The Pathogenesis of Mental Disorders
An Update of Logotherapy[1]

Elisabeth Lukas

Abstract: In this brief article, an update of the classical classification of mental disorders in Frankl's school of psychotherapy, logotherapy and existential analysis, is suggested. The proposed change takes account of recent findings on the multiple causal factors contributing to mental disorders, including neurobiological and genetic factors, without losing sight of psychogenesis. The suggested update keeps Frankl's core conceptions intact; however, it brings logotherapy's theoretical underpinnings, and especially its nosology, in line with current thinking in clinical psychology.

Keywords: neurosis, ICD 11, psychopathology, logotherapy, existential analysis, epigenetics, mental disorders

The International Classification for Mental Disorders (ICD 11) will be considerably different from the currently used ICD 10. These changes have become necessary because of multiple research results in genetics and neurobiology. These findings indicate that a number of earlier hypotheses about the development of mental disorders and illnesses are inadequate, or at least incomplete. These new facts have consequences for the doctrinal body of the traditional schools of psychotherapy, among them the concepts of logotherapy.

The most important change concerns the understanding that an unequivocal attribution of certain mental disorders to specific causes is no longer tenable because it has become apparent that the genesis for any mental disorder depends on multiple factors. Traditionally, neuroses have been considered to be psychogenic in origin, while psychoses were thought to be somatogenic. This differentiation is no longer valid as such. It is now a known fact that it is possible to codify and identify genes indicating an increased likelihood for the development of anxiety disorders in patients identified as neurotic, just as is the case in for example patients with manic symptoms.

To these genetic (endogenic) dispositions come epigenetic (exogenic) factors. Both prenatal harmful influences (e.g., exposure to chemicals in the womb) and unsatisfactory childhood attachment experiences or later traumatic life events change

genetic expression. It is now known how changes of this kind occur: Changes of the genetic make-up of a person, which occur through harmful influences, mainly consist of a demethylation of DNA sections that are then “switched off.” In other words, they are permanently lost. This leads to a reduction of the margin within which behavioral changes are possible for a person.

It has also been demonstrated that genetics cannot be changed in retrospective, however the formation of synapses and the density of the interconnectivity of neurons can be altered. This can occur either through attitudinal change or behavioral change. Here lies the physiological foundation and justification of any psychotherapy.

The abandonment of the distinction between neuroses and psychoses leads to two types of differentiation relevant for applied psychotherapy. On the one hand, more attention is now being paid to the degree of severity of a mental disorder, using it as an indication for the application of pharmacotherapy. Here the predominant opinion is that, for example, in the case of severe disorders characterized by fears (formerly termed “neuroses”) pharmacological support is necessary by all means, whereas in the case of a light paranoia (formerly termed “psychoses”) a mild neuroleptic is prescribed in the course of an acute episode suffices.

The new table in ICD 11 does justice to this criterion by listing descriptive neuropathological medical evidence instead of manifestations of the symptoms of the respective mental disorders. A further criterion of differentiation is the degree of misjudgment of reality in an individual. The more pronounced this is (previously: the more psychotic it is), the more the use of appropriate medication is indicated. A high degree of misjudgment of reality is found in delusions and hallucinations (previously termed “schizophrenia”), a medium degree accompanies borderline and post-traumatic stress disorders, and a mild degree is found in identity and self-worth disorders, irrational fears, and guilt feelings. In order to assess the severity of misjudgment of reality in a patient, it is necessary to conduct a precise anamnesis, interviews, and, if need be, standardized questionnaires and similar measures. In general, it can be concluded that the more severe the degree of a mental disorder and/or the more pronounced the degree of misjudgment of reality, the indication for psychotherapy decreases and the necessity for a medical intervention increases.

To summarize, single-cause hypotheses for the development of mental disorders are no longer considered valid in ICD 11. All mental disorders have physiological

correlates (increase or decrease of density of certain receptors for certain neurotransmitters in certain areas of the brain). The specific clinical symptoms that manifest in a patient are dependent on the following factors:

1. the point in time of a damaging influence or an injury; for example, this may be particularly harmful on the embryonic brain or during the first year of life;
2. the localization of the harmful influence in the brain, which may have a particularly harmful effect; for example, on the limbic system, respectively the prefrontal cortex;
3. the extent of the harmful influence.

It is irrelevant whether the noxa is biological or consists of a psychological stress factor (e.g. negligence). In this context, it is of particular interest (and could be empirically tested) that mentally ill persons can relate to themselves and their illnesses in various ways and are thus able to influence themselves and their neuronal processes to a certain degree. However, persons with a considerate cognitive deficit, persistent delusions, and extremely strong misjudgment of reality may be impaired in this process.

