WORK-IN-PROGRESS (SEPTEMBER 20, 2022) PARALLEL CHART FOR

Chapter 53 — Schizophrenic Reaction Types

of *Theory and Practice of Psychiatry* (1936)

by William S. Sadler, M.D.

Sources for Chapter 53, in the order in which they appear

(1) George W. Henry, A.B., M.D., *Essentials of Psychiatry* (Baltimore: The Williams & Wilkins Company, 1931)

(2) Edward A. Strecker, A.M., M.D. and Franklin G. Ebaugh, A.B., M.D., *Practical Clinical Psychiatry for Students and Practitioners, Third Edition Enlarged and Revised* (Philadelphia: P. Blakiston's Son & Co., Inc., 1931)

(3) John H. Ewen, M.R.C.P., D.P.M., *A Handbook of Psychiatry* (Baltimore: William Wood and Company, 1934)

(4) D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners, Third Edition* (New York: Oxford University Press, 1932)

> *Note:* I used the fourth edition, published in 1936. It's virtually identical to the third edition, although the pagination differs.

(5) William A. White, A.M., M.D., *Outlines of Psychiatry, Thirteenth Edition* (Washington: Nervous and Mental Disease Publishing Company, 1932)

(6) John Rathbone Oliver, M.D., Ph.D., *Pastoral Psychiatry and Mental Health* (New York: Charles Scribner's Sons, 1932)

(7) Anton T. Boisen, Chaplain, Elgin State Hospital, "Schizophrenia and Religious Experience," in *Collected and Contributed Papers* (Elgin State Hospital, Elgin, Illinois, 1932)

(8) Louise T. MacNamara, A.B., M.A., Charles F. Read, B.S., M.D., and A. Ettelson, M.D., "A Study of the Social Readjustment of One Hundred Cases of Dementia Praecox, Together with Some Psychiatric Comment Upon Those Reported Recovered," in *Collected and Contributed Papers* (Elgin State Hospital, Elgin, Illinois, 1932)

(9) A. Ettelson, M.D., "The Use of Sodium Amytal in the Psychoses," in *Collected and Contributed Papers* (Elgin State Hospital, Elgin, Illinois, 1932**)**

(10) Daniel Haffron, M.D., "Manganese Chloride Therapy in Dementia Praecox," in *Collected and Contributed Papers* (Elgin State Hospital, Elgin, Illinois, 1932**)**

(11) William S. Sadler, M.D., F.A.C.S., *The Mind at Mischief: Tricks and Deceptions of the Subconscious and How to Cope with Them* (New York: Funk & Wagnalls Company, 1929)

Key

(a) Green indicates where a source author (or previous Sadler book) first appears, or where he/she reappears.

(b) Yellow highlights most parallelisms.

(c) Tan highlights parallelisms not occurring on the same row, or parallelisms separated by yellowed parallelisms.

(d) An underlined word or words indicates where the source and Sadler pointedly differ from each other.

(e) Pink indicates passages where Sadler specifically shares his own experiences, opinions, advice, etc.

(f) Light blue indicates passages which strongly resemble something in the Urantia Book, or which allude to the Urantia phenomenon.

(g) Red indicates an obvious error on Sadler's part, brought about, in most cases, by miscopying or misinterpreting his source.

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VI: SCHIZOPHRENIC PSYCHOSES (Henry 65)

DISCUSSION (Henry 72)

We have already observed that a psychosis

is a form of human adaptation

through which the burdens of life are lightened

and that this relief is afforded through a reversion to earlier and more simple levels of human development (H 72).

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

[contd] Dementia præcox, the mystery of psychiatry, constitutes a challenge to investigators in every field of medical research.

53 — SCHIZOPHRENIC REACTION TYPES

53:0.1 The psychoses

belonging to the schizophrenic (dementia praecox) type, like all other forms of either mild or severe psychic involvement,

represent an effort of the human personality to effect an emergency adaptation

to the overload of life.

These distraught individuals are thus able, at least consciously and transiently, to

secure some immediate relief by these reversions to earlier and more simple technics of living.

Of all the reversion types of behavior, schizophrenia is the most mysterious and complex form of personality retreat or subconscious technic of adjustment.

In fact, it is the one real mystery of psychiatry.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Its etiology is unsettled; its pathology is unknown	Its pathology is unknown,
and its clinical limits in dispute and yet it is a more serious problem than either tuberculosis or carcinoma (S&E 287).	and even its clinical aspects are more or less unsettled.
II, I: SCHIZOPHRENIA (Ewen 33)	
General Ætiology. (Ewen 36)	
	These patients are largely recruited from
6. Personality. Jung's introverted type.	Jung's introvert type,
Meyer and Hoch's "shut in personality."	Meyer's "shut-in" personalities,
Kretschmer's schizoid—superior schizoid, much energy. Inferior schizoid, little energy (E 36).	and Kretschmer's schizoid group.
VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)	
Each year, not less than 30,000 to 40,000 individuals (including all cases),	53:0.2 In the United States about 40,000 new cases develop each year,
soon after adolescence or in the first flush of manhood and womanhood, fall victims to this dread disease (S&E 287).	and the vast majority are under thirty years of age.
Unless an adjustment is accomplished during the brief stage of incipiency,	If they are not afforded relief during the earlier mental phases,
they are condemned to a veritable living death,	these poor souls are condemned to eke out a miserable existence which is the equivalent of a living death.
	They are destined to go through life
devoid of emotional life	all but *devoid of emotional enjoyment,*
and unable to participate in the normal activities and affairs of living (S&E 287).	almost wholly deprived of the capacity for normal living.

