

Mental Health and Society Lecture week 10: Introduction to Schizophrenia.

In 1898 Kraepelin described what he called dementia praecox. At this time 2 kinds of endogenous psychoses were distinguished, namely dementia praecox and manic depression. Kraepelin identified symptoms such as hallucinations, delusions, negativism, attentional difficulties, stereotyped behaviour and emotional dysfunctions as being characteristic of dementia praecox.

The term *Schizophrenia* originated with Eugen Bleuler in 1908. Greek 'Schizen' split, 'phren' mind. Not the same as multiple personality which is a kind of dissociative disorder. Bleuler was convinced that underlying psychological processes were responsible for the splitting between the different aspects of the person's thought and the thought and behaviour. He originated the idea of the so called 'four As' - Alterations in affect, alterations in association, ambivalence and autism. The category of schizophrenia changes over time with different aspects given different names and placed in different categories in successive versions of the US Diagnostic and Statistical Manual.

The prevalence of schizophrenia seems to be about 1% of the population, which is a figure also detected in other countries (APA, 1994, Regier et al, 1993). About 200,000 - 400,000 new cases are reported each year in the US. Incidence appears to be related to social class with a rate of 1.9% in 'lower social classes and 0.4% in the 'upper class' in the US (Keith et al, 1991). About 3% of divorced people suffer, 1% of married people and 2% of single people. Schizophrenia might cause people to migrate down the social scale (Munk and Mortensen, 1992) or it might be that the stress of poverty makes people more vulnerable (Dohrenwend et al, 1992). Schizophrenia rates are said to be the highest in socially disorganised neighbourhoods (Logdberg et al, 2004)

Definitions: It is difficult to write a concise definition of schizophrenia. Stafford-Clark et al (1990) say schizophrenia is a group of disorders characterised by 'progressive deterioration of the personality and its relationship with the world. Capacity to interpret reality fails as contact is disturbed, while emotional impoverishment occurs as thinking deteriorates, with impairment of personal relationships and of ability to cope with life's demands.' (p 136). 'Widespread dislocation of cerebral functioning'

The psychiatrist-philosopher Karl Jaspers described an 'abyss of difference' between the 'distorted psychic life of psychosis and normality' (Jaspers, 1963: 219). Jaspers saw this to be the hallmark of psychosis:

we find understandable what strikes the patients as not at all so but on the contrary quite well founded and a matter of course. Why a patient starts to sing in the middle of the night, why he attempts suicide, begins to annoy his relatives, why a key on the table excites him so much, all this will seem the most natural thing in the world to the patient but he cannot make us understand it. (Jaspers, 1963: 581)

The symptoms of schizophrenia may be very varied.

A large array of possible symptoms which may be of several kinds - thought, perception and attention, motor behaviour, affect and emotion, and life functioning. Many people diagnosed as schizophrenic have only a few though. Some researchers believe that there are different kinds of disorder lumped together here, with different symptoms and different causes.

The symptoms are often broken down into two categories:

1) Positive symptoms: e.g. delusions and hallucinations - more on this later!!

2) Negative symptoms: e.g. deficits, including (Andreasen, 1982): i) Affective flattening. ii) Alogia - language deficits, poverty of speech, poverty of speech content, blocking and long delays before responding. iii) Avolition-apathy - lack of interest, drive and energy, occupational difficulties. iv) Anhedonia-asociality - inability to experience pleasure and feel intimacy, little interest in recreation, sex and social relationships.

And a third category is sometimes distinguished:

3) Psychomotor symptoms. The patient may grimace or do unusual gestures over and over; the so called stereotypies. There may be some manic type activity. May be catatonic immobility, unusual and uncomfortable postures adopted for long periods of time. One aspect of this is the so called 'waxy flexibility' where the sufferer's limbs can be manipulated by other people and will stay in that position for long periods of time.

Positive symptoms

These may be distinguished into delusions, disorganised thinking and speech, heightened perceptions and hallucinations and inappropriate affect. A distinction is often drawn between disorders of **form** and disorders of **content**

Disorders of the content of thought. The delusions which are subsumed under this heading are typically beliefs which the person believes in fervently but which have little or no basis in 'reality'. These can sometimes difficult to distinguish these from religious or cultural beliefs. Delusions are often divided up into the following broad types:

- i) Delusions of persecution. The most common kind according to DSM IV. People believe they are being plotted against, thwarted, attacked, or deliberately victimised.
- ii) Delusions of reference. Personal significance attached to the actions of others -e.g. believing that as radio announcer is talking to you personally, a change in the weather is a sign to change jobs.
- iii) Delusions of grandeur. Believing oneself to be a great inventor, saviour, religious figure, leader etc.
- iv) Delusions of control, e.g. the belief that one's thoughts are coming from elsewhere, the idea that other people are secretly controlling what one eats.

