CHAPTER II

NATURE OF SCHIZOPHRENIC DISORDER

I - General

One finds difficulty in identifying what schizophrenia is, and in attempting to learn something about this one has to go back to some 150 years. The first relatively clear description, one can say, was that of Pinel in 1809. Pinel & Esquirol gave description of hebephrenia. Then followed the accounts of Esquirol, who called the condition "accidental or acquired idiocy". Griensinger and B. Morel, who, in 1857, first used the word Demence Precoce. Next come the description of Kahlbaum, who, in 1868, differentiated the category of catatonia from schizophrenia; and Hecker E., who, in 1871 differentiated hebephrenic category of schizophrenia; Flaret, Magnan and Ziehen also described schizophrenic conditions. Another landmark was made by Kraepelin, who, put together the total picture which had been worked at in parts by his predecessors. Kraepelin outlined what he considered the cause, the symptoms, the course and the outcome of the disease. His descriptions are
quite remarkable. Probably, the next contribution in significance was that of Stransky in 1903 who spoke of "intra psychic staxia". Meanwhile, Freud & Adolf Meyer were making contributions in the dynamic sphere, but the next large milestone came in 1911, when Bleuler introduced the term "schizophrenia" to replace dementia praecox. He also introduced the idea of latent schizophrenia and brought out the concept of autism.

Bleuler pointed out that the name of dementia praecox was a misnomer. It neither occurs only in the young age, nor it invariably leads to mental degeneration, as reported. The symptoms associated with dementia praecox occur in persons of all ages and the mental processes do not necessarily progressively diminish in their efficiency, but rather become split off from their proper relationship to social and physical reality. The mental processes of dementia praecox patient are not without rhyme or reason but rather follow a peculiar syntax and grammar of their own. C. G. Jung (61) demonstrated this very convincingly, by putting stress on the emotional factor or "complexes" in the human being. He illustrated this by means of a word-association method adapted from Galton and Wundt. Even a
very bizarre associations of the dementia praecox patient occur in a meaningful language, but it is a language different from that which a common man is accustomed to use. It is not controlled by the real social situation. However, delusions, hallucinations, memory defects etc. are definitely meaningful when life history of the patient is taken into consideration.

The term 'schizophrenia' literally means "a splitting of the mind" and describes the basic picture of the disease much more accurately than does the term 'Dementia Praecox'. Though many psychiatrists speak of schizophrenias because symptoms of schizophrenia occur in different constellations, they have this splitting common. The central core of the personality, the ego, breaks with the reality principle so that the emotions are no longer appropriate to the real situation.

II. Incidence

Schizophrenia is one of the most frequent forms of major psychosis, constituting from 15 to 20 per cent of the first admissions to public hospitals for mental diseases (85). Because the disorder tends to chronicity and in many instances does not shorten life, it is usually said that 60 per cent of the population of the State Hospitals has been made up of schizophrenics. Hutt &
Gibby gave the incidence to be 20 per cent of those admitted to Mental Hospitals for the first time diagnosed as schizophrenia. 50 per cent of the Mental Hospital population consists of schizophrenic patients as the disturbance usually lasts a long time. Brown (16) states that in the United States 18.2 per cent of first admissions to Mental Hospitals are diagnosed as schizophrenia. Since the average hospitalization time in schizophrenia is 16 years, close to 45 per cent of the resident population are schizophrenics. Starting in the early teens, the incidence is by far the highest between twenty & thirty, and falls rapidly thereafter. There are, however, first admissions reported as late as the seventies. The disease is more frequent in males than in females and in urban than in rural communities, and its victims tend to come from the lower but not extremely low cultural and economic levels. The high incidence during adolescence is not unnatural. It is normally a period of personality discordance and emotional cross currents. The adolescent is perplexed by sex, religious, vocational and social problems. He may be plagued by a desire for independence or coupled by a too prolonged dependence. Self-consciousness, sensitiveness, moodiness, vague yearnings, sudden outbursts defensive attitudes, tendency to indulge in strange fantasies, project
Inadequacies and irritableness are particularly marked traits in adolescence.

Frequently in early stage one meets with similar characteristics in schizophrenia.

**Gradients of Severity**

The early manifestations and symptoms of schizophrenia are not fully known and are very difficult to recognize. This means that most cases are detected only after they have progressed considerably, rather than in the initial phase. What criteria have been used to collect data on incidence of schizophrenia? One is able to determine immediately the gross cases that are hospitalized. The other cases cannot be diagnosed as readily particularly when follow up data are not available. For instance, in case of the pseudo-neurotic form of schizophrenia, many of these patients show neurotic symptomatology for a long period of time and then certain number of them become grossly psychotic. These cases are very rarely spotted and very rarely diagnosed in epidemiologic study or in clinical research. However, in the majority of cases, for diagnosis, it is necessary to know the whole psychodynamic structure of these patients, which, of course, cannot be done by those doing
an epidemiologic study.

The diagnosis of schizophrenia is difficult and complicated, if one is not dealing with gross case. Needless to say, schizophrenia can be and should be diagnosed in patients without hallucination, delusion and grossly regressive manifestations as mild cases of schizophrenia are hard to diagnoses and pseudo-neurotic form of schizophrenia is particularly difficult.