SOURCE

Schizophrenic Process. ... In a Massachusetts study of 3,184 cases the clinical classification of various types was as follows:

(1) Hebephrenic (scattering type) 52 per cent.

(2) Catatonic (psychomotor types ranging between aboulia and catatonia) 10 per cent.

(3) Paranoid (pseudo systematization type) 25 per cent.

(4) Simple (simple deteriorating type) 8 per cent. (S&E 290)

VI: SCHIZOPHRENIC PSYCHOSES (Henry 65)

Frequency. ... Apparently males are affected slightly more frequently. The onset and acute symptoms occur most frequently between the ages of eighteen and thirty-five.

On account of the marked tendency toward chronicity

over 50 per cent of the patients in public hospitals are suffering from schizophrenic psychoses (H 65).

53: THE THEORY AND PRACTICE OF PSYCHIATRY

53:0.3 As to the percentage of cases making up the four grand divisions of dementia praecox,

a recent Massachusetts study of 3,184 cases yielded a classification by clinical types as follows:

53:0.4 1. Simple (simple deteriorating type) 8 per cent

53:0.5 2. Catatonic (psychomotor types ranging between abulia and catatonia) 10 per cent

53:0.6 3. Paranoid (pseudo-systematization type) 25 per cent

53:0.7 4. Hebephrenic (scattering type) 52 per cent

53:0.8 The onset of this disorder, with few exceptions, occurs between the eighteenth and thirty-fifth years,

and a few more males are afflicted than females.

Because of its chronicity and the tendency to recurrences,

even when the patient has experienced a partial or more or less complete recovery,

about 50 per cent of the inmates of state and public institutions belong to this group.

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

In 1896, after Kraepelin first made his important differentiation between the manic-depression psychosis and dementia præcox, the latter term was more or less generally accepted (H&G 191).

53:0.9 This disorder was called *dementia praecox* by Kraepelin in 1896,

[T]he term "dementia præcox" has usually implied a rather hopeless prognosis (H&G 191).

and all but a hopeless prognosis subsequently came to be associated with this diagnosis.

In 1911 Bleuler introduced the term "schizophrenia"

In 1911 Bleuler introduced the now more generally accepted term "schizophrenia."

However, he intended this

to designate all cases of functional mental disturbance, with the exception of typical manic-depressive cases (H&G 191).

to include all psychotic patients not belonging to the manic-depressive group.

53:0.10 In most instances schizophrenics are trying to escape from something in the social environment which seems to them too great a burden to bear. It is altogether true that, in the acute and early manifestations, the clinical picture may represent a conflict, a struggle in which the patient may really be putting forth some very strenuous efforts to *wrestle with the environment;* but in its later aspects it is usually the culmination of a flight from reality. Many of these cases are youths who are not disposed to accept the social restrictions and the cultural demands of their environment; they resent situations which interfere with their gratification of natural impulses, or which jeopardize their security and restrict their opportunities for gaining recognition and achieving pleasurable satisfaction.

Instead of putting forth intelligent and constructive efforts to unify personality and achieve self-realization in the midst of such difficult situations, they adopt what to them appears to be a more ready avenue of escape and revert to this technic of creating an inner compensatory world of fantasy and romance.

1. Etiology

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

Etiological and Pathological Summary. The numerous theories which have been advanced to explain dementia praecox are hopeful confessions of our ignorance.

53:1.1 Many theories have been advanced in the effort to establish the etiology of schizophrenia.

Among the more recent—none of which, however, have been confirmed by sufficient evidence to warrant their general acceptance—may be mentioned:

Nissl and others in Germany are convinced that there is actually a degeneration of the cortex;

degeneration of the cortex,

Mott in England believes that there is primary testicular or ovarian atrophy with attendant endocrine dysfunction and final brain pathology (S&E 288).

glandular atrophy,

Marcuse claims to have identified double nuclei in some of the ganglion cells of the thalamus and also marked lipoid degeneration.

pathology in the ganglion cells of the thalamus,

Kitabayashi thinks that the pathology of praecox is to be found in the choroid plexus (S&E 288).

pathology of the choroid plexus,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Focal infection in the teeth, tonsils, colon etc., is the somewhat naive belief of Cotton.	focal infections,
From the organic side the frequency of tuberculosis is striking (S&E 288-89).	and even tuberculosis.
	53:1.2 1. **Biologic Type.**—
Schizophrenic Process. ... Schizophrenia tends to develop in persons with the shut-in, seclusive type of personality (schizophrenic constitution)	There does appear to be a *schizophrenic-constitution* type of individual;
	"shut-in" youths seem to be predisposed to this form of psychosis.
often on the basis of mental conflicts,	The condition appears in young people who have suffered inordinately from emotional conflicts,
	who have trouble in finding a goal for living, and in whom there is delayed integration of personality, failure of unification.
faulty habit formation,	Faulty thinking,
and instinctive maladjustments extending back to early childhood and adolescence.	social maladjustment,
	and failure to curb daydreaming are among the predisposing causes of the disorder,
Schizophrenia frequently manifests itself early in life, the largest percentage of cases developing before the age of twenty-five years,	and the majority of the cases develop before the patient is twenty-five years of age.[1]
and it tends to progress to deterioration if treatment is not begun early (S&E 289).	

