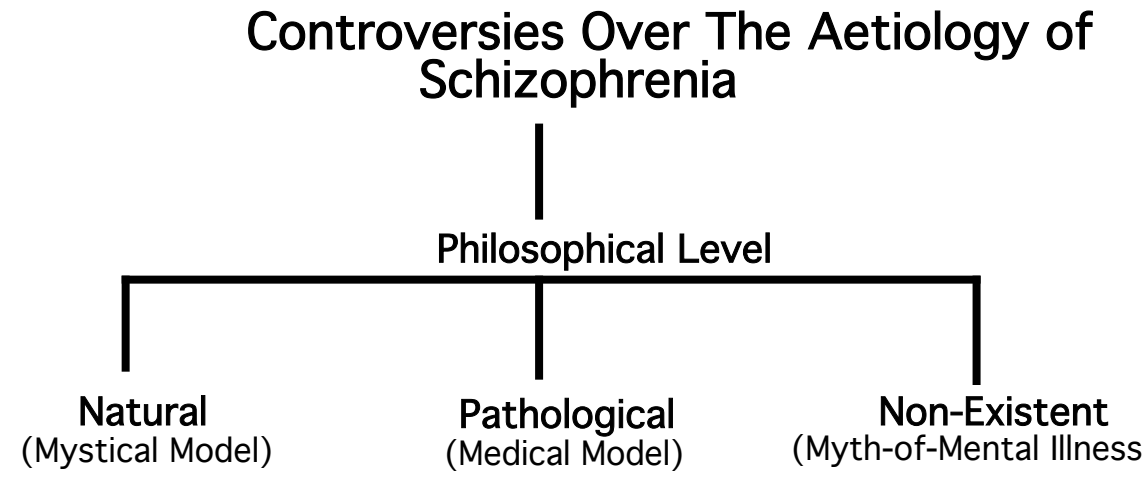
3. The Medical Model: Schizophrenic Symptoms as Pathology

This chapter begins with an introduction to the philosophical level of the debate. The concept of medical pathology is discussed, followed by a description of the current diagnostic criteria for schizophrenia. The origins of descriptive psychopathology for schizophrenia are examined and an outline is given of the work of Kraepelin and Bleuler, the first psychiatrists to define schizophrenia as a distinct disease entity.

Introduction

Controversies about the aetiology of schizophrenia first arise on a philosophical level, as distinct from the scientific/psychiatric level, largely because it is not self-evident that a condition, characterised by an unusual pattern of thoughts and beliefs, is necessarily a medical problem.

The philosophical controversies that are generated by speculation about the cause of schizophrenia can be brought into focus by assembling the main arguments into three platforms. These three platforms are: (1) the symptoms of schizophrenia have a pathological cause (medical model);[1] (2) they have a natural cause (mystical model);[2] (3) the cause is non-existent, i.e. the symptoms are consciously selected behaviours (myth-of-mental illness model).[3]



To cast light on the nature of these three platforms it is useful to briefly apply them to a couple of other conditions that also generate controversy as a result of being medicalised. Baldness might be useful as a comparative example. Does baldness have an underlying pathological cause requiring

[1] C. Tennant, 'Psychosocial factors in psychiatric illness', in Pierre J. V. Beumont and R. B. Hampshire (eds), Textbook of Psychiatry, Blackwell Scientific Publications, Melbourne, 1989, pp. 478-479.
[2] Seth Farber, Madness, Heresy, and the Rumor of Angels Open Court, Chicago, 1993, pp. 13-18.
[3] Thomas Szasz, Schizophrenia: The Sacred Symbol of Psychiatry Syracuse University Press, Syracuse, New York, 1976.

medical attention?[4] Is it a natural part of the aging process? Or, is it merely a stylistic affectation some people express by shaving their heads?

Homosexuality, which until fairly recent times was also classified as a mental disease,[5] can be compared in a similar way. Is homosexuality a manifestation of mental disease requiring medical treatment? Is it one of a variety of natural forms of sexual expression? Or, is it an adaptation some people — like prisoners — choose to make when they are denied the companionship of the opposite sex?

In the cases of baldness and homosexuality, it should be fairly apparent that the third platform, the argument that they have non-existent causes and are only the result of personal choices, most certainly applies to some people who fall into these two classes, but obviously not to all. But deciding which of the other two platforms, pathological or natural, is the more generally applicable, is not so readily apparent. To make an assessment in this regard it might be useful to examine the concept of 'disease' and see how it differs from the idea of 'natural'.

One approach to understanding what is a disease and what is not disease is to consider the concept of function.[6] Function is an attractive approach because the arguments can be made to appear objective.[7] If the function of hair on top of a man's head, for instance, is to provide insulation for his brain against extremes of heat and cold, and the climate demands this insulation so that a bald man must take special precautions, then a lack of hair might be considered a malfunction and therefore a disease.

But if, on the other hand, the function of hair on a man's head is to attract sexual attention, and the baldness only develops after the man is no longer sexually active, then lack of hair in an elderly man would hardly constitute a malfunction. But some human features have both function and accidental utility and it is important to distinguish between them. A nose, for instance, "has the function of heating and humidifying inspired air"[8] but it also has the accidental utility of being able to support spectacles. So according to this line of thinking a nose that functions properly, although it is unusually shaped, might be an oddity, but it wouldn't be diseased simply because it was unsuitable for supporting spectacles.

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[4] See for instance, Steve Dow, 'New pill hailed as cure for baldness', Sydney Morning Herald, June 10 1997.
[5] Jenny J. van Drimmelen-Krabbe, T. Bedirhan Ustun, David H. Thompson, Andre L'Hours, John Orley and Norman Sartorius, 'Homosexuality in the International Classification of Diseases: a clarification', JAMA, The Journal of the American Medical Association, Vol. 272, No. 21, 1994, p. 1660.
[6] R. Finlay-Jones, 'Disease and Illness', in Beumont and Hampshire, op.cit., p. 1
[7] Lawrie Reznek, The Nature of Disease Routledge and Kegan Paul, London and New York, 1987, p. 98.
[8] Ibid., p. 100.

The function test can also be applied to homosexuality, but there might be philosophical problems to solve in choosing between possible functions. Is the function of human sexuality to procreate, or is it to give pleasure? If it is to procreate then homosexual expression might be considered a malfunction. But such an argument would also render all other non-reproductive sexual expression, involving contraception and bad timing, a malfunction, and therefore diseased, as well.

But the test of functionality seems even more problematic when it is applied to schizophrenia.[9] One of the functions of the human mind would appear to be the formulation of thoughts and beliefs. But the mere formulation of thoughts that appear to normal people to be unusual or bizarre, and beliefs (delusions) that are judged to be false, is not enough in itself to indicate malfunction. A mind could only malfunction in this regard if it had first been clearly established that functional thoughts and beliefs must necessarily conform with social norms.[10]

A converse problem with the functionality test occurs when it is agreed that a certain condition definitely indicates malfunction but the cause of the malfunction is in dispute. Death, for instance, is a fairly definite indication of serious malfunctioning. Yet surveys of medical students, interns and hospital resident doctors have shown that only 56-57% of them can correctly identify causes of death on death certificates.[11] This converse approach to malfunction can be tested on a schizophrenic symptom like hallucinations. It might be agreed that an hallucinating mind is definitely malfunctioning but theories on the cause of the hallucinations might range from something essentially non-medical like fatigue to a cause that is indisputably medical like malarial infection.

