

PART 1

Connecting trauma and dissociation to psychosis: Historical and theoretical perspectives

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Historical conceptions of dissociation and psychosis: Nineteenth and early twentieth century perspectives on severe psychopathology¹

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An understanding of the modern construction of dissociative disorders and psychotic disorders rests on an appreciation of the historical forces shaping their evolution. Despite their independent status within psychiatric thought currently, psychosis and dissociation are not orthogonal constructs. Their histories show that while they were initially studied as separate entities, they became more fused (particularly with regard to the developing concept of schizophrenia) in the late nineteenth and early twentieth centuries before becoming disconnected again (Gainer, 1994). This chapter will focus on the history of dissociation and psychosis, particularly as it relates to the concepts of hysteria and schizophrenia, from around the time of the Enlightenment until the beginning of the twentieth century. Thus it tracks the independent study of dissociation and psychosis, and ends with these constructs more merged in psychiatric thought, in the guise of Bleuler's schizophrenia.

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1.1 Dissociation: Mesmerism, multiple personalities and hysteria

The emergence of dynamic psychiatry can be traced to a pivotal clash of ideologies that occurred in 1775 and pitted Johann Gassner, a modest country priest, popular healer and exorcist against Anton Mesmer, a flamboyant, vain and tempestuous son of the Enlightenment (Bliss, 1986; Ellenberger, 1970). Taking the side of science, Mesmer began the process of wrestling with the church's notions of mental illness being the work of the Devil, sorcery or overt diabolical possession and replacing it with a theory of illness allied to scientific explanation. Despite the imprimatur of science, Mesmer's use of magnetic cures, which involved evoking a physical 'crisis' to aid induction, in effect 'amounted to Gassner's procedure, without the use of exorcism' (Ellenberger, 1970). What both men demonstrated, though explained in their own paradigm, was that powerful unconscious processes were at work and that some individuals could, seemingly, be cured of certain maladies by succumbing to a process associated with the induction of a state of altered consciousness.

One of Mesmer's students, Amand-Marie-Jacques de Chastenet, Marquis de Puységur, made the important discovery that a 'crisis' was not needed to induce the magnetic sleep or artificial somnambulistic state that Mesmer discovered (Forrest, 1999). What was on display during Puységur's artificial somnambulism was a controlled and temporary division (dissociation) of the personality, so that one state was interacting with the magnetizer and another was not. In those capable of this seemingly complete dissociation, Puységur noted, 'The line of demarcation is so complete that these two states may almost be described as two separate existences' (cited in Forrest, 1999: 95).

The study of magnetism eventually became the study of hypnosis, when James Braid introduced the latter term in 1843. The scientific study of hypnosis was to provide a portal from which to observe, understand and treat hysteria, along with the dissociative structure and symptomatology central to hysteria-spectrum disorders (Van der Hart and Dorahy, *in press*).

Accounts of individuals switching between identity states and demonstrating amnesia between states, or switching into fugue states, had always been part of the literature associated with mesmerism. In 1791 the German mesmerist, Eberhardt Gmelin, published an 87-page report on a case of 'exchange personalities' in a 20-year-old woman who 'suddenly "exchanged" her own personality for the manners and ways of a French-born lady, imitating her and speaking French perfectly and German as would a French woman' (Ellenberger, 1970: 127; Greaves, 1993). As a German, the woman knew nothing of her French personality.

The most influential early case of multiple personality disorder (MPD; now dissociative identity disorder) was that of Mary Reynolds, first published by Samuel Latham Mitchill in 1816. The care of 'Estelle' treated by Père Despine Snr and reported in detail in 1840 represented the first report of a patient with MPD who was brought to integration by a hypnotically facilitated treatment (Fine, 1988). She was one of 40 or so MPD patients treated by Despine, his son and his nephew (who were also trained as 'magnetizers'). Many cases of dual and multiple personality were reported in the late 1800s and early 1900s, including Charcot's 1885 photographic images (a total of 10) of Augustine, in each of her dissociative states (Hacking, 1995).