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Ætiology. (Henderson & Gillespie 192)

Very few cases occur after the age of forty, and these are mainly in women (Popper) (H&G 192).

Very few appear after forty, except in women.

53:1.3 2. **Heredity.**—

[contd] Heredity plays a part (*vide supra* "Heredity") in schizophrenia. Approximately 50 to 60 per cent of cases have a family record of mental illness (H&G 192).

Fifty to sixty per cent of schizophrenics exhibit a family history of definite mental disorders.

XI: DEMENTIA PRECOX. (White 210)

Etiology.— ... Heredity plays an uncertain rôle in its etiology

There is undoubtedly a hereditary factor in the disease,[2]

but the disease seems to afford evidence of Mendelian recessive factors (W 211).

and it appears to behave in general like a *Mendelian recessive.*

53:1.4 **3. Cultivated Reaction.**—

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Ætiology. (Henderson & Gillespie 192)

The essence of [Meyer's] view is that schizophrenia is the outcome of progressive maladaptation of the individual to his environment. Schizophrenia is not a "disease",

Schizophrenia is not a disease;

it is more truly, as Meyer contended,

but a congeries of individual types of reaction having certain general similarities (H&G 195).

a "reaction type of maladaptation."[3]

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
It was from a careful study of patients ... that Meyer concluded that "schizophrenia" is the end result of an accumulation of faulty habits of reaction (H&G 195).	The disorder is really an end-result of the accumulation of defective thinking and faulty reaction habits.
[!]	Its victims fall into dishonest and unfair technics for meeting life situations; they dream, dodge, substitute, camouflage,
A sense of failure is no longer combated by renewed efforts, but by brooding over troubles and blaming others (H&G 196).	brood, blame others,
Certain kinds of faulty reaction are especially pernicious, such as hypochondriacal trends—blaming's one health for one's failures—	blame poor health,
ideas of suspicion or actual fault-finding, fantastic religious motives and persistent brooding and seclusiveness.	isolate themselves, become suspicious,
Negativism, for example, is healthy enough as mere stubbornness in certain directions;	resort to negativism,
but when it extends to every activity as an "uncontrollable blocking factor" it becomes pathological, and constitutes what has hitherto been called a mental "disease" (H&G 196).	and in the end suffer from "blocking."
Case 22.—Summary: A shy, sensitive, seclusive young man who showed increasing incapacity for social adaptation as he grew older; ... gradual loss of appreciation of reality, so that his phantasies became delusions (*e.g.* engagement-phantasy) in which he lived ... (H&G 198).	In some cases their fantasies even become delusions.
Farrar distinguishes five main types of "shut-in" personality:	53:1.5 *Farrar* distinguishes five principal types of "shut-in" personality:
(1) the "backward" type, lacking ambition, absent-minded, often playing truant;	53:1.6 1. The "backward," lacking ambition, absent-minded, often playing truant.

SOURCE

(2) the "precocious" type, the bookish, serious, prudish, "model" child;

(3) the "neurotic" variety, selfish and deceitful, with headaches and other minor ailments, temper-tantrums;

(4) the "asocial"—seclusive and day-dreaming; and

(5) "juvenile" type, which never seems to "grow up" (H&G 199).

It is ... necessary to admit that we do not as yet have a full and complete understanding of the various factors which may bring about ... schizophrenia. We can only say that

there is a special type of schizoid personality, which is partly inborn and partly acquired (H&G 199).

XI: DEMENTIA PRECOX. (White 210)

Etiology.— ... The future patient might be expected to be rather dull in his early youth and show difficulty in getting on with his studies.

While this is not infrequently the case, still cases often occur in young persons, not only of apparently usual mental power, but of brilliant, perhaps precociously brilliant faculties (W 211).

53: THE THEORY AND PRACTICE OF PSYCHIATRY

53:1.7 2. The "precocious," the bookish, serious, prudish, "model" child.

53:1.8 3. The "neurotic," selfish and deceitful, with headaches, other minor ailments, and temper tantrums.

53:1.9 4. The "asocial," seclusive and daydreaming.

53:1.10 5. The "juvenile," which never seems to "grow up."

53:1.11 4. **Double Etiology.**—

The study of a large number of schizophrenics shows very clearly that

the tendency to this disorder is partly inborn and partly acquired.

These individuals are sometimes dull,

sometimes bright, even brilliant.

IV: SCHIZOPHRENIC PSYCHOSES (Henry 65)

Causes. ... Such persons may lack self confidence, may be shy, sensitive, self conscious and prudish while at the same time they may also be proud, ambitious, determined

In general, dementia praecox youths are shy, sensitive, self-conscious, proud, prudish, determined, lacking in self-confidence,

and driven by strong sexual cravings (H 65).

many times the victims of a strong sex urge,

at others deficient in the sex impulse,

Their determination to succeed increases the conflict between the potent driving forces of the personality and as the internal conflict is increased the adjustments to the environment become more difficult and inadequate.

and they usually suffer from marked conflicts.

These introverted individuals naturally recoil from the difficulties of real life situations.