Another, the simple form of schizophrenia described long ago by Kraepellin is a well-known entity in psychiatric school, the world over. It is not easy to diagnose simple schizophrenia, if the patient does not show conspicuous manifestations, particularly social or antisocial manifestations. Observations reveal that many relatives of schizophrenic patients, show the disorder in a mitigated way. Sometimes these relatives are as sick as the patient, but for some reason, the patient is in the hospital and the relative is not.

These persons suffering from schizophrenia who are in close proximity to the admitted patient are very rarely counted, very rarely collected and investigated in epidemiologic studies. This is an important gap to be filled up in our knowledge of epidemiology of schizophrenia as, we do not know how many overt or covert
schizophrenic patients are present in the community, who are not spotted because they have a superficial adjust-
ment to the environment.

The situation becomes even more complicated, when we consider patients who are not yet "officially" 
schizophrenic, but who become so in a few months, weeks, or hours. Is the patient a schizophrenic patient a few 
hours before the outbreak of psychosis, or is he not? Should epidemiologic study count gross alterations like 
hallucinations, delusions, marked regressive phenomena and schizophrenic posturing or something which underlies 
these gross manifestations? These are unsettled issues. The same difficulties exist when the patients show 
 improvement and occasionally even marked improvement. These improved patients are released from the hospitals 
and we assume them to be alright. However, one-third of these patients relapse. Should these patients who show 
such improvement and somehow maintain themselves in the community be included in the epidemiologic studies or 
should they be excluded? So far, answer is that they should be included because the potential reappearance 
of the disorder is still very great.

The relapse rate after 5 years of fairly good adjustment is far lower than in the first 5 years after
discharge. We do not know the magnitude of the pool of persons, from which this statistics emerges. There are far more schizophrenics patients than hospital admissions would indicate and if we do not find ways and means to estimate the full number of persons, who are in that pool, we are always going to have a distorted point of view. It has been once agreed that schizophrenia occurs in about .85 to 1 per cent of the population (59) and this figure is fairly constant even in different countries; but we do not know how constant the total pool of schizophrenics is because of patients, who do not seek help are not included, leaving us with a completely distorted view of the incidence of the disorder.

III. Symptoms & Characteristics

Schizophrenic disorders are syndromes of disorganization and desocialization in which delusions and hallucinations are prominent, and in which behaviour is dominated or determined by private fantasy. The signs of cerebral incompetence, the gross disorientations and the defective retentivity which help define delirious disorganisations are characteristically absent from schizophrenic syndromes. Indeed, one of the major unsolved problems in behaviour pathology is presented by this paradox. It is a common clinical observation that
schizophrenic patients, who are suffering from severe behaviour of disunity and marked social disarticulation, may never the less, exhibit no gross defects, in reten-
tivity or in orientation (88) and this superiority over the delirious patient may be responsible in schizophrenia as it evidently is in panic, for the striking tendencies towards self-perpetuation, that the illness shows.

The normal and the near-normal behavioural antecidents of schizophrenia are essentially the antecients of disorganization and desocialization. The socially immature person, who develops a schizophrenic disorder, is usually an anxious and solitary person also. He also enters adolescence or adulthood, inadequately socialized (15, 38, 66, 75, 93). He lacks the degree of role-taking skill, which is necessary for ease in shift-
ing perspectives under stress. He has learned to rely heavily on fantasy, but he has not mastered the techniques of social validation of sharing his interpretation or conclusion or of modifying them in accordance with the attitude of others. When through attempted social interaction or private pre-occupation, he encounters severe conflict, thwarting or delay and develops marked anxiety, he is almost sure to show disorganization.
IV. Process of Development

The tremendous amount of research has not been able to reveal clearly the underlying development of schizophrenia. However, we may say that the process of schizophrenic development is evolutionary - sometimes developing very slowly. Schizophrenic behaviour is usually preceded by schizophrenic tendencies within the personality, though sometimes the onset is sudden, it should be realized that schizophrenic process has been present within the individual for a considerable long time. He may have feelings of loneliness and depression, often begins to lose social interest, spending more and more time at home, loses interest in relationship with other persons, and external activities, frequently becomes pre-occupied and seems to be far away, has speculative thoughts usually centring about vague philosophical questions or sexual problems, becomes dissatisfied with environmental situations that previously gave him high degree of satisfaction. All these symptoms tend to increase as the disease develops. Generally, he avoids activity and initiative, energy continues to be focussed on his own inner processes, he continues to retreat and remove himself from the real outside world with which he cannot cope and creates a new inner world which is much more pleasant and less threatening to him.
Instead of spending his energy in some direct relationship with external world of reality as normal persons do, schizophrenic secures his satisfaction through fantasy and through gratifying his basic id urges and wishes in symbolic way. The schizophrenic thus expresses consciously what the normal person represses. Even though, it often appears to be quite silly, irrelevant, and without meaning, the behaviour of schizophrenic does have meaning to him. If observed, for a long time, his actions and thought processes may become meaningful and intelligible to the observer. Things expressed by schizophrenic largely result from unconscious thoughts, ideas and emotions that are cherished by him, at an unconscious level without regard to his particular reality situation.

The process of development as summarized by Adolf Meyor ( ) is as under.

