PSYCHOLOGY OF DEMENTIA PRAECOX pdf

1: Project MUSE - Psychology of Dementia Praecox

Dementia praecox ("premature dementia") is a term popularized by German psychiatrist Emil Kraepelin () in , to describe the condition that would eventually be labeled schizophrenia.

Morel used the term to define a disorder that first struck men in their teenage or young adult years, after which their intellectual functioning rapidly deteriorated. Morel saw this mental disorder as being within the larger context of his theory of degeneration. These young men were beginning a rapid intellectual deterioration that would result in total disability and possible death. Morel, however, did not conduct any long-term or quantitative research on the course and outcome of dementia praecox Kraepelin would be the first in history to do that so this prognosis was based on speculation. In this book, Kahlbaum described a class of progressively degenerating psychotic disorders that he grouped under the term "Vesania typical" typical insanity. In Kahlbaum became the director of a private psychiatric clinic in Gorlitz, Prussia , a small town near Dresden. He was accompanied by his younger assistant, Ewald Hecker , and together they conducted a series of research studies on young psychotic patients that would become a major influence on the development of modern psychiatry. Together Kahlbaum and Hecker were the first to describe and name such syndromes as dysthymia , cyclothymia , paranoia , catatonia , and hebephrenia. Perhaps their most lasting contribution to psychiatry was the introduction of the "clinical method" from medicine to the study of mental diseases , a method which is now known as psychopathology. Psychiatrists made assumptions about prognosis that were not based on careful observation of the changing symptoms of patients over time. Psychiatrists and other physicians who wrote about the insane arbitrarily invented names for insanities and described their characteristic signs and symptoms based on a short-term , cross-sectional observation period of their lunatic patients. When the element of time was added to the concept of diagnosis , a diagnosis became more than just a description of a collection of symptoms: An additional feature of the clinical method was that the characteristic symptoms that define syndromes should be described without any prior assumption of brain pathology although such links would be made later as scientific knowledge progressed. Karl Kahlbaum first made his appeal for the adoption of the clinical method in psychiatry in his book on catatonia. Without Kahlbaum and Hecker there would be no dementia praecox. The quantitative component Edit In Emil Kraepelin left his position at the university in Dorpat now Tartu, Estonia to become a professor and director of the psychiatric clinic at the University in Heidelberg, Germany. Quantification helped to eliminate any subjective biases on the part of the researcher. He began the first such research program of this nature in the history of psychiatry at Heidelberg in , collecting data about every new patient that was admitted to the clinic not just interesting cases, as had been the case in the past and summarizing them on specially prepared index cards, his famous Zahlkarten. He had been keeping data on such cards since In his posthumously published Memoirs first published in German 61 years after his death Kraepelin described his method: After a while, the notes were taken out of the box, the diagnoses were listed, and the case was closed, the final interpretation of the disease was added to the original diagnosis. In this way, we were able to see what kind of mistakes had been made and were able to follow-up the reasons for the wrong original diagnosis p. Kraepelin was obsessed with finding patterns in the data on these cards, at times taking them home with him or on vacation. Clinical syndromes involved not only a diagnosis according to signs and symptoms, but also included course and outcome. In that edition he introduced a class of psychotic disorders he called "psychic degenerative processes. In it, Kraepelin stated that he was confident of the value of his clinical method of using qualitative and quantitative data collected over a long period of observation of patients as a way of developing a diagnosis that included prognosis course and outcome: What convinced me of the superiority of the clinical method of diagnosis followed here over the traditional one, was the certainty with which we could predict in conjunction with out new concept of disease the future course of events. Thanks to it the student can now find his way more easily in the difficult subject of psychiatry. In the 5th edition, dementia praecox still essentially hebephrenia , dementia paranoides, and catatonia are separate psychotic disorders included among "metabolic disorders leading to dementia. They were distinguished by the following characteristics: In dementia praecox

took its now-familiar form as a heterogenous class of psychotic disorders comprised of hebephrenic, catatonic, and paranoid forms. Change in prognosis Edit In the 7th edition of there was little change in the description of dementia praecox, but Kraepelin does admit for the first time that in a small number of cases that recovery from dementia praecox might occur. In this edition dememtia praecox became one of the "endogenous dementias. The 8th edition of is also notable for the fact that Kraepelin increased the number of forms of dementia to However, the three classical original subtypes would remain as the most influential description of this disorder for the century that followed. The 8th edition of Psychiatrie was that last Kraepelin would produce in his lifetime. He was working on a 9th edition with Johannes Lange but died in before it could be completed. Lange finished the bulk of it and published it in Addition of etiology Edit Kraepelin realized that the state of scientific knowledge was such that definitive claims about the cause of dementia praecox could not be made. Heredity clearly played a role, as Kraepelin and his research associates had demonstrated this in their quantitative research. As a result of following the clinical method suggested by Kahlbaum, Kraepelin set aside claims about underlying brain disease or specific neuropathology in diagnostic descriptions of mental disorders. Universality of the disease Edit Kraepelin believed that dementia praecox was not a culture-bound syndrome and that it represented a disease process that could be found all over the world. Kraepelin himself loved to travel, and in Asia he observed that dementia praecox was similar to the European form of the illness in Chinese, Japanese, Tamil and Malay patients, leading him to suggest in the 8th edition of Psychiatrie that, "we must therefore seek the real cause of dementia praecox in conditions which are spread all over the world, which thus do not lie in race or in climate, in food or in any other general circumstance of life. Treatment for these insanities was the same for any institutionalized patient with any diagnosis: Kraepelin himself had experimented with hypnosis early in his career and found it lacking. Psychotherapy as such was not part of the medical cognition of Kraepelin. In fact, Kraepelin detested both Freud and Jung for introducing diagnostic terms and forms of treatment that had no empirical basis. Use of term spreads Edit By Kraepelin himself had counted almost 20 German-language publications which made reference to his new diagnostic term, dementia praecox. Until the late s the terms dementia praecox and schizophrenia were used interchangeably in American psychiatry. The reception of dementia praecox as an accepted diagnosis in British psychiatry came much slower, perhaps only taking hold around the time of the First World War. Instead the French maintained an independent classification system throughout the 20th century. After , when DSM-III totally reshaped psychiatric diagnosis, French psychiatry began to finally alter its views of diagnosis to converge with the North American system. Kraepelin thus finally conquered France via America. Diagnostic manuals Edit Editions of the Diagnostic and Statistic Manual of Mental Disorders since the first one in had reflected views of schizophrenia as "reactions" or "psychogenic" DSM-I , or as manifesting Freudian notions of "defense mechanisms" as in DSM-II of in which the symptoms of schizophrenia were interpreted as "psychologically self-protected". The diagnostic criteria were wide, including either concepts that no longer exist or that are now labeled as personality disorders for example, schizotypal personality disorder There was also no mention of the dire prognosis Kraepelin had made. Schizophrenia seemed to be more prevalent and more treatable than either Kraepelin or Bleuler would have allowed. Furthermore, the disorder was a progressively deteriorating one once again, with the notion that recovery, if it happened at all, was rare. Some of the psychiatrists who worked to bring about this revision referred to themselves as the "neo-Krapelinians. International Journal of Psychology and Psychological Therapy, , 3: Infectious insanities, surgical solutions: Bayard Taylor Holmes, dementia praecox and laboratory science in early twentieth-century America. Parts I and II. History of Psychiatry, , 17 2: Autointoxication and focal infection theories of dementia praecox. World Journal of Biological Psychiatry, , 5: Dementia Praecox Studies [letter to the editor and historical note]. Schizophrenia Research, , The American reaction to dementia praecox, History of Psychiatry, , Styles of psychiatric practice:

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2: The Psychology of Dementia Praecox by C.G. Jung

Be sure to check out the excellent book American Madness: The Rise and Fall of Dementia Praecox by Richard Noll, Ph.D, associate professor of psychology at DeSales University. Related Articles.

