CHAPTER I

INTRODUCTION

There are many ways of classifying this disorder but the traditional view is to classify it in four types, viz: (i) simple, (ii) hebephrenic, (iii) catatonic and (iv) paranoid type.

Schizophrenia is one of the most frequent forms of major psychoses. It constitutes from 15 to 20 per cent of the first admissions to public hospitals for mental diseases. As the disorder tends to chronicity and in many instances does not shorten life, it is found that about 60 per cent of the population of the State Hospitals in the West is made up of schizophrenics. Since adolescence is a period of personality discordance and emotional cross currents, there is high incidence of this disorder among adolescents. The early manifestations and symptoms of schizophrenia are not fully known and are difficult to be recognized. As a consequence, most cases are detected only after they have progressed considerably rather than in the initial phase. Because of the slow and insidious growth of this disorder, it has become a challenging problem of the mental specialists and doctors.

For many years schizophrenics thought disorder has been regarded as being due to an abnormality of
concept formation of some sort. However, there has not been a general agreement about the nature of this abnormality.

There have been made four broad approaches towards operationally defining the psychiatric concept of thought disorder, for convenience of subjecting it to experimental attack. They primarily emphasize respectively the following viewpoints, viz.: (1) dissociation - as stressed by Kretschmer (1936), (2) deterioration in mental efficiency as studied by Babcock (1933), (3) concretism as noted by Kasanin (1946) and (4) over-inclusion as observed by Cameron and others (1956).

The concept of dissociation was primarily introduced by Kretschmer (70) postulating that schizophrenic thinking is essentially marked by dissociation a tendency for mental activity to occur in isolation with a consequent fragmenting and lack of logical relationship between systems of ideas. The origin of this tendency was given in typological terms, i.e. two constitutional personality types (linked to the somatotypes leptomorphic and pyknic) were postulated, namely, schizothymic (extreme manifestation of schizophrenia) and cyclothymic (extreme manifestation of Manic Depressive psychoses). Experimental work generated by this thesis has been mainly of the
dual task type. Thus the subject might be given the task of memorizing the positions of coloured letters drawn on a card and at the end of the task be asked additionally to recall the colours in which the letters were drawn (a task not mentioned in the initial instructions). The appropriate prediction would be that the schizophrenics would perform the dual task more completely (at least relatively to the single task) than Manic Depressives (extreme associaters) or normals since schizophrenics are, by nature, inclined to function dissociatively. This field of experimentation has been well reviewed by Payne (87) who found that in a large number of tests of dissociation given to normals no factor of dissociative ability emerged. Bellack and Parcell (7) investigated the prepsychotic personalities of schizophrenics and could find no evidence indicating that the typological characteristics which Kretschmer postulated were a concomitant of schizophrenia. Moreover, the type of experimental design generally used seems to imply that since schizophrenics are inferior to normals in utilizing the logical relationships between systems of ideas, they would be superior to normals in simultaneously utilizing systems of ideas which are not logically related. This seems to be a somewhat doubtful inference. Disorganized men do not necessarily flourish in a disorganized world.

Another approach to the problem of schizophrenic
thinking via.: "Deterioration in mental efficiency" was
initiated by Babcock (3), categorizing it as a process of
progressive mental deterioration particularly marked by
slowness and inability to undertake new learning, sometimes
due to organic causes analogous to those operating in
senile and paretic conditions. This explanation was
realised experimentally in the form of first measuring the
level of "abstract intelligence" operationally defined as
the subjects' level on the Terman vocabulary test and
assumed to represent old pre-illness learning; then
measuring "mental efficiency". This is operationally
defined as the subjects' level on a series of mental
efficiency tests, such as counting from 20 to 1, digit
span etc., this type of performance being taken to repre­
sent new learning and present level of function likely to
be markedly affected by deterioration of a schizophrenic
type. The discrepancy between the two levels (termed the
Efficiency Index) is the measure of deterioration. This
approach can be adversely criticised for its unquestioned
assumption that vocabulary level is a fair measure of pre­
ilness capacity - Yates (98) has reviewed the difficulti­
es implicit in this assumption; and more pertinently, the
notion's validity as a specific explanation of the
schizophrenic process is questioned by the work of
Shapiro (92) which indicates that loss of mental
efficiency as defined by Babcock is a complex and very general phenomenon in mental illness manifesting itself in depressives, organics and even to some extent in neurotics as well as in schizophrenics.

In short, this approach does not explain fully the disorders of schizophrenics. The term deterioration itself is misleading, for it implies a gradual decaying or losing permanently the capacities that the person has. But this rarely happens in case of schizophrenics. They are slow in certain tasks or performances. Moreover, their digit span is low and they are diagnosed as less mentally efficient. This does not mean that they are mentally slow and less efficient in all kinds of mental activities - rational or irrational. On the whole, it can be said that there may be a temporary retardation in both mental ability and efficiency and not necessarily deterioration.

