lack of enthusiasm and personality dysfunction. It is interesting to note that the authors clearly state that "cure is possible even in patients with delusional agitation" (p. 344) 11). This is also true for paranoid schizophrenia.

"If not cured, the patient does not remain in the state of elation characteristic of delusional excitement for a long time, but the excitement and elation gradually disappear, leaving only fixed delusional ideas, or the patient progresses to the dementia stage" (p. 345) 11). The emergence of secondary mental decline, consisting of residual delusions and a decline in the personality level, is a process that occurs in paranoid schizophrenia.

Griesinger decisively states that mania and delusional excitement "arise from the same mental process". On the other hand, there is a difference between mania and delusional excitement in the areas of mental life that are affected. It is interesting to note that Kraepelin's diagnosis of delusional agitation, which affects the "depths of the ego", is unique to early-onset dementia, and that Griesinger had already devised a similar diagnosis.

While it is not focused on by Janzarik, the theories of structural dynamics 15) and this author's own neo-Griesingerism 18) have drawn from Griesinger distinction, from the perspective of personality structure, between a mere state of mental excitement (mania) in which the "peripheral areas of mental life" are violated and a state of mental excitement (mania) in which the "depths of the ego" are violated. In his system, however, both are included in the state of mania. This can be taken as a view from the perspective of life force dynamics. In other words, we can understand that he thought that the two were continuous in terms of deviations from the life force dynamic. In this sense, Griesinger may have argued that mania and delusional excitement "arise from the same mental process", and his system of psychiatry suggests that the acute phase of manic-

depressive illness and the acute phase of schizophrenia are distinct in terms of personality structure, but continuous in terms of vital dynamics. This is a point of view that is in line with neo-Grizingealism 18), in which this author attempts to deconstruct Griesinger's system of psychiatry by incorporating Freud-Lacan's point of view based on Janzarik's structural dynamics theory.

Some have criticized Griesinger's system as a theory of monopsychosis, but if you look at it closely, you will see that it is not so simple. Griesinger's mentor, Zeller, who is regarded as a proponent of monopsychosis, argued that all psychoses begin with (1) depression (Trübsinn, Melancholie), followed by (2) mania (Tobsucht, Manie), then (3) paranoia (Partieller Wahnsinn). In this paper, we will discuss the relationship between psychosis and dementia. The term "single" can be interpreted to mean that psychosis has a distribution that follows the same course across diseases. In this respect, Griesinger inherited Zeller's theory and agrees with the theory of monopsychosis. However, Griesinger's system is based on sensitive psychopathological observations that are more closely related to clinical practice, and takes into account not only the similarities in pathology, but also the qualitative differences. This author believes that it is not possible to fit a wide variety of psychoses into a single (Einheit) perspective. The concept of a single psychosis is controversial and confusing. In this regard, Vliegen, J.'s work entitled "Single Mental Illness: History and Problems" (30) is enlightening (p. 31).

V. Die psychischen schwäch-ezustände - Manic depression as a primary affective disorder and schizophrenia as a primary language pathology

Finally, I will discuss Griesinger's secondary state of mental debility that follows primary emotional disturbance. This is described as "a state in which the disturbances of feeling and thinking are no longer evident, but are based on disturbances of the intellect itself", "a peculiar dementia based on the loss of thought energy", "diminished psychomotor activity, loss of volitional energy, diminished emotional activity, poor responsiveness", and "culminating in a complete loss of mental life" (p. 354) 11). In some cases, "fixation on a particular delusional idea" is observed, and "the few remaining mental powers are concentrated on it" (p. 354). This condition is a "residual state of primary disease group" and is mainly described as a chronic characteristic of schizophrenia by Kraepelin's psychiatric system. In German psychiatry, it is referred to as a defect condition, and represents a qualitative

change in personality and a qualitative change in personality function.

Griesinger describes this qualitative change in an elaborate step-by-step manner 11).

The mildest form of mental debility appears during mania's recovery period, when emotions become calm again, thinking and judgment normalize, memory has almost returned to normal, and speech becomes coherent and comprehensible. However, it is important to note that the personality itself has changed compared to before the disease, not being equal to the healthy personality before the disease.

The lively spirit is somehow lost, and the brilliant parts seem to have been somewhat worn away", "the former delicate and aesthetic feelings, the interest in noble things, the beauty and nobility of human nature, are absent", and "the lively countenance and humanity are changed into a general dullness, dementia, and animal lowliness. The change from lively expression and humanity to overall dullness, dementia, and animalistic lowliness suggests some kind of fundamental disease" (p. 358).

