CHAPTER V

SHIZOPHRENIC PSYCHOSIS

Simple Schizophrenia
Hebephrenic Schizophrenia
Catatonic Schizophrenia
Paranoid Schizophrenia
SCHIZOPHRENIC PSYCHOSIS.

The word Schizophrenia is derived from the two latin word, «Schizo» means division or slipt, and «phrenia» which means personality, i.e. split personality. This is commonly confused in the mind of lay people as meaning the split of personality in two individuals as the case of the famous novel «Dr. Jackel an Mr. Hyde». This is not true. Split personality refers to the disintegration of the higher mental functions like judgement, thinking, behaviour and emotion. Thus the core of the personality is shattered into pieces according to the degree of dismantling of those mental abilities. Being a Psychotic illness the individual is also deprived of the appreciation and contact with reality. Thus Schizophrenia can express itself in various forms of mental disturbance which eventually all lead to a progressive deterioration of the personality. The WHO has been launching an extensive research campaign with world-wide psychiatric experts in the «Pilot-study» of Schizophrenia (1973) to explore the prevalence, symptomatology, cause of the illness and the outcome as well as the local diagnostic criteria of Schizophrenia which is posing a great challenge in Psychiatry.

Schizophrenia can be considered as a group of disorders and not a single disease entity. This current research approach is contributing widely to the determination of the causation of each Nosological entity.

DEFINITION:

Schizophrenia can be defined as a group of mental disorders which lead to disintegration of higher mental functions and loss of touch with reality with consequent deterioration of personality and secondary impairment of social ships and cognitive functions.
AETIOLOGY:

Both genetic predisposition and hereditary factors are important. The nature of the specific constitutional defect is not yet fully known. There are various theories implicating nervous transmitters, enzyme activity or endocrine imbalance. Although the evidence for these hypothesis is still under the test, there is ample evidence seen in types of Schizophrenia like syndrome induced by drugs, i.e. Amphetamine-like Psychosis, toxic confusion state or organic brain damage like cases of epilepsy and chronic alcoholism or endocrine disturbance as shown by the high incidence of Schizophrenia in puberty, puerperium or menopause.

The theories of aetiology of Schizophrenia are various and complex and have been divided into genetic, metabolic, biochemical, endocrine, neurological, social and psychological. These are research topics and should be looked for in detailed text books of psychiatry given in the reading list.

INCIDENCE:

The incidence of Schizophrenia is about 0.85% of the general population. As it is the case with other disorders it is useful to differentiate between Shizoid personality trait, Schizoid symptoms or Schizophrenic illness. Schizoid personality occurs in about 3% of the general population characterised by traits like thin asthenic body-built, cold callous emotion, sensitive suspicious tendency, introvert and eccentric behaviour. There is some evidence to suggest that nearly half the people who develop Schizophrenic illness had previous history of Schizoid personality. It is not easy to establish a causal relationship between schizoid personality and schizophrenia and it is difficult to distinguish between the premorbid personality and the prodromal phase of a slowly developing illness. The strong positive family history in the relatives suggests a strong genetic component. Kallman’s work in 1946 has shown that adding the total incidence of Schizophrenia and Schizoid personality he obtained the following figures:

a. The parents 50%
b. The siblings 50%
c. The half siblings 24%

He concluded that homozygous individual (carrying perhaps two abnormal genes) would become Schizophrenic while the Heterozygous
INCIDENCE OF SCHIZOPHRENIA
Kallmann 1946

Schizophrenic 10%  Schizoid Personality 35%

Parents

Schizoid Personality 3%  Schizophrenic 15%  Sibling - Schizoid patients - 1/2 Sibling  Schizophrenic 7%  Schizoid Personality 15%

Schizoid Personality 35%  Schizophrenic 10%  To another Schizophrenic Children  Marriage  To another Schizophrenic Children  Schizophrenic 53%  Schizoid Personality 30%
(with one normal and one abnormal gene) would be of Schizoid personality.

«Slater» studies of uniovular twins (1953) has shown that the rate of Schizophrenia in concordant twins was 75%, thus he concluded that the genetic component in Schizophrenia is almost certainly multifactorial and recessive. But the weight of evidence of endocrine origin has not so far been convincing inspite of the developmental anomalies of sexual characteristic of Schizophrenic patients. The metabolic factors in the causation of Schizophrenia have been mainly derived from the observation that chronic Schizophrenics tend to have disturbed basal metabolic rate, anamalous response of blood pressure, pulse rate and electrolytes as well as maladaptive phenomena resembling hibernating animal. Recent studies have shown the concordance rate of MZ: DZ ratio of 42: 9 which are much lower than the previous figures given in earlier studies.