The Psychogenesis of Mental Disease Volume 3: The Psychogenesis of Mental Disease The psychology of dementia praecox. Critical survey of theoretical views on the psychology of dementia praecox. Princeton University Press, A critical survey of the theoretical views on the psychology of dementia praecox includes discussions and comparisons of the works of Freud, Gross, Jiling, and a number of others. An overview of the literature on the subject shows that the research, although fragmentary and apparently uncoordinated, agrees that the symptoms commonly include a central disturbance â€" a lowering of attention or apperceptive deterioration. This is typically manifest in superficiality of associations, symbolism, stereotypies, perseverations, command automatisms, apathy, aboulia, disturbance of reproduction, and negativism. He feels the patient suffers a perpetual distraction in which perception of external objects, awareness of his own personality, judgment, the feeling of rapport, belief, and certainty all fade or disappear when power of attention disappears. It is hypothesized that in dementia praecox there is a specific concomitant of the affect that causes the final fixation of the precipitating complex, impeding the further development of the personality. The possibility that in some cases the primary factor may be a change in the metabolism is postulated. Such ideas and their detailed psychological processes are outlined for a large selection of the leading authors on dementia praecox near the turn of the century. The feeling-toned complex and its general effects on the psyche. Observations based on experimental work are made on the feeling toned complex and its acute and chronic effects on the psyche. The feeling toned complex is defined as the whole fabric of ideas surrounding the feeling tone, an affective state accompanied by somatic effects. The attempt is made to define the essential basis of personality, which is held to be affectivity. Virtually every individual association is deemed to relate to some complex, as well as to the ego complex, the whole mass of ideas pertaining to the ego â€" in a normal person the strongest complex. Egocentric ideas are commonly interrupted by affects leading to new complexes that inhibit other ideas. The acute effects and the chronic effects of the complex are defined and compared. Disturbances caused by complexes have been demonstrated in association experiments by prolonged reaction times, abnormal reactions, and forgetting critical or postcritical reactions. The effect of a strong complex on a normal psyche is illustrated in the classical state of being in love. Other forms of the sexual complex and other complexes are sometimes influenced by various types of displacement, including disguising the complex by superimposing a contrasting mood. The influence of the feeling-toned complex on the valency of associations. The diminution of the valency of associations caused by the feeling toned complex is discussed and general remarks on the complexes are made, based on word association tests and illustrated with examples from cases. It was shown that a sudden striking increase in superficial associations during the association experiment without any artificial distraction indicates a reduction in attention, caused by a feeling toned complex. If the complex is repressed, the subject may not be conscious of it. Other examples of disturbances of attention are found in slips of the tongue, slips of the pen, misreading, melodic automatisms in which whistling or humming contain the complex in metaphorical form , and puns. Dreams, symbolic expressions of the repressed complex, are excellent examples of expression by similarity of imagery. A detailed analysis of a dream emphasizes the ambiguity of dream images, comparable to the superficial associations seen in a state of reduced attention in distraction experiments. The complexes have a tendency to cause contrasting associations, seen as emotional and verbal contrasts in hysteria and as verbal contrasts in dementia praecox. It is concluded that every affective event becomes a complex. Most complexes are held to be sexual, as are most dreams and most of the hysterias, especially in women. Time usually frees the normal individual from obsessive complexes, but sometimes he needs artificial aid, and it has been found that displacement can help. If the complex is successfully repressed, the S will be complex sensitive for a long time. If the complex remains entirely unchanged, which happens only after severe damage to the ego complex, dementia praecox can develop. It is conjectured that toxic effects may be involved in this degeneration.

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Dementia praecox and hysteria. A review of the psychological similarities of dementia praecox and hysteria compares emotional disturbances, character abnormalities, intellectual disturbances, and stereotypy in the two diseases. The emotional indifference in cases of acute dementia praecox is similar to the inadequate responses of the hysteric whose complex is under special inhibition. Explosive excitements may be brought about in dementia praecox in the same way as the explosive affects in hysteria. Typical symptoms of dementia praecox include lack of self-control and lack of emotional rapport, both of which are sometimes found in hysteria as well. Intellectual impairments found in both dementia praecox and hysteria include shades of clouding of lucidity of consciousness, ranging from perfect clarity to deepest confusion, disturbance of attention, disorientation, delusions, hallucinations, compulsive thinking, negativism, and sleep disturbances. Stereotypy, a characteristic symptom of dementia praecox, is also seen in hysteria and, in the form of automatization, is a common phenomenon in normal development. It is concluded that in hysteria the psyche is disabled because it cannot rid itself of a complex, but many hysterics can regain their equilibrium by partially overcoming the complex and avoiding new traumas. In dementia praecox, one or more complexes have become permanently fixed and cannot be overcome, but it is not clear whether the complex caused or precipitated the illness, or whether at the onset of the illness a definite complex was present which then determined the symptoms. Analysis of a case of paranoid dementia as a paradigm. The analysis of a case of paranoid dementia in a middleaged unmarried dressmaker suffering from delusions and auditory hallucinations is discussed as a typical paradigm of psychoanalysis. It is shown how the patient in her psychosis creates a complicated and utterly confused and senseless fantasy structure. She describes the hopes and disappointments of her life in her symptoms. The nearest analogy to her thinking is the normal dream, which employs the same or similar psychological mechanisms. Case studies are presented in which an argument is presented for the present position regarding the content of the psychoses. It is contended that the difference between his theory and E. However, even in the most severe cases, lasting for a period of years, an intact brain was frequently found post-mortem, which is proof that the purely anatomical approach leads only indirectly to an understanding of psychic disturbance. These insights may have general or limited validity but nonetheless there is no symptom in dementia praecox that can be described as psychologically meaningless. Pnncipal criticism of the analytic method is that it does not engage the wealth and variety of symbolism of the psychotic. The futility of understanding symbolism by the causative, analytic methods applied in science is illustrated in attempts to understand the symbolism in Faust II, which requires the subjective conditioning of knowledge to be fully appreciated. Mental development results from active speculation based on experience, not from experience alone. The psyche, therefore, creates it own future as it lives; therefore, any causative evaluation of it in retrospect can be only partially true; its dynamic quality as a creative entity eludes us. A patient, therefore, should be asked what his goals are, not only what he has felt and thought. Extraversion and introversion are explained in detail and, to simplify pathological typing, the hysterics are assigned to the former, and the psychasthenics and schizophrenics to the latter. Bleuler presents the new and interesting concept of ambivalence, which hypothesizes that every tendency is balanced by a contrary one. It is noted that all feeling tones are balanced by their opposites, giving the feeling tone an ambivalent character. But a strict sequence of psychological causes conditions the negative reaction. Bleuler does not put much emphasis on the role of sexuality, which is surprising since psychoanalysis has shown that the source of negativism is resistance, which in schizophrenia as in the neuroses arises from the sexual complex. The function of the unconscious in mental disturbances as a compensation of the conscious psychic content is discussed. The unconscious is defined as the sum of all those psychic events that are not intense enough to enter into consciousness. In normal people the unconscious effects a compensation of all conscious tendencies through a counter impulse and produces a balance. This agency expresses itself in unconscious, apparently inconsistent and uncharacteristic activities which Freud calls symptomatic actions. Dreams are examples of the compensating functions of the unconscious. In psychopathology the working of the unconscious, seen most clearly in such disturbances as hysteria and obsessional neurosis, is also seen clearly in the delusions and hallucinations of the psychoses, but is not so easily recognized. The mentally unbalanced person, suffering from a real imbalance between the conscious and the unconscious, struggles against his own unconscious, as in the case of the

