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Schizophrenia

Most of the educated peopie who read newspapers, magazines and watch scientific programmes on T.V. are aware of schizophrenia as a major mental disorder, formerly known as insanity, because of the unusual, queer and eccentric behaviour of the patient and because it appears out of this world. Such patients are branded as 'mad' and are rebuked and ridiculed by uncultured people. This pushes such unfortunate victims of severe mental disorder deeper into the process of desocialisation, which later affects the patient's social rehabilitation after treatment.

It is therefore absolutely necessary for the guardians of psychiatric patients and responsible people in general to know what really is meant by schizophrenia. Is it incurable? Should such patients be treated as outcasts, like 'lepers' who were ostracised in the last century or like AIDS patients who are condemned these days! Family members of such mental patients suffer not only from the patient's behaviour and the uphill task of giving him regular treatment but also from the prejudiced community by way of a near boycott.

Schizophrenia, though a difficult mental disorder to cure, is quite treatable by easily available modern treatment methods. Most of such patients improve sufficiently enough to return to their original position in the society.

The concept of schizophrenia is still not definite even in scientific circles. Its definition differs from country to country and has therefore become a very controversial issue; though there is some agreement about its causes, symptoms, course and treatment.

Historical Overview of the Concept

The very first reference to a severe mental disorder was made in Ayurveda as early as in 1400 B.C. However, in modern times the earliest description of schizophrenia as illness was made in late 18th century. The first scientific description of such an illness was made by Morel in 1856. He called it "Demenca Precocie". He mentioned negative symptoms (social withdrawal and inactivity) and ultimate deterioration of personality in adolescents.

Kahlbaum (1868) described 'katatonie', equivalent to 'catatonia' (with rigid postures, mutism and

impulsivity). Soon afterwards Hecker (1871) described 'Hebephrene' equivalent to Hebephrenia of today, with oddities in speech and conduct.

The first valid description of schizophrenia, as it is understood today, was made by E-Kraepelin in Germany in 1896 calling it 'Dementia Praecox, meaning premature intellectual deterioration. He classified major mental disorders into two main groups, viz, Manic Depressive Insanity and Dementia Praecox. He incorporated the diseases described by Kahlbaum (Katatonie) and Hecker (Hebephrenie) as the types of Dementia Praecox. He also added another type of his own, viz. Dementia Paranoidies (equivalent to Paranoid Schizophrenia). He speculated that this was a brain disorder of unknown pathology, causing intellectual deterioration after some years. This was earlier suggested by Griesinger in 1845. Most of the psychiatrists in Europe, UK and USA could not accept this classification because of its poorly known etiology and pathology. Bleuler, a Swiss psychiatrist, developed Kraepelin's concept of Dementia Praecox and called it 'schizophrenia' in 1911 for the first time. He emphasized its psychogenic origin. Hence the Latin term for "split mind". He was influenced by the theories of Sigmund Freud, the father of psychoanalysis and stated that the disease meant 'loosening of associations' between the different mechanisms of the mind. He named the main symptoms of schizophrenia as 'Fundamental symptoms' which were later described as "Four A's". They were: 1. Loosening of Associations, 2. Blunting and Incongruity of the emotional apparatus of "Affect", 3. Autism (shutting off from the social environment and blocking of communication), 4. Ambivalence (love and hate relationship with parents). Other symptoms of hallucinations (perception in the absence of sensation), delusions (false and firm beliefs) were called accessory phenomena of lesser importance. He also added 'simple schizophrenia' to the three types viz. Hebephrenic Catatonic and Paranoid, as described by Kraepelin, to constitute one disease entity of schizophrenia. These ideas were widely accepted in the USA because of the Psychoanalytical bias there.

As the boundaries of Bleuler's schizophrenia were loose, many other syndromes having such symptoms were diagnosed as schizophrenia in the USA, whereas Kraepelin's concept was accepted and followed more in U.K. and Europe, with the result that the number of cases diagnosed as schizophrenia were much lesser in UK than in USA.

In 1960 Langfeldt differentiated Schizophrenia from Schizophrenieform psychosis to explain the variability and inconsistency of these disorders. He found that, ECT and Insulin Therapy (prevailing then; now out of vogue) were ineffective in true schizophrenia. The latter was called Process Schizophrenia.

Elgin, Phillips and Kantor devised rating scales to differentiate between Process (True) and

Non-Process Schizophrenia on the basis of premorbid personality and psychosocial adjustment. Poor prognosis was stated as the feature distinguishing Process schizophrenia from Non-Process Schizophrenia. The former was hereditary and endogenous, whereas the latter was psychogenic and exogenous. Kraepelin believed that schizophrenia was endogenous and hereditary with prevalence of hallucinations and delusions, poor prognosis. They ultimately became chronic and true symptoms of dementia followed later. This was found to be the result of herding together of chronic patients with patients of good prognosis in mental hospitals.

K. Schneider (1959) propounded a new concept of schizophrenia and described first rank symptoms viz, auditory hallucinations and insertion of undesirable thoughts by other persons (due to loss of Ego Boundaries), thought broadcasting (thoughts shared by others), and delusional misinterpretation of real perception. His second rank symptoms were perplexity, emotional blunting, other kinds of (nonauditory) hallucination and delusions.