In the process of personality development, the individual learns various methods of coping with his problems. Some of these methods involve dealing directly with life's problems and making the most effective adjustment to them, that is possible. However, other adjustive reactions are in the nature of evasive substitutions - utilizing, rationalization, projection, fantasy satisfactions and emotional withdrawal, and insulation. These
evasive reactions invariably lead to failure and self-devaluation, which in turn makes their use even more necessary. Thus, vicious habits of response become established, which lead to a complete miscarriage of ego defences; instead of helping the individual to adjust successfully, they make such an adjustment impossible.

The individual who later develops schizophrenia usually manifests an early withdrawal from a world which he interprets as frustrating and hostile. This withdrawal is often concealed behind what seems to be exemplary childhood, but which on closer examination reveals adherence to weakness and formally good behaviour, in order to avoid fights and struggles. Instead of participating in an active and healthy way in the activities of childhood, the individual withdraws behind a faked of goodness, and meekness. This withdrawal, of course, inevitably leads to failures and disappointments, which in turn serve to encourage further withdrawal from the world of reality, and foster the use of fantasy satisfactions to compensate for real life failures.

As this "Good" child enters the adolescent period, he tends to be overly serious, painfully self-conscious, inhibited, and prone to prefer his own company, often he is unduly pre-occupied with various
religious and philosophical issues. Normal interest in the opposite sex is lacking and vivid ideas of evilness of sexual behaviour are usually only too apparent. As the adolescent enters the period of adulthood, with its demands for independency, responsibility and family relationships, the youth's lack of adequate socialization and preparation for meeting these problems proves fatal. Instead of increased effort and a vigorous attack on the problems associated with the assumption of adult's status, the youth finds the world unbearably hurtful and turns progressively inward to fantasy satisfaction.

Out of such a background schizophrenic reactions develop. Such reactions can be precipitated by the increased stress placed on the individual during the period of puberty and young adulthood or in later life. However, the conflicts centre around dependency - independency problems, and the handling of hostility and sexual drives. He feels difficulty in vigorous social competition for jobs and adult status. He tries to maintain his childhood dependency upon family. His whole problem is often complicated by unrealistic levels of aspiration and altruistic ethical ideas to which he expects others to conform.

. His highly moralistic ideas regarding sex
brings him into difficulty. He fails in normal heterosexual adjustment - it is an immature sexual behaviour. Usually he has had few, if any, sexual contacts with the other sex. If married, a little closer examination reveals that his marital sexual relationships are hopelessly unsatisfactory and conducive to feelings of repugnance and guilt.

In a similar way, the handling of hostility is a particularly stressful problem for such an individual, as he usually considers it completely immoral and terribly dangerous. The hostility generated by his feelings of hurt and frustration is often more than bearable. He lacks adequate understanding of the role of hostility in normal every day social relations because of his withdrawal from social participation. Hence he tries to repress his hostility and deny even to himself that he is a person who has such impulses.

**Early Psychic Trauma**

Mønninger (83) points out, "There is much proof that the injuries suffered by those individuals, who later become schizophrenic occur very early in infancy. This injuries may take the form of neglect and rejection by the mother, the death of parent, and other severe frustrations or disappointments. Many of these
wounds take place in what seem to be exceptionally good homes, and often the parents are quite unaware of the trauma to the child (68). These early wounds might be reinforced by subsequent events which lead to feelings of inferiority and self devaluation or to the perception of the world as a hostile and dangerous place.

Manninger described it as under: "Children injured in this way are apt to develop certain defences. They cover up, as the slang expression puts it. They deny the injury which they have experienced or the pain which they are suffering. They erect a facade or front, "All is well with me," they seem to say." I am one of the fellows; I am just like everyone else. I am a normal person." And indeed, they act like normal persons as much as they can. They go to the same schools, they complete the same work, they seek the same goals, they do the same things, that all the rest of us do. Often they are noticeable only for a certain reticence, shyness, perhaps slight eccentricity. Just as often they are not conspicuous at all.

The process seems to be like an abscess slowly growing beneath the surface of the body. There is intense conflict, and tension and anxiety, and strong feelings of bitterness, resentment and hate toward those very people
with whom the external relationships may be so perfectly normal. He tries to cover it up as long as possible; but the chief problem for him is: "How can I control the bitterness and hatred I feel because of the unendurable sorrow and disappointments the life has brought to me;" and with efforts of more and more controlling his feelings of hatred and bitterness, he becomes more and more exclusive and becomes disinterested in social participation. And if in this state of mind, certain new stresses occur, the facade may break down and the underlying bitterness and the conflicts may break through. He may suddenly begin to hear voices talking about him, saying that he is mean, hateful or he may begin to detect the hostility of other people in a far larger measure than could possibly be true. He considers himself persecuted.

Lack of Reality Checks

Many schizophrenics are handicapped in this social development by solicitous and over-protective mothers (31). This, together with their early social withdrawal, has a variety of effects which are of developmental significance. These factors tend to cut him off from normal activities of social reality testing. Because of lack of experience in social role playing, he may have very unrealistic ideas of the types of social roles open
to him and it may be easy to take himself to fantasy as a great religious saviour or some other big and prominent personality.

The schizophrenic patient is unable to view himself from the perspective of others. Consequently his attitudes towards himself are apt to be fantasy-ridden and distorted. The same is true for his environmental attitudes, which suffer from the rigidity and lack of perspective of his own limited viewpoint, uncorrected by social experience.

