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An Updated Review of Werner Janzarik's Psychopathological Model of Endogenous (Idiopathic) Psychoses

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Abstract: "Dynamische Grundkonstellationen in endogenen Psychosen" is Werner Janzarik's most influential work. It is aimed at defining an unitary psychopathological model of endogenous psychoses independently from categorical nosology. His main contribution is the distinction between dynamic (the whole of emotions, impulses and intentions) and structure (the whole of psychic contents which remain stable throughout the course of life), whose intersection is well elicitable both in organic and in endogenous psychoses. Janzarik describes different types of dynamic alterations (dynamic constellations) in the different stages of the psychotic course: dynamic reduction in depressive phases, dynamic expansion in manic states, instability and depletion in the different clinical phases of long-term schizophrenic psychoses. Janzarik's work is nowadays completely forgotten. In the paper the Authors resume his main clinical ideas on major mental illnesses, because they fit well with long term courses of psychoses as observable in mental health public services, in an era of serious crisis of categorical distinctions. Janzark supports a dynamic model of psychoses, characterized by different stages and switchovers between different psychotic categories over time. In addition, this model could be used in standardized pharmacological trials to define which treatments are really effective in the different "dynamic" alterations of both affective and schizophrenic psychotic courses.

Keywords: Psychopathology, Endogenous Psychoses, Organic Psychoses, Unitary Psychosis, Structural-Dynamic Model, Werner Janzarik

1. Introduction

Werner Janzarik (1920-2019) studied at the University of Heidelberg when Kurt Schneider was full professor of psychiatry, and in 1973 he succeeded him. He was heavily influenced by his teacher, as shown by the adhesion to his simplified nosological model and in the predominance that psychopathological reasoning analyses has in clinical practice. Some paragraphs seem to be entirely devoted to a deepening and further elaboration of concepts, such as delusional perception, that had been central in Schneider's work [1].

"*Dynamische Grundkonstellationen in endogenen Psychosen*" [2] was published in 1959 and it can be considered his most important contribution; indeed, it already contains the major themes that would be later further elaborated and systematized. Psychiatry was characterized by a profound renovation during those years, because of the introduction of the early psychotropic drugs. Psychopathology could no longer avoid the confrontation with the biological underpinnings of psychic life. At the same time, the limits of the cornerstone of psychiatric nosology, the distinction between "Dementia praecox" and "Manic-depressive illness", introduced at the beginning of the century by Emil Kraepelin [3], were acutely evident. Not a single symptom, clinical picture or pattern that could enable a

precise differential diagnosis could be obviously found. Alternative models were lacking or unsatisfactory. In his *Grundkonstellationen* Janzarik tried to put once again psychopathology at the core of the entire field of psychiatry.

Janzarik was the last exponent of the heidelbergian school, which, in its time, completely lost his international prestige, because of the renaissance of empirical-biological paradigms (after the issue of DSM-III in 1980), and because of the establishment of a community-based, public psychiatry. In this regard, Janzarik wrote a famous paper of complaints about the "crisis of psychopathology" [4]. His work has therefore been mainly confined to isolated German psychopathologists [5, 6], and only a few papers were dedicated to him in international literature [7, 8].

In the first part of this paper, we aim at providing an accurate summary of the main concepts contained in Janzarik's model. Although a revision of his work could seem to be a mere historical exercise, some of his ideas are indeed perfectly in line with the data of contemporary research. Moreover, some of the subtle clinical observations and suggestions of that time maintain an undiminished validity, as it is the case for other authors of classical psychopathology, such as Tellenbach [9] or Henri Ey [10].

2. Nosological Considerations

According to Janzarik, at the basis of psychiatric nosology lies an enormous misunderstanding: clinical entities are not seen, as suggested by Karl Jaspers [11], as ideals, but rather as matters of fact, although not always linked to a precise biological explanation. The basic principle of this nosology is the traditional dichotomy between Dementia praecox and Manic-depressive disease, first introduced by Emil Kraepelin between the XIX and the XX century [3]. Although since those times the distinction between the two entities has been controversial, still today only a handful of psychiatrists look for alternative models. Even psychopathologists have accepted Kraepelin's system, as shown by Kurt Schneider's distinction between Schizophrenia and Cyclothymia, although he saw them as a continuum of clinical conditions.