Krestschmer theory of personality type which has divided the body-built into asthenic, athletic and pyknic type has associated the asthenic type with 70% incidence of Schizophrenia. Multiple toxic substances have been claimed to affect the brain by chemical reactions altering the cortical enzyme system. The nature of the toxic substance is as yet uncertain. A sub-group of Schizophrenia described as periodic catatonia by Gjessing was supposed to be due to disturbed nitrogen metabolism. Thus all those endocrine autonomic and biochemical hypothesis remain to be established as evidence for or against the specific theory of Schizophrenia.

**CLINICAL FEATURES:**

The cardinal features of Schizophrenic disorder can be summarised into the disturbance of four mental functions:
1. Disorder of thinking
2. Disorder of emotion
3. Disorder of contact with reality
4. Disorder of behaviour

Some of the following disturbances were described as the most important symptoms of Schizophrenia. They are rarely found all together in one patient but their presence is of vital diagnostic criteria.

**THOUGHT DISORDER:** This is characterised by either sudden interruption of talk or inability to continue conversation, i.e.
«Thought block» or feeling that their ideas are being taken away from their mind (thought withdrawal) or that strange new ideas are being put into their mind which do not belong to them (Thought insertion).

a. **Delusions of Reference:** These could be of persecutory nature where the patient feels that everybody is against him or is trying to do him harm, thus the paranoid contents of the idea tend to make the patient feel alienated and withdrawn. The patient may feel ordinary conversation by people or broadcast in radio are made about him and that these ideas are of convincing nature that the patient might retaliate or act accordingly by assaulting other people.

b. **The Passivity Phenomena:** Sometime the patient feels that his body or mind is being interfered with by imagined outside forces or that he is made to do things automatically against his will (ideas of interference). These passivity phenomena are seen commonly in the catatonic type where the patient can assume very abnormal postures or maintain them for long time. This is the motor component of loss of will-power. The sensory part is seen in the conviction that they are being influenced by external agent like radio, television, magic, witchcraft according to the patient’s intelligence and culture. The patient may feel that there is a bugging device in the room or electrical wired are being connected in a mysterious way to his body, etc.

c. **Primary Delusions:** A delusion is a false unshakable belief held by the patient with a strong conviction the content of which is illogical and not understandable in the context of the intelligence or culture. It occurs out of the blue as opposed to secondary delusion and shows mystical changes in the surroundings or inside the body.

d. **Secondary Delusions:** These are delusions arising out of the patients attempt for the interpretation of the surroundings in a way to make rational explanation of his odd experience or to organise the chaos of his thoughts which indicate a relative preservation of judgement.

e. **Neologism:** This is synonymous to a new language which the patient invents to express his thoughts which have become so nebulous and disjointed that they convey no meaning except to the patient only.
2. DISORDER OF EMOTION:

Emotional Incongruity: This is one of the cardinal features of Schizophrenic disorder. It is exemplified in the distressing lack of emotion in response to personal catastrophies to the patient or his family. The patient may tell you about the death of his most intimate relative with the utmost lack of affection and callousness while smiling inappropriately or with silly giggling. It is often described as poor rapport or as if there is a sheet of glass separating the patient and the doctor throughout the interview, often referred to as flattening of affect.

3. Hallucinations: These are defined as sensory perceptions in the absence of external stimuli, i.e. hearing voices where there is no one speaking at all. These could be visual, tactile or auditory which are the most common in Schizophrenia. Voices usually occur in the third person making running commentary or discussing the patient. Hallucinations are the most distressing features of the illness and account for a great deal of the withdrawal and mental preoccupation of the Schizophrenic patient. They are responsible for a high percentage of the bizarre behaviour of the patient. The role of the phenothiazine is probably by acting on the reticular formation and cutting off the sensory stimuli and perceptions going up to the cortical level of the brain.

4. Disorder of Behaviour: The common example of the catatonic is often noticed by the lay man and described as classical madness - the impossible postures described as (waxy flexibility) that these patients can be made to maintain for long periods point to the loss of volition and behaviour disorder. The bizzare movement of the tongue and lips (facial grimaces) of the repetitive purposeless movements up and down the corridor with funny gestures are examples of the stereotyped behaviour of such patients.

DIAGNOSIS OF SCHIZOPHRENIA:

Schizophrenia presents a great diagnostic problem which suggests international disagreement in the concept of Schizophrenia as well as the disagreement between individual psychiatrists. This indicates that Schizophrenia is not a clear-cut diagnostic entity and that this state of affair is likely to continue until some objective method of diagnosis is established like the demonstration of a specific biochemical or psychological disturbance. Some Psychiatrists put too much emphasis
on a group of symptoms while other psychiatrists shift the weight of evidence towards another group of symptoms. There is a big variation in the diagnosis of Schizophrenia between European and American Psychiatrists and even greater difference between British and American Psychiatrists and this suggests that no system of classification is ideal.

