DOWNLOAD PDF THE SCHIZOPHRENIC REACTIONS: A CRITIQUE OF THE CONCEPT, HOSPITAL TREATMENT, AND CURRENT RESEARCH

Chapter 1 : Frequently Asked Questions and Answers - blog.quintoapp.com

The schizophrenic reactions: a critique of the concept, hospital treatment, and current research; the proceedings.

National Institute of Mental Health - concise overview of different disorders, diagnoses, treatments, options, and resoureces Rethink - UK mental illness charity - wealth of information for patients and family on disorders, coping, practical matters, etc. Check out our full list of web-based resources , including organizations and online reading material Also check out our online PDF reference library , with links to the most helpful pdf documents on mental illness and related issues. Watch and Listen to our archives of internet-based audio and video files on schizophrenia, mental illness, and related issues. Good files to start with include: Treatment, Access, Hope for the Future? Build a support network as soon as you can of other families with similar experiences. The discussion boards at schizophrenia. Also, consider taking a Family-to-Family class also through NAMI , a free week education course designed for and taught by family caregivers of people with severe mental illness. This class is highly recommended by many members of schizophrenia. See the Family-to-Family website for more program information and class schedules. Find the mental health support resources in your area. Search a state-by-state database of available mental health services in the U. What is the prognosis? How likely is it that a person with schizophrenia will ever have a "normal" life? With treatment, rehabilitation therapy, and lots of social support and understanding, many schizophrenia patients can recover to the point where their symptoms are more or less completely controlled. Many are living independently, have families and jobs, and lead happy lives. See the success stories of some such patients on the schizophrenia. But as time goes on, most people learn what works. They find their best medication. They learn not to drink too much alcohol, and to take care of themselves. The find a good doctor, and often others help them, such as friends, priest, or counselor. People make a decent life for themselves. They find love, ,they find work The key is to stick with the medication, and to never give up. There are factors in the course of the disease that can, to a certain degree, help predict the various outcomes. You can improve the chances for a good prognosis by knowing what the indicators for possible relapse are , working to get the best possible treatment as quickly as possible, and learning how to effectively self-manage a long-term mental illness. For a good presentation on the prognosis for people who have schizophrenia, and an update on new treatments for schizophrenia see the Stanford University "New Treatments for Schizophrenia" presentation. How is schizophrenia treated? They are not as effective in controlling negative symptoms, and may cause side-effects of their own. See our Medications area for information on commonly prescribed antipsychotic medications - how they work, how effective they are, what side-effects they cause - as well as additional info on research studies and medications in clinical trials. See also New and Newer Mechanisms of Action for Antipsychotic Medications , an online UCLA grand rounds video presentation that explains in some detail what areas of the brain different drugs target, and what effects they have. Although an important element, medication is far from the only treatment used for schizophrenia patients. Many patients and their families choose supplemental therapies these can include psychosocial or cognitive therapy, rehabilitation day programs, peer support groups, nutritional supplements, etc to use in conjunction with their medications. In certain severe cases, some patients also respond to electroconvulsive therapy which has been shown to be safe and effective or transcranial magnetic stimulation TMS. In the case of therapy, some research has shown that psychotherapy and medication can be more effective than medication alone however, the same study noted that psycotherapy alone was NOT a substitute for medication. The three main types of psychosocial therapy are: For schizophrenia, cognitive-behavioral therapy has shown the most promise in conjunction with medication. For some supplementary treatments options as well as "alternative therapies" that have been disproved , see Other Treatments on the schizophrenia. ABC news host talks with a panel of experts about what treatments are out there and how successful they are.. Link to video file and transcript. What to expect after going on medication: Medication can greatly decrease symptoms and help a person return to a functional

level; however, every case is unique, and medications are not perfect. It will likely take a long, frustrating trial-and-error process before a treatment regimen is found that works best for the patient. Keep track of every medication and at what dosage you or your loved one is on, what side effects it causes, which symptoms get better and which get worse. A journal the same journal where you write down symptoms and behaviors is an excellent place to do this. They are not frivolously experimenting; trial-and-error is the only way to eventually find a combination that works. Medications are never a perfect fit: You can help this process with feedback about the different medications see paragraph above. An antipsychotic medication can take weeks or even months to start working at full strength, so be patient and keep recording things in your journal. Medications are less likely to make any huge, noticeable changes in life; instead they should make things generally "easier. Sometimes these voices quiet down to a point where they are not harmful or debilitating, and many people with schizophrenia make a decision at this point that living with these quieter voices in the background is preferable to going through the pain of more medication and more side-effects. Some general things to be aware of: Both the illness itself and many of the medications used to treat it can make a person feel overly tired or lethargic. You may need to sleep more than you think, and it may be unrealistic to try and dive head-on back into your normal activities. Recovering from schizophrenia is like recovering from any long-term illness. Be aware if others are pushing you too hard to "get back out there" - give yourself the time and support you need. Without a good health insurance plan, antipsychotic medications particularly the newer ones can be terribly expensive. However, you have some options even if you are currently unemployed or uninsured. Here are a few suggestions: Apply for Supplemental Security Income SSI or disability benefits, federal funds that are available for physically or mentally disabled persons who are unable to work. See if you qualify for Medicare for elderly or Medicaid for low income persons health coverage. Your doctor or a hospital social worker can advise you on your eligibility, and help you apply. The older antipsychotics tend to be cheaper than the newer ones - discuss with your doctor the possibility of using a cheaper alternative. Be aware, though, that the older medications also may have significantly more side-effects, and are not as effective controlling negative symptoms Information on available low-cost medications , and what benefits are available to mentally ill or disabled persons, is available on the schizophrenia. A good psychiatrist can and should be an ally in the continual process of treatment and recovery. They should be willing to work with you as an informed member of the treatment team and ideally they should be well-informed and experienced in treating schizophrenia and related disorders. Here are some suggestions to help you find a psychiatrist you can effectively work with: Ask others in the medical profession friends, relatives, your own physician, etc who they would send their own family members to for similar problems. Contact your local support group in your state or country to get in touch with families dealing with the same situation, and ask them about good mental healthcare providers that they have used. Hospitalization - when and why is it necessary? At some point or another, most people with schizophrenia will likely have to be hospitalized for at least a short time. Hospitalization can be voluntary requested by the patient themselves or involuntary, meaning it is up to the discretion of the treating psychiatrist, emergency room staff, or a courtroom see the criteria and procedures for involuntary hospitalization by U. At the point of hospitalization, a person may be in pretty bad shape - feeling sick, scared, out of control, and abandoned. Why might somebody need hospitalization, rather than outpatient care? Hopefully, this means you start feeling better sooner. Trained staff members are always around to talk to about questions, concerns, or thoughts. Most agree, at least in retrospect, that getting treated in the hospital was the best thing for their health and well-being at the time. Some of their thoughts are quoted below: Try the meds they give you and work with the staff. They are there to help and want you to talk to them when you are having problems. The other patients on the ward will have different illnesses than just schizophrenia, like bi-polar, depression and drug addiction Hopefully if you go you can get things straighten out. So I did not like being there at all. The hospital is the place my healing started, and I find that it was not an enjoyable experience but a helpful one. I had faith that the medicine would help me from the beginning, and it turned out to be true. Psychiatric facilities include public hospitals state, county, or community , university teaching