Thus truly it is the lack of reality checks rather than the fantasy pre-occupation in itself, which is so devastating to personality development. Their language and thought-processes are not subject to reality checks, hence they become progressively more individualistic.

Regression in Thought Processes

The dynamics underlying the disorganisation and disintegration of thought processes in schizophrenic patient has advanced the belief that in schizophrenia there is a reduction from conceptual thinking to a more primitive "concrete" thinking, in which the individual is dominated by the external and internal stimuli acting upon him at the moment and in which he reacts to parts of
the perceptual field as if they were wholes. This "concrete" approach helps the patient lose the normal demarcations between himself and the world. His words lose their usual representative character, and his perceptions no longer show the expected relation of parts to a whole (63, 43, 72). Kasanin attributes this concretization or fragmentation of thought processes to extreme regression to immature and childish levels of thinking.

Kasanin points out that the child lives in a world which is partly real and partly magic and that he forms all sorts of fantastic notions and ideas about things around him. He tends to personify and vitalize inanimate objects and to endow them with various powers. He may also feel that he is the centre of the universe and tries to develop ideas of his own omnipotence. Also, commonly found, according to Kasanin, is his belief that only adults can read his thoughts.

Many of the odd and bizzare delusions of schizophrenics, are then related by Kasanin to the magical thinking and other characteristics of children's thinking.

The parallels between schizophrenic thinking and the thinking of primitive peoples have been similarly emphasized by Boisen (11,12). Regression in thought
processes has been accepted by a number of Psychoanalysts and Psychiatrists as the basic mechanism underlying schizophrenic reactions. However, there is some contradiction both in the findings and in interpretation. Despert (30), Camaron (20), Boas (10) and others find no such close resemblance between schizophrenic thinking and characteristics inherent in the thinking of either children or primitives. Camaron concluded from his studies of schizophrenic thinking that it was characterised by over-inclusion and an inability to organize and subordinate the events occurring simultaneously in the environment rather than by a regression to childish modes of thought. Boas also states, "The comparison of forms of psychosis and primitive life seems still more unfortunate. The manifestation of mental disturbances must necessarily depend upon culture in which people live and it must be of great value to the Psychiatrists to study the expression of forms of psychosis in different cultures, but an attempt to parallel forms of healthy primitive life and those of disturbances in our civilization is not based on any tangible analogy."

Ego Defensive Values of Symptoms

Emotional blunting and distortion in schizophrenic reactions protect the individual from the hurt of
disappointment and frustration. Regression enables him to lower his level of aspiration and to accept a position of dependency; projection helps him to maintain some semblance of ego integrity by placing the blame for his difficulties on others and attributing his own unacceptable desires to them. Fantasy satisfaction enables him to achieve some measure of compensation for his feelings of inferiority and self devaluation. Thus in various degrees and combinations, these mechanisms seem to constitute the basic defensive framework of schizophrenic reactions.

In the exaggerated use of fantasy and projection, we find the two mechanisms, which are most apt to lead to the development of delusions and hallucinations with their many ego-defensive values. Delusions of influence enable the patient to blame others for causing his own inadmissible thoughts and behaviour. Fantasies of being the focus of interest and attention help the patient to compensate for feelings of isolation and lack of social recognition and status. Delusions of persecution explain the patient's failure to achieve a satisfactory adjustment in the real world by placing the blame on his enemies. Delusions of grandeur and omnipotence may grow out of simple wishful thinking and may help to counteract feelings of inferiority and inadequacy by a
sense of great personal worth and power. Stereotypies and other symbolic behaviour of schizophrenic patients can also be understood in terms of the patient's mental processes and general reactive pattern, though symbolism is by no means easy to fathom.

V. Difficulty in Correct Diagnosis

While other fields of medicine often can augment or even verify clinical diagnosis by other methods - by tests that are independent of the clinical appraisal not of the patient, this is generally true in psychiatry. Although, one is fully aware of the claims that it can be done, some maintain that it cannot. Diagnosis of this disorder to-day, depends on a clinical evaluation of the patient, based on objective facts as far as that is possible in clinical work, and this is, of course, never as objective as X'ray or standardized chemical tests.

This is more so with schizophrenia as it has a slow and insidious onset.*

VI. Types

Most psychiatrists are content to use the broad categories of simple, hebephrenic, catatonic, paranoid and undifferentiated schizophrenia. Placing a patient

* See Incidence Section of this Chapter.
in one of these sub-groups entails a judgement, which is based upon all the informations at the clinician's disposal. Such data are necessarily unstandardized. The method of collection varies from doctor to doctor and from patient to patient and the criteria for classification are not uniformly agreed upon. No objective tests are available which would serve to check the accuracy of decisions taken. The basic essential of a classifying instrument is that it should produce the same results in the hands of different investigators. Let us see the various classifications.