Briquet's interest in hysteria in the mid-1800s (e.g. Briquet, 1859) was taken up by Charcot, who maintained the primary reason for hysteria was constitutional weakness (Van der

Hart, in press). It was Charcot, a world-renowned neurologist based at the Salpêtrière, who was uniquely placed to bring about what previously had not proven possible, a synthesis between the traditions of the hypnotists and that of official psychiatry, at the same time elevating hysteria to the level of a condition worthy of serious scientific investigation. He came to see hysteria as related to a dissociation of psychological unity (Van der Hart, in press), a theme which Pierre Janet considerably expanded.

With Charcot's death in 1893, his legacy was immediately undermined and Joseph Babinski, a favourite disciple, became the main protagonist in a radical reaction against Charcot's concept of hysteria. Babinski claimed that hysteria was *nothing but* the result of suggestion, and could be cured through 'persuasion', a theme that has continually been reborn to the present day, despite the absence of empirical data, and which, at the time, was severely criticized by Janet.

Janet (1859–1947), in his premedical career as a philosopher, studied a woman with hysteria named Léonie. Léonie displayed the capacity to be hypnotized and demonstrated the features of what was later called MPD. His study of Léonie initiated Janet's interest in hypnosis and hysteria and Charcot invited him to the Salpêtrière. In 1889 Janet published *Psychological Automatism*, based on his study of 14 hysterical women, five hysterical men and eight suffering with psychosis or epilepsy. Much of the research focused on Léonie and three other hysterical women. In this work Janet laid the foundations of his theory of dissociation, demonstrating that some individuals can form a number of psychic structures which come about as the personality divides in response to trauma and other events which lower integrative mental capacity (Van der Hart and Dorahy, in press). These psychological structures have their own personal traits, which Janet conceived of as coexisting, and thinking and reacting simultaneously at a subconscious level, but also capable of taking over consciousness (e.g. in hypnosis or with automatic writing; Van der Hart and Friedman 1989; Crabtree, 1993). Janet's work with patients suffering from amnesias, fugues, conversion symptoms and 'successive personalities' led to his postulation that such dissociative symptoms were attributed to split-off or dissociative parts of the personality. These dissociative parts each centred around what he referred to as 'subconscious fixed ideas' (see Witztum and Van der Hart, Chapter 2, this volume). Influencing Freud and Breuer, he demonstrated that the dissociated elements which resulted in the patients' symptoms could often be traced to past traumatic experiences and could be treated by bringing into consciousness the split-off memories and associated affects (Bliss, 1986; Ellenberger, 1970).

Josef Breuer (1842–1925) reluctantly published his description of Anna O (Bertha Pappenheim) with other cases contributed by Freud in *Studies of Hysteria* (1895/1960). Anna O was an intelligent young woman with a complex mix of symptoms (e.g. somatoform, dissociative, post-traumatic) originating from a dissociative organization (Loewenstein 1993). She switched between different states of consciousness, organized into what Breuer, following French colleagues, called 'double conscience' (double consciousness).

It is hard to avoid expressing the situation by saying that the patient was split into two personalities of which one was mentally normal and the other insane . . . Not only did the second state intrude into the first one, but . . . even when she was in a very bad condition – a clear-sighted and calm observer sat, as she put it, in a corner of her brain and looked on at all the mad business. (Breuer and Freud, 1893–1895/1955: 46)

In presenting the dissociative structure of hysteria, Breuer and Freud, inspired by Janet and other French colleagues, wrote in 1895:

The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness so striking in the familiar classical cases under the form of 'double conscience' is present to a rudimentary degree in every hysteria and that a tendency to such dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring together under the term 'hypnoid') is the basic phenomena of this neurosis. (p. 12)

Freud's (1856–1939) original work with hysteria saw him utilize Janet's ideas on dissociation, embrace Breuer's cathartic method and enthusiastically pursue a model based on the belief that hysteria invariably had its origins in sexual abuse occurring in early childhood, usually at the hands of the child's father (e.g. Freud, 1896/1959).² Yet, due to multiple determinants in personal, professional and intellectual domains (DeMause, 1991; Masson, 1984), Freud's so-called 'seduction theory' of hysteria was replaced by one based around infantile sexuality, and ultimately the allegedly pervasive and widespread tendency to develop Oedipal fantasies.