53:1.12 5. **Cumulative Crises.**—

After months or years this sort of tension, repression, and conflict, these unfortunate young people sometimes indulge in a precipitate and final retreat from reality, taking a quick plunge into an inner fictitious world of their own fantastic creation. If they do not receive help in the early stages of their afflictions, as the disorder progresses,

Eventually the situation becomes intolerable.

eventually the situation becomes intolerable

The affected person can no longer attend to the interests of the environment

until they can no longer function in society.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	Such an unfortunate youth cannot make a living, he cannot pursue a continuous course of study, *he is unwilling to face competitive situations,* to make the self-sacrifice required to meet the social demands of his environment, and he concludes that the best way out of his dilemma is to
[!]	
and he begins the retreat from the harsh world of reality and self sacrifice to a world of fancy where he may dwell in self indulgence.	retreat into a world of fancy where he can avoid competition and self-sacrifice
	and indulge his natural impulses to the full limit in fantasy.
The change is manifested by secretiveness, seclusiveness, indifference	This stage is characterized by secretiveness, seclusiveness, indifference to reality,
and even mistrust.	and often by marked mistrust, even suspicion;
As contact with the real world diminishes	but as he escapes self-consciousness of contact with the real world,
the patient becomes more and more preoccupied with his own fancies.	he becomes more and more preoccupied with the fantasy
	and romancing of this new inner world in which he has sought refuge from the irritations and vexations of real life.
	53:1.13 6. **A Pleasant Escape.**—
	In this dream world of his own creation he finds he is able to revert to easier and more primitive levels of thinking and technics of reaction.
This course is much easier because he can again make use of the earlier and more familiar modes of adaptation.	Here he can utilize the more simple nursery types of adaptation to reality;

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
In many respects he is enjoying once more the experiences of childhood.	in many cases these individuals who have thus escaped life's difficulties and irritations, find themselves in a very pleasant fantasy situation,
He is fascinated by this dream world and does not wish to be disturbed (H 65-66).	and they are so satisfied and fascinated with the results of their flight from reality that they resent all efforts to disturb them; they do not wish to return to the dreary, drab, and humdrum workaday world.
II: MENTAL ILLNESS (Oliver 26)	
SCHIZOPHRENIA (Oliver 51)	
He may withdraw himself from reality so far that he refuses to think at all;	53:1.14 Some schizophrenics may withdraw themselves so far from reality that they practically refuse to think;
refuses to eat, to move;	they often refuse to eat, sometimes decline to move,
and lapses into a so-called catatonic state of complete inactivity (O 58-59).	and speedily lapse into a catatonic state of almost complete inactivity.
	53:1.15 7. **Doubtful Pathology.**—
IV: SCHIZOPHRENIC PSYCHOSES (Henry 65)	
DISCUSSION (Henry 72)	
Post-mortem studies in over six hundred cases of schizophrenia suggest a constitutional deficiency in the vascular system.	53:1.16 Postmortem studies in over six hundred cases of schizophrenia suggest a constitutional deficiency in the vascular system.
The average dementia praecox heart was found to be one-third less than normal in weight, and the aorta was often thin, hyperelastic, and of small diameter.	The average dementia praecox heart was found to be one-third less than normal in weight, and the aorta was often thin, hyperelastic, and of small diameter.

This hypoplasia of the cardiovascular system may, however, be one of the results of a life of inactivity since the average schizophrenic spends many years in a state of apathy and inactivity.

This hypoplasia of the cardiovascular system may, however, be one of the results of a life of inactivity since the average schizophrenic spends many years in a state of apathy and inactivity.*

[*Henry, George W.: Essentials of Psychiatry, Williams & Wilkins, Baltimore, 1931.]

Except in the acute phases both clinical observation and laboratory tests show that metabolic processes are retarded (H 76-77).

53:1.17 Except in the acute phases, all observations and laboratory tests indicate that the metabolic processes are retarded.

53:1.17 8. **Theories of Causation.**—

II, I: SCHIZOPHRENIA (Ewen 33)

Theories of Causation. (Ewen 34)

1. Kraepelin postulated an auto-intoxication following a disorder of metabolism.

53:1.18 1. *Kraepelin* propounded an autointoxication consequent upon a disordered metabolism.

He considered the auto-intoxication to be produced by disordered secretions of the sexual glands (E 34).

He regarded the autointoxication as being produced by disordered secretions of the sexual glands.

2. Mott believed that a primary defect in the vital energy of the cortical neurons was the cause.

53:1.19 2. *Mott* believed there is a primary defect in the vital energy of the cortical neurons.

This defect in inherent and often inherited.

This defect is probably inherited;

There was an inborn lack of vitality and a subnormal capacity to withstand the stress of experience (E 34).

there is an inborn lack of capacity to withstand the stress of living.

[contd] 3. Freud has shown that there is fixation at the first oral stage.