Positive formal thought disorders - disorders of the form of thought. Here a patient's speech may be incoherent - follow no comprehensible logic; may make sense to the patient but not to the clinician. May use neologisms, words made up. May use loose associations - difficulty sticking to one topic, jumps to another on the basis e.g. of similar sounding words. May exhibit thought form disorders in terms of poverty of speech - amount of talk reduced, poverty of content - amount appropriate but little information. Perseveration - words and ideas repeated. 'Blocking' may occur where the train of speech is interrupted and the topic cannot be easily recovered. Many schizophrenics don't necessarily display thought form deviations, also some of these thought form characteristics may appear in depression or mania. These thought content features may be prevalent in non patient groups too, for example when people are tired or ill, but in schizophrenia they are more pervasive and profound (Holzman, 1986).

The prodrome of schizophrenia - sometimes detectable in thought form, communication and other symptoms

Before people develop the full fledged syndrome they may show some features which place them at greater risk of developing the syndrome, or some symptoms which are precursors of it. E.g. children whose parents were schizophrenic who showed more disordered speech at the age of 15 were at higher risk of developing the disorder than those who didn't. Schiffman et al (2004) found that among children whose behaviour was recorded at the age

of 11-13, those who went on to develop schizophrenia showed more neuromotor problems and difficulties with sociability.

Schneider's first rank symptoms

The delusions of people with schizophrenia were described and categorised extensively by Kurt Schneider (1959; Mellor 1970) and have formed the basis of the descriptions of these found in DSM. Schneider identified what he called 'first rank symptoms' namely:

1) Auditory hallucinations: (mostly auditory but may be visual). Sufferers may complain of three basic types i) Audible thoughts - voices repeating or anticipating what the sufferer thinks. ii) Voices discussing or arguing, usually about the sufferer, referring to him or her in the third person. iii) Voices commenting. Or doing a running commentary about the sufferer.

Most often, hallucinations are auditory, (APA, 1994; Mueser et al 1990). People hear sounds and voices either inside their heads or in the surrounding environment. These may be familiar or unfamiliar, supportive of the person, or critical or neutral, there may be many or only one, they may be overheard or addressed directly to the person.

These seem to correspond to other psychological characteristics of the sufferer. That is, people who have difficulty in imagining sounds are more likely to report hallucinated voices (Heilbrun et al, 1983). Voices are more likely to be heard at times of idleness or reduced sensory input (Margo et al, 1981). Although auditory hallucinations are more common they may also be tactile, somatic, visual, gustatory or olfactory.

2) Thought insertion. A sense of alien thoughts being put into one's mind by another source. Sometimes a celebrity or Martians or another person, an authority figure and so on.

3) Thought broadcast. A sense that one's thoughts are being broadcast, that other people can tell what you're thinking (possibly also that they judge it unfavourably).

4) Somatic passivity. Feelings impulses or acts being experienced or carried out beyond one's own control. E.g. X rays entering your body and preventing sexual response.

5) Delusional percept: A normal perception takes on a special significance and an elaborate delusional system may quickly develop. E.g. someone passes you the salt and you become convinced that this means you will be visited by the Pope.

6) Thought withdrawal. Sense of one's thoughts being stolen from one's mind by another person or agency.

7) Made feelings/acts/impulses. i) Made feelings - sense that emotions are imposed on you from someone or somewhere else - sadness euphoria. One's own emotions may be felt as suppressed and hidden. E.g. Express sadness through weeping because it is imposed but really feel anger inside. ii) Made volitional acts - may feel oneself to be manipulated by other people or things. iii) Made impulses - may feel that inexplicable actions were initiated by impulses imposed by another person or agency.

Schneider considered these kinds of symptoms to be the most telling characteristics of schizophrenia.

Heightened perceptions and hallucinations

Some people with schizophrenia report a *heightened sensitivity* to sounds, sights, even smells. Some people feel that their senses are being flooded. Schizophrenia seems to involve an attentional problem, with schizophrenic people being more vulnerable to distraction (Harris et al, 1985)

Affective symptoms

There may be flat affect. Nothing can elicit an affective response. This was found in 66% of IPSS schizophrenics (Sartorius et al, 1974). There may be inappropriate affect, where emotional responses are out of context and bizarre.