eccentric inventor, the paranoid alcoholic, or the fanatical religious convert. Psychogenesis in mental diseases is discussed, with arguments presented for their physiological and psychological origins. The materialistic dogma in psychiatry is attributed to the fact that medicine is a natural science and the psychiatrist, as a physician, is a natural scientist. The psychological and emotional experiences, however, have been proved to play a decisive role in the courses of neuroses and in mental diseases. Although there are some cases of dementia praecox in which there is change in the brain cells, these changes are not usually present, and there are striking differences between the usual symptoms of dementia praecox and those occurring in organic brain disease. Cases of dementia praecox frequently improve or deteriorate in response to psychological or environmental conditions, demonstrating that this disease should not be considered only organic. Several cases are described in which the onset of the disease, or a new outbreak of it, took place under special emotional conditions. One comparatively simple case of a sudden outbreak of dementia praecox in a young girl stresses the importance of examining the psychological factors in the etiology and course of psychoses. Psychosis considered from the psychological viewpoint is primarily a mental condition in which unconscious elements replace reality in the mind of the patient; therefore, this area is recommended to psychiatrists as a wide unexplored field for psychological research. The question of psychogenesis in mental diseases other than the neuroses, which are now generally considered psychic in origin, is discussed, and the psychic etiology of schizophrenia is affirmed. Mental processes are products of the psyche, and that same psyche produces delusions and hallucinations when it is out of balance. In turn, schizophrenia is considered as having a psychology of its own. In schizophrenia, the normal subject has split into a plurality of autonomous complexes, at odds with one another and with reality, bringing about a disintegration of the personality. The simplest form of schizophrenia is paranoia, a simple doubling of the personality. The idea of being a persecuted victim gains the upper hand, becomes autonomous. The healthy ego, unable to counter the affectivity of the second subject becomes paralyzed This is the beginning of schizophrenic apathy. An example shows how the individual, perhaps predisposed toward schizophrenia, becomes ill because of an emotional shock and is overwhelmed by the pathological idea of persecution at a given psychological moment. A study of the psychogenesis of schizophrenia explains why some milder cases can be cured by psychotherapy. Such cures are rare, however, as the nature of the disease, involving the destruction of the personality, rules against the possibility of psychic influence. The microscopic lesions of the brain often found in schizophrenia are regarded as secondary symptoms of degeneration. In a discussion on the psychogenesis of schizophrenia an attempt is made to gain insight into the nature of its origin â€" whether psychic or organic â€" by comparing certain of its primary symptoms with those of hysteria and other neuroses. Tracing the development of expert opinion on the etiology of mental disorders, a swing from a belief in organic to psychic primary causes is evident. Its effect on the personality and a variety of conditions that may produce it are outlined in detail. Most are evident in the neuroses and the psychoses. In the neuroses, however, the unity of the personality is potentially preserved, whereas in the schizophrenias it is almost always irreparably damaged. The dissociation of thought, present in both types of diseases, is more permanent and more severe in the schizophrenias. In its extreme form, an abaissement reduces the mental level to a point where the ego lacks the power to overcome the more powerful unconscious, whether this be in the form of dreams or hallucinations. No reliable evidence is reported for organic causes of schizophrenia; on the other hand, the psychogenic conditions are at best indicators of symptoms that favor the disease, and not proved causes of its origin. A thorough understanding of psychology and aberrant mentality by clinicians who practice psychotherapy is advocated. A thorough description of the schizophrenic mental process dominates the paper, in which its complexity is highlighted by comparisons with the neuroses.

PSYCHOLOGY OF DEMENTIA PRAECOX pdf

3: The Psychology of Dementia PrÃ¦cox/Chapter I - Wikisource, the free online library

Psychology Definition of DEMENTIA PRAECOX: Obselete name for schizophrenia meaning deterioration of the mind.

Analysis of a Case of Paranoid Dementia as a Paradigm. Patient was admitted to this hospital in and since then has remained continuously in the hospital. She is greatly tainted by heredity. Many years before admission she heard voices slandering her. For a time she intended to drown herself. She referred the voices to invisible telephones. According to the anamnesis the patient led a thoroughly exemplary and quiet life. The patient used here and there peculiar expressions. She generally employed a rather pretentious style. Her letters of that time will illustrate this: With these lines I request you once more to instantly discharge me. My head, as I already remarked to you in my last letter, is clearer than ever. What I have to suffer secretly on account of novelties in all domains is unfortunately known to me alone, and is too smashing for my health as well as for my mind. Unfortunately they have gone so far as to torture to death poor victims by secret cruelties, for I suffer more than you can imagine and in this manner fully expect my end, which sadly touches me more and more. I hope you will act in your place as physician and will have no need of any further reflection. Unfortunately I cannot make it possible for you to appreciate the sad conditions which have intruded themselves. I again call your attention to the simple fact, to discharge me without more ado, as I alone suffer under these novelties, and if you were to be convinced of it you would surely immediately discharge me, because I have suffered from the beginning since I came here, and am totally at the end of my health. I want an immediate discharge. It will be immediately better when I leave Zurich for another air where the horrors are not represented, etc. The patient manifests active delusions. She has a fortune of millions, in the night her bed is full of needles. In her speech became more and more disconnected and her delusions less understood; she has for example the "monopoly. A certain "Rubinstein" from St. Petersburg sends her money by the wagonload. In she complained that her spinal cord was torn out in the night time. By means "of suffocation" legions are murdered. In patient feels herself paralyzed and claims to have tuberculosis. She is the owner of a "seven-floored note factory with coal-raven-black windows, which signifies paralysis and starvation. At present the patient is as ever a diligent worker. She now and then gesticulates and whispers during her work. I have so long ago established the monopoly, I am a triple world proprietress," etc. When she does not talk about her delusions her manner of expression and behavior show nothing abnormal, though there is a certain unmistakable prinking, not rarely seen in elderly unmarried women who strive to acquire an equivalent for unsatisfied sexuality by the greatest possible perfection. She naturally has no insight as to her disease, yet to a certain extent she finds it conceivable that her delusions are not understood. There is no imbecility. Her speech is changed only in the spheres of her delusions, otherwise she speaks in a normal manner. She repeats what she reads and defines ideas in a clear manner, insofar as they do not touch her complex. During the experiments and analyses the patient readily collaborated with the examiner, apparently taking the greatest pains to explain herself as well as possible. This behavior is especially due to the fact that the examination as such is also a complex-incitor, as the patient always demands interviews, hoping thereby to finally convince everybody, and thus reach the goal of her desires. The patient is always quiet and shows nothing striking in her general behavior. While at work she whispers to herself "power-words. Such fragments appear in great numbers, but are altogether stereotyped and can always be reproduced in the same form. Motor stereotypies but rarely occur. One stereotypy, for example, is a sudden extension of the arms, as though patient would wish to embrace some one. For the last two years, at different times, I have taken from the patient simple word associations corresponding to those discussed in the Diagnost. I now present some of them:

