The history of schizophrenia

Health & Medicine, Disease

The History of Schizophrenia Schizophrenia is a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self. The word " Schizophrenia" is less than 100 years old. However the disease was first identified as a discrete mental illness by Dr. Emile Kraepelin in the 1887 and the illness itself is generally believed to have accompanied mankind throughout its history. There are documents that identify Schizophrenia can be traced to the old Pharaonic Egypt, as far back as the second millennium before Christ.

Depression, dementia, as well as thought disturbances that are typical in schizophrenia are described in detail in the Book of Hearts. The Heart and the mind seem to have been synonymous in ancient Egypt. The physical illnesses were regarded as symptoms of the heart and the uterus and originating from the blood vessels or from purulence, fecal matter, a poison or demons. Some recent study into the ancient Greek and Roman literature showed that although the general population probably had an awareness of psychotic disorders, there was no condition that would meet the moderndiagnosticcriteria for schizophrenia in these societies.

At one point in history, all people who were considered " abnormal," whether due to mental illness, mental retardation, or physical deformities, were largely treated the same. Early theories supposed that mental disorders were caused by evil possession of the body, and the appropriate treatment was then exorcising these demons, through various means, ranging from innocuous treatments, such as exposing the patient to certain types ofmusic, to dangerous and sometimes deadly means, such as releasing the evil spirits by drilling holes in the patient's skull.

One of the first to classify the mental disorders into different categories was the German physician, Dr. Emile Kraepelin. He used the term " dementia praecox" for individuals who had symptoms that we now associate with schizophrenia. The nonspecific concept of madness has been around for many thousands of years and schizophrenia was only classified as a distinct mental disorder by Kraepelin in 1887. He was the first to make a distinction in the psychotic disorders between what he called dementia praecox and manic depression. Kraepelin believed that dementia praecox was primarily a disease of the brain, and particularly a form of dementia.

Kraepelin named the disorder 'dementia praecox' (early dementia) to distinguish it from other forms of dementia (such as Alzheimer's disease) which typically occur late in life. He used this term because his studies focused on young adults with dementia. The Swiss psychiatrist, Eugen Bleuler, coined the term, " schizophrenia" in 1911. He was also the first to describe the symptoms as " positive" or " negative. " Bleuler changed the name to schizophrenia as it was obvious that Krapelin's name was misleading as the illness was not a dementia (it did not always lead to mental deterioration) and could sometimes occur late as well as early in life.

The word " schizophrenia" comes from the Greek roots schizo (split) and phrene (mind) to describe the fragmented thinking of people with the disorder. His term was not meant to convey the idea of split or multiplepersonality, a common misunderstanding by the public at large. Since Bleuler's time, the definition of schizophrenia has continued to change, as scientists attempt to more accurately delineate the different types of

mental diseases. Without knowing the exact causes of these diseases, scientists can only base their classifications on theobservationthat some symptoms tend to occur together.

Both Bleuler and Kraepelin subdivided schizophrenia into categories, based on prominent symptoms and prognoses. Over the years, those working in this field have continued to attempt to classify types of schizophrenia. Five types were delineated in the DSM-III: disorganized, catatonic, paranoid, residual, and undifferentiated. The first three categories were originally proposed by Kraepelin. These classifications, while still employed in DSM-IV, have not shown to be helpful in predicting outcome of the disorder, and the types are not reliably diagnosed.

Many researchers are using other systems to classify types of the disorder, based on the preponderance of " positive" verses " negative" symptoms, the progression of the disorder in terms of type and severity of symptoms over time, and the co-occurrence of other mental disorders and syndromes. It is hoped that differentiating types of schizophrenia based on clinical symptoms will help to determine different etiologies or causes of the disorder. The evidence that schizophrenia is a biologically-based disease of the brain has accumulated rapidly during the past two decades.

Recently this evidence has been also been supported with dynamic brain imaging systems that show very precisely the wave of tissue destruction that takes place in the brain that is suffering from schizophrenia. The 1800's saw a slow progression towards an eventual schizophrenia definition. From the 1800's on, schizophrenia history begins to gain ground as researchers began

to understand the nature of the disease: Although the nineteenth century saw great strides towards a schizophrenic definition, " lunatic asylums" of the time were often little more than human zoos.

For a fee, well to do ladies and gentlemen could tour the asylums, viewing the patients. No doubt the psychotic behavior of schizophrenics made them popular " attractions" during these degrading tours. Schizophrenia in Recent Times The start of the twentieth century saw, for the first time in schizophrenia history, a practical schizophrenia definition and the birth of effective treatments. In 1911 Eugene Beuler first used the term schizophrenia, and his schizophrenia definition includes symptoms such as blunted emotions, disordered thoughts, and loss of awareness.

Then in 1957, Kurt Schneider created the schizophrenic definition still in use today, and is the first person in the long history of schizophrenia to list the currently accepted features of schizophrenia. Schizophrenia definitely has a very significant genetic component. Those who have a third degree relative with schizophrenia are twice as likely to develop schizophrenia as those in the general population. Those with a second degree relative have a several-fold higher incidence of schizophrenia than the general population, and first degree relatives have an incidence of schizophrenia an order of magnitude higher than the general populace.

The History of Schizophrenia Treatment in the Twentieth Century Schizophrenia history abounds in unusual treatments and bizarre " cures. " Indeed, the twentieth century stands apart from the rest of schizophrenia history because it saw the first effective schizophrenia treatment: the first

antipsychotic drug was created in 1952. The twentieth century also saw some controversial schizophrenia " cures. " Portuguesedoctor, Egus Moniz, developed the lobotomy in the 1930s. Moniz won a Nobel Peace prize for his work in 1949.