It is a very detailed description. It is not until one actually meets and talks to the patient after the acute phase of the psychosis known as "mania" has passed that one realizes the overall loss of liveliness and humanity. This is based on the doctor's impression of the patient and is done from an anthropological perspective. This change in personality is guided by phenomenological intuition, similar to the precocious impression of a doctor who is confronted with a schizophrenic patient and describes his impression that he is unable to communicate with the patient and that he has hit an insurmountable wall. In depression and manic-depressive illnesses, which have a chronic course, this type of lackluster personality change may also appear.

In "The Mildest Form of Dementia in a Mentally Debilitated State", it is stated: They can perform monotonous and mechanical tasks, but want nothing more than to satisfy their simple and sensual needs. If they are transferred to a sanatorium, they can often lead long, stable, relatively healthy, and peaceful lives (p. 358). This stage of secondary mental decline, in which there is a substantial qualitative narrowing of personality functioning, is probably primarily a condition seen in schizophrenia, although it is sometimes also seen in manic-depressive illness.

In "severe dementia in a state of mental decline", the patient's ability to adapt to daily life is severely impaired. "Insensitivity progresses in all areas, not just the highly sensitive mental areas", and "mental life takes on childlike characteristics and the ability

to think abstractly is lost". This stage of mental deterioration with severe loss of personality function is characteristic of acquired dementia, and is typical of schizophrenia.

On the other hand, Griesinger described four types of secondary mental decline, including "partial paranoia" (partielle Verrücktheit), in which "only strange and fixed delusional ideas persist" (p. 359) 11). This is also considered to be a condition of schizophrenia.

In the section on "Partial Delusion 1", it is stated that "once the thoughts become agitated and enter a state of mania", they become "God, the Trinity, the Great Reformer, the Prophet, the Messenger of God, the Discoverer of Perpetual Motion, the Ruler of Nature" (p. 362) 11). The description of "agitated delusion" indicates that the delusion becomes active again after the acute phase has passed and the chronic phase has begun. On the other hand, there are "passive and depressive delusions", "delusions of being dominated and tormented from the outside", and "persecution, being involved in conspiracies, and being sent radio waves by invisible enemies". All of these delusions are characteristic of schizophrenia.

Delusions of "eternal punishment" and "loss of all property" are also described as partial delusions (p. 364) 11). The These are delusions of depression (melancholy) (delusions of guilt and poverty, which have the characteristics of Cotard's syndrome). These delusions may appear in the acute phase; however, the delusion of "eternal punishment" is often chronic and persistent.

In the section "Partial Delusions 2", we describe the automatic development of delusions and the formation of a delusional system.

Delusion is associated with all things and develops half-automatically. "From one false center, all errors are derived, and a system of meaningless thoughts permeates all human relations and moral judgments" (p. 363).

It is important to note that according to Griesinger's perspective, this delusion formation follows a primary emotional disorder called melancholy or mania. As I have already mentioned, Kraepelin distanced himself from Griesinger's view when he discussed paranoia, because he believed that primary paranoia emerges without affective change 21). Whether or not affective change precedes paranoia is a crucial difference between the two. However, as I have already pointed out, he admitted the existence of primary paranoia (Primäre Verrücktheit) in his last lecture (in 1868, the year of his death), and I would like to note that he took a position that eventually led to Kraepelin's view.

From the point of view of Freud-Lacan's psychoanalysis, delusional systematization can be understood as an automatic delusion formation by unconscious logic. The subject of delusion production is the unconscious. It can be seen as an automatic movement of language itself. In other words, delusion formation is based on the basic pathology of verbal automatism (mental automatism). In this case, the delusion emerges through language, which leads to the fruition of the delusion, which in turn may lead to secondary "emotional changes such as mood elevation". This suggests that schizophrenia begins as a primary language pathology and in which secondary emotional disturbances emerge. Janzarik does not focus on language in this way. In this respect, neo-Grizengalism 18), developed by this author, is a concept that pushes forward Janzarik's structural dynamics theory.

When understanding psychosis, we should pay attention to the sign "emotion first or language first", and if we make a contrastive and somewhat exaggerated distinction between the two, we can say that in manic-depressive psychosis, emotional changes are primary, whereas in schizophrenia, apart from the prodromal period, when depressive and manic states may appear, only at the time of manifest onset is language pathology primary. In the case of schizophrenia, it is appropriate to consider the language pathology to be primary. Bleuler, E., who proposed the term "schizophrenia" to replace "early-onset dementia", identified association laxity as the basic pathology of schizophrenia. Association laxity refers to a situation in which words are not well connected 4). It is an impediment to the significant chain, and can be viewed as nothing more than a primary language pathology.