But if the functionality test for distinguishing disease is problematic there are several others to try. One involves discarding the pseudo-objectivity of functionality by adopting normativism: "Normativism is the thesis that the concept of disease is value-laden and the most plausible Normativist Theory defines diseases in terms of harm."[12] On the surface this is a simple premise: if a person is harmed in any way by having a certain condition, and is worse off than they would otherwise be, then the condition can be described as a disease.[13]

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[9] X. F. Amador, D. H. Strauss, S. A. Yale and J. M. Gorman, 'Awareness of Illness in Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 113-132.

[10] James J. McDonald and Paul R. Lees-Haley, 'Personality disorders in the workplace: how they may contribute to claims of employment law violations', Employee Relations Law Journal, Vol. 22, No. 1, 1996, pp. 57-81.

[11] Jacqueline Messite and Steven D. Stellman, 'Accuracy of death certificate completion: the need for formalized physician training', JAMA, The Journal of the American Medical Association, Vol. 275, No. 10, 1996, pp. 794-797.

[12] Reznek, op.cit., p. 134.

[13] Carol Ann Rinzler, 'Odd ills (new ailments)', American Health, Vol. 15, No. 7, 1996, pp. 16-18.

Many non-controversial disease descriptions, like cancer and cholera, are easily accommodated by the test of 'harm'. But problems are soon encountered when the test of 'harm' is applied more widely. On the one hand there are many conditions which apparently cause harm, like ignorance and clumsiness, but which are not usually described as diseases. While on the other hand, a mild dose of what is clearly understood as a disease, in the form of a vaccination, for instance, can be good for a person, rather than harmful.

The problem with using 'harm' as the criterion for determining disease is further exacerbated if we return to our three test cases — baldness, homosexuality and schizophrenia. In each case there are circumstances in which a major aspect of the harm that can be caused by these conditions appears to come from cultural values, in the forms of aesthetics, prejudice and discrimination, rather than from individual incapacity. If we were to allow social harm to determine what is and is not disease we might leave the door open to claims that beautiful people are more healthy than ugly people; that light coloured skin in a predominantly black society, and vice versa, are diseases; and that personal traits that tend to give offence like vulgarity, loud voices and excitable behaviour,[14] are all symptoms of disease.

A further problem with the concept of 'harm' is that from time to time medical scientists develop notions that certain conditions are harmful, and forcefully propagate their view. Subsequently, however, a consensus view might develop that relegates this condition back to the status of non-disease. There are a number of examples of this tendency, the more notable ones often being to do with reproductive organs: "In 1856 T. B. Curling considered that the frequent emission of sperm gave rise to 'constitutional symptoms of a serious character', and constituted the disease of 'spermatorrhoea'. .... However, frequent ejaculation is not harmful, and so there is no such disease."[15]

Another approach to the nature of disease would be to consider the question of whether diseases are invented or discovered. To argue that diseases are discovered is to assume that disease classification is an ongoing process after the fashion of biological and botanical classification systems. But there is a major problem with this assumption. The entities that we call diseases all share one essential characteristic that isn't necessarily found amongst those entities we place in biological or botanical classes. Like 'pests', diseases all derive their class identity from human values and human attitudes towards them. Two bacteria might share very similar properties and be both placed in the same biological family but only the one that causes human disapproval, through causing ill-health in humans, or to domesticated animals or food crops, will be classified as a disease-causing organism.

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[14] See for instance, David B. Allison and Mark S. Roberts, 'On constructing the disorder of hysteria', The Journal of Medicine and Philosophy, Vol. 19, No. 3, 1994, pp. 238-259.

[15] Reznek, op.cit., p. 208.

When looked at this way it seems apparent that human values play an essential part in determining what is, and what is not, a disease.

Regression Theories

It is these human values that have produced a cultural consensus in modern industrial societies whereby people who manifest schizophrenic symptoms are said to be mentally diseased.[16] This assumption of pathology is a way of explaining a commonly held belief that people who appear to lose control of their minds are thereby deprived of some essential aspect of their humanity. This attitude has its origins in the period of European cultural development generally referred to as the Enlightenment.[17] Enlightenment thinkers bequeathed to the people of contemporary industrial societies a belief that rational, self-controlled thought is the essential function of a fully developed human being. Mental activity that lacks rationality and self-control is viewed as harmful and as being less than fully human. Throughout the Enlightenment mad people were usually treated as if they had lost their humanity and had reverted to an animalistic state.[18] This Enlightenment view of madness allowed for mad inmates of institutions to be kept in chains and sometimes displayed like zoological exhibits.[19]

It is from this treatment-as-animals that the medical profession claims to have rescued mad people around the turn of the 19th century by medicalising their condition and redefining it as mental illness.[20] In doing so, however, some elements of the medical profession retained the notion, although somewhat vaguely, that irrationality and loss of mental control are expressions of less than full humanity.[21] In relation to schizophrenic symptoms modern psychiatry has two alternative forms of 'regression' theory which are used for explaining the nature of this shortcoming. One explanation of regression is that schizophrenic symptoms indicate a reversion to thought patterns which are believed to have prevailed in the minds of early or primitive human types. In this context schizophrenic delusions have been referred to as 'paleological thinking' by some psychiatric theorists.[22] This psychiatric hypothesis, however, is largely speculative and does not have a substantial following.

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[16] Chris L. Fleshner, 'Insight from a Schizophrenia Patient with Depression', Schizophrenia Bulletin, Vol. 21, No. 4, 1995.

[17] Michel Foucault, Mental Illness and Psychology Harper and Row, New York, 1976, pp. 64-75.

[18] Michel Foucault, Madness and Civilisation: A History of Insanity in the Age of Reason Vintage Books, New York, 1965, pp. 76-78.

[19] A. Rosenblatt, 'Concepts of the asylum in the care of the mentally ill', Hospital and Community Psychiatry, Vol. 35, 1984, p. 244.

[20] Norman L. Keltner, Lee Hilyard Schwecke and Carol E. Bstrom, Psychiatric Nursing, Mosby, St. Louis, 1995, p. 5.

[21] Phil Gunby, 'Epidemiology indicates a disorder that assaults much of patients' 'humanness' in prime of life. (schizophrenia)', JAMA, The Journal of the American Medical Association, Vol. 264, No. 19, 1990, p. 2487.

[22] See for instance, S. Arieti, Interpretation of Schizophrenia, Basic Books, New York, 1974.

A second, more commonly accepted explanation was originally provided by early psychiatric theorists like Freud. These early theorists were interested in psychotic phenomena for the light that might be shed on the development of thinking processes from childhood to adulthood: "there was an assumption that psychotic processes reflected some regression to an earlier, and more 'primitive' level of organisation"[23] found in children. Freud used the term "primary process" to describe a child's first mode of thinking. He contrasted this with "secondary process" which he thought was an adult way of thinking.

> Primary process thinking is, first of all, drive-directed. Its content and direction are determined by impulses rather than by considerations of external reality. Secondary process thinking is, instead, reality-oriented, having been developed to facilitate adaptation to the world outside the self.[24]

Using this formula there are a number of ways that the inward focus of schizophrenic thinking can be likened to childish thought processes. Delusions and hallucinations can be interpreted as wish fulfilment; schizophrenics can be observed to deny reality in the pursuit of their own goals in the way that demanding children do; and demonstrably infantile forms of behaviour, like playing with faeces, can sometimes be observed in schizophrenics.