World War I revealed that traumatized soldiers exhibited the wide spectrum of symptomatology observed in hysteria including dissociative divisions in personality. In describing the psychological organization and functioning of acutely traumatized soldiers, C.S. Myers, who in 1915 coined the term 'shell shock' (Shephard, 2000), wrote of a soldier in a state of stupor:

At this stage, the normal personality is in abeyance. Even if it is capable of receiving impressions, it shows no signs of responding to them. The recent emotional (i.e., traumatic) experiences of the individual have the upper hand and determine his conduct: the normal has been replaced by what we call the 'emotional' personality. Gradually or suddenly the 'apparently normal' personality usually returns – normal save for the lack of all memory of events directly connected with the shock, normal save for the manifestation of other ('somatic') hysterical disorders indicative of mental dissociation. (Myers, 1940: 66)

1.2 Psychosis: Insanity, dementia praecox and schizophrenia

The growth of interest in hypnosis, which eventually followed Mesmer's animal magnetism, marked a systematic secularization of interest in phenomena previously ascribed to the Devil and his minions. The insane, gathered in asylums, were the recipients of patchily improving conditions and growing scientific interest on the part of superintendents increasingly motivated to study the nature of the illnesses of their patients, including how best to

²Freud's implication of the father in the patient's sexual abuse history is most clearly stated in a letter to Fliess in 1897 (Freud, 1897).

classify them. In 1808 the term *psychiatry* was first used by Johann Reil in defining treatment of the mind (Stone, 1998).

There was now an opportunity to bring scientific observations on a larger scale to the isolated accounts of earlier individual observers such as Thomas Sydenham (1624–1689) who had used the term *hysteria* to signify any mental disorder short of ‘frank alienation’ (outright psychosis), or Thomas Willis (1621–1675) who outlined a clinical picture as early as 1672 of a condition closely resembling what Emil Kraepelin, over two centuries later, would call *dementia praecox* (Stone, 1998).

The astute and detailed observations of John Haslam (1766–1844) provided profiles of various forms of paralysis including general paresis and cases consistent with what would in time be called ‘schizophrenia’ (both child and adult forms). Haslam’s *Illustrations of Madness* (1810) was the first medical book detailing a single case of insanity, that of James Tilly Matthews, a paranoid psychotic man who believed that an ‘internal machine’ was controlling his life and torturing him (Stone, 1998; Millon, 2004). Haslam also recognized, as had Aretaeus in the first century, that in some individuals states of excitement and depression alternated. Haslam, in 1809, observed,

Mad is therefore not a complex idea, as has been supposed, but a complex term for all the forms and varieties of this disease . . . [T]o discover an infallible definition of madness . . . I believe will be found impossible, as it is an attempt to comprise, in a few words, the wide range and mutable character of a Proteus disorder. (Millon, 2004: 167)

Philippe Pinel’s (1745–1826) student and successor at the Salpêtrière, Jean-Étienne-Dominique Esquirol (1772–1840), published in 1838 what many see as the first modern treatise on mental disorders, *Des Maladies Mentales*, which incorporated for the first time a statistical approach to mental illnesses. The first psychiatrist to suggest that personality vulnerabilities interacting with external precipitants might serve as a basis for understanding mental illness, Esquirol was interested in exploring the inner functioning of his patients’ minds, including those processes that generated manifest deliria and hallucinations (Millon, 2004). It was Esquirol who introduced the term *hallucinations* and differentiated them from *illusions* (‘false impressions based on misinterpretations of reality’). His nosology was relatively simple, arranged under three main headings; *délire général* (general madness), *délire partielle* (partial madness) and *affaiblissement intellectuelle* (weakening of the intellect). The first term described an all-encompassing affliction, to be distinguished from *délire partielle* describing a compartmentalized condition (e.g. paranoid thinking that was confined to just one area of life). In time the first term became *manie*, (though with a broader meaning than the ‘mania’ of bipolar illness), while *délire partielle* became *monomanie* (the forerunner of the modern ‘psychopathy’). There was ‘affective monomania’ (the *triste* type equating with the modern concept of ‘recurrent depression’), and pyromanie or kleptomanie, terms still commonly used.

Esquirol divided ‘intellectual weakness’ into congenital and acquired types (Stone, 1998), the latter taking a form that the Belgian-biologically orientated psychiatrist Benedict Augustin Morel (1809–1873) would later call *démence précoce*. Morel’s term initially referred to a 14-year-old boy who, having been a cheerful and good student, progressively lost intellectual capacities as well as becoming increasingly withdrawn and melancholic (Millon, 2004). Morel is particularly associated with launching the concept of

degeneration, where an undesirable characteristic (e.g. alcoholism, criminality), was believed to be transmitted via heredity, worsening with succeeding generations (Shorter, 1997)³.