hospitals, private psychiatric treatment centers, and VA hospitals. Fuller Torrey, in his book "Surviving Schizophrenia" pp. A JCAHO team, upon invitation by the hospital, surveys patient care and services, therapeutic environment, safety of the patient, and quality of staff and administration. The hospital may receive full 3-year accreditation, full accreditation with a contingency meaning that a follow-up inspection may be warranted , or no accreditation. Bear in mind that accreditation is given to hospital as a whole, NOT to individual wards. Ask for JCAHO accreditation at the hospital administration office, or look for a certificate by the entryway or in the lobby. Due to the staff, even individual wards in the same treament facility may vary in quality. Private facilities are not necessarily better than public ones. Again, evaulations of the staff at each location should guide you. Hospitalization is no easy experience for friends or family members either. Especially if commitment was involuntary, family may be hesitant about visiting, unsure of how to react when their loved one returns home, and fearful that their loved one will never forgive them for making that hard choice. I felt so much guilt if I allowed myself the slightest amount of pleasure, so instead would stay in continuous grief mode. It consumed me day and night - all I could think of was, what was what my child going through at that very moment? What kind of a Mother could I be if I dared allow myself to read a book, go to a movie, etc.

Chapter 2 : blog.quintoapp.com - Schizophrenia and Involuntary Treatment Laws

Schizophrenic Reactions: A Critique of the Concept, Hospital Treatment, and Current Research: The Proceedings of the Menninger Foundation Conference on the Schizophrenic Syndrome (1st Edition).

These statements are disconfirmed by scientific facts: People with schizophrenia do not usually progressively deteriorate: Psychotherapy and milieu therapy, without medications, have led even the most severely disturbed individuals with schizophrenia to full recovery and beyond. The shooting of two United States Capitol building guards in July , by a man said to be suffering from "paranoid schizophrenia," led to a flurry of media attention on "schizophrenia. These statements are inconsistent with published scientific facts and mislead the public. This is a brain disorder. These statements distort and misrepresent research findings published in the scientific literature in eight significant ways. Schizophrenia is not "a single disease. Statements to the effect that schizophrenia is "a brain disease" singular are misleading. Evidence for the brain disease hypothesis is weak. Some psychiatrists, however, attribute undue significance to weak evidence Boyle, The data actually revealed that of the 24 patients studied, only 3 In the healthy control group, one subject had a similar brain anomaly. Andreasen found that a few people without symptoms of schizophrenia have brain abnormalities similar to those of some schizophrenic subjects. The brains of the majority of individuals with schizophrenia are normal as far as researchers can tell at present" p. In addition, rarely do studies with positive findings control for the effects prolonged use of neuroleptics and other drugs. The "brain disease" hypothesis cannot accommodate solid evidence that many people completely recover from schizophrenia. Manfred Bleuler a , author of the authoritative textbook on schizophrenia, wrote: Nearly a third of schizophrenics recover for good. In general the psychosis does not progress more after five years from its outbreak but, rather, improves These and other facts concerning the course and outcome of schizophrenic psychoses are certainly not characteristic of organic cerebral and metabolic disease" p. Indeed, longitudinal studies of thousands of ex-patients in many countries show that one-half to two-thirds of the individuals diagnosed as schizophrenic have achieved full recovery or significant improvement many years later. Many of the ex-patients in the studies listed above were evaluated 20 to 35 years after discharge. Those who recovered include ex-patients once viewed as the most profoundly disturbed. Courtenay Harding and her colleagues Harding, tracked down and evaluated 82 individuals who, 20 to 25 years before, had been the most hopeless, chronically disturbed, back-ward patients when discharged from a state hospital into a rehabilitation program. Harding emphasizes that "for one-half to two-thirds the long-term outcome was neither downward or marginal, but an evolution to various degrees of productivity, social involvement, wellness, and competent functioning" p. Many of them were found to be completely symptom free. No brain disease has ever been cured with psychotherapy or the passage of time. In recent times the best known case of spontaneous recovery from schizophrenia is that of John Forbes Nash. In , at the age of 21 Nash wrote a Ph. Nine years later, Nash suffered a mental breakdown and was diagnosed with paranoid schizophrenia. His life and career were devastated. During the next 20 years he functioned marginally in the United States and Europe and was hospitalized many times for brief periods. Old friends, former colleagues, and admirers stayed in touch with him and continued to be kind to him. Then, for unknown reasons, Nash had a sudden remission. According to his ex-wife and sister, the two people who knew him best, his recovery was not due to any medications or psychological treatments Nasar, Some people diagnosed with schizophrenia progress beyond recovery. John Weir Perry reported that 85 percent of the clients all met DSM criteria for schizophrenia and were "severely psychotic" treated at Diabasis, "not only improved, without medication, but most went on growing after leaving" p. For some, a schizophrenic episode appears to function as a breakthrough to a higher level of mental and emotional functioning Pickering, ; Sannella, ; Siebert, Silvano Arieti stated that "with many patients who receive intensive and prolonged psychotherapy, we reach levels of integration and self-fulfillment that are far superior to those prevailing before the patient was psychotic" p. Earlier, Arieti wrote: The cause of schizophrenia is unknown American

Psychiatric Association, ; Gottesman, All these things add up to produce a brain injury that we then recognize as schizophrenia. Given the encompassing list of risk factors, why do not more people exposed to them develop schizophrenia? Proponents of the "brain disease" hypothesis cannot explain why schizophrenias occur so consistently in physically healthy young adults, aged 16 to 25, but rarely in anyone over 40, regardless of any physiological stressor Arieti, ; M. There is no "universal" recognition that schizophrenia is a brain disease "like all other brain diseases. None of the following neurology journals published articles on schizophrenia between and Most articles attempting to support the "brain disease" hypothesis of schizophrenia appear in psychiatry and biopsychology journals. Bleuler, a; Breggin, ; Karon, ; Lewine, ; Menninger, Even the Diagnostic and Statistical Manual fourth edition of the American Psychiatric Association , states plainly: This statement highlights that the "brain disease" hypothesis stands or falls on simple criteria. A true brain disease must be identified and confirmed by laboratory tests. However, such a test might well identify someone who has been taking neuroleptic medications for many years. This is a solidly established fact in psychiatry. Many people diagnosed as schizophrenic say they are helped by neuroleptic drugs. It is professionally irresponsible, however, for Pickar and other schizophrenia psychiatrists not to inform the public that many people are seriously harmed by neuroleptic medications and that many people can recover and maintain a full recovery from a schizophrenia without medications. Discussion As we have seen, some psychiatrists significantly distort and misrepresent research findings published in the psychiatric literature. They consistently downplay evidence that most people with a schizophrenia do not have brain or biochemical abnormalities and that some people with similar abnormalities have no signs of a schizophrenia. People with neuropathological diseases have never been cured by psychotherapy nor found decades later to be fully recovered. While some weak positive correlations have been found between the presence of schizophrenic symptoms and certain brain abnormalities, a basic scientific principle remains: In some instances, an underlying cause may lead to both brain abnormalities and schizophrenic symptoms. Some psychotherapists reporting cases of successful recovery from a schizophrenia say that the symptoms often trace back to extremely traumatic childhood incidents that created powerful, conflicting feelings of loneliness and terror Karon, What if some "schizophrenic" conditions turn out to stem from some form of chronic childhood traumatic stress disorder Ford, that has persistent effects on brain structure or function? For many, this amounts to hearing themselves sentenced to a slow, painful, early death. Yet no one ever dies of schizophrenia, even when it is untreated Mendel, Is this erroneous and misleading information contributing to the high suicide rates of people diagnosed as schizophrenic? Responsible, scientifically accurate statements to the media about schizophrenia might be expressed as follows: Research suggests that a few people diagnosed with a schizophrenia have neurological complications, but many people with the same neurological profile do not develop a schizophrenia. There is no known cure for schizophrenia. Some people benefit from medications that control their undesirable symptoms, some people are harmed by the medications, and other people do better without medications. About one person in ten never recovers from the original disturbed or disturbing experience and the effects of repeated hospitalizations, but five or six out of ten can be expected to fully recover or significantly improve. At present we cannot predict who will develop schizophrenia or why, who will recover or who will not. Further, we cannot explain why some people recover within weeks or months while others take from 5 to 20 years to recover. Diagnostic and statistical manual of mental disorders, fourth edition. Symptoms, signs, and diagnosis of schizophrenia. The Lancet, , Linking mind and brain in the study of mental illnesses: Science, 14 March , The interpretation of schizophrenia 2nd ed. On schizophrenia, phobias, depression, psychotherapy, and the farther shores of psychiatry. Understanding and helping the schizophrenic. Milieu therapy in schizophrenia. Dementia praecox or the group of schizophrenias. A year longitudinal study of schizophrenics and impressions in regard to the nature of schizophrenia. American Journal of Psychiatry, , 11 , My sixty years with schizophrenics. Psychosis and human growth. Experience, theory, and research 2nd ed. Schizophrenia, a scientific delusion? Brain disabling treatments in psychiatry. The treatment of schizophrenia: Identifying patients who should not receive medication. Schizophrenia Bulletin, 8, An