53:1.20 3. *Freud* contends that there is fixation at the first oral stage;

He believes that the symptoms are attempt at self-cure (E 34).

he believes the symptoms are attempts at self-cure.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
[contd] 4. McDougall sees in schizophrenia a disturbance of the sentiment of self-regard.	53:1.21 4. *McDougall* sees in schizophrenia a disorder of the sentiment of self-regard—
	a failure of reconciliation between
Self-regard is built up of the sentiments of self-assertion and self-submission.	the emotions of self-assertion and self-submission.
In schizophrenia these two component parts do not function smoothly; but remain in rigid balance and lead to an embarrassment, resulting in no effective action or expression.	In schizophrenia these two component parts fail to function smoothly;
The patient never freely asserts himself and never wholly submits (E 34-35).	the patient never fully asserts himself and never wholly submits.
5. Jung regards schizophrenia as an habitual tendency to introversion and a regression to elements in the collective unconscious (inherited mental disposition).	53:1.22 5. *Jung* regards schizophrenia as a habitual tendency to introversion—a regression to the collective unconscious, the inherited mental disposition.
"Let the dreamer walk about and act like one awakened and we have the clinical picture of dementia præcox" (E 35).	He says: "Let the dreamer walk about and act like one awakened, and we have the clinical picture of dementia praecox."
[contd] 6. Kretschmer correlates schizophrenia with the dyplastic or astheno-athletic type of body build,	53:1.23 6. *Kretschmer* correlates schizophrenia with the dysplastic or asthenopyknic type of physique.
and states that the dyplastic type is almost entirely found in association with schizophrenia (E 35).	
[contd] 7. Cotton regards schizophrenia as a manifestation of focal sepsis.	53:1.24 7. *Cotton* regards schizophrenia as a manifestation of focal sepsis.[4]
Removal of the sepsis is followed by cure.	Removal of the sepsis is followed by cure.
His results have not been confirmed (Kirby) (E 35).	His theory has not been confirmed by Kirby and others.

[contd] 8. Stransky emphasises lack of co-ordination between the noopsychic (intellectual, receptive) and the thymopsychic (affective) functions of mentation.

53:1.25 8. *Stransky* emphasizes lack of coordination between the intellectual and the affective functions of mentation.

This lack of co-ordination results in intrapsychic ataxia (E 35).

This lack of coordination produces intrapsychic ataxia.

9. Hesnard believes that schizophrenia is some form of organic disease.

53:1.26 9. *Hesnard* believes that schizophrenia is some form of organic disease,

It is a response to morbid excitations from the undifferentiated organic life (E 35-36).

a response to morbid excitations from the undifferentiated organic life.

2. Acute and Chronic Types

"SCHIZOPHRENIA AND RELIGIOUS EXPERIENCE" (Boisen 70)

[contd] From the standpoint of the student of religion the cases of dementia praecox which constitute so large a proportion of the new admissions to our hospitals for mental disorder fall into two chief groups (B 70).

53:2.1 There are two general fundamental types of schizophrenic involvement:

In the other we have acute emotional disturbances

53:2.2 1. The *acute emotional disturbance,*

presenting the clinical picture of violent conflict reaction

which seem not to be evils in themselves but are rather analogous to fever or inflammation in the physical organism. They are probably to be regarded as attempts to break up the malignant sets and attitudes

and the evidence of probable efforts to overthrow deeply rooted psychic attitudes and to withstand more dangerous and malignant emotional trends.

and to make possible a reconstruction or cure (B 70).

In the one we see

the end results of certain malignant character tendencies such as easy pleasure-taking and aimless drifting and concealment in its various forms (B 70).

[contd from four rows up] They are thus problem-solving experiences

which have much in common with certain types of religious experience.

There is almost invariably religious concern and a characteristic constellation of ideas

which is found also in men of such outstanding religious genius as George Fox and John Bunyan (B 70).

[*Note:* I do not have access to the full article and therefore have been unable to trace this passage.]

53:2.3 2. The *psychic involvement,* which represents, in a general way,

the terminal or accumulative results of long-continued daydreaming, chronic concealment, persistent self-easement, and malignant pleasure seeking.

53:2.4 It is barely possible that

the acute and active phase of dementia praecox may be something of a *problem-solving phenomenon.*

Some investigators have thought that

there is a resemblance between the psychic and emotional phenomena of acute schizophrenia and the clinical psychic picture presented by some phases of religious conflict.

Boisen likens the phenomena of acute schizophrenia to

the religious upheavals

which have characterized many noted religious characters, like John Bunyan,

and contends that these men escaped the dire consequences of the schizophrenic catastrophe by effecting a religious solution of the problem, thus unifying the personality and escaping the shattering results which otherwise might have attended the progressive disintegration of personality.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
If, with Adolf Meyer, we assume that the clinical pictures which we see in dementia praecox are best understood as reactions to a life situation—	53:2.5 If we agree with *Adolf Meyer* that the clinical pictures of the various types of schizophrenia are to be regarded as reaction technics to life situations,
a situation generally involving personal failure—,	situations which in general threaten disaster to the personality,
we may distinguish three major reaction patterns:	we can distinguish at least *four major patterns:*
(1) drifting and easy pleasure-taking and	53:2.6 1. The drifting, dreaming, easy-going, pleasure-seeking type.
(2) concealment in its various forms,	53:2.7 2. The repressing, retiring, and concealing type,
both of which constitute malignant character tendencies, which either prevent growth or lead to actual dissolution and destruction.	leading to progressive isolation and malignant disintegration.
We may also distinguish (3) the reaction of panic and upheaval	53:2.8 3. The acute panic type, attended by violent upheavals and sudden fluctuations
which follows upon the awareness of danger (B 75).	indicative of more or less awareness of conflict within the mind and danger to the personality.
In addition to these three groups a fourth group has been distinguished within the panic reaction type.	53:2.9 4. The fourth type, in reality a subdivision of the third,
This includes those cases in which the panic and upheaval occur in an individual	consists of those individuals,
	habitually isolated and oversuppressed,
whose habitual reaction is that of suppression of conscience	whose troubles pertain more directly to conscientious anxieties,
and transfer of blame	and who show a tendency to project the blame upon other persons;