It was around this time (the mid-nineteenth century) that the term *psychosis* was first proposed. It was coined in a psychiatric textbook (translated into English in 1847) by an Austrian physician named Ernst von Feuchtersleben (1806–1849) to replace *insanity* or *lunacy* (Beer, 1995). Feuchtersleben's purpose in coining this new term was to mediate between the 'mentalists', who believed that mental illnesses were due to a sickness of the 'soul', and the 'somaticists', who saw them as due to defects of the body (Beer, 1995, 1996). Carving out a middle ground, Feuchtersleben argued that 'psychoses' (which, like 'insanity', covered most major mental disorders, including what would today be called schizophrenia, mania, depression and paranoia) were diseases of the whole personality, whose causes were 'neither exclusively in the mind nor in the body' (Beer, 1995: 181), but which were due to an interaction between the two. Ironically, but consistent with the prevailing view at the time (and for most of the next half-century), Feuchtersleben considered hysteria to be a *neurosis* (a term proposed a half-century before for any disease caused by the functioning of the nerves), and as such *more* biologically based than *psychosis*.

In less than a generation, however, this changed as, under the influence of Wilhelm Griesinger, the somaticists 'won' and 'psychosis' became a term for organically based mental disorders (Beer, 1995). Griesinger (1817–1868) was an influential German biological psychiatrist who advanced the concept that 'mental diseases are brain diseases' and that mental disorders, like most medical conditions, are chronically progressive (Millon, 2004). Griesinger became the single most important representative of what is known as the first biological psychiatry.

Karl Ludwig Kahlbaum (1828–1899) did not accept Heinrich Neumann's 1859 assertion that there was but one 'unitary psychosis' (Shorter, 1997). He was impressed by Esquirol's emphasis on age of onset, variable chronicity and deteriorating course in making distinctions between mental illnesses. He pointed out how unhelpful diagnostically it was to group disorders on the basis of similarities in overt symptomatology and indeed the subsequent history of psychiatry has borne out this observation, with the great majority of symptoms associated with mental illness being of themselves diagnostically non-specific (Millon, 2004; Shorter, 1997; Stone, 1998).

Kahlbaum established the importance of longitudinal factors in psychiatric diagnosis, labelling two newly observed disorders, *hebephrenia* (with his student, Ewald Hecker), a psychosis of young adolescents characterized by mental disorientation and *catatonia*, a condition where the patient displayed no reactivity, and sat mute and physically immobile. Catatonia was a renaming of a phenomenon that had long been recognized as part of the immobile apathy known as melancholia attonita (attonita = thunderstruck) (Shorter, 1997).

Emil Kraepelin (1856–1926) built on the observations of Griesinger and the longitudinal approach of Kahlbaum. While he wrote about every major type of psychiatric disorder in his time, his major interest was with psychosis. Kraepelin recorded data on prodigious numbers of patients with the long-term goal of bringing order between, on the one hand, observed symptoms and, on the other, patterns of onset, course and outcome. In the course

³Belief in a chronic path of deterioration was to become a central theme of Emil Kraepelin's belief that the course of a mental disorder, rather than phenomena observed cross-sectionally, was its defining feature.

of nine editions of his textbook of psychiatry (the last unfinished at the time of his death), Kraepelin developed a nosology of psychosis that is still very evident in the structure of DSM-IV (Bentall, 2004).

On the basis of his longitudinal data of cases with poor outcome, Kraepelin began to group together illnesses previously described by others that apparently had a poor outcome. He included *catatonia*, *hebephrenia* and finally *dementia paranoides*, a disease which like the first two led to rapid deterioration, but which was characterized by bizarre fears of persecution. By the sixth edition (1899), Kraepelin had outlined the definitive pattern of two modern major disorders, *manic-depressive psychosis* (bipolar disorder) and *dementia praecox* (schizophrenic disorders). In addition to the necessary progressive and inevitable decline, Kraepelin claimed that essential features of dementia praecox included discrepancies between thought and emotion, negativism, stereotypical behaviours, hallucinations, delusions and disordered thought. For Kraepelin ‘no single morbid symptom’ characterized dementia praecox, nor was interrelationship between the great variety of symptoms that he described apparent other than as a reflection of dementia and associated loss of psychic unity.