The lobotomy procedure cut the nerve fibers from the frontal lobe to the interior of the brain, where emotions are generated. Patients were less agitated and aggressive after a lobotomy. Of course, patients were also left indifferent and with blunted emotions, but this didn't squelch the lobotomy's popularity as a schizophrenia treatment. Patients could be released from hospitals after lobotomies, saving both hospitals andfamilymembersmoney. Lobotomy procedures varied. American neurologist John Freeman created perhaps the most bizarre procedure.

Freeman traveled America performing lobotomies for the benefit of audiences comprised of journalists and medical professionals: to call him a medical showman isn't stretching the truth much. Freeman's lobotomies were simple, quick, and medically preposterous. With the patient under anesthesia, Freeman placed an ice pick (yes, you read that correctly) into an area just above the eyeball. Using a hammer, he drove the ice pick into the patient's brain to a depth of approximately one inch. Lobotomies fell into disfavor as people noticed patients often died from lobotomy-induced epilepsy or surgical infections.

Severe brain damage was also shown in many cases (not that it should have required a study to prove an ice pick to the brain caused extensive damage). Still, between the 1940s and the 1950s over 40, 000 Americans were

lobotomized. Shock therapy was developed at the same time lobotomies were darkening schizophrenia history. Approaches to shock therapy varied. Some doctors used insulin injections; others preferred Metrazol or electricity. Insulin often left patients in comas. Both Metrazol and electricity caused seizures, and electric shock therapy often caused memory loss.

Surprisingly, electroconvulsive therapy is still used to treat some cases of schizophrenia and severe depression. Current techniques are supposed to be much safer, but many medical professionals consider electroconvulsive therapy very dangerous, and something that should only be used as a last resort. Since schizophrenia may not be a single condition and its causes are not yet known, current treatment methods are based on both clinical research and experience. These approaches are chosen on the basis of their ability to reduce the symptoms of schizophrenia and to lessen the chances that symptoms will return.

Medications For Schizophrenia: Antipsychotic medications have been available since the mid-1950s. They have greatly improved the outlook for individual patients. These medications reduce the psychotic symptoms of schizophrenia and usually allow the patient to function more effectively and appropriately. Antipsychotic drugs are the best treatment now available, but they do not " cure" schizophrenia or ensure that there will be no further psychotic episodes. The choice and dosage of medication can be made only by a qualified physician who is well trained in the medical treatment of mental disorders.

The dosage of medication is individualized for each patient, since people may vary a great deal in the amount of drug needed to reduce symptoms without producing troublesome side effects. The large majority of people with schizophrenia show substantial improvement when treated with antipsychotic drugs. Some patients, however, are not helped very much by the medications and a few do not seem to need them. No frames is difficult to predict which patients will fall into these two groups and to distinguish them from the large majority of patients who do benefit from treatment with antipsychotic drugs. A number of new ntipsychotic drugs (the so-called " atypical antipsychotics") have been introduced since 1990. The first of these, clozapine (Clozaril), has been shown to be more effective than other antipsychotics, although the possibility of severe side effects - in particular, a condition called agranulocytosis (loss of the white blood cells that fight infection) -- requires that patients be monitored with blood tests every one or two weeks. Even newer antipsychotic drugs, such as risperidone (Risperdal) and olanzapine (Zyprexa), are safer than the older drugs or clozapine, and they also may be better tolerated.

They may or may not treat the illness as well as clozapine, however. Several additional antipsychotics are currently under development. Antipsychotic drugs are often very effective in treating certain symptoms of schizophrenia, particularly hallucinations and delusions; unfortunately, the drugs may not be as helpful with other symptoms, such as reducedmotivationand emotional expressiveness. Indeed, the older antipsychotics (which also went by the name of " neuroleptics"), medicines like haloperidol (Haldol) or

chlorpromazine (Thorazine), may even produce side effects that resemble the more difficult to treat symptoms.

Often, lowering the dose or switching to a different medicine may reduce these side effects; the newer medicines, including olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal), appear less likely to have this problem. Patients and families sometimes become worried about the antipsychotic medications used to treat schizophrenia. In addition to concern about side effects, they may worry that such drugs could lead to addiction. However, antipsychotic medications do not produce a " high" (euphoria) or addictive behavior in people who take them.

Another misconception about antipsychotic drugs is that they act as a kind of mind control, or a " chemical straitjacket. " Antipsychotic drugs used at the proper dosage does not " knock out" people or take away their free will. While these medications can be sedating, and while this effect can be useful when treatment is initiated particularly if an individual is quite agitated, the utility of the drugs is not due to sedation but to their ability to diminish the hallucinations, agitation, confusion, and delusions of a psychotic episode.

Thus, antipsychotic medications should eventually help an individual with schizophrenia to deal with the world more rationally. Treatment of schizophrenia depends upon a life-long regimen of both drug and psychosocial, support therapies. While the medication helps control the psychosis associated with schizophrenia (e. g. , the delusions and hallucinations), it cannot help the person find a job, learn to be effective in

social relationships, increase the individual's coping skills, and help them learn to communicate and work well with others.

Poverty, homelessness, and unemployment are often associated with this disorder, but they don't have to be. If the individual finds appropriate treatment and sticks with it, a person with schizophrenia can lead a happy and successful life. But the initial recovery from the first symptoms of schizophrenia can be an extremely lonely experience. Individuals coping with the onset of schizophrenia for the first time in their lives require all the support that their families, friends, and communities can provide.

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