The problem with categorical nosology has become more complicated since 1908, when Bonhoeffer introduced the concept of "acute exogenous reaction types" [12], meaning that acute clinical pictures resembling endogenous psychoses can appear with similar phenomenology, even after organic insults of different kinds. Various authors then began to investigate more chronic pictures with symptoms of affective or schizophrenic psychoses that appeared concurrently with organic diseases, paving the way for the so-called *endogenous reactive types*. Popper [13] investigated the schizophrenic reactive type, and from that moment on an enormous effort was made in distinguishing the variously called reactive schizophrenias from those pure or idiopathic. Something similar happened for cyclothymia, but with a meaningful difference: while schizophrenias, regardless of their origin, always represent something radically new in the lived experience of the patient, and therefore they are "easily" distinguishable from normal experience, reactive depressions can acquire an endogenous shade and constitute a continuum between normality and endogenous psychosis. Also, the line between normality and abnormality is more complicated in affective psychoses, because a lot of depression can be unchained by life or physiological events, such as childbirth and delivery or financial ruin. Curiously, analogous pictures of reactive manic states have been described more sparsely. Moreover, in many cases, the presence of manic states is only postulated but never confirmed, which can lead to their misclassification in the broad schneiderian category of cyclothymia.

The realization that the nosology of endogenous psychoses is uncertain should not lead to its abandonment, with the consequence of diagnostic nihilism. Janzarik argued ~~felt~~ that there was not a single psychopathological model ~~which was~~ independent from nosographic prejudices. Therefore, the model he proposed starts from psychological premises independent from any diagnosis.

3. Psychological Premises: Dynamic and Representation

Janzarik's psychology aims to be phenomenological and descriptive; however, influences from ethology, developmental psychology as well as Gestalt and Value psychology are evident, and it even contains some (concealed) Freudian references.

A basic premise is the distinction between "dynamic" and "representation". *Dynamic* is the whole of emotions, impulses and intentions which surge directly from the biological underpinnings of psychic life. Other idiosyncratic (or more uncommon in our days) terms are frequently used by Janzarik, whose translation is not easy, among which "disposability" (*Bereitschaft*) and "directedness" (*Gerichtetheit*) describe how mental contents interact with each other. The first word (disposability) is used to emphasize that a determined dynamic movement is selected inside a set of possibilities that is predetermined by genetics and heritability. As for the word "directedness", the author seems to have had in mind those long-term goals that determine the main pathways of a person's life. In a following article [14] Janzarik defined and further deepened the main movements of the dynamic flow with the words automatism (*Autopraxis*), disactualization (*Desaktualization*) and activation (*Aktivierung*). Automatism seems to be the most important of the dynamic functions and refers to the spontaneous coming to consciousness of mental objects. Memory plays an important role here. The dis-actualization, originally developed as a motor ability, evolved then into a mean that represses all the actions that oppose to the structural goal, optimizing behaviors or functions. Actualization is the least developed of the functions and it is involved in lending dynamic investment to the various mental objects.

With the term "*representation*", instead, the author

intended all the cognitive contents learned throughout life, from the simple motor schema to the most complex verbal meanings. These are deemed to arise from the sensory contact with the world, because the subject and the world can never be considered as entirely separate: a desire is not a desire without a desired object.

The most stable representative elements are called "*values"* and their totality constitutes the "*structure*." The "*structure*" is the stable and basic organization of a person's psychic life.

Janzarik transposed this fundamental distinction into the field of perception. He calls "*impressive perception"* the way in which the perceived object imposes itself directly on the perceiver with features that are a priori meaningful, as directly attached to dynamic involvement. Faces are an example of an impressive object.

On the other side, in the "*representative perception",* the perceived objects acquire sense because of their relationship with the structure. To give an example of this distinction, we may say that "*impressive perception"* is the direct sight of the sunset, while "*representative perception"* is the knowledge that the sun's image progressively goes below the horizon, because of the Earth's rotation.

In Janzarik's model, the lived experience (*Erlebnis*) always depends on two roots: the structure and the external environment. The structure, although stable, is not inflexible and it is always accessible to modifications and reorganizations. Quoting his teacher, K. Schneider [1], Janzarik stated: "The personality, although predetermined, develops through its lived experiences". This development is driven by dynamic and can happen in two ways: on the one hand, dynamic can rise directly from the biological ground and can be transmitted to the entire structure with an enormous potential for reorganization, as can be seen for example during adolescence. On the other hand, it can also be induced by a lived experience, and in this case, it is transmitted at first to the values that are structurally related to the experience itself, as in the case of being in love. The decline of the dynamic level during adult life explains why in older people the structure becomes harsher and less alterable by life events.