Kraepelin’s belief that the aetiology of most psychiatric disorders involved inherent bodily defects, allied with his focus on a rapid decline, encouraged pessimism in respect to the treatment of dementia praecox. An additional category of illness described by Kraepelin was *paranoia*, a chronic illness characterized by delusional beliefs in the absence of significant changes to personality and which was differentiated from dementia praecox because of the absence of deficits of thinking and volition. Kraepelin finally reached the conclusion that paranoia included some low severity cases associated with the possibility of partial recovery.

Given the centrality of auditory hallucinations to the DSM-IV criteria for schizophrenia, it is worth reflecting on Kraepelin’s observations from the eighth edition of his text,

And then there develops gradually or suddenly the symptom peculiarly characteristic of dementia praecox, namely the *hearing of voices*. Sometimes it is only whispering ‘as if it concerned me’, as a patient says, a secret language, ‘taunting the captive’; sometimes the voices are loud or suppressed . . . Sometimes they shout as in a chorus or all confusedly . . . At other times they do not appear to the patients as sense perceptions at all; they are ‘voices of conscience’, ‘voices which do not speak with words’, ‘voices of dead people’, ‘false voices’, ‘abortive voices’. (1919: 7).

1.3 Dissociation, psychosis and schizophrenia: The merging of constructs

The first use of the term ‘dissociation’ in the medical literature actually referred to psychosis, and specifically bipolar disorder. Benjamin Rush (1818) suggested the primary feature of the ‘disease’ he was explaining is ‘dissociation’. This condition ‘consists not in false perception [that is hallucinations], like the worst grade of madness, but of an association of unrelated perceptions, or ideas, from the inability of the mind to perform the operations of judgement and reason. The perceptions are generally excited by sensible objects; but

ideas, collected together without order, frequently constitute a paroxysm of the disease' (p. 259). He goes on to outline bipolar disorder, with the alterations in mood states and their seeming disconnected appearance capturing the use of the term 'dissociation'.

Yet, it was not until much after Rush that dissociation, as understood and studied by the nineteenth-century giants of psychiatry, came to be more closely associated with psychosis. In the 1800s, there were at times crossover between those studying hysteria and its dissociative difficulties and those focused on psychosis and working in asylums. Kraepelin and Bleuler (as did Janet and Freud) spent time with Charcot at the Salpêtrière, while Auguste Forel, who trained in hypnosis at the school of Nancy under Ambrose Bernheim, became one of the leading specialists in its use and had as students Bleuler and Adolf Meyer. Forel was Bleuler's immediate predecessor as head of the Burghölzli (Ellenberger, 1970). This cross-fertilization undoubtedly contributed to some links being made between psychosis and dissociation.

Hallucinations have had a long association with hysteria. Charcot gives glimpses of the meeting of hallucinations, the manifestations of hysteria (conceptualized as having a dissociative basis), and their postulated traumatic origins in a clinical vignette concerning hysteria with contractures:

At the moment of the attack, the patient was in the grip of a delirium that related to the events that presumably gave shape to the initial crises: she addressed imaginary persons with furious invective: 'Criminals!, Thieves!, Burn them!, Burn them!, Oh, the dogs! They're biting me!' So many memories, doubtless, of emotions of her youth. (Stone, 1998: 101)

It was recognized as early as 1865 by Moreau de Tours (1865) that a more florid psychotic presentation could be precipitated by acute stress. He listed four basic features of such psychosis: its similarity to dreams, its curability using psychotherapy, its plasticity or polymorphism and its analogy with chemically induced (as by hashish) 'artificial delirium'. Janet saw such a psychosis as a dissociative state associated with a splitting or doubling of the mind, the manifestations of subconscious phenomena and associated altered states of consciousness (see Van der Hart and Witztum, Chapter 18, this volume). While hysterical psychosis had widespread recognition during the latter part of the nineteenth century it, like the diagnosis of MPD, eventually faded from general use. Akin to MPD, however, it re-emerged in the mid-twentieth century, characterized as having a sudden onset following stress, a short duration (less than three weeks), and hallucinations, delusions, depersonalization and grossly unusual behaviour (Hirsch and Hollender, 1969; Hollender and Hirsch, 1964; see Van der Hart and Witztum; Witztum and Van der Hart, this volume).