At the same time, it should be pointed out that changes in vital dynamics occur in the acute phase of schizophrenia. During this phase, a deviation in vital dynamics occurs inspired by the pathology of language, and this situation has the effect of further promoting the pathology of language. Therefore, antipsychotics and other medications are effective in correcting the secondary emergence of vital deviations and in slowing the progression of language pathology. In short, the author would like to consider primary emotional disturbance (as described by Griesinger) or deviation of vital dynamics (as described by Janzarik) in the acute phase of schizophrenia as occurring in a manner inspired by primary language pathology.

I would like to return to Griesinger's clinical description. In "Partial delusion 3", which is considered to be a "stage of

generalized delusional delirium", he mentions a new linguistic event in which the patient "makes up his own words and talks about his delusions", which make no sense. "In this case, the hallucination is not the same as a verbal one", and is thought to be a linguistic hallucination that accompanies a linguistic new work, i.e., an auditory hallucination in which one hears unintelligible words. The appearance of unintelligible verbal new works and related hallucinations suggests a "progressive mental decline". This may be due to the judgment that these pathologies are intellectual decomposition. However, even in the acute stage of schizophrenia, auditory hallucinations with the content of unintelligible and enigmatic verbal works may appear. This may become the core of delusions. Even in such schizophrenia, the pathology of language is primary, and the deviation of life force dynamics occurs as a result of this pathology.

In "Partial Delusional Disorder 4", he mentions interactive auditory hallucinations, arguing with auditory voices. In terms of behavior, "even the mildest cases are full of a kind of twitchiness and unnaturalness" (p. 364). Verschrobenheit is described by Binswanger 3), a representative of phenomenological psychiatry, as a way of being that is unique to schizophrenia or schizophrenic traits that have not yet manifested themselves. "Listening to the auditory hallucination suggests that the patient is experiencing verbal automatism, in which words are spoken automatically and independently of the subject's will, i.e., a primary pathology of language". This phenomenon is not limited to the chronic phase, but also occurs in the acute phase.

The process of moving from delusion to lethargy is also described. "The patient generally becomes obsessed with delusions, and gradually his whole field of thought is violated, finally leading to delirium or lethargic dementia" (p.365) 11).

From the author's point of view, this process of (partial) delusion (Verrücktheit), which is one type of mental debility, can be understood as describing the dismantling of the personality as a result of the domination of the patient by a primary pathology of language. This is another example of a pathology that is characteristic of schizophrenia.

As described above, many of the secondary debilitating states that Griesinger envisioned as occurring secondary to primary emotional disturbance are related to the pathology of schizophrenia, and some are unique to schizophrenia from today's point of view. In addition, regarding the dichotomy between primary affective

disturbance and secondary mental debility, Griesinger is careful to take the example of "partial delusions" and states as follows: "It takes a long period of observation to determine whether the patient is still in a transitional state or has entered what we call a mentally debilitated state" (p. 355, author's supplement in parentheses).

Griesinger points out that some secondary states of mental debility are reversible, which is important diagnostically. Indeed, there are cases in which one cannot help but have the impression that the patient has undergone a change in personality after a manic episode, but that after a longer period of time, the patient's personality returns to its former glory and depth. Or, in schizophrenia, after the spectacular hallucinations and delusions have disappeared, there are cases in which the patient lacks spontaneity and has become a shell of a person. This is a state of "dementia" that may be judged as the beginning of chronicity. This point was also discussed in the section on melancholy as a problem of differentiation from dementia.

To repeat, there are cases in which the state of "dementia" disappears completely and becomes completely healthy after the course of the disease. This is a reversible condition named "post-acute exhaustion phase" 28) or "sluggish phase in remission" (p. 78) 16). "Post-schizophrenic depression" 31), listed in the subtype classification of schizophrenia in ICD-10, is similar to this condition and can be regarded as a reversible secondary mental debility in Griesinger's terms. Such a reversible state of mental debility can be said to be in the endogenous movement of vital energy, which is basically rhythmic.

Conclusion.

In general, Griesinger's system of psychiatry has a consistent and fluid perspective, with a deep insight into psychopathology, attention to the qualitative specificity of the condition, and an inherent therapeutic component. On the other hand, in the DSM-5, the specific terms for the classification of the course of schizophrenia clearly include remission, such as "first episode complete remission" and "first episode partial remission". However, in the "development and course of symptoms" section, it is lacking a reference to post-psychotic depression followed by remission. In addition, there seems to be no classification of post-schizophrenic depression or post-psychotic depression in the description of "depressive disorders" in the DSM-5.