Because this supposedly dementing disorder was known to occur primarily in adolescence and adulthood, Kraepellin proposed for it the name "Dementia Praecox", in contradistinction to "Dementia Sinilis". He gave four varieties - simple, hebephrenic, catatonic and paranoid - and both the generic term and the division into four types were later adopted as official by American Psychiatry. The types have been described in lines that follow:

(1) The simple type shows the defective interest, gradually developing apathy, but neither delusion nor hallucination, nor other strikingly peculiar behaviour. The defective interest is evident in withdrawal from the struggle for life. He becomes disinterested
and emotionally apathetic and gives up the fight to achieve social status and esteem, although the price of this withdrawal in terms of self devaluation may occasionally be reflected in episodes of mental turmoil or impulsive behaviour. The emotional insulation is generally effective with slow but gradual personality disintegration. Of course, in simple schizophrenic reactions this decompensatory process may stabilize in order that the individual becomes an apathetic drifter or remains a dependent, non-contributing member of the family - without decompensating further to the point where the hospitalization would be required.

(2) *Hebephrenic reactions:* The emotional withdrawal and personality disintegration reach their ultimate in degree. The individual gives up all claims to social approval and status and under the pressure of his conflicts seems to regress and disintegrate at the same time. The word - hash, silliness, regression and other evidences of severe personality deterioration are considered part of the general hebephrenic fragmentation or disintegration, growing out of the patient discouragement, his loss of faith in himself and his withdrawal from social contacts and reality.

(3) *The catatonic patient* is engaged in a
desperate struggle and is stirred to the bottom-most depths of his mental life in his attempt to solve his difficulties and maintain his ego integrity. Thus, Boisen regards the catatonic excitement as a frenzied attempt to deal with the threats to the ego and catatonic stupor as a retreat during which individual strives desperately to find some philosophy of life, some system of beliefs, some faith in himself and the world on which to build. Here malignant reactions have not become established as yet; and the individual, though panic-stricken is still fighting desperately to save himself to resist personality disintegration.

(4) Paranoid reactions: The patient tries to maintain feelings of personal worth and respect by misinterpreting facts. He simply projects the blame for his difficulties upon others. Now it is all the other fellows' faults. He likes them, but they do not like him. They are interfering with him and persecuting him. It is only another step to explain all the attention others are paying him by means of delusions of grandeur in which he indeed is a remarkable person with great abilities. In paranoid proper such delusional defenses hold up so well that the rest of the patients' personality remains relatively in tact. However, in paranoid schizophrenia the patient is so overwhelmed by both inner and
outer demands that even with the aid of these psychotic defenses he undergoes severe personality disorganisation.

While discussing the psychodynamic differences between types, Boisen (13), a psychiatrically trained chaplain who himself suffered an acute episode of cata-tonic schizophrenia, wrote as under:

In terms of general personality organisation he points out that schizophrenic is characteristically a good boy. This means that he has accepted for himself the role which his parents and teachers have chosen for him i.e. he has internalised the ethical and moral values of society and has judged himself in accordance with those standards. In this the schizophrenic sharply differs from the delinquent, who usually has not accepted the authority or standards of his parents and teachers; at the same time he differs from the mature adult who has evaluated these standards and modified them in his own behaviour rather than accepting them blindly.

The schizophrenic, having accepted his social role, now finds himself unable to achieve a sufficient degree of personality unification on the basis of this role. He suffers from various unresolved internal conflicts centering around feelings of failure, unacceptable sexual and hostile desire and so on. This results
in intense inner turmoil; self-condemnation and anxiety, the net result being an anxiety-ridden and intolerable self-devaluation. There are several different ways in which he may attempt to cope up with his mounting feelings of personal failure and conflict.

Over and above, the fourfold classification given by Kraepellin, Boisen added two more as under:

**Latent schizophrenic reaction:** The individual is forced to only a mild use of the various schizophrenic defenses in order to handle his inner needs and to cope up with reality. He manages to maintain his general relief orientation and to stabilize his defenses on a marginal panel of adjustment. If the stress were to increase, he would decompensate further.

**Acute unclassified schizophrenic reactions:** Here we see almost any possible combination of the dynamics of other types as well as with very acute psychotic episodes which reach to high level of intensity and then subside rather rapidly.

According to him, only catatonic and acute unclassified schizophrenic reactions hold any material possibility of spontaneous ego reorganization and remission to a more healthy level of adjustment. The others
involve more serious and chronic ego disorganisation and require long-term psychotherapy.

Despert, Cameron and other investigators have given, besides the usual form classifications, few other types. They are: Childhood schizophrenia, Schizophrenic reaction - Schizo-affective type, Schizophrenic reaction - acute undifferentiated type, Schizophrenic reaction - chronic undifferentiated type, Schizophrenic reaction - residual type - (unclassified and mixed schizophrenic reactions). The American Psychiatric Association's Committee on classification distinguished these nine types.

Cameron-Margaret's Classification

The heterogenity, we find, among schizophrenic disorders, however, make some kind of grouping necessary and the fluid state of our present day conception of these syndromes favours the provisional adoption of as simple a classification as possible. In view of the fact that disturbances in patient's relationship to the social community are fundamental characteristic of schizophrenic disorders, the groupings may be made in accordance with this relationship. Accordingly, we shall distinguish in what follows between prominently aggressive, submissive
and detached behaviour. The disorders in any of these sub-divisions may be sudden or insidious in onset. Its progress may be rapid or slow, episodic or uniform and the outcome may be in one of complete recovery or no recovery. Recurrences, even in cases with apparently complete recovery, are common in all three sub-divisions.

