



Jung's understanding of schizophrenia: is it still relevant in the 'era of the brain'?¹

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Abstract: Jung was highly committed to grasping the meaning of psychotic thinking, and left behind precious insights to treatment scattered through his works written between 1906 and 1958. The tendency of today's psychiatry is to attribute the psychotic process to alteration in the brain's anatomy, biochemistry and electrophysiology, thus exempting the subject, i.e. the afflicted person, from responsibility for attachment to reality and their sanity. Jung understood schizophrenia as an 'abaissement du niveau mental', a similar phenomenon to the one encountered in dreams, and caused by a peculiar 'faiblesse de la volonté'. He contested that complexes in schizophrenia, in contrast with neurotic disorders, are disconnected and can either never reintegrate to the psychic totality or can only join together in remission 'like a mirror broke into splinters' (Jung 1939, para. 507). Accordingly, a person who does not fight for the supremacy of ego consciousness and has let himself be swayed by the intrusion of alien contents arising from the unconscious (even to the point of becoming fascinated by regression) is exposed to the danger of schizophrenia. The contemporary relevance of these notions and their necessity in understanding the psychotic process in the light of modern scientific findings are discussed.

Key words: ego consciousness, Jung, responsibility, psychiatry, psychosis, schizophrenia

A few months ago I was asked by a colleague to do a consultation, needed for forensic purposes. I will tell the story in brief and later return to aspects relevant to this talk. We had to deliver an expert opinion in the case of a young woman, aged 23 or 24, accused of having murdered her children. The story was terrible and had indeed reverberated through the news media. A young woman, from a Bedouin settlement in the south of the country, waited for her husband to leave for work and then killed her three children. The story went even further. It seemed that she killed her baby child, then the brother who was aged one or two years, whilst the eldest child aged two or three ran away crying that mother was beating him. He was met by good intentioned neighbours who calmed the

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child down and took him back to his mother, only for her to kill him as well soon afterwards.

I was sure I was going to meet a modern Medea, an evil sorceress motivated by who knows what dark forces, or at least a very disturbed sub-human monster. I was surprised to meet a young woman, clean, tidy, good looking, even coquettish. She spoke good Hebrew (not very common with young Bedouin women). She came from a traditional family, had been to school and graduated from high school (again, not very common). She had hoped to become a nurse, maybe even a doctor. Actually she had good grades and had she applied, could have been considered, and had good chances to be accepted at one of our medical schools.

However before she could understand it, at the age of 17, forced by her family and traditions, she found herself married to a cousin twenty years her senior. Soon afterwards she was pregnant, and then again and again. Her husband would leave for work early in the morning and return late in the evening, and she was surrounded by lots of family members expecting her to conform and behave. Eventually she discovered that her husband was on the verge of taking a second wife. For years she had experienced a '*genie*'—a kind of evil spirit—talking to her, saying dirty words and pushing her to commit suicide or alternatively kill her husband or her children. She struggled with this voice but it became more and more present, more difficult to resist and one day she gave in, submitted to the *genie* and enacted its promptings. Was she sick? Was she schizophrenic? Was she supposed to be declared incompetent to stand trial? How, and if at all, are Jung's teachings helpful today, in spreading light on this human tragedy?

The origins and assumptions of contemporary psychiatry

Modern psychiatry began with the French Revolution and probably the first modern psychiatrist was the French revolutionary physician August Pinel. Being a man in the spirit of his time, Pinel believed that the natural human condition is to be free, i.e., to be responsible for one's fate, to be able to make choices and to give meaning to one's life through the exercise of one's own agency. The mad ones, the so called 'lunatics', were those who, due to a brain disease, became alienated from their true nature. Due to their disease, he claimed, they became unable to decide on their future. Therefore, according to Pinel, treating the alienated is not only a matter of curing their brain disease but of helping them to become real human beings again, capable of exercising free agency. With this ideology in mind the first modern psychiatric hospitals were founded: so in a way we are all Pinel's followers today, but only to some extent. We all may believe that for someone to be mentally ill there must be an underlying brain pathology, a certain inherited vulnerability, but we tend to disregard this other aspect of Pinel's insights.

Nowadays, when a person dear to us is afflicted with a serious disease—take cancer for example— we all encourage him to fight for his health, to be brave

and go through painful treatments. A strong spirit, so we believe, will make the difference in many cases (unfortunately not always) between a terminal disease, and, more and more often, a serious but treatable condition. But when a person dear to us is diagnosed with schizophrenia, though most of us will have pity on him and on his relatives, we will look upon him as a victim of his brain's organic pathology and, at most, we will encourage him to comply with the doctors' advice, take medication etc. We do not tend to encourage him to fight for his sanity. This attitude has tended to be compounded by the tremendous human effort that has driven the 21st century research in the field of mental illness which is characterized by the investment of enormous financial resources and breathtaking discoveries in areas such as human genetics, biochemistry, epidemiology and imaging. But does our widened understanding of brain functioning in health and in disease have sufficient impact on the destiny of the individual? Before taking a short 'tour d'horizon' of the current state of the art in the field of schizophrenia, let us remind ourselves once more of the Jungian perspective: it may well be that Jung's teachings offer us a refreshing alternative to current assumptions.