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
and whose beliefs are already distorted in the effort to maintain self-respect by the method of	those who have sought to maintain self-respect by the persistent practice of
	distorted thinking which proceeds even to the borderland of
delusional misinterpretation (B 78).	delusional misinterpretations.
	53:2.10 It may be possible thus to divide all schizophrenics into the *acute and chronic groups,*
We seem thus justified in concluding that the acute schizophrenic psychoses are problem-solving experiences	looking upon the acute as unsatisfactory attempts at problem solving,
	and upon the chronic as more or less of a retreat from reality upon the failure to find a satisfactory solution for the problems of living.
	It appears that the acute phases of the disorder are a life-and-death struggle,
which tend either to make or to break the individual	one designed to make or break the individual,
and that some there are who emerge from them to grow in the direction of social effectiveness and unification around those interests and purposes which are conceived of as universal and abiding (B 81).	and that they result either in an enhanced ability to adapt the unifying personality to real life situations
[*Note:* I do not have access to the full article and therefore have been unable to trace this or the following passage.]	or, in case of failure, in a more or less complete isolation of the personality, thus achieving complete relief from the psychic, emotional, social, and moral demands of the environment.

53:2.11 It should be noted that many *acute cases of schizophrenia do recover.* Certainly this disorder must no longer be looked upon as one of hopeless prognosis. We should recognize this fact, although we are forced to admit that recurrences are not uncommon among these supposedly recovered schizophrenics. The more hopeless type is that in which the onset has been gradual and insidious. It is in the acute cases that religion may be of great service in facilitating a quick and thoroughgoing unification of personality and in the establishment of attractive, alluring, worth-while goals.

3. Personality Isolation

53:3.1 The isolation of the schizophrenic is predicated directly on failure of socialization, inability to assimilate new experiences; and it matters not whether this unassimilated new experience is one that pertains to social situations, sex impulses, or economic adjustment. It represents something which bulks large in the individual's own consciousness, and as a result of which his self-respect is challenged, *the drive for self-realization is thwarted.* These individuals accept the social and moral standards of civilization, and when they do not readily live up to, or adjust for, them, they find themselves in isolation from their fellows; in attempting to adjust to this isolation, they meet with such difficulties that they prefer the alternate relief of retreat into the more congenial and inner world of their own fantasy creation.

53:3.2 1. **Socialization Failure.**—

[!]

I think we would be warranted in saying that no youth or adult will suffer from a serious mental disorder as long as he is conscious of being an acceptably functioning unit of some social group of human beings whose standards of living he is willing to accept and able to comply with.

It is only when such predisposed individuals find themselves unable or unwilling to meet the standards of their group that they retrogress to lower levels of social integration or retreat from the reality situation by means of the schizophrenic technic of escape.

XI: DEMENTIA PRECOX. (White 210)

[A schizophrenic psychosis is ... characterized by an insidious onset ... (Henry 64).]

53:3.3 2. **The onset** is many times precipitous but more often insidious.

Of exciting causes it would seem that severe shocks, both physical and mental,

The first symptoms indicative of schizophrenia often show up immediately following some shock, either physical or mental.

as, for example, severe hemorrhages, infections—

The disorder frequently appears subsequent to infections,

such as influenza

often puerperal—

or puerperal infection.

fright, and that train of emotional disturbances following seduction and desertion are found (W 212).

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Precipitating Factors. (Henderson & Gillespie 199)	
[A] certain proportion of cases begin in association with such stresses as toxic-infectious illness, pregnancy	Many times it makes its first appearance in connection with pregnancy,
and the puerperium,	but more often immediately after childbirth.
	Among other precipitating factors may be mentioned fright, seduction,
financial and domestic difficulties and love affairs. Influenza is probably the commonest infection playing a causative rôle (H&G 199-200).	financial and domestic worry,
Of more long-standing factors, worry over masturbation is perhaps the commonest.	worry over masturbation,
The patient goes on for years ruminating over the habit till his feeling of guilt, no longer bearable, comes to be projected, first as ideas of reference, and later as hallucinations or delusions (H&G 200).	guilt complexes,
A homosexual experience, long ruminated over, may act in a similar way (H&G 200).	and homosexual experiences.
XI: DEMENTIA PRECOX (White 210)	
Mode of Onset.— ... These early manifestations may take the form of	53:3.4 3. **Early manifestations** of a schizophrenia may be in no way different from
	those of an ordinary neurosis.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	Many cases at first appear to be more like
the various types of the manic-depressive psychoses,	a manic-depressive psychosis.
	In others the initial symptoms are definitely those of
psychasthenia, neurasthenia, hysteria, hypochondria,	a psychasthenia, anxiety neurosis, hysteria, or hypochondria.
	The disorder frequently appears as an
acute confusion	acute confusion,
and paranoid states (W 222).	and at other times the paranoid trend very early manifests itself.
	The most characteristic early symptom is *emotional indifference* in association with mild *attention disorders.*
	53:3.5 4. **Isolation Tendencies Are Always Significant.**—
II: MENTAL ILLNESS (Oliver 26)	
Moreover, at the beginning of the psychosis, the patient may develop unsocial habits.	Among the early symptoms are these unsocial habits.
He will remain for long hours in his room, doing nothing;	The boy threatened with dementia praecox will remain for long hours in his room, apparently doing nothing.
	He is reluctant,
he will refuse to get up in the mornings;	in fact sometimes refuses, to get up in the morning;
or will walk the streets alone all night;	will walk the streets late at night, perhaps remaining out all night.
	He is slow at dressing;
at table he is moodily silent;	at mealtime he is moody, often silent.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
he is often boorish and rude.	He is sensitive, irritable, easily bored, and often rude.
Sometimes he will tell you that he has discovered he is not his father's son;	Sometimes the first alarming symptom is his announcement of his discovery that *he is not his father's son;*
that he is an illegitimate child,	that he is an adopted or illegitimate child;
	he may designate some prominent person as his father
with some important mysterious ancestry (O 56).	or hint at a secret and mysterious ancestry.
	53:3.6 5. **Reality Dodging.**—
XI: DEMENTIA PRECOX. (White 210)	
Etiology.— ... These persons do not meet difficulties openly and frankly,	Among the trends of schizophrenia is the persistent tendency to shun reality.
they are inclined to be seclusive,	These youths are seclusive.
not to make friends,	They experience great difficulty in making friends.
	They have no chums as a rule,
to have no one to whom they are close and with whom they can talk over things.	and there is no one with whom they talk things over in a confidential way.
	They get along badly with the family, are out of harmony with friends, relatives, and neighbors,
They do not come into natural and free relation with the realities, are apt to be prudes, overscrupulous, and exhibit a sentimental religiosity (W 213).	and have a general tendency to be prudish, overcritical, overscrupulous, and in many ways develop a characteristic religiosity.