The study of abnormal psychic phenomena is concerned with observations on the «form» that the phenomena take in contrast with dynamic psychopathology which deals with the significance of the «content» of the experience. Part of this variation is due to the differences between Psychiatrists in the use of the diagnostic terms and to bridge this gap both the American Psychiatric Association and the General Register Office in Britain have produced glossaries defining the psychiatric terms used in the World Health Organization International Classification of Disease (I.C.D.) but even so the glossaries sometimes differ in their definitions.

There are certain specific abnormalities which are important to make the diagnosis of Schizophrenia with some confidence. These abnormalities include Schizophrenic thought disorder, passivity phenomena, catatonic symptoms, flattening of affect and certain types of delusions and hallucinations. These are listed in detailed text books of psychiatric but a summary could be given here for illustration. The most important abnormalities in order of significance to the diagnosis was thought disorder, incongruity of affect, paranoid delusions, stereotype and delusions in general.

Schneider (1959) has listed those symptoms which he regards as being of first-rank importance in distinguishing Schizophrenia from other functional psychosis and he asserts that if a person with no relevant organic disease experiences any of them, the diagnosis is Schizophrenia. Schneider first-rank symptoms are:

1. Certain types of auditory hallucinations, i.e. audible thoughts, voices heard arguing and voices giving a running commentary on the patients actions.
2. Somatic Passivity phenomena - the experiences of influences playing on the body.
3. Thought withdrawal and other interferences with thought.
4. Diffusion of thought or (thought broad-casting) where the patient experiences his thoughts as being also thought by others.
5. Delusional perceptions.
6. All feelings, impulses (drives) and volitional acts that are experienced by the patient as the work or influence of others.

All other abnormal subjective experience in schizophrenia are according to Schneider of much less diagnostic importance and he calls them secondary rank symptoms.

Failure to illicit the first-rank symptoms does not exclude the possibility of schizophrenia as most of these symptoms tend to become less evident with the progress of the disease.

While most Psychiatrists have very little difficulty in diagnosing typical cases of schizophrenia there are many patients whose mental disorder is not typical but seems to merge with other mental illness.

The differential diagnosis of schizophrenia would need to distinguish paranoid schizophrenia from involuntional parophrasia and from acute paranoid reactions. Schizo-affective and affective psychosis are sometimes hard to differentiate as are latent schizophrenia and schizophrenia. Occasionally the mental abnormalities seen in other conditions such as hysteria or obsessive compulsive neurosis may be unusual and raise the possibility that the illness is Schizophrenic as in organic condition such as chronic alcoholism and temporal lobe epilepsy.

**CLINICAL FEATURES:**

For the sake of simplicity these clinical varieties can be grouped into four types, the first two of which Krapkin has described as dementia precox referring to the eventual intellectual deterioration of the illness occurring in the early adult life or puberty. Now it became clear that not all varieties occur in puberty nor do they all end with dementia.

1. **Simple Schizophrenia:** This usually occurs in the early years of school age with gradual deterioration in school performance, social relationship and behaviour disorder. The case may pass undiagnosed or may be given different diagnostic labels until they reach the stage where personality features show gradual disintegration. There is a high tendency for chronicity and progressive deterioration. So it might be very rewarding to consider the possibility of simple Schizophrenia in any youngster showing abnormal behaviour or any unexplicable change in life style.
2. **Hebephrenic Schizophrenia or Hebephrenia**: This word is derived from the Latin origin where «Hebe» means young and «phrenia» means personality, i.e. disease of young people. They are characterised by neglecting the appearance and personal cleanliness with indulgence in alcohol drinking, drug abuse, law-breaking and gang making. The label «Hebes» is often used to refer to such a group of youngsters with classical gangbehaviour living in slums and wandering around hitch-hiking from one place to another. They convey the description of such a group with a bad prognosis as in simple Schizophrenia.

3. **Catatonic Schizophrenia**: This is the classical example commonly seen in the streets. They are usually referred early to mental hospitals and they respond well to electrical treatment, especially when they go in catatonic stupor where parental feeding and proper nursing care are needed. Though prognostically they are better than the former group but socially they are the worse off in the eyes of the relatives who easily lose hope in their treatment and send them to mental asylums or keep them in chains at home.