Impairments in life functioning.

There may be visible before frank schizophrenia is manifest. Generally people become less competent in running their lives as the problem progresses. DSM says that the sufferer's 'Level of functioning in work, social functioning and self care is clearly below the highest level achieved in the past. (APA 1987, ps 194-195). People may become more preoccupied with their own problems and fantasies (Bellack et al, 1989; Falloon et al, 1984) and may distance themselves from others and avoid talking to them. Cutting and Murphy (1988; 1990) found that 75% of schizophrenics they surveyed were less knowledgeable than people with other disorders about everyday issues.

Subtypes of schizophrenia:

Kraepelin distinguished three types of dementia praecox which were catatonic, hebephrenic & paranoid. When Bleuler developed the concept of schizophrenia he added a fourth type, simple schizophrenia. DSM categories based on these are 1) Disorganised Schizophrenia, 2) Catatonic Schizophrenia 3) Paranoid Schizophrenia, 4) Undifferentiated and 5) Residual.

1) Disorganised Schizophrenia. Corresponds to what used to be called 'hebephrenic'. Incoherence, flat or inappropriate affect, loose associations. May show disregard of social conventions. May be active but relatively aimless and unproductive. Giggling, silly mannerisms, inexplicable gestures. The likelihood of recovery is low and the condition tends to be progressive. Often a history of difficulties, poor adjustment before the full syndrome emerges.

2) Paranoid Schizophrenia. Tends to be coherent and well organised. Tends not to show flat affect, not show unusual patterns of movement. Delusions, primarily cognitive. Delusions and sustained extreme suspiciousness about a single theme. Misinterpret the world. Often correct perceptions but make extreme negative inferences, resist positive or disconfirmatory feedback cues. May involve grandiose delusions - people have an exaggerated sense of their own importance. May have delusions of reference, sufferer interprets everyday events within their own referential framework as having personal significance. May have delusional jealousy. Sometimes people develop well defined systems of delusions which do not qualify them for a diagnosis of paranoid schizophrenia. E.g. people who become infatuated with another and believe that this other person secretly fancies them too. Can make a nuisance of themselves. Or perhaps the person is convinced that spouse is having an affair, despite evidence to the contrary. These latter kinds of people have (according to DSMIV) 'delusional disorder' because of their otherwise good social functioning.

3) Catatonic Schizophrenia. Disturbance in motor activity. May refuse to speak or move and may exhibit waxy flexibility. Or may be agitated, catatonic excitement, active but purposeless, may be very destructive.

Two further categories are distinguished, namely:

4) Undifferentiated schizophrenia. May have symptoms which do not fit into the above three categories, or may show mixture of symptoms.

5) Residual Schizophrenia. According to DSM this is used 'when there has been at least one episode of schizophrenia but where the clinical picture...is without prominent psychotic symptoms though signs of the illness persist' (American Psychiatric Association, 1987: 198)

All these subtypes are ideal types and don't always occur as distinct clinical syndromes. Knowing that people have one type or other of schizophrenia does not necessarily help in estimating the likelihood of them getting better or worse, or in therapy & treatment choices.

Schizophrenic spectrum disorders:

Some researchers have noted that the family members of schizophrenics exhibit some eccentricity, may be asocial or antisocial, peculiarities in thinking. Maybe the whole spectrum of disorders should be considered under the rubric of schizophrenic spectrum disorders. May have the same or related causes. Schizophrenic spectrum disorders include unusual emotional responses and thinking, but schizotypal and paranoid personality disorders occur more frequently in the families of schizophrenics (Baron & Risch, 1987). Other disorders have sometimes been linked to schizophrenic spectrum disorders - schizoaffective disorder, a combination of depression or manic symptoms and schizophrenic symptoms; atypical psychoses and paranoid disorders.

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Mental Health and Society week 10 Cognition, Cognitive Behaviour Therapy and Schizophrenia.

In terms of stuff to read to accompany this, I've put some materials in a section of resources for schizophrenia on my website <http://www.brown.uk.com> - and follow the link to schizophrenia. In particular there are some fairly user friendly reviews by McCann (2000) or Kuipers (2008), and a personal account by Fisher (2003).

After half a century or so where drugs were the mainstay of treatment for schizophrenia there has been renewed optimism about the role of psychotherapy in treatment, particularly therapy based on CBT models and principles.