4. Unitary Psychosis

The main thesis of Janzarik is that endogenous psychoses are caused mainly by a dynamic disorder, while organic psychoses by a representative one (what in contemporary terminology would be translated as a cognitive disorder). Endogenous psychoses can of course lead to a secondary involvement of representative objects, but this follows the phenomena of removal and forgetfulness that are present also in normal life. At the same time, a dynamic derailment is regularly present also in organic psychoses, for example in the form of the apathy or affective instability of demented patients, but it is not their defining feature.

A third aspect, whose consideration is required to correctly diagnose a psychotic picture, is the state of consciousness, which is grossly altered in acute organic psychoses, but whose less pronounced disorders also play a role in the passage from endogenous to organic psychoses.

The clinical distinction between endogenous and organic psychoses is often difficult, and there are often some theoretical perplexities, as already mentioned, concerning the problem of the nosological classification of endogenous reactive types. Various efforts have been made to overcome this difficulty. Kraepelin [15], for example, proposed an all-inclusive neurodevelopmental theory of psychopathology, later adopted also by Henry Ey [16], which stated that psychopathological experiences were the expression of rudimental psychic instruments, usually silent, but pathologically actualized because of the dissolution of cortical inhibition, a general theory that meets also Janzarik's consent.

At the basis of these reflections, the author proposed to reconsider the idea of a unitary psychosis. He wanted to draw attention to the fact that all kinds of psychoses have in common a dynamic derailment. Various authors had already proposed to conceptualize psychoses as primarily dynamic facts. The most famous is Klaus Conrad with his formal and gestaltic explanation of acute delusion referring to growth and decline of the dynamic potential [17]. The concept however was not new: Zeller, the mentor of Griesinger, had spoken of a "dynamic disorder" already in 1838. This dynamic approach paved the way for a return to the concept of *unitary psychosis*.

The central chapters of the *Grundkonstellationen* are dedicated to the rigorous description of the different dynamic characteristics of the various endogenous psychoses, which the author calls "constellations*"* inside an Unitarian view of mental illnesses.

5. Dynamic Constellations

5.1. Dynamic Reduction

The main dynamic feature of cyclothymic depression (bipolar disorder in nowadays terminology) is called *reduction* because of the generalized decline of energy and activity. The values of the structure still remain at cognitive disposal, but they seem to lose their dynamic meaning. Nothing elicits the interest of the patient anymore. Those psychic objects that still remain at disposal evolve into the contents of typical depressive delusions. These contents can, in fact, on the background of the emptiness left by reduction, acquire by contrast a pathological meaning. If the main value regards the importance of money and richness, it will give raise to delusion of poverty and ruin; if it regards some moral duties, a delusion of guilt will develop; if it regards physical health, a hypochondriac delusion will develop. The most striking feature of dynamic reduction is its uniformity: the patient shows no changes over time, sometimes even over years. This uniformity can occasionally be interrupted by anxiety, which leads to dynamic instability and is therefore better understandable as a transition toward schizophrenic psychosis.

It is quite common that patients affected by cyclothymic depression, who have been tortured by gnawing delusions for months, seem to completely remove such delusions when the acute phase remits. This has no counterpart in normal psychic life, where all intense experiences leave traces behind them. This is a proof of the peculiarity of the dynamic disorders. If the patient can regain his early dynamic status, the delusional themes are completely lost. Dynamic reduction does not in fact change the structure of the patients, but it works on the values they already have. In some cases, however, this previous level can no longer be reached and chronic sequelae may develop, for example in the form of an increased irritability or vulnerability to hypochondria. This is markedly different from what happens in schizophrenia, in which the specific dynamic facts lead to the development of entirely new values that can persist and become an integrating part of the structure even after the resolution of the acute episode. This is more likely to happen if the delusional values merge with everyday experiences over time. Clinical experience teaches indeed that those patients that develop abrupt and weird delusions are more likely to reach a complete recovery.