The Jungian perspective

The term schizophrenia was coined by Bleuler in 1908 in the Burghölzli hospital in Zurich. This term was a reaction to the 'Dementia Praecox Syndrome' coined by his colleague Kraepelin, because, to quote Bleuler: 'Today we include patients whom we would neither call 'demented' nor exclusively victims of deterioration early in life' (Bleuler 1950/1987). Bleuler needed a term that referred to a disease process characterized by destruction of the internal connections of the personality, leading to a specific alteration of thinking, feeling and relation to the external world. In its course the personality loses its unity, its ability to integrate its different complexes. The course of the disease is at times chronic and, although at times marked by intermittent attacks which can stop or retrograde at any stage, it does not permit a full *restitutio ad integrum*. Bleuler discriminated between fundamental symptoms in the areas of thinking, feeling and volition and secondary symptoms such as delusions and hallucinations. During those years Bleuler worked with two young assistants, Jung and Binswanger. The latter was the founding father of existential analysis. Little wonder that working together in these formative years Jung and Binswanger influenced each other reciprocally, and the footprints of existentialist thinking are to be found in many of Jung's later works, particularly in the field of psychoses in which they worked together and further developed Bleuler's insights. For Jung the research and the understanding of the psychotic process became fundamental in the formation and the consolidation of analytical psychology. His papers on the field of schizophrenia are spread over all his productive years from 1906 till 1958. For Jung schizophrenia resulted from an 'abaissement du niveau mental', a lowering of the consciousness threshold caused by a peculiar 'faiblesse de la volonté' (notions borrowed from Janet). This weakening of will power manifests itself in

the way that a train of thought is not carried out to its logical conclusion but is interrupted by strange contents that are insufficiently inhibited. As a result of this 'lowering of consciousness' complex-contents take over, and the predominance of ego consciousness is endangered. In contrast to neurotic conditions where complexes maintain a connection to the ego and the unity of the personality is maintained, in schizophrenia this connection can be completely lost. In schizophrenia the disconnected complexes will never reintegrate to the psychic totality or, if they can join together in remission, it will be like 'a mirror broken into splinters'.

Let us consider some important essentials regarding Jung's theory of schizophrenia. He maintained that the lowering of the level of consciousness plumbs depths which are rarely reached in neurotic conditions while releasing, discharging and constellating deep, archetypal, collective materials which were usually inhibited and suppressed by the ego. Naturally, these conditions remind us of dreaming, particularly of 'big dreams' experienced on the cross roads of our existence. And indeed much similarity exists between psychosis and dreaming. It was Jung's original contribution to understand psychosis as a dream without sleep, or to put it in his words, 'The dreamer is normally insane, or that insanity is a dream which has replaced consciousness' (Jung 1939, para. 523).

The following examples, one a fragment from a dream, the other a fragment from the narrative of an acutely psychotic patient, will demonstrate the similarity:

Then I am with S. and other unknown girls in some kind of a new house, modern, rich, and everything (the rooms, ceiling etc.) is round. Between the rooms there are no doors, just glass and everything is transparent. Suddenly, I don't know what happens but I am alone. On the floor there are some triangular, elaborate glass stones and I realize that they are not from this world. They are a little bit raised above the floor and activated by my movements. They see me. When I pass nearby they begin to rotate and then break into thousands of sharp glass splinters in the room. I must flee to another room. I realized the stones were evil and they aimed at killing me. I tried to run away and while running I activated more and more stones. I was running from room to room activating more and more glass stones. I felt exhausted moving from room to room and I felt I was going to die.

And every night D. (my husband), as if he were putting S. (my son) to bed, kills him, and in the morning resurrects him.

Indeed, without knowing the context it will not be easy to guess which is which.