4. Transformation of Personality

53:4.1 The shocking suddenness with which schizophrenia will develop is overwhelming.[5] A young person who has previously had good standing in the community, has done excellent work at school, perhaps has been an honor pupil if not at the head of the class, a youth who has been in every way apparently normal in his affections and social activities, is suddenly stricken with indifference, laziness, and marked irritability. *He rebels against discipline,* both at home and at school. This formerly carefree and companionable youth abruptly becomes shy, taciturn, introspective, and isolated; he emerges in a cynical and supercilious role, exhibiting a nonchalant attitude bordering on that of the desperado, and then just as quickly retires from this gay phase of early schizophrenia into his well-nigh melancholic isolation.

53:4.2 *Looked at superficially,* these cases present the picture of a youth who has grown up normally to about the time of puberty or shortly thereafter and then suddenly develops a strange mental attitude, queer emotional reactions, seeming to have become a victim of general "cussedness." His power of attention is lost; he appears to be lazy and shiftless, sometimes with a tendency to run away from home. Ambition is gone. *The personality has changed.* Stupidity seems to have replaced the former keenness of intellect, and the day-dreaming fantasy is rapidly drifting into delusional trends.

53:4.3 *The general picture,* then, once the uncertainties of the onset have passed, is that of a formerly normal-appearing individual who has more or less suddenly developed this characteristic enfeeblement of mind, emotional indifference, with weakened powers of attention and marked blocking of the mental process. Judgment is impaired. There is an indecision and flightiness about all mental activity. Obedience is more or less mechanical and automatic. Actions are impulsive. *Affections are blunted.* The laughter is mechanical and unemotional, and in the more serious type, hallucinations and even delusions of persecution or grandeur put in their appearance.

5. Symptomatology

XI: DEMENTIA PRECOX. (White 210)

General Symptomatology.— ... This fundamental difference in the impression created in us by the dementia precox patient from that produced by other types of the mental order STRANSKY traces to what he believes to be the basic factor in the symptomatology—*intrapsychic ataxia.*

53:5.1 Schizophrenia, as clinically manifested, is really an *intrapsychic ataxia.*

[This condition of intrapsychic ataxia does exist but BLEULER has shown quite conclusively, I think, that it is only one expression of what he calls a *splitting of the psyche* (W 215).]

This disorder is a real splitting of personality in a psychic sense

By this term he means a disturbance of coördination between the intellectual attributes of the whole psyche and the affective attributes,

and connotes lack of coordination between the thinking and the emotions.

or as he calls them respectively the noopsyche and the thymopsyche (W 213).

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Quite commonly a certain state of feeling dominates all conditions of consciousness, a certain stupidity and apathy,	53:5.2 There is real *emotional apathy,* sometimes so far involving the intellect as to result in a *characteristic stupidity.*
a surprising poverty of affect, which is in strong contrast to the clearness which the patient may demonstrate.	
	In many cases it is quite proper to speak of the condition as a combination state of deficient attention and emotional blunting.
	53:5.3 1. **Emotional Blunting.**—[6]
	As the disorder progresses,
Cold and passive,	these youths become emotionally cold, socially passive.
	They can even face the threat of electrocution
without so much as moving an eye lash,	without moving an eyelash.
	In the most appealing emotional situations they are
without any spontaneous reaction,	*devoid of spontaneous reactions.*
without expressing a wish,	They are loath to express a wish,
he is oriented to time and place and person,	and though they are well orientated as regards time, place, and persons,
is conversant with everything going on about him,	though they are cognizant of everything going on in their immediate environment,
shows good school knowledge, his memory is faultless,	exhibiting good memory of former educational and social advantages,
shows up well in an examination of his intelligence,	although they can pass a good intelligence test