overview of the schizophrenic syndrome. Behavioral Publications Cannon, M. Journal of Neurology, Neurosurgery, and Psychiatry, 61, Catamnesic long-term study on the course of life and aging of schizophrenics. Schizophrenia Bulletin, 6, Broken brains or wounded hearts.

Chapter 3 : Unethical Psychiatrists Misrepresent What is Known About Schizophrenia

- The schizophrenic reactions: a critique of the concept, hospital treatment, and current research; The proceedings by Robert Cancro.

A good community system can dramatically cut down on the use of involuntary treatment. On the other hand, it is important to be aware of the cost of the status quo: Put another way; of the 2 million people who are living with schizophrenia today, , of them will kill themselves. Each year over 30, individuals with serious neurobiological disorders NBD serve time in our jails does not include state or federal prisons Each year over 11 million days are spent by individuals with NBD in jail does not include state or federal prisons , individuals with serious neurobiological disorders live on the streets or in shelters While a variety of factors account for these facts, the question has to be asked, "would the lives of some people with NBD be improved if they had had access to some form of involuntary treatment? In the past few years, there has been a trend towards changing involuntary treatment laws. There are two main reasons for this: The public wants the authorities to make the problem of violence by people with NBD go away. Hence, the "expressed" wishes of a consumer regardless of whether they have the ability to express their true wishes are paramount. Up until recently, it has been this second group, rather than the first group which has dominated the debate. This is due to several factors: NAMI groups are underfunded and can not afford to hire the technical skills lawyers, lobbiests, community organizers necessary to effect change. Hence we tend to rely on volunteers who may or may not have the time or expertise. Desire to deny violence: Many NAMI members believe that it is in our best interest to deny that individuals with even the most severe NBDs are more prone to violence than others. They believe this is stigmatizing and talking about it will prevent communities from welcoming housing and services for people with NBD. Since the issue of violence is often at the core of involuntary treatment decisions, the failure to address violence stymies progress. There has been no written consensus around involuntary treatment and most boards have not to tried to rectify this. Just the use of the words "involuntary treatment" carries so much emotional baggage that rational discussion is often impossible. There are 5 preliminary steps to take before trying to change the laws: Get educated about the history of the laws 2. Get educated about the current status of research particularly as it involves lack of insight, violence, treatment efficacy, health care costs and involuntary treatment. Develop a policy for your board based on the above. After you have done all this, you will be in a position to change the laws. History of involuntary treatment laws Before attempting to change the laws in your state you must get a good education on the history of involuntary treatment laws. There have been many court cases and laws passed which provide the framework within which you must operate. I can not emphasize this enough. Without this background on what has gone before, and how we got where we are, you will be out-gunned by those trying to prevent you from making changes. The single most important book you should read is Madness in the Streets: What follows is an extremely basic introduction to some of the concepts you should know about. The state has "police" and "parens patriae" powers Involuntarily committing someone involves taking away freedom. Hence, it is not a decision that can or should be made lightly. The first is to protect the citizenry from harm and the second is to protect the individual from harming himself. Almost all state laws involving commitment, evolve from these basis. When someone is actively trying to shoot someone, there is no doubt that the state can detain that person to protect society. When someone is trying to shoot their own self, there is also no doubt that the state can detain the person. For example, the Civil Liberties Union once brought in an expert witness to testify that just because a homeless mentally ill psychotic woman was eating feces, that it would not kill her and therefore she was not in imminent danger of being a danger to herself. Others may argue that an individual should only have to exhibit a condition which will predictably lead to dangerousness before they can be confined. That way they can be helped before they become dangerous, rather than after. This offers greater protection to both society and the individual. There have been numerous court cases which have addressed this issue. Schmidt, etc But I would caution the careful

advocate from placing blind faith in these previous decisions. First of all, all court decisions can be overturned. But it was overturned. Secondly, many decisions are routinely misinterpreted by the mental health bar to mean what they would like them to mean. But Paul Stavos, Esq. Unfortunately, the state rarely exercises its ability to commit individuals with NBD under parens patriae standards. These standards are most often used by the state to prevent children from abuse and to provide care for the developmentally disabled. The problem here is that our laws have not kept pace with the current status of research proving NBD is real see below. In addition, the concept of least restrictive setting would seem to argue for a greater use of outpatient commitment this is a court order which allows someone to live in the community provided they follow a court ordered treatment plan such as staying on meds or off drugs. Unfortunately, very few states make use of involuntary outpatient commitment. Instead, they rely on the more restrictive and often abusive inpatient setting. As a result of decisions like Rivers vs. Klien; In the Matter of Richard Roe, etc. These hearings often occur weeks apart resulting in the ludicrous, cruel, expensive, and dangerous proposition of having someone hospitalized but not allowed to be given treatment. The reason for this is that there are two different criteria used. Hence, one can be acting dangerously, yet still retain capacity. In that case the individual would be committed but have a right to refuse treatment and a second court hearing would be needed on whether or not they retain capacity. If they have capacity, they can not be treated over objection. It does not mandate that they give treatment. This fact is sometimes purposefully ignored. Again, please read Madness in the Streets, for a more complete and useful understanding of the laws. Examine the laws in your state or province and their real-world application. After you have a general understanding of the issues, and before attempting to change the laws in your state it is important that you get a good handle on what the laws in your state say and how they are or are not enforced. In addition there are two kinds of laws in each state. It was a specific act of the legislature. In other words, in interpreting Codified Laws, judges often create legal precedents that are as binding as laws. You have to know not only what is written in the law, but what has been decided by the courts. You also have to know what policies your health care establishment have adopted in interpreting these laws. You do not have to be a lawyer to do this. You only need to be resourceful. It is not easy to find out what the laws are in your state. Very few people are knowledgeable about this esoteric area and even those who are, often make mistakes self-included. So the very first step is to collect information from as many different sources as you can. If you rely on a single source for your information, I can pretty much say you will not get the whole picture or perhaps even an accurate picture. Following are people you should ask for information from. Ask for the information from all of them: Ask all your elected representatives in your state capital Assembly and senate for a copy of the relevant laws. The more people you ask, the more different bits of information you will be sent. Ask your local Protection and Advocacy Organization and Civil Liberties Union if they can provide you with a copy of the law and any materials they have on it. Ask your hospital administrator for a copy of their policies on involuntary treatment. Very often, hospitals have written policies which were written in reaction to laws and court decisions. This info will show you how your hospital is applying the decision on a person to person level. Find out how they feel the procedure has worked. Ask your state Department of Mental Health for a copy of all laws and policies they have on involuntary treatment. Ask your local American Psychiatric Association if they have a resident expert on these issues who you can talk to. Ask your local American Bar Association if they have a subcommittee or expert on these issues who you can talk to. Talk to members of your AMI who have been involved in a personal level with this issue and find out what their experiences have been. This is very important. My research has shown that in many areas, what the laws say, and what is actually done, are not always the same. The fact is, not many lawyers, doctors, or judges are expert in this area, and often application of the laws is inconsistent with the content of the laws. Not only must you know what the laws say, you must know how they are enforced. Talk to consumers who have experienced involuntary treatment. I have found that this is best done one on one. Consumers are uniquely qualified to tell about the quality of care they did or did not receive as a result of involuntary proceedings. They may also have good information on what actually takes place during the proceedings. While many