5.2. Dynamic Expansion

Janzarik argues that the psychopathology of manic states is elicitable in a number of clinical conditions far more expanded than classical mania. The defining feature of the dynamic *expansion* in manic states is the excess of dynamic *movement*. The excess of actualizations and the liberation of impressive perception are features that manic states share with acute schizophrenias. On the contrary, both in depressive and in manic states, the dynamic facts are incredibly uniform, which is in striking opposition with schizophrenic episodes and their incredible unpredictability. The discussion about the disappearance of depressive delusions holds true also for the manic ones. The author hypothesizes that manic delusions should be more likely to persist in some form after the resolution of the acute episode than the depressive ones. A long-lasting modification always requires in fact an excess of dynamic, which is exactly what happens in expansion. Clinical practice however is rather contradictory on this topic.

5.3. Schizophrenic Delusion and Its Analogies with Expansion

In describing dynamic constellations of schizophrenia, Janzarik recognizes that these are far more complex than in affective psychoses and therefore he splits the course of schizophrenic psychoses in acute episodes and residual states. In acute episodes the psychopathological stages that since Jaspers have been most extensively studied are delusional mood (*Wahnstimmung*) and delusional perception (*Wahnwahrnehmung*). *Delusional mood* is the discontinuous and oscillating affective state that may characterize the prodromes of an acute episode. The predominant emotion is usually anxiety, but sadness, guilt or euphoria can as well be present. *Delusional perception* is the subjective, idiosyncratic meaning that an object acquires for the patient without any logical reason. Although with some controversy, in the coeval work by Conrad [17] about schizophrenic acute breakdown, delusional perceptions are hypothesized to arise in the context of an increasing self-referential atmosphere (ptolemaic regression or anastrofè), a view that foreruns Kapur's concept of *salience* [18]. The concept of *delusional intuition (Wahneinfall)* has been more neglected, maybe because of the lack of specificity for schizophrenia. For Kurt Schneider [1] it had indeed only a secondary importance, while delusional perceptions were "first rank symptoms".

In these episodes one can find a dynamic expansion very similar to manic states. The border between mania and schizophrenia is therefore labile. Not rarely, before the first episode of psychosis, a patient experiences an augmented capacity for intuition or sensibility. This increase of dynamic leads to a dominance of external impressions over internal actualizations in defining the lived experience. There is a parallelism here with the creative artistic experience: the artist tries to express in a new way what has come to his inspired mind.

5.4. Dynamic Instability

Dynamic *instability* (*Unstetigkeit*) explains the differences between acute schizophrenia and manic states: the dynamic flux changes during time and can rapidly move from one representation to another. An obvious phenomenal counterpart is the delusional mood with its rapid shifts between different objects with different emotional shades.

According to Janzarik, a *conditio sine qua non* for instability is the failure of structural background: a solid structure would in fact prevent unstable ideas from spreading and gaining importance. Quoting Grühle [19], the author states that an idea, however bizarre it may be, becomes delusional only when the person believes in it so much to live a new, delusional existence (*ein neues, verrücktes Dasein*).

In the analysis of delusional perceptions that are so characteristic of unstable, acute episodes of schizophrenia, Janzarik deepens the previous work of K. Schneider with subtleness. He distinguishes two components: *structural actualizations* (internal objects) and *impressive perceptions* (external ones). A delusional perception is always built on both, but usually one of the two prevails. In a purely impressive delusion, some perceptive features are *per se* meaningful and they immediately acquire a dynamic investment. A patient could for example think that a nurse is a Russian spy because of some facial traits or a particular accent. On the other hand, in a structural actualization, the meaning of the delusion can be appreciated only after considering the ongoing train of thoughts of the patient. A patient who is afraid of going under earth (in German "*unter Erde*") could be paralyzed by panic if he saw some nuts (in German "*Erdnüsse*"); in this case the experience of panic can be better understood if the previous state of the patient is taken into consideration. The comprehensibility of delusional ideas, however, should not be exaggerated and sometimes it lies outside our possibilities. Janzarik also states that during

the development of schizophrenia the roots of delusional experience move toward the interior world, and the structural actualizations become predominant, while during the first episodes impressive experiences are at the forefront.

The delusional objects that are originated by delusional perception, whatever their root might be, stand in striking opposition with what remains of the structure, namely everyday values. These are indeed more stable and therefore longer preserved. This opposition between an "ordinary world" and a beginning "delusional world" makes itself evident, from the point of view of symptomatology, in the form of those experiences of reference (*Beziehungserlebnis*) that are so characteristic of acute schizophrenic episodes.