The interest in cognitive, phenomenological and emotional aspects of schizophrenia stems from the notion that maybe schizophrenic symptoms are similar to many everyday cognitive processes. 'There is now good evidence for this idea of a continuum, with considerable overlap between 'normal' populations and those with identified psychosis. This suggests strongly that those who comprise clinical populations are more likely to show distress, and that high levels of conviction and preoccupation do not distinguish normal and delusional ideas' (Kuipers, 2008: 447)

Whilst the greater part of research on the causes of schizophrenia has tended to emphasise twin and family linkage studies, propose genetic mechanisms and explore neurological and physiological factors, there is a growing body of work which emphasises psychotic symptoms as the after-effects of trauma Read et al (2005) provide a review of these studies to date. They conclude that 'Child abuse is a causal factor for psychosis and 'schizophrenia' and, more specifically, for hallucinations, particularly voices commenting and command hallucinations' (Read et al 2005: 330). Wicks et al (2005) say that indices of social disadvantage, like parental unemployment, low socioeconomic status, and household receiving welfare benefits make schizophrenia more likely.

Karon (2001: 15) says 'Psychotherapy with a competent psychotherapist is the optimal treatment for schizophrenics and other serious mental disorders'. Research such as the Michigan State Project (Karon & Vandenbos, 1981) with Detroit inner city chronic schizophrenics showed that 70 sessions of psychotherapy was more helpful than medication. Benedetti and Furlan (1987) described a 'very good' outcome for 80% of 'severe schizophrenics' treated intensively with psychoanalytic therapy in Italy. Similar results were obtained by Alanen (1997) with community mental health in Finland. Randal et al (2003) treated patients with 'treatment resistant' psychotic disorders using multimodal psychotherapy. The treatment group showed clinically significant improvements over and above the control group in their scores on the 'Positive and Negative Symptom Scale'. Kehoe (1999) suggests that group work focusing on religious issues can provide even seriously mentally ill people with valuable therapeutic experiences.

This shows the advantage of competent psychotherapy that takes seriously the meaning of the symptoms. As Karon (2001: 15-16) notes, 'Caring volunteers can be helpful because they know that what they offer is not technical expertise but benign human contact, something which has been missing in the lives of most patients (Mosher & Menn, 1976; Matthews et al, 1979)'.

The function of delusions

Perhaps delusions of persecution arise as a result of trying to maintain a positive self image (Kinderman & Bentall, 1996). Delusions may arise from the discrepancy between how individuals perceive themselves and how they would like to be. Persecutory delusions are a kind of external causal attribution which is evoked for negative events. Thus, believing negative events are someone or something else's fault can have a positive function for the individual. Indeed, Zigler & Glick (1988) have suggested that paranoia is a form of camouflaged depression.

When people with persecutory delusions are compared to 'normals' or depressed people they do indeed show a strong tendency to attribute negative events to external causes (as reviewed by Garety & Freeman, 1999). They tend to personalise - they blame other people when things go wrong. People who are prone to delusions also are more likely to manifest a reasoning style called 'jumping to conclusions' (White and Mansell, 2009).

Bentall (2001) argues that delusions are not sharply distinguishable from ordinary beliefs and that they can be understood by reference to the context in which the subject forms and maintains his or her delusional belief. Bentall's model involves six elements: 1) the event in the world that is responsible for the formation of the delusional belief (realistic element), 2) the subject's perception of that event, 3) the subject's selective attention, 4) the subject's inferential capacities, 5) the formation of the delusional belief on the basis of (2), (3) and (4), and 6) the maintenance or revision of the delusional belief when new evidence becomes available.

Getting people to give up delusions or hold them with less conviction

A good deal of cognitive therapy is geared towards reducing the strength with which delusions are believed. Levine et al (1998, p. 3) argue as follows:

"Bloch in 1993 reviewed the current state of cognitive strategies in schizophrenia and stated '*recent studies have suggested that systematic cognitive interventions aimed at reducing the convictions with which these beliefs are held may be more successful than conventional wisdom would suggest*'. Further support for this unorthodox approach was supplied by Perris (1989) who stated that: '*It must be emphasised that cognitive psychotherapy can, when used in individual format, represent an answer to the search for a known reductionistic psychotherapeutic approach that takes into account the heterogeneity of the schizophrenic disorders and allows therapists to cope with their complexity*'."