The schizophrenic complex has its distinctive features: whereas elements of a normal or neurotic complex are well developed, even hypertrophied on account of their heightened energetic value, the schizophrenic complex is characterized by a peculiar deterioration and disintegration, leaving the field of attention undisturbed. It looks as if in schizophrenia the complexes are destroying themselves by disturbing and distorting their own contents. Their elements become disconnected, or they are connected in an idiosyncratic manner, expressing themselves in loosened and bizarre associations. The symbolic

content is perceived as concrete and very often it acquires a hostile meaning or is perceived in a very personal form that overwhelms the ego, leaving the subject with the feeling of being in a direct, though usually strange, contact with the divine. These complexes do not seem to draw energy from other mental processes, but devour their own energy, subsiding into their own foundations and leaving the personality impoverished (or 'residual' to put it in modern terms). Whereas the neurotic dissociation never loses its systematic character, schizophrenia shows a picture of unsystematic randomness in which continuity of meaning is often mutilated to the point of unintelligibility. The picture of the personality dissociation in schizophrenia is different from what is seen in other situations—the split off figures assume grotesque, persecutory or highly exaggerated names and characters. They do not cooperate with the ego consciousness and often torment it. There is an apparent chaos of visions and voices and characters that is overwhelming and alienating. In schizophrenia the *abaissement* reaches a degree never heard of in neurosis: the very foundations of the personality are impaired. Contents of the unconscious which are normally inhibited, usually collective ones, only rarely encountered in 'big dreams', are now allowed to invade consciousness. Due to this very deep lowering of the level of consciousness, not encountered in non-psychotic conditions, materials from archaic level of the psyche find a direct way to the surface without being interpreted and elaborated by the ego.

It is Jung's appreciation that it is this problem of the lowering of the level of consciousness and, especially, the individual's attitude towards it, which is so fundamental to schizophrenia that is for me the main lesson to be taken from his teachings:

Any *abaissement*, one that leads to neurosis, means a weakening of the supreme control. A neurosis is a relative dissociation, a conflict between the ego and a resistant force based upon unconscious contents. Every neurotic fights for the supremacy of ego consciousness and for the subjugation of unconscious forces. A patient who allows himself to be swayed by the intrusion of strange contents from the unconscious, a patient who identifies with, and does not fight with, or is even fascinated by the morbid elements, exposes himself to the suspicion of Schizophrenia (becoming fascinated by regression!). The *abaissement* can reach an extreme degree where the ego loses all power.

(Jung 1939, para. 516)

Another case history

M, a young professional in his late thirties, was referred to me a few months after the birth of his first born son. He had previously accompanied his wife into the maternity room. The delivery was complicated and evolved to a forceps procedure. He witnessed the gynaecologist about his work with his hands inside his wife's body. He saw the blood. Little by little he felt more and more humiliated, he felt his wife being defiled. Subsequently he could not be intimate with her anymore and he began to develop strange and hostile beliefs towards

men gynaecologists: in particular he had murderous drives towards her doctor and began to walk around his house driven by impulses to attack him. He had recurring visions of his wife being torn to pieces in the hospital and more and more felt the urge to save society from what he perceived as perverted wicked gynaecologists.

And yet he also felt something had gone wrong inside him, and whenever he felt overwhelmed by his visions and by his aggressive impulses he would bite himself, make himself bleed, so that the physical pains would weaken his phantasies and put him back in touch with reality. One day he was so tormented by inner destructive powers that he had to leave his office and went and sat in a public garden, biting and talking loudly to himself. This drew attention and he was approached by a policeman who wanted to refer him to the nearest psychiatric emergency room. Luckily for him he managed to avoid being hospitalized.

We can imagine that had he been admitted to a hospital he would have been put under heavy surveillance, heavily medicated, and probably diagnosed, leaving him in a serious danger of irretrievable initiation into the schizophrenic path.

I met with M shortly after the beginning of his tragedy. He came to meet me reluctantly, not knowing what my attitude towards his story would be. I must confess that from the very beginning I was not sure what attitude to adopt. On the one hand it was clear to me that M was facing a psychotic breakdown triggered by painful scenes he witnessed in the maternity room. I figured out these probably evoked hidden aggressive impulses which overwhelmed his weakened ego. M had doubts about what course of action he should take. He expressed his need for help and emphasized that this is what he came for. On the other hand I could not be sure that M would not carry out his murderous impulses toward his wife's gynaecologist and I considered warning the potential victim about the danger he might face. But in doing so I would be disregarding the inner struggle M was facing, and shifting the control of the situation from M and the emerging therapeutic alliance to the world outside. We discussed this, and M promised that as long as the therapy was going on, out of respect for me and because of his doubts, he would make every effort to contain his murderous wishes. But still I could not feel reassured, and this persisted for quite a long while. What helped me decide to engage in therapy and to contain my own fears about possible outcomes of M's situation was the strong impression he left on me of being committed to make the utmost effort to fight for his sanity. I was impressed by the efforts M made to keep in touch with reality and not to give in, and not to surrender his ego consciousness to the shadowy aggressions which were threatening to take over.

Discussing such therapies Jung advised that the adoption of a 'method' would be ineffectual and that what mattered most was the personal commitment of both patient and therapist. He advocated taking precaution and keeping a distance from contents of the unconscious; dream analysis especially should be avoided, he warned. The psychic rapport was central and the respectful

discussion of the psychotic symptoms seemed to him of greatest value. Fascination by archetypal contents (like the messianic drives to purge the world of evil gynaecologists in M's case) was particularly dangerous and was to be understood and interpreted on a universal and impersonal level in contrast to the usual consideration of personal complexes.