Like Schneider, Janzarik states that there are continuous transitions between affective and schizophrenic constellations. The passage from mania to schizophrenia is announced by the appearance of ideas of reference that can develop into stable delusions of persecution. As a rule, these cases are characterized by an extreme richness of the symptomatology. The development of a schizophrenic psychosis from a depressive one, which is usually announced by anxiety, is more frequent. Rather than a real passage, the affective symptomatology can also represent the prodrome of a schizophrenic psychosis, the "trema" phase, using Conrad's terminology. The ideas of reference typically appear when anxiety transiently remits.

Like affective delusions, also schizophrenic symptomatology can disappear as meaningless remembrances after the recovery, once the original dynamic equilibrium is re-established, although in clinical practice this is rather uncommon. The stereotypical reappearance of delusional contents that had been completely corrected in occasions of dynamic turmoil is instead more common. The psychology of affects provides here an important parallelism. Intense affects like love and hate can push a person to irrational acts that subside once the initial passion is extinguished; they can however appear with the same intensity even after years if a new occasion arises. Still more often the delusion never remits and proceeds to those *residual states* that are better explained through the lenses of dynamic *insufficiency*. On the other hand, when the delusion persists but the original dynamic state is re-established, or in other terms a dynamic insufficiency never manifests, Janzarik prefers to use the term *paranoia*.

5.5. Dynamic Insufficiency

Following the acute episode, the schizophrenic patient often shows a *dynamic insufficiency*, the fourth of the constellations described by Janzarik. Dynamic insufficiency can be found in its purest form in patients with paucisymptomatic (or subapophanic, in Conrad's terms) schizophrenias and in the long-lasting courses, where a complete absence of emotions and long-term projects and a "resistance against activation", as described, can be clinically detected.

In residual states, structural objects undergo a process of atrophy at the end of which what remains is constituted mainly by biological needs (eating, evacuating, sleeping) and the so-called "pseudo-needs" (values that for that specific patient had previously been of particular importance). This is the level from which the break-in of dynamic instability can eventually re-start: the dynamic movement encounters a structure that is markedly debilitated and does not oppose any resistance. Consequently, there cannot be any tension between psychotic and ordinary experience and therefore any creation of new psychotic contents. The delusion proceeds from outside to inside, and delusional perceptions of the structural type gain predominance. In addition to this, acoustic hallucinations typically appear in this advanced stage as a sort of automatization of already formed delusional contents. According to Janzarik, those cases in which it seems that schizophrenia has rapidly developed with acoustic hallucinations as major symptoms are to be taken with caution; a deeper anamnesis often reveals a long-lasting prodrome.

The structure of a residual patient is the result of various acute episodes, each of which may have left signs in the form of delusional values that get integrated in the structure itself. Referring to patients he encountered in his clinical practice, often with long personal histories of institutionalization, Janzarik calls *disintegration* this particular state, in which the internal objects are completely chaotic.

Sometimes the patient, despite the advanced phase of depletion, retains a certain capacity of contact with the external world that can push the delusion in the background, even after years. Even in these cases, however, the delusion that appears in the residual state represents a profound existential change for which the anthropological approach, which tries to see the person in its wholeness, is the most suitable.

The structural-dynamic model sees in schizophrenia, in particular in the residual states, something more than just a clash between the disease and the personality. In the residual states, structure and disease merge and amalgamate in an inextricable way. The heterogeneity of this process, which means the heterogeneity of the structural values that remains after the various episodes, explains the extreme clinical differences between residual patients, which is to say that each one is unique in his personal history and phenomenology. Here lies the main difference between affective and schizophrenic psychoses: the homogeneity of dynamic facts in the first ones and the huge heterogeneity of the long-term changes in the second ones.

