

# THE SCHIZOPHRENIAS---- A DELUTIONAL DISORDER

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## **INTRODUCTION**

We probably have some familiarity with the term “SCHIZOPHRENIA”. We use its plural form, “THE SCHIZOPHRENIAS” for my paper’s title in recognition of the growing consensus that what is meant by “SCHIZOPHRENIA” encompasses several different types of relatively several mental disorder. As the American Psychiatric Association(1997)has recently put it, “It is likely that schizophrenia is the final common pathway for a group of disorders with a variety of etiologies, courses, and outcomes.”

Nevertheless , THE DSM-IV provides diagnostic criteria for only “SCHIZOPHRENIA” thus treating it as though it were a singular entity. To avoid confusion, therefore, and also for the sake of convenience, we frequently employ the singular form of the term in what follows. It should be understood, however, that the diagnostic criteria for the diagnosis of SCHIZOPHRENIA are probably a manifestation of an unknown number of differing pathological conditions sharing a “FINAL COMMON PATHWAY” ---- a striking and essential feature: a significant loss of contact with reality, often referred to as psychosis.

The typical SCHIZOPHRENIA person is someone who has lost or become detached from a set of anchoring points fundamental to adequate mental integration and communication with the surrounding human environment.

We will in addition consider here the the condition the DSM-IV calls DELUTIONAL DISORDERS, whose main features were formerly included under the classic rubric Paranoia, or “TRUE” Paranoia (to distinguish it from the paranoid subtype of SCHIZOPHRENIA,). Patient with delutional disorder, like many SCHIZOPHRENIA persons, nurture, give voice to, and sometimes take actions based on, beliefs that are considered completely false and absurd by those around them unlike SCHIZOPHRENIC individuals, however, persons with delutional disorder may otherwise behave quite normally. Their behaviour doesnot show the gross disorganization and performance deficiencies characteristics of SCHIZOPHRENIA, and general behavioural deterioration is rarely observed in this disorders, even when it proves chronic.

## **DEFINITION OF SCHIZOPHRENIAS**

The disorders now called SCHIZOPHRENIA were at one time attributed to a type of mental deterioration beginning early in life. In 1860 THE BELGIAN PSYCHIARTIST BENEDICT MOREL described the case of a 13 years old boy who had formerly been the most brilliant pupil in his school but who gradually lost interest in his studies, become increasingly withdrawn, lethargic, seclusive, and quite and appeared to have forgotten everything he had learned. He talked frequently off killing his father. Morel thought the boy’s intellectual, moral, and physical functions had deteriorated as a result of brain degeneration of hereditary origin, and hence were irrecoverable. He the term DEMENCE PRECOCE (mental deterioration at an early age) to describe the condition and to distinguish it from the dementing disorders associated with old age.

## **ORIGINS OF SCHIZOPHRENIA CONCEPT**

The Latin form of this term –DEMENTIA PRAECOX –was subsequently adopted in the late nineteenth century by the German Psychiatrist EMIL KRAEPELIN to refer to a group of condition that all seemed to have the feature of mental deterioration beginning early in life. Actually however, the term is somewhat misleading. There is no compelling evidence of progressive (i.e, worsening over time) brain degeneration has been observed , it sometimes appears to have been treatment induced by virtue of excessive dosing with

antipsychotic medication (Cohen, 1997; Gur et al, 1998). We will address this issue further in the section on neuroanatomical factors. Finally, SCHIZOPHRENIC symptoms sometimes make their first appearance well into middle age or beyond, although onset in adolescence or early adulthood is far more typical.

It remained for a Swiss Psychiatrist, EUGEN BLEULER, to introduce in 1911 a more acceptable descriptive term for this general class of disorders. He used "SCHIZOPHRENIA" (split mind) because he thought the condition was characterized primarily by disorganization of thought processes, a lack of coherence between thought and emotion, and an inward orientation away (split off) from reality. The splitting thus does not refer to multiple personalities, an entirely different form of disorder discussed in new called dissociative identity disorder. Instead in SCHIZOPHRENIA there is a split within the intellect, between the intellect and emotion, and between the intellect and external reality. The subtitle of BLEULER'S monograph on the subject (BLEULER, 1911/1950) was the group of SCHIZOPHRENIAS, indicating his own belief in multiple in which the basic psychic splitting might be manifested.

## **THE CLINICAL PICTURE IN SCHIZOPHRENIA**

### **1. DISTURBANCE OF ASSOCIATIVE LINKING**

Often referred to as formal thought disorder, associative disturbance is usually considered a prime indicator of a SCHIZOPHRENIC disorder. Basically, an affected person fails to make sense, despite seeming to conform to the semantic and syntactic rules governing verbal communication. The failure is not attributable to low intelligence, poor education, or cultural deprivation. MEEHL (1962) aptly referred to the process as one of "COGNITIVE SLIPPAGE"; others have referred to it as "DERAILMENT" or "LOOSENING" of "ASSOCIATIONS" or "INCOHERENCE".

### **2. DISTURBANCE OF THOUGHT CONTENT**

Disturbances in the content of thought typically involve certain standard types of DELUSIONS or false beliefs ( OTTMANN and MAHER, 1988) . Prominent among these are beliefs that one's thoughts, feelings or actions are being controlled by external agents; that one's private thoughts are being broadcast indiscriminately to others; that thoughts are being inserted into one's brain by alien forces; that some mysterious agency has robbed one of one's thought; or that some neural environmental event (such as a television program or a billboard) has an intended personal meaning , often termed an "IDEA or REFERENCE".