In other words the therapist is expected to stand by the patient's ego, to speak the ego's language and to be ready to help the patient in his Herculean struggle not to give in to the contents which threaten to take over his ego consciousness.

Therapy with M has continued along these lines for a long period now, my fears subsiding over the years as the therapeutic relation gathers strength. M's aggression is expressed more and more within the therapeutic encounters, allowing more and more ego distancing from unconscious contents. Or to put in different words, M is less frightened of and more critical towards his impulses, trusting that he has someone to assist him in his efforts to maintain the supremacy of his ego consciousness.

Psychiatric understandings of and responses to schizophrenia

Now let us consider just what schizophrenia is in this 'era of the brain' and let us assess the implications of our actual research endeavours.

As a definition, schizophrenia is a devastating psychiatric syndrome with a median lifetime morbid risk of 7.2 per 1000. The age of onset is typically in adolescence or early adulthood with onset after the fifth decade and in childhood both being rare. All-cause mortality is elevated approximately 2.6-fold for patients with schizophrenia, with excess deaths mainly from suicide during the early phase of the disorder, and later from cardiovascular complications. Schizophrenia commonly has a chronic course, albeit with fluctuating patterns and cognitive disability. Its hallmark is psychosis, mainly characterized by positive symptoms, particularly hallucinations and delusions, frequently accompanied by negative (deficit) symptoms such as reduced emotions, speech and interest and by disorganization of speech and behaviour (Gejman et al. 2011).

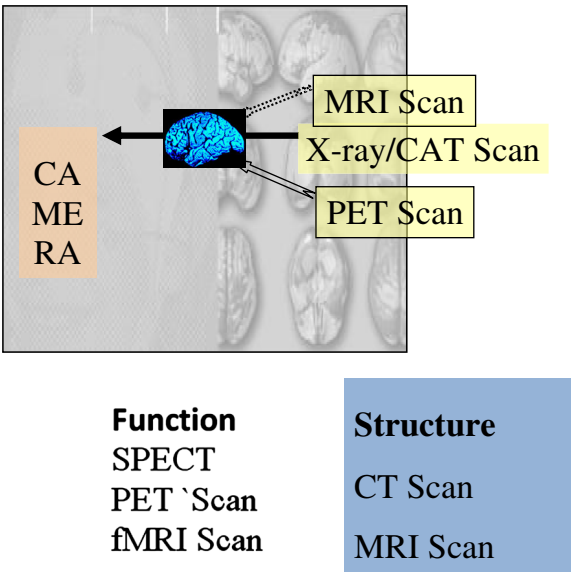
DSM V

- 2 or more of the following, for a significant portion of time during a month period
 - Delusions
 - Hallucinations
 - Disorganized speech
 - Grossly disorganized or catatonic behaviour
 - Negative symptoms
 - Social/occupational dysfunction
 - Duration of at least 6 months
-

Picture number one shows us the current (DSM-V 2013) definition of the syndrome, showing how far we are today from the original Bleulerian definition. This original definition looked upon delusions and hallucinations as secondary and not necessary attributes of the disease, in contrast to the four fundamentals symptoms (autism, association, ambivalence and affect). For Jung the secondary symptoms are to be understood as having a psychogenic origin. As to the fundamental ones, he argued with himself whether they should be looked upon as the result of a specific inborn constitutional vulnerability or as being the result of ‘an initial emotion which gives rise to metabolic alterations. These emotions seem to be accompanied by chemical processes that cause specific temporary or chronic disturbances or lesions’ [Letter to the chairman of a symposium on Chemical Concepts of Psychosis held at the second International Congress for Psychiatry in Zurich September 1–7,1957] (Jung 1957).
Is schizophrenia an inherited condition?

Familial Risk	
Population	Prevalence (%)
General population	1.0
Non twin sibling of a schizophrenic patient	8.0
Child with one schizophrenic parent	12.0
Dizygotic twin of a schizophrenic patient	12.0
Child of two schizophrenic parents	40.0
Monozygotic twin of a schizophrenic patient	47.0

Bearing in mind familial risk factors it is little wonder that the deciphering of the human genome yielded hopes of uncovering the underlying secret causes of schizophrenia. Up to date over 1000 genes have been tested for association with the disease. The hope is that finding one gene, or an association of genes, would lead to identifying a specific protein which is in the background of the disturbance. As the research deepens it becomes more and more clear how difficult it is to investigate the condition we call schizophrenia. On clinical grounds it shares clinical features with a range of other psychiatric disorders and needs to be diagnosed with high accuracy. On the other hand, the transcription of proteins is much more complicated than previously predicted, even if genes involved with psychiatric illness are identified. As much as there may still to be learned from the evolving study of human genetics, we should keep in mind that even between monozygotic twins, sharing exactly the same genetic load, there is only less than 50% concordance for schizophrenia and moreover, most of the schizophrenic patients do not have a first degree sick relative.
The developing field of brain imaging is a second area which raises high expectations. Access to the living structure and the functioning of the brain in real time stimulates the hope of understanding ‘what goes wrong’.