Coming to the third approach to the problem of schizophrenic thinking, the works of Vigotsky (95), Bolles and Goldstein (14) and others which form the focus of Kasanin (62) symposium imply that schizophrenic thinking is essentially concretistic and marked by inability to form abstractions. Operationally "abstraction" is usually defined in terms of subjects' ability to group
and categorize objects in object sorting tests (e.g. grouping blocks by form, colour, size, weight etc.) or ability to give meanings of proverbs in terms of acceptable generalizations. Examples of work critical of this approach are the studies by Rapaport, Gill and Schafer (88) who found the schizophrenics to have a tendency to produce unusual generalisations rather than to fail to abstraction. Hunt and Jones (61) showed that when trained clinicians used the dimensions "schizophrenia", "intelligence", "communicability" and "concrete-abstract" to scale schizophrenic vocabulary responses, "concrete-abstract" scaling had the lowest inter-judge correlation and correlated insignificantly and negatively with the scale "schizophrenia". Experimental work on "concretism" is reviewed in relation to comparative experiments utilizing over-inclusion theory by Payne, Matussek and George (87), as noted in next section.

The fourth and the most recent attack on the problem, viz: 'over-inclusion' derives, in part, from the suggestion by Cameron (18) that schizophrenics are unable to preserve the conceptual boundaries of a task and thus include in the data before them such a variety of categories that specific problems become too extensive and too complex for a solution to be reached. This suggestion has been steadily developed by workers such as Lovibond (77)
until it has now been very explicitly formulated by Payne, Mattussek and George. Exemplary experimental work can be found in Zaslow (99), Moran (85) and Epstein (32).

Out of the four approaches mentioned, only the 3rd & 4th approaches carry some meaning with references to the disorders of schizophrenic thinking because the concept formation has been postulated basic to the disorders. In this respect, the following questions may be raised:

1. How are concepts formed?
2. What is the relative speed with which the different concepts are developed.
3. What concepts are developed with ease.
4. What is a concept in itself.

Such questions have been attempted within the present investigation. It purports to study the concept formation in thought disordered schizophrenics mainly with reference to 3rd and 4th approaches mentioned earlier viz. concreteness and over-inclusion in the thinking of schizophrenics. An effort also has been made to investigate how far Babcock's approach to schizophrenic thinking - "Deterioration in mental efficiency" is valid. Several
tests for these three approaches have been selected and administered to a group of 45 thought disordered schizophrenics and to a matched group of 80 normals, thus making a total of 125 subjects as a sample for the study.

However, it can be argued that the four approaches of dealing with schizophrenic thinking are limited in the sense that they describe the schizophrenic condition rather than define the schizophrenic process. The process of schizophrenic thought disorder hints at the causal factors which are totally left out in the four approaches described above. Moreover, these explanations do not refer back to the clinically observed behaviour upon which the concept of schizophrenic thought disorder was originally based.

Hence, in an attempt to utilize a theoretical orientation which would not only operationally define the nature of schizophrenic thinking but would generate hypothesis, as to the causal factors involved and which would comment specifically on the broad behavioural manifestations of schizophrenic thought disorder, the second half of the work to be described was carried out within the framework of Personal Construct Theory as proposed by Kelly (68) and with the help of Repertory Grid Technique fully described in chapter 8. For this latter part of
the investigation, the experimental population consisted of 101 subjects out of whom 23 were adult schizophrenics who at the time of administering tests in the Mental Hospitals and were firmly diagnosed as thought disordered schizophrenics by the Psychiatrists in charge of these patients. The remaining 78 subjects were matched normals matched in terms of age, sex, education, and socio-economic status who have never been hospitalized for mental illness, nor treated for mental illness, nor officially diagnosed to be mentally ill. Both these groups were fairly representative of their population, since they were as randomly drawn as possible. The data furnished by all these subjects formed the bulk of material for discussion and conclusions in the investigation.

Curan and Partridge (28) while defining a schizophrenic patient enumerates five major symptoms, viz. thought disorder, inadequacy or inappropriateness of affect, low volition, disturbances of motility and primary delusions. However, schizophrenia itself appears to be a disjunctive concept and the diagnosis may, in practice, be applied to a patient manifesting one or some but not necessarily all of these five major symptoms. Thus, in psychiatric practice, thought disordered schizophrenics have been regarded as a sub-group of the class of schizophrenics.
The primary features of talk (and inferentially the thinking) of these thought disordered schizophrenics have been listed by Meyer - Gross, Slatar and Roth (80) as under:

(1) Inconsequential following of side issues.

(2) Tendencies of thought to be directed by alliterations, analogies, clang associations, associations with accidents of the speaker's environment, symbolic meanings and condensation of several (perhaps mutually contradictory) ideas into one.

(3) Words used out of context e.g. concrete meanings taken where abstract meaning would be appropriate.

(4) Clinging to unimportant detail.

(5) The use of laconic answers e.g. I don't know, may be, perhaps, - indicative of emptiness and vagueness of ideas.

(6) Thought is generally marked by gaps, poverty, indefiniteness and vagueness.

(7) Indications of thought blocking.

(8) Indications of pressure of thoughts.