However, there is no universal pattern to these observations and the same childish thinking and behaviour can be observed in various types of non-schizophrenic people. Prisoners, for instance, will sometimes smear faeces on the walls of cells as a form of protest and many gamblers may attempt wish fulfilment by holding delusions about being in contact with forces that control the outcome of chance.

But the weaknesses of regression theories do not threaten to undermine the medical model. The security of the mainstream psychiatry position does not rest on either closely argued theory or empirical evidence. Instead it remains largely unformulated and mostly relies on affirmation provided by a widespread lay understanding, often gained directly through observation of family members, that the behaviour of people with schizophrenic symptoms is self-evidently caused by a weakness in the mind. This weakness is most easily explained by notions of illness:

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[23] Fred R. Volkmar, 'Childhood and adolescent psychosis: a review of the past 10 years', Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 35, No. 7, 1996, pp. 843-852.

[24] Loren J. Chapman and Jean P. Chapman, Disordered Thought in Schizophrenia Prentice-Hall, Englewood Cliffs, New Jersey, 1973, p. 208.

> Literary portrayals such as the madness of Orestes in the *Oresteia* of Aeschylus and the mumblings of Poor Tom in *King Lear* make it clear that serious psychoses have been recognised even by lay people for many years.[25]

In this situation the psychiatric profession prefers to focus most of its attention on the problem of standardising the diagnostic criteria for schizophrenia rather than going to the trouble of providing a persuasive philosophical rationale for pathology.[26] This is to ensure some consistency of diagnosis since it has to be done in the absence of any confirmation from laboratory tests.

Current Diagnostic Criteria

There are two internationally-recognised diagnostic systems for mental disorders which psychiatrists currently use in most countries of the world.[27] One is the 10th revision of the International Classification of Diseases (ICD 10),[28] compiled and published by the World Health Organisation. The other is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM IV),[29] compiled and published by the American Psychiatric Association. The respective teams of psychiatric researchers responsible for compiling successive editions of the ICD and DSM systems have cooperated closely in their work to ensure that the two systems maintain a high level of compatibility.[30] Whereas the DSM system is dominant in English-speaking parts of the world like North America and Australia, the ICD is the main diagnostic reference in European and developing countries.

Both manuals begin their respective descriptions of the symptoms of schizophrenia with a general outline of the disorder and then give definitive lists of diagnostic criteria that must be fulfilled in order for a diagnosis to be made. Schizophrenia is said to display psychotic symptoms but "the term psychotic has historically received a number of different definitions, none of which has received universal acceptance."[31] Nevertheless, the core understanding, to which most psychiatrists subscribe, is that when delusions, hallucinations, disordered thoughts or extreme moods give rise to irrational behaviour, then psychosis is likely to be present.[32]

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[25] Donald W. Black, William R. Yates and Nancy C. Andreasen, 'Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders', in John A. Talbott, Robert E. Hales and Stuart C. Yudofsky (eds), Textbook of Psychiatry, American Psychiatric Press, Washington, 1988, p. 358.

[26] Mark J. Sedler, 'Foundations of the new nosology', The Journal of Medicine and Philosophy, Vol. 19, No. 3, 1994, pp. 219-239.

[27] Nancy C. Andreasen, 'Symptoms, signs, and diagnosis of schizophrenia', The Lancet, Vol. 346, No. 8973, 1995, p. 478.

[28] World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines World Health Organisation, Geneva, 1992.

[29] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, American Psychiatric Association, Washington, 1994.

[30] Ibid., p. xxi.

[31] Ibid., p. 273.

[32] Ibid., p. 770.

Schizophrenia is defined as a sub-type of psychosis: "The essential features of schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months."[33] In conjunction with these signs and symptoms there is also a "marked social or occupational dysfunction".[34]

Although clarity of consciousness and intellectual capabilities might still be present there are "characteristic distortions of thinking and perception".[35] These often take the form of delusions that "supernatural forces are at work to influence the affected individual's thoughts and actions in ways that are often bizarre".[36] In these circumstances the person might believe himself/herself to be at the centre of world-shattering events that are taking place around him or her.

"Hallucinations, especially auditory, are common and may comment on the individual's behaviour or thought."[37] This leads to disturbances in thinking patterns and particularly in behaviour. To observers of a person with schizophrenia, the person's thinking seems vague and when it is expressed in speech it is sometimes impossible to understand. There are "breaks and interpolations in the train of thought"[38] and the person's mood appears to be characterised by shallowness, ambivalence and inertia.

Delusions can be of many types and cover a variety of characteristic subject matter. Delusions may be persecutory, in which case the person might believe "he or she is being tormented, followed, tricked, spied on, or subject to ridicule".[39] Alternatively, delusions can be referential, meaning that the person interprets certain signs and signals in the surrounding environment, like bill-board advertisements or newspaper headlines, as being directed specifically at themselves and containing hidden messages. Or the delusions might be bizarre. Examples of bizarre delusions can include "a person's belief that his or her thoughts have been taken away by some outside force ("thought withdrawal"), that alien thoughts have been put into his or her mind ("thought insertion"), or that his or her body or actions are being acted on or manipulated by some outside force ("delusions of control")".[40]

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[33] Ibid., p. 274.
[34] Ibid.
[35] World Health Organisation, op.cit., p. 86.
[36] Ibid.
[37] Ibid.
[38] Ibid., p. 87.
[39] American Psychiatric Association, op.cit., p. 275.
[40] Ibid.

Hallucinations may be associated with any of the senses but auditory hallucinations are particularly characteristic of schizophrenia. "Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts."[41] These voices might take the form of presenting a running commentary on the person's thoughts and behaviour or they might enter into dialogue with the person's own thoughts.

Disorganised thinking is also one of the definitive markers of schizophrenia. In diagnostic settings psychiatrists have to rely on patterns of speech to indicate this symptom. Speech can indicate the presence of disorganised thoughts in a number of ways: "The person may 'slip off the track' from one topic to another ('derailment' or 'loose associations'); answers to questions may be obliquely related or completely unrelated ('tangentiality'); and, rarely, speech may be so severely disorganised that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganisation ('incoherence' or 'word salad')."[42]

Disorganised thoughts and delusions may also affect a person's behaviour so that it becomes irrational: "Grossly disorganised behaviour may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation."[43] The person may find it difficult to carry out normal tasks necessary for day to day living concerning things like meals and personal hygiene. Dress may become eccentric and behaviour may become inappropriate to situations in the form of indecent sexual displays, shouting and unpredictable shows of anger and agitation.

One of the more extreme forms of behavioural disorder associated with schizophrenia is catatonia: "Catatonic motor behaviours include a marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures (catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement)."[44]

All the symptoms discussed so far fall into the category of "positive" symptoms. Juxtaposed to the positive symptoms are a range of "negative" symptoms: "The negative symptoms account for a substantial degree of morbidity associated with the disorder".[45] There are three principal negative symptoms — flattened mood, poverty of speech and avolition. Flattened mood "is especially common and is characterised by the person's face appearing immobile and unresponsive, with poor

[41] Ibid.
[42] Ibid., p. 276.
[43] Ibid.
[44] Ibid.
[45] Ibid.

eye contact and reduced body language."[46] Poverty of speech is indicated by an inability to engage in useful communication while "avolition is characterised by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities".[47]

A major difficulty in diagnosing schizophrenia is that there are, "No laboratory findings [which] have been identified that are diagnostic for Schizophrenia."[48] This means that a diagnosis can only be made by a psychiatrist interviewing a person and making assumptions about the person's mental state by observing self-expression through speech and behaviour. This gives rise to a need to standardise psychiatric interpretations of observations so there is consistency in diagnoses. In order to facilitate this standardisation both the ICD-10 and DSM IV supply diagnostic guidelines which act as a ready reference to narrow down the otherwise excessive subjectivity of the diagnostic process.