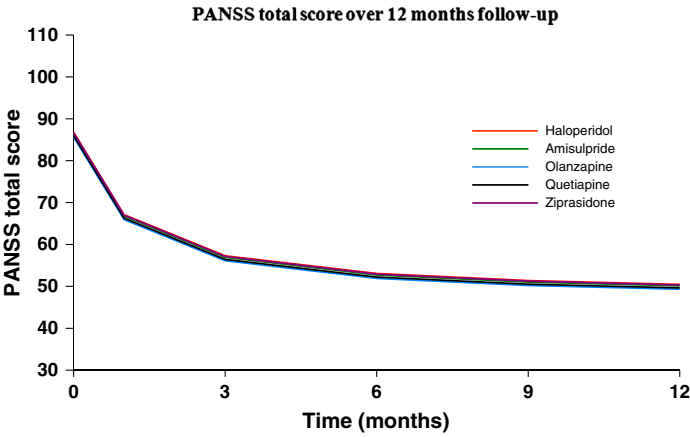
The first findings, dating from the 70s and 80s of the last century with the introduction of the CT scan, showed the enlargement of the intra-cerebral ventricles and the atrophy of the grey matter in chronic schizophrenics compared to healthy subjects. These findings raised numerous concerns. It was not clear whether these structural findings were the cause or the effect of the psychotic process. They may even have been the result of years of psychotropic medications.

Other techniques aimed at demonstrating the functioning brain include the fMRI with which for example we can detect functional differences between hallucinating patients and non-hallucinating healthy controls. It is clearly observed from images obtained that additional neuronal centres are activated in the hallucinatory subjects. Yet the same question remains: is the brain executing an order given by a higher hierarchical function in the way a motor neuron is activated to initiate a movement, or is there a detectable defect in the functioning brain tissue initiating perceptions independent of external stimuli? One more technique is the PET scan, demonstrating differences in the level of metabolism of different centres of the brain activated during different processes.

So actually we do have ways of beginning to grasp the functioning brain, but whether these research findings will indeed help us to understand the psychotic process is still to be established: moreover this focus on the defective functioning of the organic brain may lead us to neglect the importance of the agency of the patient.

A new generation of psychotropic drugs appeared on the market at the beginning of the nineties. They were supposed to be the next pharmacological revolution, after the first one which took place in the fifties of the last century with the introduction

of the first modern neuroleptic (anti-psychotic) drugs. They acted on new categories of neuro-transmitters and were promised to be more efficient and almost lacking in side effects. Their launch was accompanied by a worldwide aggressive campaign by the pharmaceutical companies, with abundant money and gifts (more or less under disguise) distributed to institutions and psychiatrists to encourage their introduction. This second generation of anti-psychotics soon became established as the first line of treatment, despite their considerably increased expense. But new classes of side effects emerged: we may now seldom encounter the Parkinsonian patients so typical of the old psychiatric wards, but instead we find more obese patients, at risk of developing diabetes, hyperlipidemias and cardio-vascular complications. Two major studies, the CATIE in the US and the EUFEST in Europe, financed by public funds devoid of commercial interests, show the equal efficacy of First and Second generation anti-psychotic drugs, leaving the clinician and the patient with the choice of the least desirable side effects (Kahn et al., 2008).



Common to all these research endeavours to connect brain sciences with mental disease is the effort to formulate structures and categories – biological or clinical; this stands in contrast to psychoanalysis, which keeps looking for meaning and for the personal.

From all those afflicted with psychotic tendencies, who will become schizophrenic, and what lesson should we keep in mind in 2013 from Jung’s teachings?

The prevalence of psychosis exceeds by far the prevalence of schizophrenia. Kelleher et al. (2010) reported a prevalence of 5-8% of psychotic disorders in the general population with 14% of eleven years old children reporting psychotic symptoms. These data were reproduced and published in 2012 (Werbeloff et al. 2012) showing that over 14% of a large healthy cohort will show at least one frequent attenuated psychotic symptom. It is astonishing to

see how close this modern observation is to Jung's observation. In 1957, five years after the psychopharmacological revolution, he writes: 'The number of latent and potential psychoses is astoundingly large in comparison with the manifest cases. Without being able to give exact statistics, I reckon it at 10:1 (Jung 1958, para. 558).