6. Practical Applications of Janzarik's Concept in His Time

During the early years of Janzarik's career, a lot of new therapeutic possibilities were introduced in clinical practice. For most of them, however, the mechanisms of action were unknown. The proposal of Janzarik is to guide the choice of the therapeutic procedure through the dynamic constellations, although he admits that the main limitation is the difficulty in

recognizing them in clinical practice. The treatments should try to reverse the dynamic alterations induced by psychosis and thus promote its stabilization. In the field of psychopharmacology, thymoplegic molecules reduce the dynamic expansion and derailments in mania and in productive schizophrenias, whereas thymoleptic drugs increase the dynamic level in depressive patients but also in residual states. As it will be shown later, this is even more true after years of psychopharmacological practice: for example, early neuroleptic dopamine antagonist turns off dopamine hypertone in acute psychotic and manic states, meanwhile atypical second-generation neuroleptics and actual dopamine-partial agonists exert antipsychotic or antidepressant effects depending on different doses.

The shock procedures (at that time ECT but also still insulin-induced coma) exercised a dynamic effect that differs according to the level of paroxysmal stimulation, with a minor stimulation that raises the dynamic level and a more intense one that lowers it. As a consequence of this variability of the effect, the indications to shock-based therapies were far more expanded than those of all other therapies.

At the time when Janzarik was writing, there were no sufficient studies on the effectiveness of psychotherapies in psychoses. He seems rather skeptical on this topic. An exception is represented by those cases in which psychological factors prevent a return to normality or lead to relapses; in these cases, psychotherapy is of primary importance. The combination between psychotherapy and somatotherapy is always possible and indeed indicated.

The psychotherapeutic attitude with the patient should not be affected by these speculations about its possibilities. What then causes the clinical improvement seen during psychotherapy is still largely unknown. Janzarik, however, criticizes those authors who claimed to have found "the psychotherapy of schizophrenia" (a real trend between the fifties and the seventies of the XXth century) moving from patients in which the structure remains accessible and recognizable for a longer time because, as seen in the previous chapters, this is rather uncommon.

Some last words are dedicated to the possible dangers of psychotherapy. This moves dynamic forces that can eventually give rise to psychotic episodes, above all with patients who already have a susceptibility in this direction. This possibility should always be kept in mind in order to provide a prompt and appropriate treatment.

7. Relevance of Janzarik's Model in Contemporary Psychiatry

In psychiatry nothing is completely forgotten. The time has indeed come to reconsider some of the reflections of the sixties and seventies, not only because they are the result of a phenomenological attitude and a peculiar attention to clinical manifestations, as the patients refer and describe them, that have been broadly lost in the last decades, but also because they are in line with the results of a part of contemporary research. This is surely the case for Janzarik. In some points his thought may seem too distant from ours and this is obviously an expression of his time. His reading also requires a preliminary knowledge of some concepts and the vocabulary of classic German psychiatry that is not within everyone's reach. Some of his general ideas, however, are still true and could serve as a guide in order to stem some oversimplified directions of contemporary research. His work, moreover, is full of subtle clinical considerations, for example about the transitions between the various forms of psychosis, endogenous and organic, that cannot be summarized in an article like this, but that would help even the most seasoned contemporary clinicians in their efforts to better understand their psychotic patients.

The first point on which Janzarik is of great contemporary interest is his critique of classical nosography, which was categorical and saw mental diseases as "*natural entities"*. This approach has resisted almost unchanged, as exemplified by the various versions of the American Diagnostic and Statistical Manuals of Mental Disorders, although in the last edition there were some evolutions in the direction of a dimensional approach, for example in the chapter about what is now called "Schizophrenia Spectrum and other Psychotic Disorders" [20]. The limits of categorical diagnoses, however, had already been pointed out by Kraepelin in his last article [15] and have been extensively researched throughout the last century. Various authors have come to question not only their validity, but also their clinical utility [21, 22]. What is getting discussed is not only whether current diagnoses really correspond to biological entities or not, which was a source of discussion already in classical psychiatry, but also if they are of some practical meaning in the selection of the most appropriate treatment for a specific patient. Unfortunately for the patients, the data at disposal seem to suggest that the answer to both questions is more likely to be negative. Janzarik would have been a great supporter of this non-categorical evolution. Already in the first chapter of his monograph he states clearly that "nosography of endogenous psychoses is quite uncertain". However, unlike some authors belonging to the so-called anti-psychiatric movement of the last century, for example Thomas Szasz [23], Janzarik never reaches diagnostic nihilism. He never puts into question the existence of mental diseases; he never doubts that "they guide medical reasoning"; he just states that diagnoses "should not be the building blocks of the entire building (psychiatry)" and he summarizes his thought on this point with a powerful metaphor: "*one does not leave a house that is no more suitable if there isn't at least the project of building a new one*".