What is striking about the DSM-5 description of the course of schizophrenia is that it emphasizes the persistence of cognitive deficits. "Cognitive changes are already present

at the onset of the illness, prior to the onset of psychotic symptoms, and take the form of fixed cognitive deficits in adulthood. Cognitive deficits persist even when other symptoms are in remission and may affect the ability to perform due to the disease" (p. 102).

This perspective, which views schizophrenia as a cognitive disorder from the pre-symptomatic stage to the onset and throughout the chronic stage, lacks a dynamic perspective and has no therapeutic outlook. This is the same as attitudes that regard schizophrenia as a new "neurocognitive disorder", and could be called a modern version of Kraepelin's notion of "early-onset dementia". In contrast, Griesinger's respect for the autonomous rhythmicity of life force dynamics is favorable. Now that molecular psychiatry has identified a large number of cross-disease related genes and pharmacotherapy supports a cross-disease perspective, it is time to reevaluate Griesinger's findings.

In the section on "dementia" in depression, I mentioned the idea of the depression-dementia transition (intermediate) area. Concerning this connection, it can be said that Griesinger's system of psychiatry thematizes the transition (intermediate) between depression and mania, or between primary emotional disturbance and secondary mental debility.

Kraepelin's system, on the other hand, is a linguistic act of performativity that attempts to enforce the perspective of categories. The two categories created by Kraepelin make sense, and this author believes that this is due to the fact that each of them are based on a distinctive personality structure. Based on this, this author reconsiders that the basis of manic-depressive illness is primary emotional disturbance, while the basis of schizophrenia is primary language pathology, including verbal automatism. In this respect, manic depression and schizophrenia are qualitatively different. More precisely, because schizophrenia is characterized by language pathology, it ranks higher than manic-depression, which is characterized by emotional pathology. To be logically precise, they are not in the same category, and it would be a category error to discuss them on the same level.

Conrad's explanation of this idea in "The Beginnings of Schizophrenia" may be easier to understand: "It would be a correct formulation, with which no one could disagree, to say that Mr. X's schizophrenia began with endogenous depression" and "Conversely, we would never say with equal right that Mr. Y's depression or mania began with schizophrenia". In this way, he asserts that schizophrenia and manic-depression are "not parallel as

equivalent morbidological units" and that schizophrenia is superior to manic-depression (p.80) 7). In this author's view, the reason why schizophrenia ranks higher than manic-depression in this category is that the basic pathology of schizophrenia is rooted in the language dimension.

Nevertheless, primary language pathology also leads to a deviation of the life force dynamics in conjunction with it. In this respect, manic depression and schizophrenia are continuous. From the perspective of neo-phragicism, various suggestions can be made regarding the pathology and treatment of both disorders.

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Annotation

1. "Die Erscheinungsformen des Irreseins" (The Phenomenal Forms of Insanity) is translated as "The Phenomenal Forms of Mental Illness" in the Japanese translation, but since "Irresein" is considered to have a broad meaning, this author has translated it as "insanity".
2. In the original text, "Die psychischen Schwächezustände" (p. 322) is translated to "mentally debilitated state". For the sake of brevity, we use this expression.
3. The original word for "life force dynamics" is Dynamik, which is translated as "force dynamics" in Japanese. It is a technical term that refers to the way of being in terms of

emotion and activity, and is based on the "life" that is rooted in the biological body. This author has translated it as "life force dynamics" because the word "force dynamics" alone is difficult to understand.

4. "Insanity based on abnormality of thought and will" is translated as "psychosis based on abnormality of thought and will" in the Japanese translation. In the sentence "Irresein in Störung des Vorstellens und Wollens" in the original 11) (p. 212), "Irresein" is translated as "psychosis". In this paper, however, this author has translated it as insanity.

5. The original word for "personality structure" is Struktur, which means the sum of personalities. Therefore, this author has translated it as "personality structure". In my understanding, "personality (cognitive and linguistic) structure" would be more appropriate (see p. 153-155 of my article 18). In the secondary insult that follows the primary emotional insult, Janzarik states that there is a failure of personality structure and a failure of life force dynamics.

6. The original word for "depression" is Schwermuth (original 11, p. 213), which is translated as "depression" in the Japanese translation. The term "Schwermuth" is no longer used today, but is retained in the original.