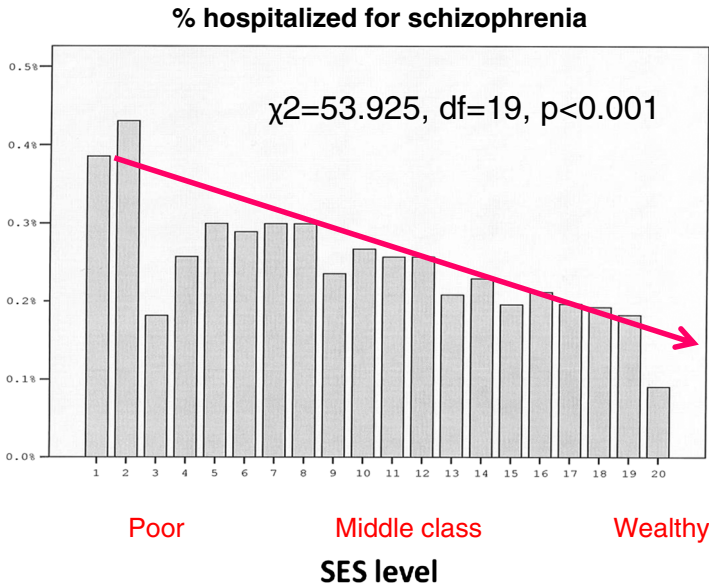
The problem is, who amongst those with a specific vulnerability will become schizophrenic, and who will remit.

A personal view

At this point I wish to share my personal experience of over thirty years as a practising psychiatrist working intensively with schizophrenics. I believe that schizophrenia is the disease of the poor and the unprivileged members of society. The typical schizophrenic patient (but of course not all) will be a young man or woman, generally coming from a disruptive family, often having just one active and present parent who is likely to be unemployed, alcoholic or weak. They will also probably have a low socio-economic status and often originate from an immigrant family which is either from a different culture or has become a victim of urbanization. They may also have a record of minor criminal offences, have a background experience with drugs, mainly OTC drugs, and often have minor neurological deficits (like attention deficit or similar). They are usually not able to afford good therapy and, most important, are without hopes for a better future and without motivation to struggle for their sanity. Such a person, being probably constitutionally born with an inherited vulnerability, can one day, in reaction to stress or to a life event, decompensate to an acute psychosis or to a subclinical (prodromal) one. From this point on the fight for the supremacy of the ego-consciousness, the recruiting of willpower against the 'faiblesse de la volonté'—so beautifully described by Jung needs to be understood as conditional on what reward might be expected from regaining the capacity for reality testing, i.e., from meeting the demands of life. What does the future offer? In a competitive, technologically-based, stratified society, if an individual feels hopelessly unadapted, it is so tempting to give in and to submit to the lure of the collective unconscious.

Large epidemiological surveys sustain this thesis. For instance the draft board registries like the Swedish one (Lewis et al. 2000) showing that 18-year-olds with personality disorders, neurosis, alcohol or substance abuse were at increased risk for future schizophrenia. The Israeli National Draft Board registry is very illuminating as it combines assessment of all adolescents with the national registry of psychiatric hospitalization (Goldberg et al. 2011). Only up to 25% of conscripts later diagnosed as schizophrenics had a previous non-psychotic psychiatric diagnosis. 75% of future schizophrenics were never diagnosed previously.

More illuminating is the next picture demonstrating that the lower the socio-economic background the higher the chance to be hospitalized and diagnosed with schizophrenia.



Goldberg et al, Schiz Bull March 2011

Being an immigrant, especially being an immigrant from a remote society, will be a risk factor as well (Weiser et al. 2008).

An immigrant from the former USSR to Israel could be at risk of mental disease, but an immigrant from rural Ethiopia having to adjust to a very different way of living would be much more vulnerable.

Let us return to the patients with whom I opened this discussion. M, the young professional who accompanied his wife to the maternity room and decompensated to psychosis soon afterwards, is most certainly a courageous man. He fights for his ego-consciousness, struggles painfully to remain in touch with reality and has fairly good chances for his future. But we must take into account that M is Israeli born, lives and works in the environment and in the language in which he grew up, was brought up in a good enough functioning family, is married and has an average income. Maybe the most important additional factor is that he is lucky to be able to afford a good reasonably continuous therapy.

The Bedouin young woman is in a totally different situation: for her a return to ego-consciousness means facing an unbearable situation. For her there is no way back. Even if there was a way she would not take it, for the images of the collective unconscious, even when tormenting, offer a better alternative.