In particular, Janzarik focuses on the nosography of endogenous psychoses. Current classificatory systems have substantially accepted the classical distinction of endogenous psychoses in two entities (schizophrenia and bipolar disorder) that dates back to IV edition of Kraepelin's Treaty [3] and which has profoundly influenced last-century psychiatry. Janzarik challenges this dichotomy. He goes even further

when he states that there is something, a dynamic dysfunction, that brings together all psychotic manifestations, whatever origin they might have, therefore including somatic psychoses (called in modern nosography "Psychotic manifestations due to other medical conditions"). Data from different lines of research are actually going in the direction pointed out by Janzarik. In the field of genetics, a meta-analysis [24] suggests that the genetic correlation between the diagnoses of schizophrenia and bipolar disorder could be as high as 0.6, a number that in other fields of medicine would promptly lead to reconsider the two diseases as one. An analogous value is obtained even when a wider spectrum of psychiatric conditions is considered [25]. Psychopharmacology is pointing in the same direction too. In particular, for the molecules that are called "antipsychotics" it is now clear that they work well on a plethora of symptoms that are far more extended than originally supposed. Their value in the therapy of bipolar disorder is widely recognized [26] and used in clinical practice. These data, analyzed in their entirety, support the original intuitions of Janzarik. In recent times some authors have even gone further and re-proposed a unified model of psychopathology, the so-called "p factor" hypothesis [27] according to which, studying a large sample of psychiatric patients with different diagnoses, the authors found that, psychometrically, all the symptoms were shown to correlate with one latent factor ("p factor"). In this model psychiatric symptoms were firstly distinguished in three main domains on the basis of previous research: externalizing, internalizing and thought disorders. These dimensions however showed to correlate with one another and the so-called p-factor was therefore introduced to measure this correlation. Coming from another line of research, McGorry has proposed something similar with his clinical staging model which does not take into consideration categorical diagnosing but only transversal elements [28]; in his opinion, this model should guide in the choice of the most appropriate treatment.

Another significant and still contemporary contribution is the distinction between dynamic and structure: the concept of dynamic is difficult to translate within nowadays terminology. It is a direct expression of the biological underpinnings of psychic life of which it pre-determines the configuration but its exact definition remains elusive. Janzarik refers variously to "emotions", "impulses" and "intentions" but does not go into details. On the other hand, the structure is similar to our concept of personality, although, in a passage, Janzarik explicitly criticizes the use of this term that was becoming too generic and therefore useless. For the author, the structure comes only from the contact with the external world and in this sense, it is acquired and not inherited. *Endogenous psychoses are primarily disorders of dynamic, not of structure*: in most patients, structure is untouched in his fundamental values and cognitive equipment. In other words, at least at the beginning, psychosis does not act on psychic contents but only on their meaning and on the overall importance they acquire because of the effect of dynamic. The psychosis "embodies" in a single individual and takes form largely depending on his "structure" so that any single psychotic patient is irreducible to any other [29]. This idea will seem rather straightforward for those clinicians who interact with these patients on a daily basis. Classical psychopathology had often proposed the concept that delusional ideas are understandable as originating from logical processes that are present also in non-psychotic individuals. Recent neuroscience-based research, however, has focused on the "why" rather than on the "what" of delusions, namely "why" a patient develops a delusion, not "why" that specific patient develops that specific delusional idea [30]. In fact, only a handful of studies has dealt with the question of the relationship between the delusional content and its meaning for the person who develops it. The re-proposal of a structural-dynamic model, more than 60 years after its first formulation, could thus serve as a stimulus to abandon an oversimplified view that qualifies delusions merely as incorrect ideas [31].