ICD-10 Diagnostic Criteria for Schizophrenia

The diagnostic guidelines from the ICD-10 are as follows:

> Although no strictly pathognomonic symptoms can be identified, for practical purposes it is useful to divide the above symptoms into groups that have special importance for the diagnosis and often occur together, such as:
> (a) thought echo, thought insertion or withdrawal, and thought broadcasting;
> (b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations: delusional perception;
> (c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
> (d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
> (e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear effective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
> (f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

[46] Ibid.
[47] Ibid., p. 277.
[48] Ibid., p. 280.

(g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
(h) "negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;
(i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time *during a period of 1 month or more*. Conditions meeting such symptomatic requirements but of a duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder (F23.2) and reclassified as schizophrenia if the symptoms persist for longer periods. Symptom (i) in the above list applies only to a diagnosis of simple schizophrenia (F20.6), and a duration of at least one year is required.[49]

There are two more paragraphs describing prodromal symptoms, like loss of interest in work, which may have been present for an extended period of time, and instructions that the 1 month criteria is only to apply to the specific symptoms given in the list above. There is also a warning about the difficulty that is sometimes encountered in distinguishing schizophrenia from the affective disorders and that schizophrenia should not be diagnosed in the presence of known disorders that have physical causes like brain disease, drug intoxication or epilepsy.[50]

The above symptoms are meant to be guidelines for identifying the presence of schizophrenia in general. Once a diagnostician decides schizophrenia is present the next task is to determine which of the various subtypes is the most appropriate label. The ICD-10 diagnostic system provides a choice from seven subtypes:

[49] World Health Organisation, op.cit., pp. 87-88.
[50] Ibid., pp. 88-89.

Paranoid schizophrenia. This is the most common type of schizophrenia. It is where the delusions and auditory hallucinations inspire beliefs of persecution, exalted birth, special mission or other paranoid beliefs and where the "voices" often threaten or give commands.[51]

Hebephrenic schizophrenia. This is a variety of schizophrenia in which the "delusions and hallucinations are fleeting and fragmentary" and which tends to be marked by a shallow mood and "giggling or self-satisfied, self-absorbed smiling, or a lofty manner, grimaces, mannerisms, pranks, hypochondriacal complaints and reiterated phrases".[52] Hebephrenic schizophrenia tends to have an early onset, between the ages of 15 to 25 years, hence the name, derived from the Greek goddess of youth, Hebe.

Catatonic schizophrenia. This type of schizophrenia requires one or more of the following symptoms to be a dominant clinical feature before a diagnosis can be made:

(a) stupor (marked decrease in reactivity to the environment and in spontaneous movements and activity) or mutism;
(b) excitement (apparently purposeless motor activity, not influenced by external stimuli);
(c) posturing (voluntary assumption and maintenance of inappropriate or bizarre postures);
(d) negativism (an apparently motiveless resistance to all instructions or attempts to be moved, or movement in the opposite direction);
(e) rigidity (maintenance of a rigid posture against efforts to be moved);
(f) waxy flexibility (maintenance of limbs and body in externally imposed positions); and
(g) other symptoms such as command automatism (automatic compliance with instructions), and perseveration of words and phrases.[53]

Undifferentiated schizophrenia. This diagnosis is used when the person meets the general requirements for schizophrenia but doesn't conform to any of the other subtypes.

Post-schizophrenic depression. As the name suggests this involves depression which is experienced after a schizophrenic episode and while some symptoms of schizophrenia are still present, but which "no longer dominate the clinical picture".[54]

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[51] Ibid., pp. 89-90.
[52] Ibid., p. 90.
[53] Ibid., p. 92.
[54] Ibid., p. 93.

Residual schizophrenia. This diagnosis is used when schizophrenia appears to have entered a chronic stage.

Simple schizophrenia. "An uncommon disorder in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance. Delusions and hallucinations are not evident, and the disorder is less obviously psychotic than the hebephrenic, paranoid, and catatonic subtypes of schizophrenia."[55]

DSM IV Diagnostic Criteria for Schizophrenia

The diagnostic guidelines in the American Psychiatric Association's DSM IV present the symptoms of schizophrenia in the form of grouped criteria:

> **Diagnostic criteria for Schizophrenia**
>
> **A.** *Characteristic symptoms:* Two (or more) for the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
> (1) delusions
> (2) hallucinations
> (3) disorganised speech (e.g. frequent derailment or incoherence)
> (4) grossly disorganised or catatonic behaviour
> (5) negative symptoms, i.e., affective flattening, alogia, or avolition
>
> **Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.
>
> **B.** *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
>
> **C.** *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms

[55] Ibid., p. 95.

listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are present for at least a month (or less if successfully treated).[56]

The DSM IV system follows the same pattern as the ICD-10 by providing the diagnostic criteria for schizophrenia in general and then going on to define a number of subtypes for refining the diagnosis. Most of the DSM IV subtypes are the same as those in the ICD-10. The duplicated subtypes are: Paranoid Type, Disorganised Type (Hebephrenic in the ICD-10), Catatonic Type, Undifferentiated Type, and Residual Type. However there is no DSM IV equivalent of the ICD-10's Post-schizophrenic depression and, whereas the DSM IV describes Schizoaffective Disorder as a subtype of schizophrenia, in the ICD-10 it is given a coding that places it in an independent category, as a separate and distinct mental disorder, located between Schizophrenia and the Affective Disorders.

The subtype that is called Simple Schizophrenia in the ICD-10 has no exact equivalent in the DSM IV. The nearest subtype in the DSM IV is called Schizophreniform Disorder, and its description gives it a curiously different twist. Although Simple Schizophrenia (ICD-10) and Schizophreniform Disorder (DSM IV) are both largely distinguished from other forms of schizophrenia by having a reduced number and variety of symptoms, the prescribed reductions for each are very different from one another. Whereas Simple Schizophrenia is largely concerned with social malfunctioning, and doesn't require the presence of psychotic features like delusions and hallucinations, Schizophreniform Disorder is the opposite. A diagnosis of Schizophreniform Disorder requires

[56] American Psychiatric Association, op.cit., pp. 285-286.

psychotic symptoms of a reduced duration (1-6 months) but social/occupational dysfunction is not necessary.

This difference might point to an interesting divergence of philosophical priorities between the cultural environments that respectively prefer to use the two different diagnostic manuals. The ICD-10 environment, mainly Europe, apparently sees social dysfunction as the main residual symptom to be concerned about in this milder subtype of schizophrenia. The North Americans, however, would seem to be more concerned with identifying abnormal mental activity as the residual symptom.