Aggressive schizophrenic reaction may be prominently hostile and revengeful towards others, the patients believing themselves plotted against and wronged. Or instead, their aggression may take the form of claims of omnipotence and special eminence from which hostility and revenge are often absent. Or, often the aggressive schizophrenic patients, like depressed ones, frequently turn their enmity and vengeance against themselves, becoming actively and sometimes dangerously self-punitive, or demanding insistently of others that they be punished cruelly. We may call the first of these three persecuted, the second grandiose and the third self-punitive.

The aggressive persecuted patient builds his poorly organised pseudo-community around the threats, culminations and frustrations that he almost fears or believes he most deserves. This pseudo-community, like any other, will include real persons, to whom are ascribed some functions which they indeed perform and some which
they do not and often cannot. It also includes imaginary persons to whom, likewise, are ascribed functions, socially valid for a social person and also functions that are unreal and for a human being frequently impossible. Against the hostile pseudo-community, thus structured, the patient may take arms, attacking, injuring and sometimes killing real persons to avenge imagined crime. The persecuted person may confine his attacks largely to words using counter-threats, recriminations and demands for public vindication and redress, or he may maintain attitudes of irreconcilable malice towards his pseudo-community, hating and destroying in his fantasies, but giving them neither voice nor any other direct overt-action.

The aggressive grandiose patient builds a confused pseudo-community which casts him in the role of distinguished and an influential person, a saint, incarnation of some character in fiction or the re-incarnation of some one in history or the representative of the deity, a powerful agency or an illustrious personage. Like the persecuted patient he mingles together, real and fancied individual with socially valid functions and socially meaningless or impossible functions. From his imaginary persons he succeeds in exacting the admiration, respect,
adulation and applause he needs, but not from the actual persons. Indded, a great deal of aggression in grandiose schizophrenic patients, arises as a response to the contradiction, resistance and ridicule of the social community. The normal person can seldom recognize the potential gravity of delusions of grandeur, or understand the misery that prompts them, until they have developed into something which is completely unintelligible to him.

The aggressive self-punitive patients, is in effect, a persecuted individual, who is his own persecutor. He is likely also to resort to self-mutilation and self-sacrifice, such as, we occasionally see in compulsive, Sadomasochism, and more often in depressive patients, bent on expiation. In many ways, the aggressive schizophrenic patient is the greatest hazard of them all. His behavioural disintegration makes his next step unpredictable.

2. Submissive schizophrenic reactions - The submissive schizophrenic patient takes the role of a passive instrument, in the hands of an obscure but powerful pseudo-community or autistic community, which irresistibly controls him. The prevailing delusions are those of influence. Many submissive patients object to
and complain about what they believe is happening to them; but they do not aggressively resist, fight back or threaten reprisal. They neither actively seek help against the exploitation and control to which they feel subjected, nor do they take steps to escape it.

(3) Detached Schizophrenic reactions: All schizophrenic persons, of course, are to some degree socially disarticulated or detached, but this group deserves particularly this designation because the patients in it have succeeded more nearly than the others in achieving total social isolation. Indeed, some of them retreat into the protracted social inaction, we call stupor, in which they may often seem more unresponsive than the stuporous patient suffering from the cerebral incompetence.

Most detached schizophrenic patients, never become stuporous. They continue to react minimally to stimulation from their surroundings, so that it is possible for them with some prodding and some help, to carry through the simple routine of daily living. Most detached patients are able to converse a little, however, reluctant they may be to do it.
Kleist-Leonhard Scheme of Classification

A detailed scheme of classification of schizophrenia has been produced by Prof. Karl Kleist and elaborated by Prof. K. Leonhard. The validity of this scheme has been established by other investigators (Schneider, 1955; Schulte-von der Stein, 1955). Leonhard and Kleist (36, 37) have classified schizophrenic disorders into following detailed sub-types:

(A) Paranoid Schizophrenic:

(1) Typical Forms:

(a) Phantasio Phremia
(b) Progressive confabulosis
(c) Progressive verbal hallucinosis
(d) Progressive somato psychosis
(e) Progressive auto psychosis
(f) Progressive inspiration psychosis
(g) Progressive influence.

(2) Combined forms.

(3) Extensive forms: Progressive reference psychosis.

(a) Progressive self-reference psychosis
(b) Progressive signification
(c) Circumscribed delusional psychosis.

(B) Catatonias:

(1) Typical forms:

(a) Speech - inactive catatonia
(b) Speech - prompt catatonia
(c) Akinetic catatonia
(d) Parakinetic catatonia
(e) Negativistic catatonia
(f) Prosectic (Proskinetic) catatonia
(g) Stereotyped catatonia

(2) Combined forms.

(3) A typical forms.

(a) Iterative catatonia.

(4) Unclassified.

(C) Confused Schizophrenias:

(1) Typical forms:

(a) Schizophrenia
(b) Incoherent schizophrenia
(c) Paralogical schizophrenia.

(2) Combined forms.
(3) Atypical forms

(a) Atypical shift like confused schizophrenia.

(D) Hebephrenias:

(1) Typical forms:

(a) Silly hebephrenia
(b) Depressive hebephrenia
(c) Apathetic hebephrenia
(d) Antistic hebephrenia.

(2) Combined forms.