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4: History of Psychology: The Birth and Demise of Dementia Praecox

The Psychology of Dementia Praecox has 6 ratings and 0 reviews. Jung began his career as a psychiatrist in , when he was 25, as an assistant working.

Hence one must not attribute to them any general validity. The first general view concerning the nature of the psychological disturbance in catatonia was that of Tschisch, [1] who, in , thought that it was essentially due to inability of attention. A similar but somewhat differently conceived view was given by Freusberg. The motor disturbances are only symptomatic expressions for the degree of psychic tension. According to Freusberg the motor catatonic symptoms are dependent upon corresponding psychological manifestations. The "weakening of consciousness" points to the quite modern view of Pierre Janet. Also Kraepelin, [3] Aschaffenburg, [4] Ziehen and others affirm that there is a disturbance of attention. In we meet for the first time with an experimental psychological work on the subject of catatonia. The frequent obstructions the retardations of reaction time are explained by Sommer by the visual fixation. Catalepsy according to Sommer is another phenomenon closely related to optical fixation and which he considers "in all cases as a phenomenon of thoroughly psychic origin. The logical mechanisms in insanity are put in motion not through the apperceptive or associative conscious psychic activity, but by pathological irritations lying under the threshold of consciousness. This view does not seem to me to be without its objections. Firstly, it is based upon an anatomical conception of the psychic processes, a view against which too much warning cannot be given. What part the "subordinate centers" play in the origin of the psychic elements, such as presentations, feelings, etc. An explanation of this kind rests merely upon words. Secondly, the Roller-Neisser view seems to presuppose that beyond consciousness the whole psyche ceases. From the French psychology and from experiences with hypnotism we learn that this is not the case. Thirdly, if I understand correctly, by "pathological irritations lying under the threshold of consciousness" Neisser means cell processes in the cortex. This hypothesis goes too far. All psychic processes are correlates of cell processes, as well according to materialistic conceptions as according to the doctrine of psycho-physical parallelism. It is therefore not singular that psychic processes in catatonia should be correlates of a corresponding physical series. We know that normal psychical processes originate under the constant influence of numerous psychological constellations which as a rule are unknown to us. Why should this fundamental psychological law suddenly vanish in catatonia? Is it because the ideational content of the catatonic is foreign to his consciousness? Is it not the same with our dreams? And yet no one will assert that dreams originate so to speak directly from the cells without psychological constellations. Whoever has analyzed dreams according to the method of Freud knows what an enormous influence the constellations have. The appearance of strange ideas in consciousness without any demonstrable connections with former contents of consciousness is not an unheard of thing in either the psychology of the normal or the hysteric. The "pathological fancies" of catatonics have rich analogies in the normal and in hysterics see further. What we lack is not so much comparative material but the key to open the psychology of the catatonic automatism. Unfortunately to the great detriment of psychopathology, in which we are just beginning to agree upon our misunderstandings of conceptions applied, our knowledge of the normal psyche is still on a very primitive basis. We are grateful to Sommer [9] for further fruitful studies of the associations in catatonia. In certain cases of catatonia [10] the associations flow in a normal manner only to be suddenly interrupted by an apparently totally disconnected, peculiarly-mannered connection of ideas, as will be seen by the following example: These saltatory associations were also confirmed by Diem, [11] who conceives them as sudden "fancies. The "pathological inspirations" as described by Breukink, [12] who follows Ziehen, can be readily found in every insane asylum where these authors have observed them. The problem instigated by the discovery of Sommer is by no means settled, but until we become more enlightened we are obliged to group under the same heading the phenomena observed by various authors which are nearly all designated by almost the same name. Flournoy [14] reports the most interesting examples. Similar sudden invasions of changed psychological activity I observed in a very clear case of hysteria, [15] and recently I could again confirm it in a similar case. Finally, as I have shown,

sudden disturbances of association by the incursion of seemingly strange connections of ideas also appear in the normal. Sommer, in examining the associations of catatonics, found numerous sound associations and stereotypies. By stereotypies we mean frequent repetitions of former reactions. In our examinations we simply name it "repetitions. In Ragnar Vogt [17] again took up the problem of the catatonic consciousness. Accordingly, in catatonia the tendency to perseveration of the psychophysical functions would be especially marked. Hence it must be assumed that there is a certain narrowing of consciousness. From this we can also understand the resemblance between the hypnotic and the catatonic states. Vogt is apparently under the influence of Pierre Janet, to whom the "narrowing of consciousness" and diminution of attention is the same as abaissement du niveau mental. Kindred views are advanced by Evensen. Lack of ideas in a narrowed consciousness is the foundation of catalepsy, etc. He conceives attention in a very general and comprehensive sense corresponding to his French training in psychology. He says, "The perception of external objects, the perception of our own personality, judgment, the ideas of relationship, faith and certitude disappear when the power of attention disappears. However, scarcely any concept of human language should be so broad; indeed, there is no one who has not already been impressed by some school or system with the biased limits of meaning. German critics have reproached him for this discovery, but certainly unjustly when we consider that Masselon means only the reproductive ability. If a patient gives a wrong answer to a direct question it is taken by the German school as by-speaking Vorbeireden as negativism; in other words, as active resistance. Masselon, however, considers this as an inability to reproduce. When superficially considered it may mean both, the divergence being due to different interpretations bestowed upon this phenomenon. When a hysterical patient replies during the anamnesis "I do not know, I have forgotten," it simply means "I cannot or will not say it, for it is something very unpleasant. I have given many experimental proofs to show that the defects occurring in the association experiments, such as want of reaction, have the same psychology. Sometimes one is certain that the patients know it, again it is an obstruction Sperrung which makes quite an involuntary impression upon one, and finally there are cases in which one is obliged to talk about an "amnesia" just as in hysteria, where from amnesia to unwillingness to talk is only a step. Finally the association experiment shows us that these phenomena exist in the normal person, though only in nuce. In contrast to this the author finds ideas that obstinately persist, which he qualifies as follows: It is a pity that the author does not linger any longer on this point. It would be very interesting to know in what way, for example, a few neologisms or a "word salad" are associations of the complex of personality, as indeed these are often the only remnants through which we become informed of the existence of ideas. As to the origin of negativism he offers but vague suppositions, although the French literature on impulsive phenomena afforded him many essential facts for analogous explanations. Masselon also tried association experiments. He found many repetitions of the stimulus words and frequent fancies of an apparently quite fortuitous nature. From these experiments he concluded that the patients are unable to pay attention. Masselon, however, spent too little time on the "fancies. According to this definition apperception is will, sensation, affect, suggestion, impulsive phenomena, etc. It embraces every positive psychic function, especially the progressive acquisition of new associations; that is, no more and no less than all enigmas of physical activity both conscious and unconscious. It is too general to be of any force in the deduction of all symptoms. Madeleine Pelletier [36] examines in her thesis associations in manic flight of ideas, and in mental debility. The theoretic standpoint from which this author considers flight of ideas agrees in its essentials with that of Liepmann. The characteristic of flight of ideas is "absence du principe directeur" absence of directing principle. Pelletier is right in finding a great similarity between normal revery and the shallow associations of maniacs, but only when the associations ire written on paper. Clinically the manic does not by any means look like a dreamer. The richness and acceleration of presentations in manic flight of ideas differentiates it sharply from the very stagnant slowly-coursing association type of dreams and especially from the poverty and numberless perseverations in the associations of catatonics. The analogy is correct only in so far as concerns the directing idea which is absent in both of these cases; in mania because all presentations crowd themselves into consciousness with marked acceleration and with strong feeling tones, [38] therefore no attention can probably take place, [39] and in revery there is no attention to begin with, and where this is lacking the flow of associations must sink into revery. According