The taxonomies relating to psychosis in both the ICD-10 and the DSM IV are presented as if it is assumed there is a continuous spectrum of disorder that has to be broken up into recognisable segments. The result is that Schizophrenia, as it is described in both manuals, shades into a number of descriptions of similar, but clinically distinct, disorders. These schizophrenia spectrum disorders, as they are sometimes called,[57] are described in both manuals in pages adjacent to, and following, the descriptions of Schizophrenia. The more similar the description is to Schizophrenia, the closer it is positioned to Schizophrenia in the pages of the manuals. It is worth briefly describing this spectrum of disorders because it will help to clarify what Schizophrenia is by examining the descriptions of disorders psychiatrists think are similar, but distinct from Schizophrenia.

In the ICD-10 the description of Schizotypal Disorder follows that of Schizophrenia. This positions Schizotypal Disorder adjacent to Schizophrenia on the spectrum of schizophrenia disorders. As the name suggests this condition has characteristic features that are similar to Schizophrenia but, unlike Schizophrenia, there is an absence of any "dominant or typical disturbance".[58] Schizotypal Disorder is followed in the ICD-10 by the Persistent Delusional Disorders, and then Acute and Transient Psychotic Disorders, and then by Induced Delusional Disorder and finally by the Schizoaffective Disorders, which are to be diagnosed when both "affective and schizophrenic symptoms are prominent within the same episode of illness".[59] After the Schizoaffective Disorders the ICD-10 goes on to describe the Affective Disorders (mood disorders) associated with the bipolar mood extremes of mania and depression.

The DSM IV system sees the order in the spectrum a little differently. Following the subtypes of Schizophrenia is Delusional Disorder. The DSM IV gives a fairly complex description of Delusional Disorder with a number of subtypes. One of the puzzling features of this DSM IV description is an instruction that Delusional Disorder is to be distinguished from Schizophrenia by

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[57] A. M. Persico, Z. W. Wang, D. W. Black, N. C. Andreasen, G. R. Uhl and R. R. Crowe, 'Exclusion of close linkage of the dopamine transporter gene with schizophrenia spectrum disorders', American Journal of Psychiatry, Vol. 152, No. 1, 1995, pp. 134-136.

[58] World Health Organisation, op.cit., p. 95.

[59] Ibid., p. 105.

the absence of any symptoms from Criterion A of the diagnostic guidelines for Schizophrenia.[60] However, when one refers back to Criterion A the first symptom given is "delusions". The distinction between the two disorders apparently largely rests on an understanding that the "delusions" of Schizophrenia are "bizarre" whereas those of Delusional Disorder are non-bizarre.[61] To facilitate this distinction the DSM IV defines a "bizarre" delusion as one "that involves a phenomenon that the person's culture would regard as totally implausible."[62]

This problem of differentiating Schizophrenia from Delusional Disorder draws attention to a couple of interesting points that should be noted at this stage. The first concerns the contradiction between the general outline for Schizophrenia and the diagnostic instructions for Delusional Disorder in the DSM IV. Whereas a number of non-bizarre delusions — like delusions of reference and persecutory delusions — are clearly listed as symptoms of Schizophrenia, at the same time, the diagnostic instructions for Delusional Disorder claim all non-bizarre delusions for that particular disorder. Contradictions like this suggest an underlying arbitrariness in the taxonomic mapping of mental disorders and lays a basis for questioning the validity of pathologising any of the symptoms described.

Indeed, the question of pathological validity is the second point to be raised about Delusional Disorder. If DSM IV defines a bizarre delusion as one "that involves a phenomenon that the person's culture would regard as totally implausible", while stating that Delusional Disorder is only concerned with non-bizarre delusions, then it begs the question as to whether Delusional Disorder pathologises delusions that the person's culture would find plausible. When the diagnostic criteria are examined in the light of this question, this does indeed seem to be the case.

Seven subtypes of Delusional Disorder are given in the DSM IV. The Erotomanic Type, for instance, pathologises unrequited love and "applies when the central theme of the delusion is that another person is in love with the individual. The delusion often concerns idealised romantic love and spiritual union rather than sexual attraction .... Most individuals with this subtype in clinical samples are female."[63]

Similarly, a Delusional Disorder of the Jealous Type is a supposedly pathological delusion which "applies when the central theme of the person's delusion is that his or her spouse or lover is unfaithful".[64] It could perhaps be successfully argued that unwarranted suspicion about the fidelity of a spouse or lover is a pathological condition. But how would a psychiatrist know with any

[60] American Psychiatric Association, op.cit., p. 296.
[61] Ibid., p. 284.
[62] Ibid., p. 765.
[63] Ibid., p. 297.
[64] Ibid.

certainty that a patient's suspicion was unwarranted? This kind of question is highly relevant when one considers the power vested in psychiatrists to impose involuntary treatment on people diagnosed with delusional symptoms.[65]

Following Delusional Disorder on the DSM IV taxonomic spectrum is Brief Psychotic Disorder, which is followed by Shared Psychotic Disorder (the equivalent of the ICD-10's Induced Delusional Disorder in which one person is persuaded to share another person's delusion), Psychotic Disorder Due to a General Medical Condition and then Substance-Induced Psychotic Disorder. A final residual category, Psychotic Disorder Not Otherwise Specified, is given before the DSM IV introduces the Mood Disorders.

The significance of the implication contained in both manuals, that Schizophrenia is one section of a spectrum of psychotic disorders, can be brought into focus when one considers the conditions under which a diagnosis is made. Without any laboratory tests a diagnostician has to rely on evidence provided by the speech and behaviour of the person in question,[66] together with reports from third parties. The person's behaviour first has to be tested, in the diagnostician's own mind, against the range of normal speech and behaviours that is within the diagnostician's experience.[67] This will determine whether the person's mental state deviates too greatly from normal and is therefore pathological. Then, if it is judged to be abnormal, it has to be fitted into the correct point on the spectrum of mental disorders.

In regard to diagnosing schizophrenia this would seem to be a task fraught with possibilities for inconsistency. If, for instance, a person is expressing religious beliefs the diagnostician must first determine whether they are delusional; i.e. false beliefs not "ordinarily accepted by other members of the person's culture or subculture".[68] If they appear to be delusional the diagnostician then has to decide whether the delusions are bizarre, and therefore indicative of Schizophrenia. If they are non-bizarre the alternative diagnosis might be Delusional Disorder - Grandiose Type: "Grandiose delusions may have a religious content (e.g., the person believes that he or she has a special message from a deity)."[69]

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[65] "Delusions" is one of five symptoms specified in the NSW Mental Health Act which, if identified by a medical practitioner, can lead to involuntary incarceration and treatment. See Mental Health Act 1990, NSW Government Information Service, Reprinted as in force at 17 October, 1994.

[66] See for instance, Mary Hollis Johnston and Philip S. Holzman, Assessing Schizophrenic Thinking, Jossey-Bass, San Francisco, 1979.

[67] Nancy M. Docherty, 'Communication disturbances in schizophrenia and mania', JAMA, The Journal of the American Medical Association, Vol. 276, No. 1, July 3, 1996, p. 4B.

[68] American Psychiatric Association, op.cit., p. 765.

[69] Ibid., p. 297.

The risk of inconsistency is further apparent when one considers there is often a distinctly bizarre appearance to many religious beliefs that are culturally acceptable, and therefore not delusional (in the psychiatric sense, that is). Thousands of people may practise a pseudo-cannibalistic ritual together, believing the biscuits and grape juice they consume to symbolise the body and blood of a god, but if the ritual belongs to a respectable mainstream Christian church, and is therefore culturally acceptable, by necessity psychiatrists must view it as being motivated by a non-pathological cause. However, if a solitary individual were to invent and practise a similar ritual it is unlikely the same protection would be available. Such a person might easily be given a diagnosis of schizophrenia and, if so, would probably also be considered dangerous.