While Kraepelin's concept of dementia praecox did not directly embrace dissociation,⁴ many others writing around his time were convinced that a dissociation-like mechanism was central to the disorder (Scharfetter, 2001; Chapter 4, this volume). Psychological concepts argued to be central to dementia praecox, such as Erwin Stransky's (1877–1962)

⁴But dissociative concepts were not completely absent from his conceptualization. See, for example, his insistence that dementia praecox led to a 'loss of the inner unity of the activities of intellect, emotion and volition, in themselves and among one another' (Kraepelin, 1919: 74–75), a description that sounds very much like contemporary definitions of dissociation.

intrapsychic ataxia (a disconnection between emotional and intellectual spheres), and Otto Gross's (1877–1920) *dementia sejunctiva*, relied heavily on a 'splitting' metaphor (Berrios, Luque and Villagrán, 2003), and Carl Jung, working closely with Bleuler, explicitly linked dissociation (and hysteria) with dementia praecox in his 1907 book, *The Psychology of Dementia Praecox* (Jung, 1907/1960). This in turn, infused with Janetian concepts (despite Jung's insistence on Freud's influence), was a major influence for Bleuler, whose concept of schizophrenia, with its core deficit *the 'splitting' of psychological functions*, provides the most clear fusion of dissociation and psychotic concepts to date (see Moskowitz, Chapter 3, this volume).

As the last flickering lights of professional interest in dissociative disorders dimly lit the path into the twentieth century, Forel observed in 1907 (1927) that 'one can produce many phenomena (hallucinations, false beliefs, deceptions of memory and the like) in the hypnotized [induced dissociation] which are also to be observed in the insane' (pp. 170–171). Prince listed automatic writing, hypnosis, visual and auditory hallucinations, dreams and crystal-gazing as examples of the subconscious revealing 'forgotten' experiences. In 1906, he published what up to then was the most detailed study of a single case of MPD. In presenting Miss Beauchamp, Prince clearly understood that her hallucinations had their origin in dissociated fixed ideas from the patient's autobiographical past. In one instance, he demonstrated that a fixed idea not to divulge a particular secret, which resided in a dissociative identity with its origin in childhood, was experienced as an auditory hallucination when another dissociative identity attempted to disclose the details: 'A warning voice which seemed to her to come from the next room sounded in her ear, "Don't, don't"' (1906: 507).

The increasing overlap between dissociation and psychosis meant that many theoreticians of the time felt it important to clearly distinguish dissociation from psychosis (e.g. Kraepelin, 1919; Prince, 1908). In describing dissociation and the 'double' or 'multiple personality' it can lead to, Prince (1908) recognized the possibility for confusion with psychosis. In differentiating the terms, he used 'disintegrated' to illustrate how divisions (dissociation) can occur in the so-called 'normal personality' and alternate or simultaneous secondary personalities can develop. He notes:

It will thus be seen that secondary personalities are formed by the disintegration of the original normal personality. Disintegration as thus used must not be confused with the same term sometimes employed in the sense of degeneration, meaning a destroyed mind or organically diseased brain. Degeneration implies destruction of normal psychical processes, and may be equivalent to insanity; whereas the disintegration resulting in multiple personality is only a functional dissociation of that complex organization which constitutes a normal self. The elementary psychical processes, in themselves normal, are capable of being re-associated into a normal whole. (p. 3)

1.4 Conclusion

What had started out a century earlier as two different journeys with two different groups of patients – the magnetizers and their hysteria-spectrum patients and the asylum physicians and their psychotic in-patients, was now a field of overlapping enterprises. Paradigms developed on one side of the original divide between hysteria/dissociative

disorders and the functional psychoses/schizophrenia moved over to occupy the middle ground. In the 136 years between the launch of Mesmerism and Bleuler's (1911/1950) text on 'the group of schizophrenias', Western psychotherapy had evolved along with sophisticated observations on the unconscious. Hysteria and related dissociative conditions briefly enjoyed an insecure prominence, and a system of classification for psychotic illnesses had been laid down that in its essentials is still very recognizable in DSM-IV (American Psychiatric Association, 1994). Yet already basic trends were in evidence that are being now revisited and which are expanded upon by other authors in this volume.

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