to the laws of association there results a slowly progressive course, tending principally towards likeness, contrast, coexistence and motor-speech combinations. This can best be seen by an example: It is a very shallow one and carries many sound associations. Yet the disintegration is so marked that we cannot compare it to the reveries of the normal state, but are obliged to compare it to dreams. Only in dreams is such speech observed. She calls this diminution by the words of Janet, "abaissement du niveau mental. It is encountered everywhere among the persecuted and weak-minded. It is a very inferior form of thought. The symbol couid be defined as a false perception of a relation of identity or very marked analogy between two objects which in reality present only a very vague analogy. This supposition is decidedly supported by the fact that the symbol has since long been known as a usual manifestation in revery and dreams. The psychology of negativism, concerning which numerous publications already exist, forms a separate chapter. The symptom of negativism certainly ought not to be considered as something definite. There are many forms and grades of negativism which have not as yet been clinically studied and analyzed with the necessary accuracy. The division of negativism into active and passive forms can be easily understood. The most complicated psychological cases appear under the form of active resistance. If an analysis were possible in those cases, it would frequently be found that very definite motives exist for the resistance, and it would then be doubtful if one could still talk of negativism. In the passive form, too, there are many cases which are difficult to interpret. Notwithstanding this there are numerous cases in which one may clearly point out that even simple processes of volition are always blindly converted into their opposite. According to our view negativism always ultimately depends on corresponding associations. Whether there is a negativism taking place in the spinal cord I do not know. The most general standpoint on the question of negativism is taken by Bleuler in his work on negative suggestibility.

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5: Emil Kraepelin - Wikipedia

Excerpt from The Psychology of Dementia Praecox To Kracpelin belongs the credit of having introduced new life into psychiatry by his indefatigable study of his patients for long years, his keen clinical insight, and especially by an independence of thought which led him to fearlessly shatter the traditions of centuries as regards the classification of mental diseases.

Fortunately, in , year-old Meyer got the crash course he needed when he set off on a tour of European psychiatric facilities. At the time he was working as a pathologist at Worcester Lunatic Hospital in Massachusetts; the goal of the trip was to get ideas for potential improvements he could make at his hospital. His most important stop would be in Heidelberg, the location of a small university psychiatric clinic. There, Meyer met psychiatrist and chief Emil Kraepelin â€" the man behind dementia praecox. It was in this book that Kraepelin described dementia praecox, an incurable psychotic disorder. This later edition had a major impact. There was no such thing as specificity or discrete diseases. And it was at Worcester that the first person was diagnosed with dementia praecox. As Noll told the Harvard University Press Blog in this interview , dementia praecox would become the most prevalent diagnosis: Beginning in , as one American asylum after another slowly introduced dementia praecox as a diagnostic box, it became the most frequently diagnosed condition, labeling a quarter to a half of all patients in each institution. What we do know is that being young and male made it more likely someone would receive this diagnosis. The public was introduced to dementia praecox by a piece in the New York Times that recounted the testimony in the murder trial of architect Stanford White. The superintendent of an asylum in Binghamton, N. But these disorders had distinct differences. The symptoms that were directly caused by the disease process were, writes Noll: Unfortunately, Americans put their own spin on schizophrenia. According to Noll in his interview: When Bleuler visited the United States in he was horrified to see what the Americans were calling schizophrenia. He insisted it was a physical disease with a chronic course characterized by exacerbations and remissions of hallucinations, delusions and bizarre behaviors. According to Noll in American Madness: Dementia praecox was the vehicle through which American psychiatry reentered general medicine. It descended into American asylums from the Valhalla of superior German medicine and presented American alienists with a divine gift: There can be no biological psychiatry in the twenty-first century without schizophrenia. D, associate professor of psychology at DeSales University. She also explores self-image issues on her own blog Weightless and creativity on her blog Make a Mess:

PSYCHOLOGY OF DEMENTIA PRAECOX pdf

6: What is DEMENTIA PRAECOX? definition of DEMENTIA PRAECOX (Psychology Dictionary)

THE PSYCHOLOGY OF DEMENTIA PRAECOX reason for the inadequate behaviour. So long as the complex which is under special inhibition does not become conscious, the patients can safely talk about it, they can even "talk it away" in a deliberately light manner.