consumers are against involuntary treatment in every case, many more in my opinion believe that there is a time and place for it. However, few consumers believe that changing laws is worth the time spent vs. Start a clipping file of newspaper articles you come across about these issues. Keep notes of everyone you speak to.

Chapter 4 : Paranoia and schizophrenia: Symptoms, causes, and diagnosis

*The schizophrenic reactions: a critique of the concept, hospital treatment, and current research;: The proceedings [Robert Cancro] on blog.quintoapp.com *FREE* shipping on qualifying offers.*

It appears in the writings of Hippocrates, as well as of Plato and Aristotle, and was apparently used by the ancient Greeks and Romans to refer to a variety of mental disorders, more or less as the term insanity is used today. The term fell into disuse after about the second century and does not reappear prominently in the psychiatric literature until the latter part of the eighteenth century, when, again, it was used with a variety of meanings. The much more specific sense in which paranoia is used today was formulated explicitly in by Kraepelin, who reserved the term for a syndrome characterized by insidiously developing fixed, systematized delusions, unaccompanied by hallucinations or by general personality deterioration. In addition, symptoms which figure prominently in other disorders, such as hallucinations, deterioration, and inappropriate affect, must be absent or else the diagnosis e. Depending mostly upon the chronicity, rigidity, and degree of systematization of the delusional structure, it is current practice to distinguish two diagnostic categories, paranoia and paranoid state,together constituting the superordinate categoryparanoid reactions. Paranoid schizophrenia is not included in this classification. Paranoia is a psychotic disorder that occurs relatively rarely. The delusional structure develops slowly, over a prolonged period, and reaches an extreme degree of organization and rigidity. Delusions are highly systematized and intricately elaborated. Details of the delusional system are often worked out with considerable respect for logic, and the patient may provide a persuasive account of his plight if only the initial premise is conceded. The delusions resist attempts at refutation and alteration and may persist for years. Outside the arena of the delusional system the personality remains relatively intact. There are no hallucinations, there is no general personality disorganization or deterioration, and intellectual functioning is well preserved. The psychotic features seem, superficially at least, to be isolated from the rest of the personality, and many patients have been able to continue in business or professional activities with unimpaired efficiency. Paranoia is considered to be relatively unresponsive to therapy. Paranoid state is a less severe psychosis than paranoia. It occurs more commonly and has a more favorable prognosis. The delusional system lacks the close-knit logic and elaborate systematization seen in paranoia. Delusions are briefer and vaguer; they are more in flux and less resistant to change. On the other hand, they are not so bizarre or fragmented as those found, for instance, in schizophrenia. The delusions in paranoid states often develop more suddenly than they do in paranoia, perhaps in response to a specific situational stress. They are usually of shorter duration and may even clear up spontaneously with the passage of an emotional crisis. Sometimes, though, the delusions become chronic. Again, as in paranoia, there is no general personality or intellectual deterioration. In this article, a distinction will be made between paranoia and paranoid state where data are available for the two conditions separately. For the most part, the two forms of the disorder will be discussed collectively as paranoid reactions or paranoid disorders. Symptomatology The content of paranoid delusions varies widely and it is not uncommon to find several types of delusions in a single patient. By far the most frequent are delusions of persecution. The patient may believe himself to be pursued and plotted against by a person or persons who intend him a variety of harms. He may be concerned that his food has been poisoned or his mail tampered with. In carrying out their evil designs his adversaries may enlist the aid of numerous technological devices, which, incidentally, tend to keep pace with scientific progress: Political ideologies, too, may be involved in the delusional system, again often reflecting contemporary polarities; in the United States , persecutors are frequently held to be communist agents. Delusions of grandeur are much less common than delusions of persecution and usually occur in the more severe forms of the illness. They are more typical of paranoia than of paranoid states and are characteristically stable, persistent, and well organized. The patient may consider himself a person of great importance, noble birth, unique and superior endowment, or divine appointment. He may attempt sometimes successfully to