### **3. DISRUPTION OF PERCEPTION**

Major perceptual disruption often accompanies the criteria already indicated. The patient seems unable to sort out and process the great mass of sensory information to which all of us are constantly exposed. As a result, stimuli overwhelm the meagre resources the person has for information processing.

### **4. EMOTIONAL DYSFUNCTION**

The SCHIZOPHRENIA syndromes are often said to include an element of clearly inappropriate emotion, or affect. In the more severe and chronic cases, the picture is usually one of apparent anhedonia ( inability to experience joy or pleasure) and emotion shallowness or "BLUNTING"(lack of intensity or clear definition). The person may appear virtually emotionless, so that even the most compelling and dramatic events produce at most an intellectual recognition of what is happening. In other instances, particularly in the acute phases, the person may show strong affect, but the emotion clashes with the situation or with the content of his/her thoughts. For example : the person may respond to news of a parent's death with gleeful hilarity.

### **5. CONFUSED SENSE OF SELF- SCHIZOPHRENIC**

person may feel confused about their identity to the point of loss of a subjective sense of self or of personal agency. DELUSIONAL assumption of a new identity including a unique one such as JESUS CHRIST or the VIRGIN MARY, is not uncommon. In other instances the person maybe perplexed about aspects of his/her own body, including its gender, or maybe uncertain about the boundaries separation the self from the rest of the world. The latter confusion is often associated with frightening “COSMIC” or “ OCEAN” feelings of being somehow intimately tied up with universal powers, including GOD or the DEVIL.

#### 6. **DISRUPTED VOLITION**

Goal- directed activity is almost universally disrupted in SCHIZOPHRENIC individuals. The impairment always occurs in areas of routine daily functioning, such as work, social relations, and self-care, such that observers note that the person is not himself/herself any more.

#### 7. **RETREAT TO AN INNER WORLD**

Ties to the external world are almost by definition loosened in the SCHIZOPHRENIC disorders. In extreme instances the withdrawal from reality seems deliberate and involves active disengagement from the environment. This rejection of the external world maybe accompanied by the elaboration of an inner world in which the person develops illogical and fantastic ideas, including the creation of strange beings who interact with the person in various self-directed dramas.

#### 8. **DISTURBED MOTOR BEHAVIOUR**

Various peculiarities of movement are sometimes observed in the SCHIZOPHRENIAS; indeed, this is the chief and defining characteristic of CATATONIC SCHIZOPHRENIA. These motor disturbances range from an excited sort of hyperactivity to a marked decrease in all movement or an apparent clumsiness. Also included here are various forms of rigid posturing, mutism, ritualistic mannerisms, and bizarre grimacing.

### **THE CLASSIC SUBTYPES OF SCHIZOPHRENIA**

1. **UNDIFFERENT TYPE-** As the term implies, the diagnosis of SCHIZOPHRENIA, UNDIFFERENT TYPE, is something of a wastebasket category. A person so diagnosed meets the usual criteria for SCHIZOPHRENIA- including( in varying combinations) delusions, hallucinations, disordered thoughts, and bizarre behaviours- but doesnot clearly fit into one of the other types because of a mixed symptoms picture. People in the acute , early phases of schizophrenic breakdown frequently exhibit undifferentiated symptoms, as do those who are in transitional phases from one to another of the standard subtypes.

#### 2. **CATATONIC TYPES**

The central feature of Schizophrenia, Catatonic type, is pronounced motor signs, either of an excited or a stuporous type, which sometimes make for difficulty in differentiating this condition from a psychotic mood disorder. The clinical picture is often an early manifestation of a disorder that will become chronic and intractable unless the underlying process is somehow arrested. Though at one time common in Europe and North America , Catatonic reactions have become less frequent in recent years.

#### 3. **DISORGANIZED TYPE**

Compared with the other subtypes of schizophrenia, schizophrenia, disorganized type, usually occurs at an earlier age and represents a more severe disintegration of the personality. Fortunately,like catatonia, it is relatively uncommon. In pre-DSM-III classifications, this type was called HEBEPHRENIC SCHIZOPHRENIA.

#### 4. **PARANOID TYPE**

Formerly about one-half of all schizophrenic first admissions to hospitals were diagnosed as schizophrenia, paranoid type. In recent years however, the prevalence of the paranoid type has shown a substantial decrease, while the undifferentiated type has shown a marked increase. The reasons for these changes are uncertain but may relate to the promptness with which newly diagnosed schizophrenic patients are now put on antipsychotic medication, which has an especially powerful effect in suppressing "POSITIVE" symptoms such as paranoid delusions.

#### **CONCLUSION**

Schizophrenia is a psychotic type disorder which is not curable, but through the proper use of medication, and use of proper therapies we can lessen the degree of this disorder. Through the cognitive behaviour therapy we can treat the schizophrenic patient to avoid the delusion, hallucination and treat them to think about rationally.

The concept of schizophrenia is dying. Harried for decades by psychology, it now appears to have been fatally wounded by psychiatry, the very profession that once sustained it. Its passing will not be mourned. Arguments that schizophrenia is distinct disease have been "FATALLY UNDERMINED".

#### **REFERENCES**

1. Abnormal psychology by Robert C. Carson
2. Civilization and its discontents by Sigmound Freud
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