Origins of descriptive psychopathology for Schizophrenia

The origins of the pathological approach to schizophrenia can be traced in the history of the relevant diagnostic language. The key words and terms that are currently used to describe the symptoms — like delusions, hallucinations, thought disorder and catatonia — all have long histories of development for usage as diagnostic tools, first for madness in general, and later for specific forms of mental illness like schizophrenia.

Berrios has recently undertaken extensive research into the development of descriptive psychopathology.[70] (I mostly rely on this research for this section). Berrios found that up to the middle of the 19th century the French word *délire* meant either madness or delusion and when it was used for delusion the meaning was interchangeable with delirium.[71] This means that for several centuries in France the three concepts — madness, delusion and delirium — were often indistinguishable. Influenced by religious beliefs, all three forms of *délire* were thought to be organic in nature because "the soul is always in the same state and is not susceptible to change. So the error of judgement that is délire cannot be attributed to the soul but to bodily organs".[72]

In pre-18th century Italy a similar view was expressed about the cause of delusion and delirium:

> Delirium was caused by organic changes for the soul cannot become diseased: 'How can delirium be called affection of the soul, in view of its [the soul's] unchangeable nature?' 'Where is the seat of delirium?' It is evident that true and basic errors of judgment and of reasoning, without any lesion in the organ of external senses, must be due to a physical disease of the brain.[73]

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[70] German E. Berrios, The History of Mental Symptoms University of Cambridge Press, Cambridge, 1996.
[71] Ibid., p. 85.
[72] Arnulphe d'Aumont, 1754, quoted in Berrios, ibid.
[73] Vincenzo Chiarugi, quoted in Berrios, ibid., p. 86.

British thinkers appear to have had a more circumspect view of delusions and madness, sometimes being less willing to associate delusions with brain disease. Hobbes saw delusions as being the primary indicator of madness but he was equivocal about the cause, unsure whether to adopt an ancient interpretation blaming "Daemons, or Spirits, either good, or bad, which .... might enter into man, possess him, and move his organs in such strange, and uncouth manner,"[74] or whether to adopt the opinion current in his time that underlying "passions" were the cause.

John Locke introduced the belief that delusions and madness were caused by associating inappropriate ideas: "some of our ideas have a natural correspondence and connection with one another: it is the office and excellency of our reason to trace these, and hold them together in that union and correspondence".[75] However, to Locke madmen "do not appear to me to have lost the faculty of reasoning, but having joined together some ideas very wrongly, they mistake them for truths, and they err as men do that argue right from wrong principles."[76]

Locke's view remained popular up to the middle of the 19th century after it was amplified by 18th century associationists like David Hartley. But Hartley believed, like the French, that delusions and madness could also have organic causes:

> the causes of madness are of two kinds: bodily and mental. That which arises from bodily causes is nearly related to drunkenness, and to the deliriums attending distemper. That from mental causes is of the same kind with temporary alienation of the mind during violent passions, and with prejudices of opinionativeness, which much application to one set of ideas only occasions.[77]

In the late 18th century French and German commentators agreed that hallucinations can be the cause of mental disorder but they didn't agree on the extent of this disorder. The Frenchman Dufor was of the opinion that "The false impression of the external senses, then, must necessarily create disorder and confusion in a person's conduct."[78] Crichton, a German, responded "that the diseases of the external senses produce erroneous mental perceptions, must be allowed; but it depends on the concurrence of other causes, whether delusion follows".[79]

Disagreements like these led on to a 19th century debate about whether hallucinations could be a cause for insanity. Hallucinations were defined early in the debate: "If a man has the intimate

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[74] Thomas Hobbes, quoted in Berrios, ibid., pp. 86-87.
[75] John Locke, quoted in Berrios, ibid., p. 88.
[76] John Locke, quoted in Berrios, ibid.
[77] David Hartley, quoted in Berrios, ibid., pp. 88-89.
[78] Jean Francois Dufor, quoted in Berrios, ibid., p. 35.
[79] German E. Berrios, ibid., p. 35.

conviction of actually perceiving a sensation for which there is no external object, he is in a hallucinated state."[80] But unfortunately the word *hallucination* was closely linked with the word *vision* and therefore produced some difficulties in dealing with false perceptions that were not concerned with the sense of sight.

Even so, a vigorous defence was mounted for the use of the word by the 19th century French psychiatrist, Esquirol. As a result *hallucination* has been inherited by modern psychiatry:

> Hallucinations of vision have been called visions but this is appropriate only for one perceptual mode. Who would talk about auditory visions, taste visions, olfactory visions? .... However, the functional alterations, brain mechanisms and the clinical context involved in these three senses is the same as in visions. A generic term is needed. I propose the word hallucination.[81]

An important early debate about the nature of hallucinations was concerned with whether the fault was to be found in the external sense organs or whether it was in the "central organ of sensitivity itself".[82] Esquirol was of the opinion that "hallucination is a cerebral or psychological phenomenon that takes place independently from the senses. The pretended sensations of the hallucinated are images and ideas reproduced by memory, improved by the imagination, and personified by habit .... visionaries are dreaming whilst awake"[83]

Baillarger took up similar arguments after Esquirol died and in 1844 presented his views to the Royal Academy of Medicine in Paris: "The most frequent and complicated hallucinations affect hearing: invisible interlocutors address the patient in the third person, so that he is a passive listener in conversation .... the insane deaf is more prone to hear voices."[84] But Baillarger's view was challenged by another of his countrymen named Michéa who posed a complicated argument that "hallucination consisted of a metamorphosis of thinking, was neither a sensation nor a perception but intermediate between perception and pure conception. It occupies the middle ground between these two facts of consciousness and participates in both."[85]

In the middle of the 19th century an important debate broke out amongst French psychiatrists about the nature of hallucinations. According to Berrios there were three main points to the debate: "could hallucinations ever be considered as 'normal' experiences? Did sensation, image and hallucination

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[80] E. Esquirol, quoted in Berrios, ibid., p. 37.
[81] Ibid.
[82] Ibid.
[83] Ibid., pp. 37-38.
[84] J. Baillarger, quoted in Berrios, Ibid., p. 39.
[85] C. F. Michéa, quoted in Berrios, ibid.

form a continuum? Were hallucinations, dreams and ecstatic trance similar states? A fourth issue (as Henri Ey noticed) 'haunted everyone but was not made the base of the debate', namely, whether hallucinations had a 'psychological' origin."[86]

All of these issues remain unresolved today.[87] Indeed, they form much of the basis for the current controversy. It seems that although considerable progress has been made in the past century and a half in categorising, identifying and treating unusual mental phenomena, little progress has been made in understanding their underlying nature. This point is well illustrated by the example of thought disorder.