Conclusion

The lessons to be learnt from Jung’s heritage in the field of treating psychosis are multi-faceted. Even inside our professional community, and surely in the general public, Jung is looked upon as being something of a mystic; a

spiritual and religious thinker. The other aspects of his teachings, such as his being a sharp and well-grounded clinician, are often forgotten and neglected. We must allow that he was sometimes overly optimistic by asserting, for example in 1957, that: 'It is now about fifty years since I became convinced, through practical experience, that schizophrenic disturbances could be treated and cured by psychological means'(Jung 1958, para. 559). But even so, now in this 'Era of the Brain' when we can look at and observe the functioning brain in real time, when the human genetic code divulges its secrets, when we look upon mental disease through the perspective of statistics, clusters of symptoms, cost-effectiveness, when we look at the homogenous and not at the particular, it is especially invigorating for the therapist to remember the teachings of the young Jung. By 1914 he had realized that the schizophrenic narrative has its unique meaning, is not so distant and bizarre, and cannot be reduced to just clusters of symptoms:

Though we are still far from being able to explain all the relationships in that obscure world, we can maintain with complete assurance that in dementia praecox there is no symptom which could be described as psychologically groundless and meaningless. Even the most absurd things are nothing other than symbols for thoughts which are not only understandable in human terms but dwell in every human breast. In insanity we do not discover anything new and unknown: we are looking at the foundations of our being, the matrix of those vital problems on which we are all engaged.

(Jung 1914, para. 387)

In line with this view, with respect to therapy he reflected in 1939:

The other fact that impressed me is the discovery I made when I began my psychotherapeutic practice: I was amazed at the number of schizophrenics whom we almost never see in psychiatric hospitals. These patients insist upon treatment and I found myself, Bleuler's loyal disciple, trying my hand on cases we never would have dreamed of touching if we had them in the clinic, cases unmistakably schizophrenic even before treatment. I felt hopelessly unscientific in treating them at all – and after the treatment I was told that they could never have been schizophrenic... (and he continues) ... Even if I am not very hopeful about a patient, I try to give him as much psychology as he can stand, because I have seen plenty of cases where the later attacks were less severe and the prognosis was better as a result of increased psychological understanding.

(Jung 1939, para. 539)

There are limitations of course to Jung's understanding of schizophrenia: he never elaborated, for example, on the peculiarity of the schizophrenic complex, how and why it is so different, energetically, from the over inflated neurotic complex, and why it is so self-devouring. He never elaborated as well on the reasons for the alienation the sufferers feel from their surroundings, luring them to give up the struggle for sanity. He was not concerned with those economic, social and familial disadvantages which are so decisive in shaping the destiny of those afflicted with psychosis, and have such influence over who will become schizophrenic and who will remit. But he certainly emphasized the

central place of one's own responsibility for one's mental sanity, and insisted on the respect we should all accord those who do not let themselves be dragged under by the intrusion of those strange contents stemming from the unconscious.

TRANSLATIONS OF ABSTRACT

Jung se sentait très engagé à comprendre la pensée des psychotiques et laissa de côté de précieux aperçus sur le traitement, éparpillés dans ses œuvres écrites entre 1906 et 1958. La psychiatrie contemporaine a tendance à attribuer le processus psychotique à une altération de l'anatomie cérébrale, à la biochimie et à l'électrophysiologie, évitant ainsi le sujet, c'est-à-dire la personne souffrante, en privilégiant l'attachement au réel et la santé mentale. Pour Jung, la schizophrénie est un « abaissement du niveau mental », un phénomène semblable à celui rencontré dans les rêves, dû à une « faiblesse de la volonté » particulière. Il contestait que, dans la schizophrénie, à l'opposé des troubles neurologiques, les complexes puissent être dissociés sans jamais pouvoir réintégrer la totalité psychique, ou se réunir seulement lors des rémissions « comme un miroir brisé en éclats » (Jung, 1939, § 507). Par conséquent, quelqu'un qui ne se bat pas pour la suprématie de la conscience du moi et qui se laisse dominer par l'intrusion de contenus étrangers surgissant de l'inconscient (jusqu'à être fasciné par la régression) est exposé au risque de schizophrénie. On débattrait de la pertinence de ces notions à l'heure actuelle et de leur importance dans la compréhension du processus psychotique à la lumière des découvertes scientifiques contemporaines.

Jung war hochgradig engagiert im Erfassen der Bedeutung psychotischen Denkens und hinterließ, verstreut in seinen zwischen 1906 und 1958 geschriebenen Werken, wertvolle Einsichten in die Behandlung. Die heutige Psychiatrie tendiert dazu, den psychotischen Prozeß auf Veränderungen in der Hirnanatomie, Biochemie und Elektrophysiologie zurückzuführen und so das Subjekt, d.h. die betroffene Person freizustellen von ihrer Verantwortung für ihren Realitätsbezug und ihre Gesundheit. Jung verstand die Schizophrenie als ein 'abaissement du niveau mental', ein ähnliches Phänomen wie es in Träumen erfahrbar ist, verursacht durch eine bestimmte 'Faiblesse de la volonté'. Er bestritt, daß Komplexe innerhalb der Schizophrenie im Kontrast zu neurotischen Störungen unverbunden und entweder niemals in die psychische Gesamtheit reintegrierbar seien oder sich per Remission zusammenfügen könnten 'wie Splitter eines zerbrochenen Spiegels' (Jung 1939, § 507). Folglich unterliegt eine Person, die nicht um die Vorherrschaft des Bewußtseins kämpft und die sich durch das Eindringen fremder Inhalte, die aus dem Unbewußten aufsteigen (mitunter bis zu dem Punkt, an dem die Regression faszinierend wird), ins Taumeln hat bringen lassen, der Gefahr der Schizophrenie. Die gegenwärtige Relevanz dieser Gedanken und ihre Notwendigkeit zum Verstehen des psychotischen Prozesses im Lichte moderner wissenschaftlicher Erkenntnisse werden diskutiert.