This condition could be innate or acquired, and the concept had no reference to a necessarily irreversible condition. It is the concept in this popular notion of psychosocial incapacity that forms the basis for the idea of legal incapacity. Moreover, it was now understood as an irreversible condition and a particular emphasis was placed on memory loss in regard to the deterioration of intellectual functions. It was applied as a means of setting apart a group of young men and women who were suffering from "stupor. He did not conceptualise their state as irreversible and thus his use of the term dementia was equivalent to that formed in the eighteenth century as outlined above. Morel, however, did not conduct any long-term or quantitative research on the course and outcome of dementia praecox Kraepelin would be the first in history to do that so this prognosis was based on speculation. It is impossible to discern whether the condition briefly described by Morel was equivalent to the disorder later called dementia praecox by Pick and Kraepelin. Karl Ludwig Kahlbaum â€" Psychiatric nosology in the nineteenth-century was chaotic and characterised by a conflicting mosaic of contradictory systems. He was accompanied by his younger assistant, Ewald Hecker â€" , and during a ten-year collaboration they conducted a series of research studies on young psychotic patients that would become a major influence on the development of modern psychiatry. Together Kahlbaum and Hecker were the first to describe and name such syndromes as dysthymia , cyclothymia , paranoia , catatonia , and hebephrenia. When the element of time was added to the concept of diagnosis , a diagnosis became more than just a description of a collection of symptoms: An additional feature of the clinical method was that the characteristic symptoms that define syndromes should be described without any prior assumption of brain pathology although such links would be made later as scientific knowledge progressed. Karl Kahlbaum made an appeal for the adoption of the clinical method in psychiatry in his book on catatonia. Without Kahlbaum and Hecker there would be no dementia praecox. Attacking the "brain mythology" of Meynert and the positions of Griesinger and Gudden , Kraepelin advocated that the ideas of Kahlbaum, who was then a marginal and little known figure in psychiatry, should be followed. Therefore, he argued, a research programme into the nature of psychiatric illness should look at a large number of patients over time to discover the course which mental disease could take. After a while, the notes were taken out of the box, the diagnoses were listed, and the case was closed, the final interpretation of the disease was added to the original diagnosis. In this way, we were able to see what kind of mistakes had been made and were able to follow-up the reasons for the wrong original diagnosis. Prognosis course and outcome began to feature alongside signs and symptoms in the description of syndromes, and he added a class of psychotic disorders designated "psychic degenerative processes", three of which were borrowed from Kahlbaum and Hecker: Kraepelin continued to equate dementia praecox with hebephrenia for the next six years. What convinced me of the superiority of the clinical method of diagnosis followed here over the traditional one, was the certainty with which we could predict in conjunction with our new concept of disease the future course of events. Thanks to it the student can now find his way more easily in the difficult subject of psychiatry. In the 6th edition of Psychiatrie, Kraepelin established a paradigm for psychiatry that would dominate the following century, sorting most of the recognized forms of insanity into two major categories: Dementia praecox was characterized by disordered intellectual functioning, whereas manic-depressive illness was principally a disorder of affect or mood; and the former featured constant deterioration, virtually no recoveries and a poor outcome, while the latter featured periods of exacerbation followed by periods of remission, and many complete recoveries. The class, dementia praecox, comprised the paranoid, catatonic and hebephrenic psychotic disorders, and these forms were found in the Diagnostic and Statistical Manual of Mental Disorders until the fifth edition was released, in May These terms, however, are still found in general psychiatric nomenclature. The ICD still uses "hebephrenic" to designate the third type. Eugen Bleuler reported in that in

many cases there was no inevitable progressive decline, there was temporary remission in some cases, and there were even cases of near recovery with the retention of some residual defect. Kraepelin died while working on the ninth edition of Psychiatrie with Johannes Lange â€" , who finished it and brought it to publication in Both theorists insisted dementia praecox is a biological disorder, not the product of psychological trauma. Thus, rather than a disease of hereditary degeneration or of structural brain pathology, Kraepelin believed dementia praecox was due to a systemic or "whole body" disease process, probably metabolic, which gradually affected many of the tissues and organs of the body before affecting the brain in a final, decisive cascade. He argued that, without knowing the underlying cause of dementia praecox or manic-depressive illness, there could be no disease-specific treatment, and recommended the use of long baths and the occasional use of drugs such as opiates and barbiturates for the amelioration of distress, as well as occupational activities, where suitable, for all institutionalized patients. Based on his theory that dementia praecox is the product of autointoxication emanating from the sex glands, Kraepelin experimented, without success, with injections of thyroid, gonad and other glandular extracts. Protect your sanctified diagnoses! Adolf Meyer was the first to apply the new diagnostic term in America. He used it at the Worcester Lunatic Hospital in Massachusetts in the fall of The term lived on due to its promotion in the publications of the National Committee on Mental Hygiene founded in and the Eugenics Records Office Its many revisions served as the official diagnostic classification scheme in America until when the first edition of the Diagnostic and Statistical Manual: Schizophrenia was mentioned as an alternate term for dementia praecox in the Statistical Manual. In both clinical work as well as research, between and five different terms were used interchangeably: They were defined differently, had different population parameters, and different concepts of prognosis. The reception of dementia praecox as an accepted diagnosis in British psychiatry came more slowly, perhaps only taking hold around the time of World War I. There was substantial opposition to the use of the term "dementia" as misleading, partly due to findings of remission and recovery. Some argued that existing diagnoses such as "delusional insanity" or "adolescent insanity" were better or more clearly defined. Instead the French maintained an independent classification system throughout the 20th century. From , when DSM-III totally reshaped psychiatric diagnosis, French psychiatry began to finally alter its views of diagnosis to converge with the North American system. Kraepelin thus finally conquered France via America. When Freudian perspectives became influential in American psychiatry in the s schizophrenia became an attractive alternative concept. The term "schizophrenia" was first applied by American alienists and neurologists in private practice by and officially in institutional settings in , but it took many years to catch on. It is first mentioned in The New York Times in Until the terms dementia praecox and schizophrenia were used interchangeably in American psychiatry, with occasional use of the hybrid terms "dementia praecox schizophrenia " or "schizophrenia dementia praecox ". Diagnostic manuals[edit] Editions of the Diagnostic and Statistical Manual of Mental Disorders since the first in had reflected views of schizophrenia as "reactions" or "psychogenic" DSM-I , or as manifesting Freudian notions of "defense mechanisms" as in DSM-II of in which the symptoms of schizophrenia were interpreted as "psychologically self-protected". The diagnostic criteria were vague, minimal and wide, including either concepts that no longer exist or that are now labeled as personality disorders for example, schizotypal personality disorder. There was also no mention of the dire prognosis Kraepelin had made. Schizophrenia seemed to be more prevalent and more psychogenic and more treatable than either Kraepelin or Bleuler would have allowed. Vague dimensional approaches based on symptomsâ€"so highly favored by the Meyerians and psychoanalystsâ€"were overthrown. Furthermore, after the disorder was a progressively deteriorating one once again, with the notion that recovery, if it happened at all, was rare. Some of the psychiatrists who worked to bring about this revision referred to themselves as the "neo-Kraepelinians".

PSYCHOLOGY OF DEMENTIA PRAECOX pdf

7: Dementia praecox | Psychology Wiki | FANDOM powered by Wikia

Jung began his career as a psychiatrist in , when he was 25, as an assistant working under Dr. Eugen Bleuler at the Burgholzli Hospital in Zurich. In , after he had become senior staff physician and before his first meeting with Freud in Vienna in , Jung wrote his famous monograph "On.