Thought disorder, as a symptom of schizophrenia, is indicated by disorganised or nonsensical speech.[88] Unlike delusions and hallucinations, of which the people experiencing them usually have some insight, the identification of disordered thoughts must usually be made by an observer.[89] For a long time this necessity caused the symptom to be considered as secondary in importance to delusions and hallucinations. As a result it wasn't until the second half of the 19th century that psychiatrists began to form theories about the causes and nature of disordered thoughts:

> Two models of 'thinking' vied for supremacy during the nineteenth century: the associationistic approach was the legacy of British empiricism and started with Locke's description of simple and complex ideas .... The second approach was based on Faculty Psychology .... that the mind is a cluster of independent powers, capacities or faculties ....[90]

Both models are now deeply embedded in modern psychiatric thinking about schizophrenia. After passing through dubious stages of development, like the 19th century phrenology movement, based on the belief that a person's personality could be revealed by measuring and mapping the pattern of bumps on their head, faculty theory is now largely at the base of current attempts to draw maps of the brain by identifying various mental functions with parts of the brain.[91] This area of research, as

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[86] German E. Berrios, ibid., p. 40.

[87] J. M. Cleghorn, S. Franco, B. Szechtman, R. D. Kaplan, H. Szechtman, G. M. Brown, C. Nahmias and E. S. Garnett, 'Toward a Brain Map of Auditory Hallucinations', American Journal of Psychiatry, Vol. 149, No. 8, 1992, pp. 1062-1071.

[88] T. C. Manschreck, B. Maher, M. T. Celada, M. Schneyer and R. Fernandez, 'Object Chaining and Thought Disorder in Schizophrenic Speech', Psychological Medicine, Vol. 21, No. 2, 1991, pp. 443-446.

[89] P. D. Harvey, M. F. Lenzenweger, R. S. Keefe, D. L. Pogge, M. R. Serper and R. C. Mohs, 'Empirical Assessment of the Factorial Structure of Clinical symptoms in Schizophrenic Patients: Formal Thought Disorder', Psychiatry Research, Vol. 44, No. 2, 1992, pp. 141-151.

[90] Berrios, op.cit., p. 72.

[91] Bruce Bower, 'Hallucinating brains pose for first scans', Science News, Vol. 148, No. 20, 1995, p. 310.

will be discussed further on, is central to current scientific endeavours to link schizophrenia with defects in brain architecture.[92]

The associationistic approach, on the other hand, had considerable influence on both Kraepelin and Bleuler, the two psychiatric researchers who are most commonly cited as being the first pioneers, the inventors/discovers/definers, of the disease entity called schizophrenia.[93] Through Kraepelin and Bleuler the associationistic approach has had an important influence on nominating the primary indications of schizophrenia that are found in modern diagnostic manuals.

Kraepelin and Bleuler

Emile Kraepelin was a German psychiatrist practising in the late 19th century. In Kraepelin's time the psychiatric nosology was still very much in flux and there was only a shifting consensus about matching particular symptoms with specific mental diseases. This situation provided scope for individual psychiatrists to "discover" new disease entities and then persuade their colleagues to recognise their new discovery. Kraepelin was the first psychiatrist to observe a certain pattern in a form of madness that had an early onset and, as he falsely thought, led finally to a deteriorating condition:[94] "To accentuate the progressive destruction of mental abilities, emotional responses and the integrity of the personality which he saw as central to this condition, Professor Kraepelin termed it dementia praecox — dementia of early life."[95]

Kraepelin's argument was that three psychiatric conditions, previously recognised separately, were actually different aspects of a single disease he called dementia praecox. The three pre-existing disease entities were hebephrenia, which was characterised by "aimless, disorganised and incongruous behaviour; catatonia, in which the individual might be negativistic, motionless or even stuporous or, at other times, extremely agitated and incoherent; and finally dementia paranoides, in which delusions of persecution and grandeur were prominent."[96]

Kraepelin had to overcome professional opposition to gain recognition for his new interpretation. One of its central features was a clear distinction from other forms of madness, which sometimes produced similar symptoms, but which have a demonstrable biological cause, like cerebral syphilis.

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[92] Daniel R. Weinberger, 'From neuropathology to neurodevelopment (Schizophrenia, part 2)', The Lancet, Vol. 346, No. 8974, 1995, pp. 552-558.

[93] Louis L. Lunsky, 'A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders', JAMA, The Journal of the American Medical Association, Vol. 276, No. 10, 1996, p. 836.

[94] For a discussion which compares Kraepelin's view to modern interpretations of schizophrenia see, R. S. Keefe, D. S. Lobel, R. C. Mohs, J. M. Silverman, P. D. Harvey, M. Davidson, M. F. Losonczy and K. L. Davis, 'Diagnostic Issues in Chronic Schizophrenia: Kraepelinian Schizophrenia, Undifferentiated Schizophrenia, and State-Independent Negative Symptoms', Schizophrenia Research, Vol. 4, No. 2, 1991, pp. 71-79.

[95] Richard Warner, Recovery From Schizophrenia Routledge & Kegan Paul, London, 1985, pp. 9-10.

[96] Ibid., p. 10.

He also sought to distinguish dementia praecox from other forms of mental illness that are clearly stress induced, and also from cyclical mood disorders. The description he gave of dementia praecox has become the foundation for the modern psychiatric description of schizophrenia.

Kraepelin worked as part of a highly successful team of psychiatric researchers that included Alzheimer, after whom Alzheimer's Disease takes its name. Kraepelin believed that dementia praecox was a "brain disease and that its neuropathological substrates would be identified by the new techniques that he and his investigative team were developing."[97] This focus on a search for a biological cause was largely based on what emerged to be a false assumption that the disease necessarily takes a deteriorating course, from which sufferers do not recover.[98]

As Kraepelin's research progressed he began to find that the symptoms of a substantial percentage of the patients he had selected, according to the new diagnostic criteria, did not follow a deteriorating course, and that 12% of these patients actually made a complete recovery.[99] This potential for recovery intrigued a Swiss psychiatrist named Eugen Bleuler who realised that the new disease of dementia praecox had been misnamed: "Stimulated by the psychoanalytical theories of his assistant, Carl Jung, Dr Bleuler formulated a new unifying concept for the condition and gave it a new name."[100] Bleuler believed that the major identifying characteristic of the condition was not a progressive deterioration but was instead a discontinuity and fragmentation between thinking and feeling. So he reformulated the description and called the condition *schizophrenia*, meaning split mind.

In 1911 Bleuler published a monograph entitled Dementia Praecox or the Group of Schizophrenias[101] in order to propagate his new description. Although this book was not translated into English for some 30 years it is generally recognised as the foundation for the modern psychiatric understanding of schizophrenia.

In the first few pages of the book Bleuler painstakingly explained why Kraepelin's description was unsatisfactory and why he found it necessary to rename the condition.[102] His argument was that the name *dementia praecox* inappropriately limited the disease to young people who progressively

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[97] Nancy C. Andreasen, Laura Flashman, Michael Flaum, Stephan Arndt, Victor Swayze II, Daniel S. O'Leary, James C. Ehrhardt and William T. C. Yuh., 'Regional brain abnormalities in schizophrenia measured with magnetic resonance imaging', JAMA, The Journal of the American Medical Association, Vol. 272, No. 22, 1994, pp. 1763-1770.

[98] For a discussion about research on recovery from schizophrenia see, Anne D. Walling, 'Residential status of schizophrenic patients', American Family Physician, Vol. 50, No. 3, 1994, pp. 688-691.

[99] Warner, op.cit., p. 15.

[100] Ibid., p. 14.

[101] Eugen Bleuler, Dementia Praecox or The Group of Schizophrenias, Translated by Joseph Zinkin International Universities Press, New York, 1950.