4. **Paraphrenia or Paranoid Schizophrenia**: This is a group of disorders formerly described as Paranoia. Paraphrenia refers to Schizophrenia that occurs late in life for the first time. The most striking feature of this group is the relative preservation of the personality which remains intact for a considerable period inspite of the pathological process. The delusions which could be persecutory or grandiose seem logically knitted and well-systematised often described as «encapsulated delusions». Apart from this delusional area the patient makes a good show of his personal assets. The disorder takes insidious and progressive course with gradual development of thought disorder and emotional disturbance with hallucinations. Only then can the diagnosis become obvious or the behaviour seems distressing enough to warrant medical consultation; otherwise the patient may get into trouble with the police who may often then refer them for psychiatric opinion.

**TREATMENT:**

The effective, authoritative treatment of Schizophrenia is handicapped by the ambiguous nature of the underlying cause and the yet not fully understood mechanism of action of the various drugs in the variety of such disorder.
1. **Psychotery**: Simple supportive and not analytical type is needed. Contrary to a lot of expectations some Schizophrenics in the early stage of the illness need reassurance and understanding to help them find some order in the chaos of their life and develop confidence in the treatment.

2. **Specific Medical Measures**: These include the major tranquillizers especially the Phenothiazine group like Chlorpromazine and in high doses (anti-hallucinogenic). They help to reduce the distress.

3. **Electrical Treatment**: especially in severe excitement not responding to drug or cases complicated by depression or catatonic stupor where results are very rewarding.

4. **Prefrontal leucotomy**: is indicated in chronic intractable cases resistant to all sorts of treatment and accompanied by distress and suffering.

5. **Deep Insulin Coma**: This has now become obsolete since it was introduced by Sakel in 1927. It has become obsolete following the introduction of modern Psychotropic drugs. The idea was based on the assumption that epileptic patients do not develop Schizophrenia probably due to the convulsive fit. It was then thought that if a similar condition could be induced by hypoglycaemic coma this would provide cure. A full course comprised of 30-40 comas used to be given. Now it has been established that epileptic patients can develop Schizophrenia-like Psychosis while ECT can give a well controlled modified fits to improve their condition. In brief one should add that Schizophrenia remains one of the greatest challenges in Psychiatry as cancer remains one of the greatest challenges in general medical practice.

**PROGNOSIS:**

Manfred Bleuler, the Swiss Psychiatrist, has done a great historical study in 1941 of the prognosis of Schizophrenia which would remain as one of the corner-stones in the research of Schizophrenia. He divided them into two equal percentage, i.e. 50%:

- Of the first 50% -25% would recover from the first attack 25% would show marked improvement with slight residual defect.
- Of the 2nd 50% -25% show some improvement but with severe residual deficit.
- **25%** No recovery and can only benefit from leucotomy after 20 years of prolonged suffering.
Wing and others have recently investigated the clinical and social outcome of Schizophrenia and compiled a list of symptoms with good and bad prognostic features.

REHABILITATION OF CHRONIC SCHIZOPHRENIA:

The WHO and the various Health Organizations are at present engaged in an extensive research into the rehabilitation of chronic Schizophrenics since they constitute from 60 to 80% of the inmates of big mental hospitals. Since the emergence of the concept of institutional neurosis people have become more aware of the danger of keeping Schizophrenic in the mental hospitals for long period. The term «Institutional neurosis» refers to the clinical condition of chronic or long-stay patients in mental hospitals who suffer from understimulation, lack of socialisation and poor environmental condition. These patients show poverty of speech, loss of touch with surroundings, defective cognitive function and failure to adjust to life outside the hospital, i.e. they become institutionalised. The work of «Clark» in therapeutic community and the provisions in the English Mental Health Act 1959 regarding the rehabilitation and after-care facilities under the local authorities, every country is providing legislation to cater for primary, secondary and tertiary health care within the frame-work of community Psychiatry as a whole. The therapeutic community refers to the treatment milieu in which the patient receives an intensive rehabilitation programme like active involvement in occupational therapy, participation in social activities inside and outside the wards, outgoing trips organised by voluntary agents, token economy programmes of behavioural therapy, working in sheltered work-shops with nominal fee etc. It is the movement towards the recent trend of open-door policy of mental hospital as opposed to the old closed mental asylums. The social aspect of the treatment in the rehabilitation of chronic Schizophrenic is receiving greater emphasis in the family and community. It involves the area of accommodation, work, social readjustment, improvement of family contacts, etc. The increasing number of out-patient departments in general hospitals are being built with the closure of big mental hospitals, provision of day hospital and moderate clinics or suitable half-way homes or hostels on trial leave basis for the gradual integration of the patient in the community and replacements of the old fashion locked door policy into seclusive wards or bed in chains. The primary aim of modern therapeutic intervention is to consider disposal action from the first interview. The greatest con-
tribution of those undertaking Psychiatric treatment as a team is to return the patient back to the society into a sheltered environment and a regular secured job that is suitable to his mental and physical resources.