Kleist points out that his method of classification differs from that of Kraepelin in that it depends on signs of illness which are definite and easily understood.

The four main groups of schizophrenia are recognised by Kleist, while the word confused applies to the speech and thought of the patient and does not mean that the patient is disorientated.

In each main group of schizophrenia there are simple basic forms and atypical forms. The basic forms are for the most part distinguished by a few simple
symptoms which are present throughout the whole course of the illness. These symptoms increase in severity and extent as the disease progresses.

Thought-disorder, according to Kleist, occurs to some degree in all schizophrenics and in some form of schizophrenia, thought disorder may be characteristic. Kleist distinguishes between thought disorder and a speech disorder in schizophrenia. Other authors have denied the validity of such a distinction, but Kleist has pointed out that certain disorders of speech similar to aphasic disorders do occur in schizophrenia. Apart from this, some patients with grossly disordered verbal productions behave in a reasonably ordered way which would not be expected if the speech was purely an expression of thought disorder.

VII. Theories of Causation

The underlying cause of the disease schizophrenia is not yet determined. For centuries it was not even recognised as a disease and at times was even punished as a misdemeanor, when the conception of the disease was generally accepted, the underlying causation was sought for as it was in every other established disease. Unfortunately, the search for cause was not
only unsuccessful but very frustrating because it did not provide the slightest clue about its nature (78). It is no wonder, therefore, that in this scientific era of medicine, due to the lack of substantiated facts in a cause-and-effect fashion to support any particular reason for the disease process various theories have been put forward. Some of the views postulated by noted investigators are very briefly summarized below:

**Meyer:** Accumulation of life-long faulty habits of adaptation, often complicates by inferior psychological endowment.

**Freud:** Inadequate ego development and primitive ego defenses due to disturbed parent-child relations and inability of child to identify with strong parents and use them as models.

**Jung:** Weak ego or exceptionally strong unconscious resulting in powerful complexes, breaking into consciousness and absorbing the entire energy of the individual with consequent lack of contact with reality.

**Menninger:** Early psychic trauma leading to defenses which impair subsequent socialization and create unbearable feelings of frustration and hostility.
Kasanin:— Regression to immature childish levels of thought with loss of capacity to conceptualise. Eventual fragmentation of thought processes and primitive magical thinking as in childhood.

Kallmann:— Genetic predisposition, which becomes manifest under psychological stresses.

Meyerson:— Rationalization of increasing social failure, creating anxiety and splitting process, with one part of the self continually condemning the other part in endless dialogue; eventually delusions, hallucinations and withdrawal in a compensatory fantasy world.

Heath:— Production of "Taraxein" under stress with resulting impairment of central integrative processes and schizophrenic symptoms.

Pincus and Hoagland:— Failure of normal adrenal stress response equivalent to stage of exhaustion of general adaptation syndrome.

Osmand and Smythies:— Specific disorder of the adrenals resulting in faulty metabolism and production of masculine-like compound, the final clinical picture depending upon the amount of masculine produced and the age and the previous personality of the
Mott: He finds the schizophrenics have endocrine imbalance in the sex, pituitary and adrenal glands.

Kraepelin: finds that the onset of the disease is associated with manufacturing of the sex glands caused by auto-intoxication from pregnancy, climacteric period or menstruation.

Gibbs - finds that female patients have an abnormal amount of hair on the face and body and vertical pubic hair; the male has little hair on the face and body and horizontal pubic hair.

Lewis - finds:

(1) the hebephrenic’s heart is small while the thyroid and adrenal glands are atrophied.

(2) the paranoid’s heart is large and the adrenal and thyroid glands are large.

Bender: Lag or irregularities in biological development with creation of secondary psychological difficulties in identifications, reality testing, self-picture, and handling of anxieties.
Although different points of emphasis have been indicated, these investigators do not necessarily deny the possible importance of other factors on the total clinical picture.

The above causation can be mainly divided into three groups: (i) theories ascribing basic cause to hereditary factors, (ii) the result of various physiological changes within the brain caused by organic or chemogenic agencies, (iii) those that stress underlying dynamic factors.

Responsibility for schizophrenic development has been attributed at one time or another to numerous biological factors:-

(1) Heredity,

(ii) Endocrine and other physiological disfunctioning,

(iii) Constitution, and

(iv) Cerebral birth trauma.

(1) Heredity

Kraepellin found an incidence of 53.8 per cent of mental disorders in the families of thousand and fifty
Kallmann has summarized the statistical evidence for a genetic theory of schizophrenia, by pointing out that an individual's average expectancy of becoming schizophrenic varies directly with the closeness of his blood relationship to a schizophrenic patient.

The children of one schizophrenic parent have a probability of developing this disorder with 19 times that of the general population; and the grand children, nephews and nieces are about 5 times more likely to show an outcropping of schizophrenia than the average person. When both parents are schizophrenic, the average expectancy rate for their children is 80 times the normal.