[102] Ibid., pp. 3-12.

deteriorate. He said this had caused great confusion within the psychiatric profession in a number of countries since it was readily apparent that many victims experienced the first onset later in life and not all victims progressively deteriorated.

Bleuler then went on to categorise the symptomatology of schizophrenia into two groups. The first group he called "fundamental symptoms". These were symptoms "that are present in every case and at every period of the illness even though, as with every other disease symptom, they must have attained a certain degree of intensity before they can be recognised with any certainty".[103] According to Bleuler the "fundamental symptoms consist of disturbances of association and affectivity, the predilection for fantasy as against reality, and the inclination to divorce oneself from reality (autism)."[104]

The second group of symptoms he called "accessory symptoms". These involve "manifestations such as delusions, hallucinations or catatonic symptoms. These may be completely lacking during certain periods, or even throughout the entire course of the disease; at other times they alone may permanently determine the clinical picture."[105]

As a "disturbance of association", thought disorder was one of Bleuler's "fundamental symptoms" which he described in an unusually candid fashion. He supplied numerous examples taken from conversations with his patients, as well as extracts from their letters, to demonstrate what he thought were the illogical and bizarre effects that can be produced by inappropriately associating ideas. The effect was to give an insight into psychiatric thinking that is rarely available in modern psychiatric writing.

One of Bleuler's examples, for instance, utilises quotations from a patient's written impression of ancient Egypt. According to Bleuler the patient's writing demonstrates a failure to control impulses of fantasy which have opened the way for all sorts of incongruous material to be introduced. The writing refers to the habits and preferences of various national and religious groupings including Parsees, Afghans, Jews, Moors and Arabs and finishes with the assertion that "China is the Eldorado of the Pawnees".[106] Much of this material clearly does not belong in a factual account of ancient Egypt. But Bleuler's argument that the writing demonstrates clinical evidence of madness is also doubtful in a modern context. What might have been an excellent example of bizarre self-expression to a turn-of-century scientist is, to a contemporary reader, somewhat familiar as a variety of stream-of-consciousness writing.

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[103] Ibid., p. 13.
[104] Ibid., p. 14.
[105] Ibid., p. 13.
[106] Ibid., p. 15.

Bleuler also gives examples of questions that he asks his schizophrenic patients. The answers they give are then offered as clinical evidence to demonstrate the nature of disordered thinking. But as Bleuler describes his method he seems to disregard the underlying humanity of his patients and seems to be unaware of the potential that might exist for the patients to give flippant or witty answers, or for them to be teasing or joking with him, instead of expressing their most seriously held beliefs. In his effort to appear scientific Bleuler has been careful to demonstrate objectivity as he interprets and records his interactions with patients. But what might be objectivity in other scientific research looks more like naivety — and a tendency towards the literal — in psychiatric research.

He gives an example of schizophrenic symptoms concerning, "A female patient, supposed to help in the household work, is asked why she is not working. The answer, 'But I don't understand any French', is logically related neither to the question nor the situation."[107] Bleuler's assumption is that her answer indicates disordered thoughts. However, it is possible to read a sophisticated retort into the answer. If, for instance, a similar dialogue were encountered in a novel a reader might simply assume that the woman was protesting against being asked to do housework and, with tongue in cheek, was perhaps asserting that she was not a French maid.[108]

Throughout Bleuler's book there is an unsettling single-mindedness and inflexibility in the record of his interactions with patients. He gives the impression of having exclusively adopted the role of an investigative scientist in his personal interactions with patients, and that everything they say is firstly scientific evidence before it is human communication. In this situation it seems highly likely that distortions would be introduced into the communications and behaviour of the patients interacting with him. If one places oneself in the position of the patient in the interactions described by Bleuler it is apparent that the patients might have encountered some difficulty in responding to this scientist who was talking to them as if they were all laboratory exhibits.

This same point has been raised by R. D. Laing in relation to Kraepelin's work. In The Politics of Experience[109] Laing quoted from Kraepelin's Lectures on Clinical Psychiatry[110] in which Kraepelin described a clinical examination of a female patient he conducted in front of a live audience of doctors to demonstrate dementia praecox. In Kraepelin's account the woman paced back and forth on a stage while he attempted to distract her. The woman's indifference to Kraepelin's activities constituted the evidence of her condition. In Laing's reproduction of the account all of Kraepelin's actions in relation to the woman are printed in italics.

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[107] Ibid., p. 22.

[108] R. D. Laing has observed that when psychiatric patients are given the opportunity they will often boast about how they have deliberately used subtle language to insult or contradict a psychiatrist.

[109] R. D. Laing, The Politics of Experience Penguin, Harmondsworth, 1967.

[110] E. Kraepelin, Lectures on Clinical Psychiatry Bailliere, Tindall and Cox, London, 1906.

> *.... On attempting to stop her movement .... if I place myself in front of her with my arms outstretched .... if one takes firm hold of her .... will not allow it to be forced from her .... If you prick her on the forehead with a needle ....*[111]

Laing's purpose was to separate out the psychiatrist's own actions in his account and to demonstrate how extraordinary these actions were and how bizarre was the situation with which the woman had to deal.

Both Kraepelin's and Bleuler's works raise an important question about psychiatric research work in general: Is it possible for a patient's mind to be used as a laboratory exhibit for scientific investigation, and for it still to give responses that are considered normal? Perhaps another way of examining this problem is to ask: Is it normal to behave like a normal person when the situation is clearly abnormal? There is also a variant of this question which has considerable significance for the discussion at hand: If a psychiatrist assumes a patient's mind is diseased, and the patient's mind perceives the psychiatrist's assumption, is it possible for the patient's mind to function in response to this perception in a way that is normal?[112]

This second question implies that patients might have choices about how to adapt to the situations they find themselves in. The possibility that schizophrenic symptoms are merely adaptive behaviour will be discussed more fully in the sections of the thesis which analyse the mystical and myth-of-mental-illness models. However, it seems apparent that the argument for a pathological cause relies heavily on the assumption that all symptomatic behaviour for schizophrenia is necessarily involuntary. The medical model tends to disregard the possibility that schizophrenic symptoms might sometimes be a deliberate strategy induced by the circumstances in which psychiatry is practised.

Conclusion

The symptoms of schizophrenia are similar to the phenomena of baldness and homosexuality in that it is impossible to make sound arguments that define them in pathological terms. It is apparent that diagnostic procedures utilised by the medical model for schizophrenia have been developed, and are applied, independently from any certain knowledge about the cause of the symptoms. The current diagnostic criteria are quite wide-ranging and include negative and positive symptoms that can affect both mental and social activity. When the history of the descriptive psychopathology for schizophrenia is examined it becomes apparent that debate over the cause and significance of these mental symptoms has been going on for hundreds of years within European intellectual circles.

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[111] Laing, op.cit.

[112] For a discussion on the effects of labelling and cognitive dissonance see, Warner, op.cit., pp. 181-186.

However, a determination of medical pathology was only definitively stamped on these symptoms when Kraepelin amalgamated a number of separate and distinct forms of mental pathology and called the new hybrid mental disease dementia praecox.

Bleuler's subsequent observation that people who were diagnosed with this new consolidated mental disease did not necessarily degenerate into dementia necessitated refinements to the descriptive psychopathology of the condition. Bleuler also renamed the disease schizophrenia. A major criticism of the disease explanation involves arguments that the symptoms are sometimes only behaviour that has been adapted to the extraordinary conditions caused by the practice of psychiatry itself.