obtain a patent on a most remarkable invention, or he may have discovered an elusive cure for a crippling disease. Religion, science, and politics provide the principal sources of subject matter for delusions of grandeur. Other types of delusions have been described in paranoid patients, most notably erotic delusions and delusions of jealousy. At one time, it was customary to classify paranoid reactions in terms of the type of delusion manifested. This practice has proved ineffective because of the great diversity of delusions and the many ways in which they can combine in a single patient. Delusions also occur as secondary symptoms in a wide variety of psychotic disorders, and a differential diagnosis is not always easy to achieve with confidence. They appear frequently in schizophrenia and manic-depressive states and in such organic illnesses as general paresis, senile dementia, and alcoholic psychosis. In addition to the prominence of delusions, the symptom picture in paranoid reactions is rounded out by a number of other traits which may be viewed as reinforcing and maintaining the general delusional structure. The patient displays exaggerated self-reference, perceiving himself as the object of what goes on around him. He assigns special meanings, consistent with his delusions, to the remarks and gestures of others, or to items in newspapers and on the radio, and interprets them as directed toward him personally. He is reaction-sensitive Cameron a, p. He is especially sensitive to attitudes and tendencies of others which coincide with his own impulses and conflicts. His perception of his environment reflects the fact that the paranoid person is almost invariably an intensely hostile person. He is characteristically suspicious and vigilant, living in a world teeming with potential dangers and implied threats. His delusions may lead the patient to outbursts of verbal hostilities and accusations and, much less frequently, to direct physical attacks on others. Distribution Incidence Paranoid reactions are relatively rare in the mental hospital population, currently constituting about 0. Most likely, these figures greatly underestimate the incidence of the illness in the population at large; many patients are able to control the more blatant, socially disruptive manifestations of their delusions and are never hospitalized; others, especially where the disorder is less severe, are tolerated at home and at work as eccentrics. Also, many psychiatrists tend to avoid diagnoses of paranoia and paranoid state, preferring, where possible, another category, such as paranoid schizophrenia. Prevalence Paranoid reactions are chiefly disorders of middle age. The majority of first admissions to mental hospitals occur in the year age range, though, especially in cases of paranoia, the illness may have been a number of years in developing. A large percentage of patients hospitalized with paranoid reactions have never married, and many are divorced or separated. Little is known about the sex distribution of paranoid states, and the opinion of most earlier writers that paranoia is more common in men is not supported by more recent statistical evidence indicating that the disorder occurs almost twice as frequently in women Tyhurst , p. Again, there are no conclusive data regarding intelligence and educational level in these disorders; it is generally believed, however, that the paranoid patient is more intelligent and has had more formal education than the average hospitalized patient. Paranoid reactions appear to be more prevalent among groups who are to some extent isolated from the larger societal setting. Relatively higher rates of the disorder have been reported for displaced persons and refugees and for migratory and minority groups. In Freud published the first and still most influential attempt to work out in detail the interplay of psychological forces leading to the development of paranoid symptomatology. Freud based his thinking mostly on the autobiographical account of a psychosis with prominent delusions written by Daniel Paul Schreber, a German jurist. According to this view, the paranoid individual has been fixated at the psychosexual stage of primary narcissism but has been able during his prepsychotic lifetime to keep repressed the homoerotic impulses characteristic of this stage. Seeking desperately to repair the breach in his defensive structure, the patient draws excessively upon the defense mechanisms characteristic of this stage, most notably denial and projection. In a later paper, Freud demonstrated that homosexuality played a significant role in the development of paranoia in a female patient, too. In addition, Freud emphasized that delusions also serve a restitutive function. They represent an attempt at reconstruction, at re-establishing, albeit in an unrealistic manner, the object relations relinquished in the initial withdrawal and regression. In a typical experimental approach to the problem, Zamansky gave male mental hospital patients an opportunity to examine paired pictures of men and women; he found that, on the average,

paranoiacs and paranoid schizophrenics looked longer at pictures of men, while nonparanoid schizophrenics and, in another study, a normal control group looked longer at pictures of women. Not all the delusional patients preferred the male pictures, however. The failure to uncover a homosexual concern in some paranoid patients suggests that conflicts other than homosexual ones may also serve as a focus for the illness. There is further the question of whether homosexuality plays precisely the role specified by Freud in the development of the psychosisâ€”whether it is the primary etiological agent or merely a link perhaps itself serving a defensive function in a chain of psychodynamic factors leading ultimately to the delusional structure. Interpretations favoring this latter view are reviewed in the following section. Beyond the importance assigned to homosexual conflicts in paranoid disorders, the broad outlines of the psychodynamic picture sketched by Freud have never been seriously challenged. The illumination of such concepts as regression, restitution, projection, repression, and return of the repressed remains a hallmark in the history of psychiatry. Some later psychoanalytic contributions Later theorists have differed most sharply with Freud in their emphasis on the primacy of hostility in the development of delusions. The frequent presence of a homoerotic conflict is not denied, but it is assigned a position of much less central importance. For some theorists, homosexual stirrings serve merely to emphasize and reinforce generalized feelings of inferiority and inadequacy. For others, the relationship posited by Freud between homosexuality and hostility is turned around, and homosexuality is seen as a defensive maneuver against more basic destructive wishes. Knight , a spokesman for this latter notion, believes that the homosexual wish of the paranoid patient is in actuality an intense and desperate attempt to neutralize and erotize a tremendous unconscious hate. The powerful need to keep the homosexual urges from awareness is based not on cultural pressures, which prohibit their expression, but on the fact that the least approach to the love object arouses intense anxieties that both the object and the patient will be destroyed by the hostility in the patient and the consequent hostility aroused in the object. The British psychoanalyst Melanie Klein also singles out aggression as the central problem in paranoid disorders. In addition, she stipulates that the related fixation is at a much earlier age than Freud believed: The infant in this phase is said to be dominated by intense primitive feelings of hostility, and it is the projection of these feelings that leads the infant and the adult psychotic who regresses to this phase to attribute hostile designs to the people around him. Again, homosexuality, where it occurs, is considered to serve a secondary, defensive function against the hostile and destructive fantasies. Prepsychotic personality and breakdown Paranoid symptomatology may be most profitably regarded as an exaggeration and intensification of personality patterns characteristic of the individual during much of his life. As children and throughout their prepsychotic adult years, paranoid patients are mostly described as having been suspicious, secretive, hostile, resentful, and seclusive. A craving for praise and recognition, coupled with a hypersensitivity to criticism, signifies the presence of profound feelings of inadequacy and insignificance Schwartz , though not necessarily at a conscious level. Undoubtedly for some, a vulnerable self-esteem is further threatened by the borderline awareness of homosexual interests or by the guilt and anxiety that accompany destructive fantasies. Other traits which frequently characterize the lifelong behavior of the paranoid individualâ€”aloofness, airs of superiority and self-importance, arrogance, pride, disdainâ€”may be regarded as related maneuvers to maintain self-esteem. For many persons such an array of defensive traits provides a successful adaptation to potentially threatening impulses and fantasiesâ€”successful at least in that the individual is not pressed to the development of a full-blown delusional system. For the paranoid patient, however, something goes wrong. He encounters an experience or, more likely, a series of experiences which overburden his defensive structure, and anxiety-laden impulses threaten to break through to consciousness. In any event the patient presses into use the wellpracticed, overlearned, often-reinforced modes of reaction at which he has become expert; only now they are applied excessively and with greater intensity and rigidity. He becomes more suspicious and vigilant, desperately probing the motives and acts of others for an explanation of the unfamiliar, disturbing impulses that are at the outposts of awareness. By an excessive application of such mechanisms as denial, reaction formation, rationalization, and projection, ego-alien impulses are disowned and attributed to sources

outside the self. Self-esteem is once again safe, but the price is insanity. The development of normal, socially organized behavior, Cameron points out, depends heavily on the maintenance of effective channels of communication with others. Through a constant interchange of ideas, the normal person acquires considerable skill in role taking, in shifting his social perspective so that he can see things from other points of view than his own. As a result, he comes to perceive himself and other people relatively objectively, since he can check and modify erroneous ideas before they develop to any considerable extent.

Chapter 5 : Recent Schizophrenia Research Articles - Elsevier

Search the history of over billion web pages on the Internet.