Probable incidence of schizophrenia among persons with various relationship to schizophrenic patient has been illustrated with the following chart:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>% of probable incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Unrelated person</td>
<td></td>
</tr>
<tr>
<td>Step - sibling</td>
<td>0.85</td>
</tr>
<tr>
<td>Half - sibling</td>
<td>1.8</td>
</tr>
<tr>
<td>Full - sibling</td>
<td>7.0</td>
</tr>
<tr>
<td>Fraternal Twins</td>
<td>14.3</td>
</tr>
<tr>
<td>Identical Twins</td>
<td>14.7</td>
</tr>
</tbody>
</table>
Neither Kallmann nor most other contemporary investigators, however, assume that schizophrenia is inherited directly, but hold rather that it is transmitted by recessive genes in the form of "Predisposition". The theory is that individuals with this predisposition will develop schizophrenia when placed under severe stress, whereas other persons will develop some other defensive pattern.

Many others are inclined to minimise the concept of predisposition to schizophrenia. They point out that the life situation of an individual with a family background of schizophrenia or other serious mental disorder is usually characterized by considerable stress as well as undesirable parental example. Certainly, one would expect a much higher incidence of mental illness among children reared in families of schizophrenic parent. Blow to Kallman's theory came from Pastore's critical evaluation of his experimental methods and procedures. He found many weaknesses in Kallmann's experimental methods and concluded that "The genetics of schizophrenia is still an open question".

(2) Constitution

Since Kretschmer's contention that schizophrenics tend to be of asthenic (Slender) physique,
considerable effort has been directed towards the importance of constitutional factors in the etiological pattern.

Sheldon confirmed Kretschmer's finding, indicating that about 2/3 of all schizophrenic patients do have an asthenic build; among the remainder all types of body builds are found.

The relation of physique to schizophrenia, however, is difficult to evaluate. For one thing, schizophrenia occurs among the younger age group—a group generally more slender than older age groups. Second, schizophrenics often reveal a long history of gradual increasing withdrawal and introversion, a type of background that would not be conducive to muscular development. In any event we are dealing with inter-action of factors, whose specific importance is not clear, but it seems doubtful that physique in and of itself is of great etiological importance.

(3) Organic Pathology

Many investigators following the early needs of Kraepelline and Bleuler have attempted to establish an organic basis for schizophrenia. These attempts have resulted in a tremendous amount of research in
Neuropathology, endocrine-pathology and bodily biochemistry - and have revealed many interesting correlations between schizophrenic disorders and physiological disorders.

(4) Psychological Factors

Despite the fundamental organic bias, both Kraepelin and Bleuler believed in the importance of certain psychological processes in the development of schizophrenia. Bleuler in particular emphasized the role of frustration and conflict, concluding that there was a splitting of personality, determined by complexes, as discussed under the "process of development" of this chapter.

(5) Sociological Factors

It should be hinted at this stage that the role of sociological factors in the development of schizophrenia is poorly understood. There is more schizophrenia in our culture than in certain primitive cultures and within our own culture there is a higher incidence in the poor areas of our larger cities. Social disorganization in these poorer areas intensifies the personal problems of the individual and also provides social environment in which no satisfaction, conventional
solutions are available. Falris (33) and Malzberg (77) suggest that the increased stress and strain and lesser security of the larger cities are responsible for the higher incidence in urban areas than in the rural ones.

To summarise, it is increasingly believed by psychiatrists that schizophrenia represents a special type of personality disintegration, a maladapted way of life manifested by a person who is grappling unsuccessfully with the following:

(1) Environmental stresses and internal difficulties.

(2) Basic personality of the individual.

(3) Limits of his adaptive power.

(4) The experiences which life has brought him.

(5) Mental mechanisms, and

(6) Patterns of reaction by which he has attempted to deal with his special problems.

Faulty methods which constitute the symptoms of the disorder may be put as under:

(1) Methods of dealing with sexual and other instinctive urges.
(2) With persistent childhood attitudes and phantasies.

(3) With social cravings and requirements on the part of persons whom we meet daily and the caricatures of these methods manifested by the schizophrenic.

It is, therefore, only through a careful analysis of the personality and its evaluation, of an equally detailed study of the concatenated life events and subjective experiences of the individual are the cause of the psychosis to be found; its manifestations understood and its psychological connections discovered and formulated.

Among these factors are:

(1) early conditioning experiences,

(2) intra-psychic conflicts,

(3) insistent but consciously rejected demands of various instinctive drives and urges.

(4) feelings of guilt or of insecurity,

(5) various other long-standing troublesome problems and frustrated purposes.
In addition to these specific factors we often have to do with:

(a) a complicated personality imperfectly organised and inadequately prepared for the life experiences to be confronted.

(b) one inclined to give up the struggle with reality.

(c) manifesting evasive and substitutive ways of meeting problems.

(d) reacting to handicaps with over sensitiveness.

(e) tending to secure satisfactions not from the real world but from a subjective world of individual's own making.

Most persons who develop schizophrenia have failed to advance to mature adult types of social and personal adaptation and integration.

As viewed by almost all psychologists, thought disorder is the main characteristic that is at the basis of most of schizophrenic behaviour pattern. The schizophrenic patient markedly differs from the normal in the
mode of formation of concepts which are the vehicles of thought. The present investigation aims to study the nature of this thought process in schizophrenics. In view of this, after understanding what schizophrenic behaviour is, it is equally apt to understand what concepts are, how they are formed and what their role is in thinking process, so that the reader may be equipped with the background necessary for tackling with the main problem of schizophrenic thinking. The next chapter, accordingly, deals with the nature of concept formation in general.