Levine et al (1998) used a group approach and aimed to use CBT to explore and reduce the impact of delusional thinking. They began by getting participants to identify different reasons for everyday events and got them to agree that 'it is axiomatic that every event has several alternative explanations perceived by the keen observer' and therapy sessions involved getting patients to provide explanations for events in their own and each others lives as well as for their 'delusions'. By the end of the process the patients were asked to come up with reasons why they had been hospitalised too. Whilst the discussion of delusions was going on therapists used positive reinforcement for reasons and explanations that might have been true. There was positive change in the therapy group over and above the change in a comparable group whose members were receiving support. Moreover, the

experience of doing the therapy and generating explanations in a group setting might have had a positive effect too, as a group conformity effect might have helped the process.

The phenomenology of schizophrenic symptoms

There is a good deal of evidence to suggest that people in the general population experience auditory hallucinations (Posey & Losch, 1983, Barrett & Etheridge, 1992) where rates in the population of as much as 37 -39% have been reported.

There are a number of psychological theories about these symptoms and most seem to hinge on the possibility that auditory hallucinations result from internal cognitive events that are misattributed to an external source (e.g. Morrison et al, 1995; 2000), Perhaps this occurs as a result of a difficulty in integrating current sensory input with material that is already stored in memory (Hemsley, 1993). A further explanation from Morrison et al (1995) suggests that perhaps the hallucinators' 'metacognitive' beliefs (beliefs about how we think and about how the mind works) influence their experience of hallucinations. That is if we do not expect to have intrusive thoughts or sudden changes in the direction of our thought, we might attribute these to an external agency. The person's response to this hallucinatory experience might well increase the likelihood of their recurrence, especially if the experience is distressing.

Chadwick and Birchwood (1994) found that people's beliefs about their voices are meaningfully related to the emotional and behavioural consequences. That is, people were more likely to engage with their voices when they were perceived to be benevolent. Miller et al (1993) discovered that up to 50% of a sample of patients found some positive content in their voices, and found them relaxing, soothing or a source of companionship. Voices which were perceived as malevolent were less likely to be engaged with and patients reported that they tended to resist these. However it may be that resisting the voices or trying to suppress them might be counterproductive (Morrison et al, 1995). Moreover, in another study by Baker & Morrison (1988) they found that patients experiencing auditory hallucinations were likely to hold positive beliefs about worry and negative beliefs about uncontrollability and danger.

Close and Garety (1998) conducted a study to examine the nature of people's schizophrenic symptoms and their beliefs and feelings about them. For example, one patient with an interest in opera heard voices representing people in his amateur operatic society saying 'We're not going to perform your composition, its bullshit' He felt that the voices occurred because of his mental illness and because he was under too much stress. He felt the voices knew a lot about him and that one particular voice - a girl - said she wanted to sleep with him. Sometimes he felt he could smell her scent which was overpowering and off-putting. He answered the voices back and said they made him unhappy, and that he was an idiot and a piss-artist. Most people in Close & Garety's study were unhappy about their voices, experiencing depression, anger, fear and anxiety.

Romme and Escher (1996) say that:

"The following examples illustrate different categories of life influences which we have found to be related to the onset of voices.

1. Intolerable or unsatisfying living situations
2. Recent traumas
3. Aspirations or ideals
4. Childhood trauma
5. Emotional intolerance and control

When discussing these examples, the following areas are of special interest in understanding the dynamics of the interaction between voices and the life history of

- * the person hearing them:
- * the identity of the voices
- * the characteristics of their communication with the person, e.g. the way of talking, the age of voices and what they say
- * what triggers the appearance or disappearance of the voices
- * what important change in the individual's life was related to the onset of hearing voices
- * the characteristics of a person's upbringing and childhood including any special experiences that occurred in that period."

Moritz and Laroï (2008: 104) 'We assert that a parsimonious explanation as to why a bothersome cognition is considered a self-generated intrusion or an external voice is, at least in part, based on liberal acceptance. We have previously maintained (Moritz et al., 2006) that when a healthy person experiences a hallucination, careful appraisal of its characteristics gives rise to the attribution that the source must be one's own mind. In schizophrenia patients, on the other hand, a limited set of voice-like characteristics may suffice to mistake self-generated cognitions as real voices'.

Freeman et al (2008) say that people who suffer hallucinations and delusions are more likely to have a 'jumping to conclusions' reasoning style.

The effectiveness of cognitive behaviour therapy in schizophrenia

This is being demonstrated in an increasing number of studies; where patients treated appear to show reductions in symptoms over and above control groups, people waiting or people receiving supportive care or routine treatment. Kuipers et al (1997) describe one of the earlier studies with 60 participants (28 treatment and 32 controls) to evaluate a cognitive behavioural therapy programme which was intended to

- i) Reduce the distress and interference arising from the experience of psychotic symptoms
- ii) Reduce the emotional disturbance and modify dysfunctional schemas
- iii) Encourage the patient to help regulate their own risk of relapse and social disability.