Impaired thinking and memory Lack of insight. Not all people affected by schizophrenia have all these symptoms. Hallucinations, delusions and thought disorder Hallucinations and delusions are psychotic symptoms. Hallucinations can involve hearing, seeing, tasting, feeling or smelling something that does not exist, but which the sufferer believes is real. Similarly, delusions are unfounded beliefs, for example, of persecution, guilt or grandeur that seem utterly real to the person experiencing them. Thought disorder manifests as disconnected, illogical speech. Social isolation â€" a major problem While these psychotic symptoms are more alarming, other symptoms reinforce the alienation of people with schizophrenia. They are often unable to participate in normal social events or conversations, and lack sufficient motivation for simple activities like bathing or cooking. In addition, sufferers lack the insight to recognise how their inappropriate behaviour appears to others. Schizophrenia is not a split personality There are many myths about schizophrenia. Current treatments for schizophrenia Medication, hospital care and rehabilitation are the best forms of treatment. Admission to hospital is only necessary during crises; normal living can resume once symptoms subside. Effective antipsychotic medications enable many people with schizophrenia to lead full and productive lives. Antipsychotic drugs help stabilise some symptoms, but do not cure the disease and are frequently associated with side effects. Most people need to stay on medication to prevent relapse. Carers, guardianship and rights Some people with schizophrenia may be unable to manage their own affairs and their carers may take out a power of attorney. In some situations, applications may be made to the Guardianship List of the Victorian Civil and Administrative Tribunal VCAT for a Guardianship Order concerning finances, medical treatment, accommodation and other related issues. If there are concerns about the appropriateness of treatment, the Health Services Complaints Commission, the Office of the Public Advocate or the Equal Opportunity Office may provide help. Current research Schizophrenia is highly complex. Several lines of research are currently being pursued at the Florey Institute of Neuroscience and Mental Health. Some of these include: Molecular research aims to develop new antipsychotic medications. A protein that appears altered in people with schizophrenia has been identified â€" this may be relevant to the development of future drug treatments. Structural changes have been found in the hippocampus a brain region involved in memory and thinking after the onset of psychotic symptoms. This suggests that brain changes are actively occurring during the period of transition to illness. This may help researchers find ways to prevent or reduce the impact of schizophrenia. Clinical studies have shown reduced cognitive thought processes are associated with reductions in volume of the right hippocampus; these deficits increase during the illness. Research looking at the protective effect of oestrogen in schizophrenia may help with delaying the onset of illness and treating negative symptoms. Clinical research has led to the development of resources for professionals to support families where children are living with mentally ill parents. Clinical researchers are collecting data as part of an international study of families in which there is a clearly inherited pattern of the illness. This may help them to learn more about genetic links in the illness. Where to get help Mind Australia Tel. The cause of the illness is not yet known, but research has yielded several important clues. Researchers are actively investigating different aspects of this disease. Antipsychotic medications treat the psychotic symptoms, but do not cure the disease.

Chapter 6 : Bertram P. Karon: Publications

The schizophrenic reactions: a critique of the concept, hospital treatment, and current research by Menninger Foundation Conference on the Schizophrenic Syndrome Topeka , , Brunner/Mazel edition, in English.

Grossly disorganized or catatonic behavior Negative symptoms, such as emotional flatness, lack of pleasure in everyday life The two symptoms must include least one of the first three listed: The following criteria are also necessary: It can take some time to reach a diagnosis. Schizophrenia and paranoia can be lifelong, but treatment can help relieve symptoms. Treatment must continue, even when symptoms seem to have receded. If treatment stops, symptoms often reappear, especially if they have already returned after previously stopping medications. Options depend on the severity and type of symptoms, age, and other factors. Medications Antipsychotics can reduce the disturbing thoughts, hallucinations, and delusions. They may be given as pills, as liquids, or as a monthly injection. There may be some side effects. Hospitalization A person with severe symptoms may need hospitalization. This can help keep the person safe, provide proper nutrition , and stabilize sleep. Partial hospitalization is sometimes possible. Compliance or adherence in medicine can be difficult for people with schizophrenia. If they stop taking their medication, the symptoms can return. Hospitalization can help people get back onto their medication while keeping them safe. Psychosocial treatment Psychotherapy, counseling, and social and vocational skills training may help the patient live independently and reduce the chance of relapses. Support can include improving communication skills, finding work and housing, and joining a support group. Electroconvulsive therapy Electroconvulsive therapy ECT involves sending an electric current through the brain to produce controlled seizures, or convulsions. The seizure is thought to trigger a massive neurochemical release in the brain. Side effects may include short-term memory loss. ECT is effective in treating catatonia, a syndrome which occurs in some people with schizophrenia. ECT may help patients who have not responded to other treatments. Patients often stop taking their medication within the first 12 months of treatment, so lifelong support will be necessary. Caregivers and family members can help the person who has a diagnosis by learning as much as possible about schizophrenia and by encouraging the patient to adhere to their treatment plan. Possible complications may include:

Chapter 7 : Schizophrenia Research - Journal - Elsevier

Rosenthal, D. Genetic research in the schizophrenic syndrome. In Cancro, R. (Ed.),The Schizophrenic Reactions: A Critique of the Concept, Hospital Treatment, and.

Childhood schizophrenia manifests before the age of 13, so its correct names are "childhood-onset schizophrenia" COS and "very early-onset schizophrenia" VEOS. Adolescents teenagers are persons between the ages of 13 and History[edit] Sante De Sanctis first wrote about child psychoses, in He called the condition "dementia praecocissima" Latin, "very premature madness" , by analogy to the term then used for schizophrenia, " dementia praecox " Latin, "premature madness. Also in , Julius Raecke reported on ten cases of catatonia in children at the Psychiatric and Neurological Hospital of Kiel University , where he worked. He described symptoms similar to those previously recorded by Dr. Karl Ludwig Kahlbaum , including " stereotypies and bizarre urges, impulsive motor eruptions and blind apathy. Through the s, childhood psychosis began to become more and more common, and psychiatrists began to take a deeper look into the issue. At the current time, however, some researchers, regarded autism autistic disorder and schizophrenia as two distinct entities. Signs and symptoms[edit] See also: Basic symptoms of schizophrenia Schizophrenia is a mental disorder that is expressed in abnormal mental functions and disturbed behavior. The signs and symptoms of childhood schizophrenia are nearly the same as adult-onset schizophrenia. Some of the earliest signs that a young child may develop schizophrenia are lags in language and motor development. Some children engage in activities such as flapping the arms or rocking, and may appear anxious, confused, or disruptive on a regular basis. Children may experience symptoms such as hallucinations , but these are often difficult to differentiate from just normal imagination or child play. It is often difficult for children to describe their hallucinations or delusions, making very early-onset schizophrenia especially difficult to diagnose in the earliest stages. The prodromal phase, which precedes psychotic symptoms, is characterized by deterioration in school performance, social withdrawal , disorganized or unusual behavior, a decreased ability to perform daily activities, a deterioration in self-care skills, bizarre hygiene and eating behaviors, changes in affect , a lack of impulse control , hostility and aggression, and lethargy. Positive symptoms have come to mean psychopathological disorders that are actively expressed, such as delusions, hallucinations, thought disorder etc. Many children with auditory hallucinations believe that if they do not listen to the voices, the voices will harm them or someone else. Tactile and visual hallucinations seem relatively rare. The children often attribute the hallucinatory voices to a variety of beings, including family members or other people, evil forces "the Devil ", "a witch ", "a spirit " , animals, characters from horror movies Bloody Mary , Freddy Krueger and less clearly recognizable sources "bad things," "the whispers". They displayed illogicality, tangentialiry a serious disturbance in the associative thought process , and loosening of associations. Negative "deficit" symptoms in schizophrenia reflect mental deficit states such as apathy and aboulia , avolition , flattened affect , asthenia etc. This section is transcluded from Diagnosis of schizophrenia. According to the manual, to be diagnosed with schizophrenia, two diagnostic criteria have to be met over much of the time of a period of at least one month, with a significant impact on social or occupational functioning for at least six months. The person has to be suffering from delusions, hallucinations, or disorganized speech. A second symptom could be negative symptoms, or severely disorganized or catatonic behavior. First rank symptoms for schizophrenia [26] Summary These studies were of limited quality. In lower resource settings, when more sophisticated methods are not available, first rank symptoms can be very valuable.