There are a relative absence of mental activity, a progressive lessening in the use of inner resources, and a retreat to simpler or stereotyped forms of behaviour. The hebephrenic or disorganized subtype of schizophrenia is typified by shallow and inappropriate emotional responses, foolish or bizarre behaviour, false beliefs delusions , and false perceptions hallucinations. The catatonic subtype is characterized by striking motor behaviour. The patient may remain in a state of almost complete immobility, often assuming statuesque positions. Mutism inability to talk , extreme compliance , and absence of almost all voluntary actions are also common. This state of inactivity is at times preceded or interrupted by episodes of excessive motor activity and excitement, generally of an impulsive, unpredictable kind. The paranoid subtype, which usually arises later in life than the other subtypes, is characterized primarily by delusions of persecution and grandeur combined with unrealistic, illogical thinking, often accompanied by hallucinations. The residual subtype is typically distinguished by the lack of distinct features that define the other types and is considered a less severe diagnosis. Individuals diagnosed with the residual type generally have a history of schizophrenia but have reduced psychotic symptoms. The different subtypes of schizophrenia are not mutually exclusive , and persons affected by schizophrenia may display a mixture of symptoms that defy convenient classification. There may also be a mixture of schizophrenic symptoms with those of other psychoses, notably those of the manic-depressive group. Hallucinations and delusions, although not invariably present, are often a conspicuous symptom in schizophrenia. The most common hallucinations are auditory: Patients with schizophrenia are subject to a wide variety of delusions, including many that are characteristically bizarre or absurd. One symptom common to most patients with schizophrenia is a loosening in their thought processes; this syndrome manifests itself as disorganized or incoherent thinking, illogical trains of mental association, and unclear or incomprehensible speech. Epidemiology Schizophrenia crosses all socioeconomic, cultural, and racial boundaries. Worldwide it affects about 0. Schizophrenia is the single largest cause of admissions to mental hospitals and accounts for an even larger proportion of the permanent populations of such institutions. The illness usually first manifests itself in the teen years or in early adult life, and its subsequent course is extremely variable. About one-third of all schizophrenic patients make a complete and permanent recovery, one-third have recurring episodes of the illness, and one-third deteriorate into chronic schizophrenia with severe disability. Theories on the origin of schizophrenia Various theories of the origin of schizophrenia have centred on anatomical, biochemical, psychological, social, genetic, and environmental causes. No single cause of schizophrenia has been established or even identified; however, there is strong evidence that a combination of genetic and environmental factors plays an important role in the development of the disease. Researchers have found that rare inherited genetic mutations occur three to four times more frequently in people with schizophrenia compared with healthy people. These mutations typically occur in genes involved in neurodevelopment, of which there are hundreds. In addition, many small-effect genetic variants have been identified on various chromosomes in persons with schizophrenia, including chromosomes 6 and In the case of chromosome 6, it is thought that the interaction of these variantsâ€”many of which occur in a region of the chromosome that contains the major histocompatibility complex , a group of genes associated with regulating responses of the immune system â€”contributes to some 30 percent of cases of the illness. A similar polygenic pattern, in which many minor genetic variants interact to give rise to disease, has been found in persons with bipolar disorder. This knowledge sheds light on the enormous complexity of mental disorders associated with genetic factors. Today scientists continue to investigate the mechanisms by which genetic mutations give rise to biochemical abnormalities in the brains of people suffering from schizophrenia. For example, therapies involving antipsychotic drugs and estradiol the most active form of estrogen have proved effective in reducing certain psychotic symptoms in postmenopausal women with schizophrenia. In addition, there is some evidence

that estradiol treatment can reduce psychotic symptoms, such as delusions and hallucinations, in premenopausal women. Hormone therapy has become an important area of schizophrenia research because decreased estrogen levels in women affected by the disease are associated with an increased occurrence of severe psychotic symptoms. In addition, estradiol therapy has the potential to enable doctors to prescribe lower doses of antipsychotics, which can have harmful side effects e. Types and causes of mental disorders.

PSYCHOLOGY OF DEMENTIA PRAECOX pdf

8: Volume 3: The Psychogenesis of Mental Disease - IAAP

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He was first introduced to biology by his brother Karl, 10 years older and, later, the director of the Zoological Museum of Hamburg. Kraepelin would be a disciple of Wundt and had a lifelong interest in experimental psychology based on his theories. For the Use of Students and Physicians , was first published in and was expanded in subsequent multivolume editions to Ein Lehrbuch der Psychiatrie A Textbook: Foundations of Psychiatry and Neuroscience. In it, he argued that psychiatry was a branch of medical science and should be investigated by observation and experimentation like the other natural sciences. He called for research into the physical causes of mental illness, and started to establish the foundations of the modern classification system for mental disorders. Kraepelin proposed that by studying case histories and identifying specific disorders, the progression of mental illness could be predicted, after taking into account individual differences in personality and patient age at the onset of disease. Four years later, on 5 December , [1] he became department head at the University of Heidelberg , where he remained until There he began to study and record many clinical histories in detail and "was led to consider the importance of the course of the illness with regard to the classification of mental disorders". Following a large donation from the Jewish German-American banker James Loeb , who had at one time been a patient, and promises of support from "patrons of science", the German Institute for Psychiatric Research was founded in in Munich. He rejected psychoanalytical theories that posited innate or early sexuality as the cause of mental illness, and he rejected philosophical speculation as unscientific. He focused on collecting clinical data and was particularly interested in neuropathology e. The ninth and final edition of his Textbook was published in , shortly after his death. It comprised four volumes and was ten times larger than the first edition of This turned out to be his paradigm-setting synthesis of the hundreds of mental disorders classified by the 19th century, grouping diseases together based on classification of syndrome â€”common patterns of symptoms over timeâ€”rather than by simple similarity of major symptoms in the manner of his predecessors. Kraepelin described his work in the 5th edition of his textbook as a "decisive step from a symptomatic to a clinical view of insanity. The importance of external clinical signs has. Thus, all purely symptomatic categories have disappeared from the nosology". Drawing on his long-term research, and using the criteria of course, outcome and prognosis, he developed the concept of dementia praecox , which he defined as the "sub-acute development of a peculiar simple condition of mental weakness occurring at a youthful age". When he first introduced this concept as a diagnostic entity in the fourth German edition of his Lehrbuch der Psychiatrie in , it was placed among the degenerative disorders alongside, but separate from, catatonia and dementia paranoides. In the sixth edition of the Lehrbuch in all three of these clinical types are treated as different expressions of one disease, dementia praecox. What distinguishes each disease symptomatically as opposed to the underlying pathology is not any particular pathognomonic symptom or symptoms, but a specific pattern of symptoms. In the absence of a direct physiological or genetic test or marker for each disease, it is only possible to distinguish them by their specific pattern of symptoms. Kraepelin also demonstrated specific patterns in the genetics of these disorders and specific and characteristic patterns in their course and outcome. Though, of course, this does not demonstrate genetic linkage, as this might be a socio-environmental factor as well. He also reported a pattern to the course and outcome of these conditions. Kraepelin believed that schizophrenia had a deteriorating course in which mental function continuously although perhaps erratically declines, while manic-depressive patients experienced a course of illness which was intermittent, where patients were relatively symptom-free during the intervals which separate acute episodes. This led Kraepelin to name what we now know as schizophrenia, dementia praecox the dementia part signifying the irreversible mental decline. In addition, as Kraepelin accepted in , "It is becoming increasingly obvious that we cannot satisfactorily distinguish these two diseases"; however, he maintained that "On the one hand we find those patients with irreversible dementia and severe cortical lesions. On the other are those patients whose personality remains intact". Kraepelin devoted very few pages to his