Jung fu molto impegnato nel odernhr di afferrare il significato del pensiero psicotico e lasciò preziose intuizioni sparse nei lavori scritti tra il 1906 e il 1958. La tendenza della

psichiatria attuale è di attribuire I processi psicotici ad alterazioni nell'anatomia, nella biochimica e nella elettrofisiologia del cervello, esentando così il soggetto, cioè la persona odern, dalla responsabilità per attaccamento alla realtà e al loro equilibrio. Jung intese la odernhrenia come un 'abaissement du niveau mental', fenomeno simile a quello incontrato nei sogni e causato da una particolare 'debolezza della volontà'. Contrastò l'idea che nella odernhrenia, contrariamente a quanto accade con I disturbi nevrotici, I complessi siano disconnessi e non possono né essere odernhren nella totalità psichica o possono nelle remissioni congiungersi insieme 'come uno specchio rotto in pezzi' (Jung 1939, para. 507). Di conseguenza una persona che non combatte per la supremazia della coscienza dell'io e si è lasciata influenzare dall'intrusione di contenuti alieni odernh dall'inconscio (persino fino al punto da essere affascinata dalla odernhre) è esposta al pericolo della odernhrenia. Vengono discusse la rilevanza attuale di tali nozioni e la loro necessità per la comprensione dei processi psicotici alla luce delle odern scoperte scientifiche“.

Юнг был искренне предан постижению смысла психотического мышления и оставил после себя драгоценные мысли, озарения, рассыпанные по его трудам, написанным между 1906 и 1958 годами. Тенденция сегодняшней психиатрии приписать психотические процессы изменениям анатомии мозга, биохимии и электрофизиологии, таким образом высвобождая субъекта, т.е. затронутого этим человека, от ответственности за привязанность к реальности и за собственное здравосмыслие. Юнг понимал шизофрению как «abaissement du niveau mental» (снижение умственного уровня), феномен, сходный с тем, что мы испытываем в сновидениях, и вызванный особым состоянием «faiblesse de la volonté» (ослабления воли). Он отстаивал свой взгляд на то, что комплексы в шизофрении, в отличие от невротических расстройств, не связаны и не могут быть реинтегрированы в психическую целостность или же могут воссоединиться лишь в ремиссии «подобно зеркалу, разбитому на осколки» (Юнг, 1939, пар 507). Соответственно, человек, который не борется за превосходство эго сознания и позволяет себе быть управляемым потоком чужеродных содержаний, поднимающихся из бессознательного (даже до степени увлеченности регрессией) подвергается опасности шизофрении. Значимость этих понятий в современности и их необходимость в понимании психотических процессов в свете современных научных открытий обсуждаются в этой статье.

Jung estaba profundamente comprometido por entender el significado de pensamiento psicótico y dejó preciosas ideas dispersas sobre su tratamiento en sus obras escritas entre 1906 y 1958. La tendencia de la psiquiatría actual es atribuir al proceso de alteración psicótica a la anatomía del cerebro, a la bioquímica y la electrofisiología, y a exonerar a los sujetos, es decir, la persona afectada, de la responsabilidad para la conexión con la realidad y su cordura. Jung entiende la esquizofrenia como un 'abaissement du niveau mental', un fenómeno similar a la encontrada en los sueños, y causada por una peculiar 'faiblesse de la volonté'. Él expuso que los complejos en la esquizofrenia, en contraste con trastornos neuróticos, se desconectan y nunca puede reintegrarse a la totalidad psíquica o sólo puede reunirse en su remisión 'como un espejo roto en pedazos' (Jung 1939, párr. 507). Por lo tanto, una persona que no lucha por la supremacía de conciencia

del ego y se ha dejado influir por la intrusión del contenido alienante derivado del inconsciente (incluso hasta el punto de ser fascinado por la regresión) está expuesta al peligro de la esquizofrenia. Se discute la relevancia contemporánea de estas nociones y su necesidad para la comprensión de los procesos psicóticos a la luz de hallazgos científicos modernos.

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