Chapter 8 : - NLM Catalog Result

Bellak L: The validity and usefulness of the concept of the schizophrenic syndrome, in Cancro R (ed): The Schizophrenic Reactions: A Critique of the Concept. Hospital Treatment and Current Research.

American Sociological Review, 20, Personality factors which may be associated with the development of mathematical ability. Educational Testing Service Research Memorandum. Stability of equated test scores. Journal of Experimental Education, 23, American Sociological Review, 21, The Cureton-Tukey technique for equating test scores. Educational Testing Service Research Bulletin. Some implications of the Eysenck-Prell study of "The inheritance of neuroticism": Journal of Mental Science, , Some clinical notes on the significance of the number four. Psychiatric Quarterly, 32, Study of the mother-child relationship in a case of paranoid schizophrenia. American Journal of Psychotherapy, 12, The Oedipus complex in an apparently deteriorated case of schizophrenia. American Abnormal Social Psychology, 57, The homosexual urges in schizophrenia. The reviewer missed the point. Human Relationships, 33, A direct analytic contribution to the understanding of post-partum psychoses. Psychiatric Quarterly, 33, Differentiation and differential counsel of two types of neurotic personalities. Journal of Psychology, 47, A clinical note on the significance of an "oral" trauma. Journal of Abnormal Psychology, 61, Techniques of primitive witchcraft in modern psychotherapy. Acta Psychotherapy and Psychosomatics, 9 6 , An experimental investigation of parental castration phantasies in schizophrenic patients. A note on the treatment of age as a variable in regression equations. American Statistician, 18, Suicide as the wish to hurt someone else, and resulting treatment techniques. Journal of Individual Psychology, 26, Systematic studies of dreams: The relationship between ratings of the manifest content of dreams and associations to dream elements. Comprehensive Psychiatry, 1, The resolution of acute schizophrenic reactions: A contribution to the development of non-classical treatment techniques. Theory, Research, and Practice, Paradigm or paradox, with especial reference to personality tests. Journal of Projective Techniques and Personality Assessment, 30, A study of the schizophrenogenic mother concept by means of the TAT. Rorschach validity as measured by the identification of individual patients. Journal of Projective Techniques and Personality Assessment, Intellectual test changes in schizophrenic patients in the first six months of treatment. Theory, Research, and Practice, 6, Journal of Counselling and Clinical Psychology, 34, An experimental study of parental castration phantasies. British Journal of Psychiatry, , Experience, medication, and the effectiveness of psychotherapy with schizophrenics. A new therapist dimension related to clinical effectiveness. Journal of Personality Assessment, 35, The price of privilege: The effects of the American caste system on the Deep South white. Social Behavior and Personality, 1 2 , The consequences of psychotherapy for schizophrenic patients. Theory, Research and Practice, 9, Black and white development. Black and white identity formation: Studies in the psychosocial development of lower socioeconomic class adolescent boys. Contemporary Psychology, 17, A Rorschach validation study of the ego regression theory of psychopathology. Journal of Counselling and Clinical Psychology, 42, Thought disorder in schizophrenia, length of hospitalization, and clinical status ratings: Validity for the Feldman-Drasgon Visual-Verbal test. Journal of Clinical Psychology, 30, Psychotherapy with schizophrenics--a reply. Schizophrenia Bulletin, 9, Which part of the elephant have you touched? International Mental Health Research Newsletter, 17 3 , All in the family. Origin and Treatment of Schizophrenic Disorder. Comtempory Psychology, 20, Treatment costs of psychotherapy as compared to medication for schizophrenics. Professional Psychology, 6, Issues in current research on psychotherapy vs. Methodological issues in research. Theory, Research and Practice, 12, Contempory Psychology, 20, Professional Psychology, 7, You have to read more than the chapter headings. Contemporary Psychology, 22, Contemporary Sociology, 6, Psychotherapuetic technique and the economically poor patient. Theory, Research, and Practice, 14, Projective tests are valid. American Psychologist, 33, Psychotherapy with schizophrenics requires relevant training. Its scope and its insurability. Michigan Psychiatric Society Update, 1, The treatment of

schizophrenia by short-term psychotherapy. The adaptive significance of the catatonic stupor in humans and animals from an evolutionary perspective. Academic Psychology Bulletin, 3, Truth therapy and lie therapy. Contempory Psychology, 28, Journal of Nervous and Mental Disease, , The indispensability of medication. American Psychologist 38, The fear of reducing medication, and where have all the patients gone? Schizophrenia Bulletin, 10,

Chapter 9 : Schizophrenia : Important Theories of Schizophrenia | Abnormal Psychology

Unethical Psychiatrists Misrepresent In R. Cancro (Ed.), The schizophrenic reactions: A critique of the concept, hospital treatment, and current research (pp.

Some of the important theories of schizophrenia are as follows: Schizophrenia is a regression to the oral stage when the ego has not emerged from the id. As there is no distinct ego, by regressing to the primary narcissistic stage, schizophrenics lose contact with the world. There is heightening of id impulses specially of sexual nature during adolescence. As Shanmugam points out, lack of interpersonal relations and libidinal attachment are attributed to their heightened sensitivity to criticism and behaviour. By trying to adapt with the demands of the id impulses and to have contact with some stimulus, symptoms of delusions, hallucination and thought disorders are found. Bellack, Hunvich and Geidman have conducted some investigation to prove that in schizophrenia ego impairment is caused by an increase in id impulse. Social learning theory of schizophrenia: Schizophrenics according to this theory do not respond appropriately to the social environment like their normal counterparts. Thus deficit in attention to social environment leads to lack of proper association and disturbances in the thought processes of the schizophrenics. Moreover, lack of proper attention to the stimuli coming from the social environment makes the individual appear withdrawn. According to Ulman and Kreshmer schizophrenia is primarily a reaction to the reinforcement it receives within the mental hospital. The hospital staff attends to the patients more when their speech is incoherent and behaviour irrational. Attempts have been made to verify social learning theory by Braginsky, Grosserking by conducting a study to examine whether hospitalised patients can manipulate to create an impression on others through the administration of M. Hence, they create their own social role to protect themselves from social expectations and demands. However, though a split occurs between their outer and inner selves, their hopes, aspirations etc. Experimental theory of schizophrenia: This theory of schizophrenia advanced by Ronald Laing holds schizophrenia not as an illness but as a label for a certain kind of problematic experience and behaviour. According to the experimental theory, it is the family which first stamps a specific behaviour as schizophrenia instead of accepting it as an experience which is potentially meaningful and beneficial to the individual. He further views that schizophrenia is like a person on a psychedelic trip who needs guidance and not control. From the schizophrenic point of view an attitude which considers their illness as positive experience may have beneficial effects. The schizophrenics will continue to be what they are and have a marginal existence after being discharged from the hospital. Frankly speaking, at present there is no single psychological theory to explain schizophrenic behaviour fully. Aetiology of schizophrenia Being the most complex functional psychoses, the wide range of dysfunctions commonly found in all types of schizophrenia cannot be fully explained by any single theory advanced to explain the causes of schizophrenia. According to Duke and Nowicki schizophrenia is so complex, so puzzling phenomenon that theorists from many disciplines have joined in a massive effort to explain it. Research findings on the causes of schizophrenia are more or less controversial. However, different theories have been advanced to explain the aetiology of schizophrenia. They are organic and functional or biological and psychological. Schizophrenia has been found in all cultures and socio-economic classes. However, in the industrialised nations schizophrenic patients are found in a disproportionate number in lower socio-economic classes. This suggests that the affected individuals either move to a lower socio economic class or fail to rise out of a lower socio-economic class because of illness. Immigration, industrialization, urbanization and abrupt change contribute to the aetiology of schizophrenia as it becomes quite difficult to adjust to such abrupt changes. The revalence of schizophrenia appears to rise among third world populations as contact with technologically advanced culture increases. It is an accepted fact that schizophrenia is less visible in less developed nations where persons are reintegrated to their community and family more completely than they are in more highly civilized western societies. This is why schizophrenia has been called a disease of civilized society. It is held that an individual may have a specific