speculations about the etiology of his two major insanities, dementia praecox and manic-depressive insanity. However, from to his death in he held to the speculation that these insanities particularly dementia praecox would one day probably be found to be caused by a gradual systemic or "whole body" disease process, probably metabolic, which affected many of the organs and nerves in the body but affected the brain in a final, decisive cascade. He attributed this mainly to degeneration. They were treated under a theory of degeneration. Four types were distinguished: The concept of " psychopathic inferiorities" had been recently popularised in Germany by Julius Ludwig August Koch , who proposed congenital and acquired types. Kraepelin had no evidence or explanation suggesting a congenital cause, and his assumption therefore appears to have been simple " biologism ". Others, such as Gustav Aschaffenburg , argued for a varying combination of causes. Nevertheless, many essentials of these diagnostic systems were introduced into the diagnostic systems, and remarkable similarities remain in the DSM-IV and ICD Kraepelin had referred to psychopathic conditions or "states" in his edition, including compulsive insanity, impulsive insanity, homosexuality , and mood disturbances. From , however, he instead termed those "original disease conditions, and introduced the new alternative category of psychopathic personalities. In the eighth edition from that category would include, in addition to a separate "dissocial" type, the excitable, the unstable, the Triebmenschen driven persons, eccentrics, the liars and swindlers, and the quarrelsome. It has been described as remarkable that Kraepelin now considered mood disturbances to be not part of the same category, but only attenuated more mild phases of manic depressive illness; this corresponds to current classification schemes. Kraepelin was confident that it would someday be possible to identify the pathological basis of each of the major psychiatric disorders. He was a strong and influential proponent of eugenics and racial hygiene. His publications included a focus on alcoholism , crime , degeneration and hysteria. He appears to have held Lamarckian concepts of evolution, such that cultural deterioration could be inherited. Kraepelin saw a number of "symptoms" of this, such as "weakening of viability and resistance, decreasing fertility, proletarianisation, and moral damage due to "penning up people" [Zusammenpferchung]. He also wrote that "the number of idiots, epileptics, psychopaths, criminals, prostitutes, and tramps who descend from alcoholic and syphilitic parents, and who transfer their inferiority to their offspring, is incalculable". He felt that "the well-known example of the Jews , with their strong disposition towards nervous and mental disorders, teaches us that their extraordinarily advanced domestication may eventually imprint clear marks on the race". However, his views now dominate many quarters of psychiatric research and academic psychiatry. In this role he took in clinical information from a wide range of sources and networks. Despite proclaiming high clinical standards for himself to gather information "by means of expert analysis of individual cases", he would also draw on the reported observations of officials not trained in psychiatry. The various editions of his textbooks do not contain detailed case histories of individuals, however, but mosaiclike compilations of typical statements and behaviors from patients with a specific diagnosis. In broader terms, he has been described as a bourgeois or reactionary citizen. Abridged and clumsy English translations of the sixth and seventh editions of his textbook in and respectively by Allan Ross Diefendorf â€” , an assistant physician at the Connecticut Hospital for the Insane at Middletown, inadequately conveyed the literary quality of his writings that made them so valuable to practitioners. One of his own famous contributions to this journal also appeared in the form of a monograph pp. The dreams Kraepelin collected are mainly his own. They lack extensive comment by the dreamer. In order to study them the full range of biographical knowledge available today on Kraepelin is necessary see, e. Berlin, Heidelberg, New York:

9: Dementia praecox | Define Dementia praecox at www.enganchecubano.com

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Edit In , at the age of 30 and after only eight years of training, he was appointed to a professorship at the University of Tartu then Dorpat in what is today Estonia and became the director of an eighty-bed University Clinic. There he was able to study and record many clinical histories in detail and "was led to consider the importance of the course of the illness with regard to the classification of mental disorders. He referred to the traditional view as "symptomatic" and to his view as "clinical". This turned out to be his paradigm-setting synthesis of the hundreds of mental disorders classified by the 19th century, grouping diseases together based on classification of syndromes -common patterns of symptoms- rather than by simple similarity of major symptoms in the manner of his predecessors. In fact, it was precisely because of the demonstrated inadequacy of such methods that Kraepelin developed his new diagnostic system. One of the cardinal principles of his method was the recognition that any given symptom may appear in virtually any one of these disorders; e. What distinguishes each disease symptomatically as opposed to the underlying pathology is not any particular pathognomonic symptom or symptoms, but a specific pattern of symptoms. In the absence of a direct physiological or genetic test or marker for each disease, it is only possible to distinguish them by their specific pattern of symptoms. Dementia Praecox and Manic-Depression Edit Kraepelin is specifically credited with the classification of what was previously considered to be a unitary concept of psychosis , into two distinct forms: Manic Depression now seen as comprising a range of mood disorders such as Major Depression and Bipolar disorder , and Dementia praecox i. Drawing on his long-term research, and using the criteria of course, outcome and prognosis, he developed the concept of dementia praecox , which he defined as the "sub-acute development of a peculiar simple condition of mental weakness occurring at a youthful age. In the sixth edition of the Lehrbuch in all three of these clinical types are treated as different expressions of one disease, dementia praecox. Kraepelin also demonstrated specific patterns in the genetics of these disorders and specific and characteristic patterns in their course and outcome. Generally speaking, there tend to be more schizophrenics among the relatives of schizophrenic patients than in the general population, while manic-depression is more frequent in the relatives of manic-depressives. He also reported a pattern to the course and outcome of these conditions. Kraepelin believed that schizophrenia had a deteriorating course in which mental function continuously although perhaps erratically declines, while manic-depressive patients experienced a course of illness which was intermittent, where patients were relatively symptom-free during the intervals which separate acute episodes. This led Kraepelin to name what we now know as schizophrenia, dementia praecox the dementia part signifing the irreversible mental decline. It later became clear that dementia praecox did not necessarily lead to mental decline and so was renamed by Eugene Bleuler to correct the misnomer. Kraepelin was confident that it would someday be possible to identify the pathologic basis of each of the major psychiatric disorders. Equally important, but also little known, the method of differential diagnosis was first suggested for use in the diagnosis of mental disorders by Emil Kraepelin. It is more systematic than the old-fashioned method of diagnosis by gestalt impression. However, his views now dominate psychiatric research and academic psychiatry, and today the published literature in the field of psychiatry is overwhelmingly biological in its orientation. The diagnostic approaches exemplified by these two nomenclatures are very similar to one another and represent a return to descriptive psychiatry in which careful observation of symptoms, signs, and course of mental diseases become the diagnostic criteria themselves. In many ways, these newest classification schemata can be considered a return to phenomenological psychiatry perhaps best exemplified at the start of this century by Emil Kraepelin. Thus, recent developments in psychiatric diagnosis can be thought of as neo-Kraepelinian. Because they represent a relatively radical change from psychodynamic approaches to evaluation and diagnosis, they can also be called revolutionary.

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