In the sixties and early seventies, there were different concepts of schizophrenia all over the world, thus lacking in a standard definition of schizophrenia. So in 1973, WHO organised a project of "International" study of schizophrenia in Colombia, Czechoslovakia, Denmark, India, Nigeria, Taiwan, UK, USA and USSR.

The last two countries had a broader concept of schizophrenia resulting in it's over diagnosis. Subsequently, tendency to diagnose on the basis of symptoms and its course became rudimentary because etiology was neither clear nor confirmed.

Different countries followed different definitions of schizophrenia, and duration and mode of onset were considered to be better. Diagnostic aids than the symptoms of acute illness. Now it is almost agreed by various defining institutions that duration of symptoms must be at least for one month.

At present, the most widely used definitions of schizophrenia, at least for research purposes, are the St. Louis Criteria (Feighner eta11972), the Research Diagnostic Criteria (RDC) (Spitzev etal 1975) and the American Psychiatric Association's DSM IV (1994) Criteria as well as W.H.O's lCD 10 Criteria (1992).

They all require clear evidence of psychosis at present or in the past and all but the Feighner

Criteria specify particular kinds of hallucinatory experiences or delusional ideation. All the four stipulated that affective symptoms must not be prominent and all require a minimum duration of illness. (Only 2 weeks for RDC definition), 1 month for ICD and 6 months for Feighner. All definitions are arbitrary, justified only by their usefulness. They are liable to be altered or supplemented.

Though schizophrenia and its types are discussed as a single disease, it probably comprises a group of disorders with heterogeneous causes, and definitely includes patients whose clinical picture, treatment responses and defined causes of illness are varied.

Mayergrom defined schizophrenia as a group of mental illnesses characterised by specific psychological symptoms and, in the majority of cases, leading to a disorganisation of the patient's personality.

Some of the recent etiological themes are -

1. Dopamine hypofunction in mesofrontal areas of the brain are associated with manifestations of negative symptoms.
2. There is Computer Tomographic evidence of cerebral atrophy, enlarged ventricles causing extensive cognitive impairment in schizophrenia with negative symptoms which are often unresponsive to neuroleptic treatment.

What schizophrenia should mean to ordinary folks?

After this explanation of the scientific concepts and definition of schizophrenia I have to write about what schizophrenia should mean to ordinary people especially parents and close relatives or friends of persons diagnosed to be afflicted with schizophrenia.Unfortunately, even today schizophrenia is regarded with great prejudice, abhorrence and apprehension just like leprosy in the last century and AIDS in recent years.

Whereas we all must understand the implications of such a diagnosis in adolescents and young adults and take prompt therapeutic measures, it is equally important that we show a realistic and healthy attitude of sympathy, courage as well as determination to do everything possible to help doctors to bring the patient out of the snake pit as early as possible. The patient as well as his guardians should remember that there is a possibility that the diagnosis is incorrect. Fears of incurability are exaggerated by rumors and hearsay.

Indian research has identified a disorder named Acute Psychotic Disorder which is often mistaken for acute schizophrenia (Wig & Singh, ICMR). The ICD classification also contains

another disorder named Acute and Transient psychotic disorder which also could be mistaken for schizophrenia. Both the above stated disorders have much better prognosis than schizophrenia.

My own experiences of over a long period of 50 years are more encouraging. About 25% of the patients treated for schizophrenia recover and stay well for long periods after recovery. Another 30% get short attacks at longer intervals but recover enough to return to their occupation and family life. Only about 20% do not recover adequately and have to be kept under psychiatric observation and treatment over a long period. They may not be fit to return to their family or society. About 10% of patients become chronically ill.

Recent addition of atypical antipsychotic drugs to psychiatrist's repertoire has raised the hope of continuous and prolonged medication even for chronic patients without significant side effects. The demented schizophrenia patients seen by Kraepelin were desocialised, rejected or untreated patients of old style mental hospitals, when there were no antipsychotics at all. However he later did admit that 15% of all his patients recovered fully.

I have treated scores of chronic patients who later continued in their jobs till retirement, of course with the sympathetic help of colleagues and superiors. Some have helped their close relative to run small shops or trades over a long period.

One could compare schizophrenia patients with those of diabetes, hypertension, bronchial asthma, which also run a very long course in spite of regular treatment perhaps even for a lifetime. They are also not 'curable'. Often such chronic physically ill persons are a burden to the family and perhaps to the society.

Yet they are not rejected like the persons afflicted with schizophrenia. The prejudice of the people is often based on superstitious beliefs that the person is possessed by evil spirits and should be avoided. Few of such prejudiced people realise that they can also act almost like the patients they reject when they lose control due to the influence of extreme joy or anger or under the effect of alcohol or a religious trance. In short, persons afflicted with schizophrenia under treatment are in no way much different from those who are physically ill over a long period. Their relatives must have hope of cure and show courage and determination to give their unfortunate relatives best chance for recovery and for returning to family life.