Let us now turn to the question what these findings might mean for Viktor Frankl's teachings about neuroses and psychoses.

Frankl was only able to rely on the scientific standards of his own time. However, he was far ahead of his time with his statements about: "psychophysical parallelism"; neuronal correlates in neurotic disorders; "pathoplastic" (specific involvement of the individual) accompanying any "pathogenesis"; and the somato-psychological effects, which play a part even in noogenic crises. The abandonment of clear attributions of causes of psychological disorders has much less impact on logotherapy than on, for example, psychoanalysis, since the latter concentrates its therapeutic approach entirely on the detection of (supposed) psychological causes for illness. Contrary to this the discovery of causes, e.g. in a thorough investigation of a life story, in search of potential risk factors plays a very subordinate role within the logotherapeutic setting. The search for protective factors, however, a characteristic of the logotherapeutic approach, completely corresponds with the modern desideratum to epigenetically evoke improvements of the psychological condition of a patient. That it could be proved in the meantime that changes in attitude can set in motion improvements of this kind, is an excellent confirmation of Frankl's theses.

In my opinion there is only one thing in logotherapy, which needs adjustment with regard to these new insights: the terms *somatogenic*, *psychogenic* and *noögenic* need to be corrected. (I intentionally do not say they need to be abandoned.) For those who are well acquainted with logotherapy, it is clear that Frankl was not creating a final causal explanatory model for different patterns of disorders, but was reaching far beyond causal questions, namely at their *attribution to an ontological dimension*, where life problems manifest and are in need of a solution or an alleviation.

For him "somatogenic" meant that an occurrence became virulent on a physical level of being and needs to be brought to appropriate treatment. "Psychogenic" meant that irregularities in the psychological dimension have reached a critical density and wait for satisfaction. "Noögenic" (which outside of logotherapy does not even get diagnosed!) meant that a person as a spiritual being stumbled during the search for meaning and values and is in need of support.

The entire range of combinations and connections of the above is possible, requiring in turn "therapeutic tongs" (e.g. medication in addition to psychotherapeutic measures or psychotherapeutic measures in addition to conversations about the finding of meaning). Admittedly, the word ending "–genic" suggests an etiological connection, but neither in theory nor in application is the logotherapist focused on etiology, but rather on taking the human being seriously in its ontological manifoldness. In logotherapy, attention is drawn to the fact that to be human is not fully captured in a sum of neuronal processes or in the recording and processing of psychosocial influences.

Frankl himself used the example of crying. A person may cry because the smell of an onion can irritate his eyes. He can also cry because his self-confidence is weak and he is not good at handling criticism. He can cry because he lost a loved one through death. If one would want to abandon all of these differentiations, one would have to claim by abbreviation, that in all cases the activity of the tear glands is responsible for crying, whereby it would be useful to wipe the tears off the crying person. In the case of more intense crying, more handkerchiefs would be indicated. The primitive nature of this approach is self-evident. If one wants to help, one needs to differentiate the origin of the crying. On the physical level, it will be useful to remove the onions. On the psychological level, it will be appropriate to strengthen self-confidence and the ability to tolerate frustration. On the noetic level, consolation only will be helpful,

placing the permanent, indestructible validity of the experiential relationship into the foreground of awareness.

My proposal with reference to an adjustment of logotherapeutic nomenclature is therefore to change the word ending "–genic" to a different one in order to clearly define Frankl's position. Perhaps the word ending "–focal" would be an appropriate alternative. *Focal* means "concerning the focus" and, in medical context, even makes reference to the "seat of a disease." Without having to change that much in Frankl's teachings, it would consequently be possible to say "somato-focal"; this would mean that the focus of suffering of a patient and the therapeutic field of intervention would be found on the physical level. "Psycho-focal" would mean that the focus of suffering of the patient and the therapeutic field of intervention, would be found in the psychological field. "Noo-focal" would mean that the focus of the suffering of the patient and the field of therapeutic intervention are to be found in the spiritual field of the person. I cannot claim that I would be happy about this change in terminology, but I yield to the insight that, with progressive understanding, flawed dictions of the past have to be revised.

Concerning the old classification of mental disorders into neuroses and their subdivisions as well as psychoses and their subdivisions, I believe that, in logotherapy, we can move with time and gradually say farewell to these terms. However, we cannot abandon the description of what these terms stood for, because mental illnesses and disorders have not changed since the inception of psychotherapy as a serious science and these disorders have certainly not lessened in frequency in the population.

It will be a little bit tedious to use, instead of short, albeit simplifying, but nevertheless precise special terms, these terms of broader descriptions of variations of mental disorders. But this should not be an obstacle to preserve and pass on to future generations the precious and incredibly helpful wealth of thought of logotherapy.

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