The programme involved:

- i) Improving coping strategies and developing new ones - e.g. activity scheduling, relaxation and skills training and encouraging clients to e.g. go shopping or socialising. Also, using strategies like distraction and avoidance was encouraged.
- ii) Developing a shared model in collaboration with the client, discussing the nature of the symptoms and nature of the 'illness'.
- iii) Modifying delusional beliefs and beliefs about hallucinations - by using gentle challenge and the possibility of alternative explanations. Links between clients' experience of voices and events earlier in their lives were explored. Beliefs held with less conviction were explored first, before tackling those held with greater conviction.
- iv) Modifying dysfunctional schemas. Re-examining evidence for clients dysfunctional beliefs about themselves.
- v) Management of social disability and relapse - discussing relapse signatures, issues of stigma and the kinds of events that triggered psychotic symptoms and how they might be avoided.

The outcome of all this intervention was that the group receiving the CBT showed improvements over the time of the study - more so than the control group. Indeed, the improvement shown was comparable to similar studies of drugs like Clozapine. The authors conclude that 'talking to patients about psychotic symptoms and their meaning to the individual is a skill that clinicians working in this area should develop' (p. 325).

CBT has also been explored for people at risk of psychosis - in the prodromal period - (Morrison et al, 2004; Addington and Manusco, 2009).

Treatment of auditory hallucinations (Wykes et al, 1999).

Wykes et al (1999) report a study using a group psychotherapy that emphasised individual power and control and the use of coping strategies to attempt to reduce distressing treatment resistant auditory hallucinations. There appeared to be an effect on the experience of auditory hallucinations in that treatment reduced the impact of voices. There was an increase in the variety of coping strategies used by the patients after the treatment too. For example, beforehand they tended to watch TV or listen to music whereas afterwards they tended to talk to other people, tell the voices to go away, tell the voices to come back later, reason with voices etc.

According to Tarrier et al (1999) the effects of CBT on treated patients are still apparent 12 months later. Interestingly, although symptoms reduction was sustained for a CBT group in their study a group who had received supportive counselling showed a similar reduction in symptoms. The effects were pronounced for positive symptoms and approaching significance for the negative ones.

Jackson et al (2009) describe a CBT based intervention designed to address the trauma of a psychotic episode. There were three components: (a) engagement and formulation; (b) trauma processing; and (c) appraisals of psychotic illness (shame, loss and entrapment). The intervention was intended to help first episode patients adjusting to and recovering from an episode of psychosis. Trauma processing evolved from the exploration of the primary appraisals of the first episode of psychosis including symptoms (voices, paranoia), the management of the condition (hospital admission) and the social context in which they occurred (interpersonal reactions of others). A relapse prevention framework; 'back in the saddle' (Plaistow & Birchwood, 1996) was used to aid this process. The intervention appears to be an effective intervention to help young people adapt to the traumatic aspects of a first episode of psychosis.

Building a sense of self and recovering

Lysaker and Lysaker (2006: 171) emphasize that as part of the recovery from schizophrenia 'persons must recover a sense of their own identity, agency, and personal worth'. Schizophrenia involves a profound diminishment in the ability to experience and represent one's life as an evolving story (Lysaker & Lysaker, 2001; 2004; 2006; Parnas & Handest, 2003). This may involve the generation of narratives that lack conceptual and temporal organization (Gallagher, 2003; Holma & Aaltonen, 1998) and/or self-presentations without agency or meaningful interpersonal connections (Davidson, 2003; Kline et al, 1996; Lysaker et al, 2003).

Getting better? Studies that have followed schizophrenic patients long term, often for more than 25 years found that approximately one third of the patients will completely recover, that another third will become self-sufficient, and only one-third have the morbid course [originally described by Eugen Bleuler and Kraepelin, and still described in most textbooks and in DSM-IV (American Psychiatric Association, 1994)] (Ciompi, 1980; Harding, 1995; Harding, Zubin, & Strauss, 1987). This benign outcome has been noted for patients since 1900, so it is not due to recent advances in medication or treatment. In one American long-term study (Harding, 1988), fifty percent of the patients stopped taking their medication, usually against medical advice. All of the thirty percent who fully recovered were among that group. No patient who stayed on medication as advised by their doctor ever fully recovered.

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