When Janzarik deals with the treatment of psychoses, he addresses another point that is still unsolved. He states indeed that even in the most successful scenario treatments can correct dynamic derailments while the structure remains untouched. Times may have changed, with an evolution towards more sophisticated modalities of treatment, namely psychopharmacology, but this idea still perfectly fits those patients that maintain intact the delusion they had created in previous episodes, despite numerous trials with different antipsychotic medications. As stated by Janzarik, these patients do not perceive their delusions as something disease-related; they have in fact become a part of their being, that is to say, what they are. Classical psychiatry used the words "residual" or "defective" to describe these patients but nowadays these terms have regretfully fallen in disuse even if these patients have not at all disappeared. A recent meta-analysis of follow-up studies of schizophrenic patients with a duration of at least 20 years has shown that 40.3% of patients diagnosed with schizophrenia have a bad outcome [32]. This number tells that almost half of the patients develop that "residual state" for which today there is a painful dearth of terminology. Another interesting meta-analysis confirms the clinical suggestion that patients in the earlier episodes respond better to medications than chronic patients [33]. The emphasis that in the last years has been put in the research, both pre-clinical and clinical, of the first episodes of psychosis is surely comprehensible and justified, given that these patients are generally young and their clinical manifestations entail in various senses a loss for their community. Still, research is profoundly invited to reconsider those chronic patients that are unduly neglected.

Other theorizations of psychosis are more or less explicitly in line with some of Janzarik's basic assumptions, but they have gained more popularity, mainly because they have a direct anchorage in neuroscience-related research. The model of basic symptoms, for example, originally developed by Gerd Huber [34], another student of Kurt Schneider, has found important applications mainly in the field of early prediction of psychosis [35]. The author himself has often

acknowledged a similarity with the model of Janzarik. Indeed, the model of basic symptoms not only conceptualizes psychosis as a continuum, rather than subdividing it into specific categories, but it also considers the basic disturbances as interfering with the patient's personality. The patient is therefore compelled to find coping strategies in order to mitigate the basic symptoms; this formulation is very similar to the one of Janzarik's dynamic-structural model. Also the popular model of salience, first described by Kapur [18], tries to integrate the phenomenology of the lived experience, as directly accessible in the exploration of the patient, with a neurobiological underpinning, namely the excessive dopaminergic activity in mesolimbic circuitry. The concept of salience, simply stated, refers to the subjective importance that an object acquires for the perceiver and it is very close to that of "impressive perception", in Janzarik's terminology. In both cases this perceptive hyper-function leads to productive psychosis as seen in manic states or schizophrenic episodes. In a late article [36], Janzarik himself quotes this model underlining its similarities with his thought.

8. Conclusions

A lot of conceptual mistakes and confusion in worldwide psychiatric literature and praxis of the last decades can be referred to the dearth of shared psychopathological models of psychoses, including bipolar, schizophrenic and even obsessive-compulsive ones. It is commonly accepted that these illnesses follow a course that begins in adolescence (often earlier in occurrence with puberty) with unspecific manifestations, which then interfere with personality (structural) development [28]. Thereafter unpredictable dynamic fluctuations and oscillations may continue for years and sometimes lifelong. Categorical (cross-cutting) diagnoses change over time in most patients, especially in the first years after the onset, depending on neurodevelopmental trajectories and the great number of environmental and relational factors that interfere with the brain functioning [37].

The role of psychopathology is to make diagnoses more careful but, at the same time, to reduce their "ontological value", taking into account the dynamics of the basic neurobiological disturbance, especially in its early course. On the contrary categorical labels compel the clinician to follow long-term standardized treatments that have been proved effective in samples of often very heterogeneous patients but gathered under the same diagnosis, in order to control symptoms and avoid relapses; sometimes these prescriptions are continued chronically for years and decades without properly considering the burden of side effects, especially in the periods of remission. A psychopathological approach that considers the dynamics of the illness could improve psychopharmacological choices: common guidelines are static, clinical reality fluid and dynamic.

In addition, many mistakes are caused by an excessive focus on the so-called "personality disorders" that are often diagnosed without properly considering the role of dynamic alterations in the expression of individual personality (structural) traits. A renaissance of the psychopathological thought, that could better integrate clinical and neuroscientific knowledge, is recurrently called upon [38] but remains a minor paradigm in anglo-saxon psychiatry, dominated by neuroscientific, evidence-based clinical and pharmacological trials, neurocognitive and psychosocial models and other approaches focused on categorical diagnoses.

The study of the classics of psychopathology, for example Janzarik's masterpiece, in post-graduate schools and in continuing education programs of psychiatrists and other mental health professionals could represent an unexpected resource to better understand and take care of our patients but also to start new lines of clinical research. The development of new and more accurate and evidence-based models of psychopathology should be a mandatory goal for our discipline, but it entails the knowledge of at least some of the classical psychopathologists, in respect to whom we are only dwarves on the shoulders of giants.

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