vulnerability for the disease and when the symptom of schizophrenia to develop acted upon by some stressful environmental influence shows. The stress can be biological or environmental or both. Kraepelin first classified psychoses and said that schizophrenia is due to metabolic disorder in which the glands play an important role. He said his investigators have proved this by examining the schizophrenic patients. They said that in schizophrenia the ovaries and testis deteriorate. The works of Mott, Gibbs and Lewis support the hypotheses of Kraepelin. But Moss views that it may be an accompanying factor among the several causes of schizophrenia. In support of her view she found in 3 or 4 schizophrenic the gonads are microscopically normal. Later on, Kallman advanced the view that schizophrenia is due to some inherent defect in the genes. The higher incidence of schizophrenia in the families of schizophrenic patients has stimulated many valuable investigations on the genetic basis of schizophrenia. The data of Kallman , on identical twins revealed the incidence of schizophrenia in the families of schizophrenic patients to be The genetic theorists propose that schizophrenia is physically inherited. Approximately 50 to 60 per cent of the schizophrenic patients have a family record of mental illness. A further study by Kringten using more refined techniques reported the incidence rate to be 38 per cent for identical twins and 10 per cent for fraternal twins. The disease is most frequently seen in parents and children than in brothers and sisters. Sometimes it is found that a schizophrenic patient has not a schizophrenic father, but a schizophrenic grandfather. Kallman explains this by saying that there may be a recessive genes. The genetic theorists thus view that schizophrenia occurs frequently among people who are closely related and more so when the genetic similarlity is closer. In other words, in case of identical twins, the concordance rates are found to be greater than in the case of fraternal twins. Duke and Nowicki view that when concordance rates for schizophrenia spectrum disorders among twins are calculated, genetic component is even clearer. For example, Shields, Hestow and Gottesman have been able to show that using spectrum diagnosis concordance rates for dizygotic twins as well as monozygotic twins could be elevated above the 50 per cent level. Heston conducted a valuable study which places learning in the role of genetic factors in schizophrenia. Children from schizoid parents but separated and reared by adopted parents were his subject of study. These children were compared with those who did not have schizophrenic parents. Findings indicated that Ketyelal , and Rosenthal; Wender Kety, Welner and Schulsinger have made some important studies on adopted children to throw more light on this problem. Kety , b has reported that the percentage of schizophrenia spectrum disorders in biological relatives of schizophrenic adoptees is significantly greater than in non-biological relatives. Kety further reported piat half of the schizophrenic adoptees he studied had no biological or adopted relatives with schizophrenic spectrum disorders. He has conducted that there may be two different types of schizophrenia one with a strong genetic basis and the other with little or no genetic basis. To solve this riddle, Stromgren , the modern geneticist views that there are schizophrenics which are caused genetically and which are caused environmentally. These studies on adoptees shacked the field of genetic research in schizophrenia. The strong belief that child rearing patterns and practices and other social and psychological factors were most important in the development of schizophrenia changed with the research findings of Ketty, Rosenthal el at. They have studied populations where the risk of schizophrenia is considered very high due to several genetic factors such as close relatives of schizophrenics showing higher incidence rates than distant relatives. To add to this, Slater and Cowie have found that while the risk of schizophrenia in children with one psychotic parent is Analysis of these studies on adoptees thus leads one to conclude that the probability of one becoming schizophrenic is more with those having a defective genetic background. But there are also instances where one of the twins are not schizophrenic though either parents or one of them are schizophrenics. It can therefore be concluded that besides the defective genetic background, environmental factors such as anxiety and stress are also important in the causation of schizophrenia. Many investigators point out that life situation of a person with a family background of schizophrenia is usually coloured by sufficient stress and anxiety; undesirable child rearing practices and pathological child parent relationship and family interaction. These variables are likely to predispose individuals psychologically to schizophrenia. Research on the hereditary factors has been reviewed by Jackson

and Gregory and they point out several flaws in these research undertakings. Commenting on his critical analysis on these research findings Gregory has stated that the role of possible genetic factors in the development of schizophrenia and other functional disorders will remain in the realm of speculation. Besides being the result of faulty heredity, constitutional differences liable to schizophrenia may be due to early environmental influences. Toxins, viruses and several other stresses during pregnancy of the mother may have strong after effects upon the development of the embryo. Early postnatal influences similarly arrest the normal development of the child. Such errors of development lead the individual to make faulty responses to life situations. But what specific part the constitutional defects play in the development of schizophrenia is not very clear due to the paucity of researches in the area. In the meanwhile, investigators are in the process to get specific answer to their haunches in relation to the role of constitution in the development of schizophrenia. But it would be quite unjustified to draw a positive relationship between slender constitution and schizophrenia on the ground that research findings are not sufficient to corroborate this view of Kretchmer and Sheldon. The notable study of Bender , , and in particular has stressed the role of retarded and arrested growth during childhood being responsible for schizophrenic reactions. She specially emphasized the effect of immaturity and lack of integration of respiratory, autonomic, nervous and other organs upon the normal behaviour of the child. Due to these typical developments, he is unable to cope with the world around him and show normal sensory and motor responses to various stimuli. His self image is destructed and is unable to develop ego defences necessary to meet anxiety provoking situations. All these consequently, lead to disturbed interpersonal and parent-child relationship. Escalona has pointed out that disturbed parent-child relationship which is advocated to be one of the core causes of schizophrenia is an outgrowth of these developmental irregularities. However, researches in this area do not lead to any generalised conclusion supporting early atypical developments being the characteristics of individuals who show schizophrenic reactions. Neurological disease, an imbalance of neurotransmitters, a slow acting viral infection and self generated hallucinogenic chemicals are included under the biochemical explanation of schizophrenia. Meltzer has found evidences in support of his view that neuro muscular dysfunctions present in the schizophrenics leading to disorder of nervous system are a typical function of schizophrenia. He noted that in comparison to their normal counterparts abnormal musculator is found in high percentage of schizophrenics. He further observed that close relatives of schizophrenics showed higher than normal levels of muscle tissue. All these evidences lead one to believe that schizophrenic person may possibly have some physical defect or more specifically neurological disease or nerve disorder. There is some evidence to believe that schizophrenia is caused by a long acting virus Torrey and Peterson, This hypotheses states that certain slow viruses may combine with genetic predispositions for the onset of schizophrenia. Duke and Nowicki hold that acquisition of the virus prior to birth would account for the higher concordance rates for schizophrenia among monozygotic twins than dizygotic twins in as much as MZ twins share the same placenta and for more likely to be simultaneously affected. The experimental evidences of Penn, Racy, Laphan, Mandel and Sandt support the viral hypotheses.