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
and he denies feeling sick.	and are free from all evidence of disease,
	nevertheless, such intellectually competent individuals, when arrested for crime or incarcerated in an institution for the insane,
However, he shows no longing after freedom,	show little or no interest in gaining their freedom.
	They do not seem to be embarrassed by their predicament,
or feeling of sadness at his position; all these appear extinguished in him.	and there is no emotion attached to the situation.
	There is characteristic indifference to the environment.
This coldness produces an unnatural impression. One	In many ways the psychiatrist,
	in observing such a patient,
gets the impression of the dream state in epilepsy, the mental state of which has a certain symptomatic relationship with many forms of dementia precox (W 214-15).	is impressed with the resemblance to the dream state often observed in epilepsy.
	They are out of touch with reality.
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Symptomatology. (Henderson & Gillespie 201)	
[See next pg.]	53:5.4 2. **Lack of attention** is an early indication of the threat of schizophrenia.
The emotional deterioration leads to a state of mental facility, in which the patient is, up to a point, easily suggestible, and his conduct is more easily affected by those in contact with him (H&G 201).	These patients are highly suggestible.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Associated with this [the patient's indifference to his condition] is a certain dreaminess and a lack of touch with reality;	There is a tendency to dreaminess,
the patient lives a life with which his relatives and his doctor cannot get in touch (H&G 201).	
	a defect in interest in practical things.
XI: DEMENTIA PRECOX. (White 210)	
General Symptomatology.— ... They sit idly about, giving no heed to what goes on about them ... (W 216).	Many times they seem to be oblivious to what is going on about them.
From this lack of attention things in the environment are often not perceived at all, but when they are perceived	When their attention is focused,
they are understood quite fully,	they are capable of quite fully understanding questions asked or situations presented.
and we usually find these patients are *well oriented* in all respects, temporal, spatial and personal,	They are well orientated in all respects—temporal, spatial, and personal.
and show no *evidences of clouding of consciousness* (W 216).	There is, in the earlier stages, no clouding of the consciousness.
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Symptomatology. (Henderson & Gillespie 201)	
The apathy and lack of interest are usually so marked that active attention to any specific problem is fleeting.	Active attention is lacking;
On the other hand, passive attention is remarkably good, so that he may remember long afterwards events of which he had seemed to take no notice (H&G 201).	passive attention may be fairly normal.

53:5.5 3. **Alarming Indifference.**—

XI: DEMENTIA PRECOX (White 210)

A death, a birth, a marriage, the visit of a long lost relative,

Disconcerting news, whether of death, birth, or marriage,

are all apprehended with the same lack of emotional expression.

is all received with the same emotional indifference.

No matter how much pleasure or pain the event might be supposed to give, or would give in a normal person,

No matter what the promise of pleasure or the threat of pain,

the patient receives it with indifference,

the victims of this disorder confront each situation with equal indifference,

without surprise,

without expression of surprise

without an expression of interest often, in the most matter of fact sort of way, as if such things were occurring hourly (W 217).

and without the indication of even the slightest interest.

53:5.6 4. **Inconsistent Thinking.**—

Not only are indifference and emotional stolidity manifested by these patients, but there is also present a peculiar and characteristic *dilapidation of thought.*

The *dilapidation of thought* becomes more and more manifest as deterioration progresses,

As the disease progresses, the thinking becomes more and more disordered and sloppy,

leading finally in its expression to almost complete incoherence ... (W 217).

terminating later on in almost complete incoherence.

The ideas, the *content of thought,* show a *shallowness* indicating an intellectual enfeeblement (W 217).

The content of thought becomes increasingly shallow, all of which indicates progressive intellectual enfeeblement.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	It is characteristic that,
Aside from the fact that the fantastic, unusual, bizarre character of the delusions indicates the dilapidated groundwork on which they are founded,	aside from the bizarre nature of their delusions and associated fantastic reactions,
the patients make little or no effort to support their false beliefs ... (W 217).	these patients make little effort to support their delusional attitudes by argument.
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Schizophrenic Thinking and General Behaviour (Henderson & Gillespie 203)	
He hesitates between one feeling and the other, so that he may waver between strong like and dislike, between wanting and not wanting something—rejecting and accepting almost at the same time. This is the so-called "ambivalence" (H&G 206).	53:5.7 They are ambivalent—they like and dislike at the same time; they accept and reject an idea or feeling simultaneously.
The vagueness which is so obvious a characteristic of the concepts which the schizophrenic entertains, and of his thinking generally, has been likened to the assumed pre-logical nature of the thought of primitive peoples (H&G 204).	Thought processes are frequently similar to those of mythology, archaic and primitive.
Ideas of death and rebirth, such as are common in primeval myths and in religious writings,	Ideas of death and rebirth
are frequently found in schizophrenic patients, who tend moreover to ... give dramatic representations of them. For instance, the stupor of some katatonics seems to be a dramatisation of the idea of death,	may have their physical counterpart in stupor

and some states of ecstasy have as their corresponding mental content the idea of being born again (H&G 205).

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

Summary from the Viewpoint of Findings in the Mental and Physical Examination. (S&E 291)

2. *Stream of Activity and Talk.*

Incoherence, rambling, blocking, evasiveness, verbigeration,

neologisms, echolalia, exchopraxia, etc. Mutism, negativism, catatonia (S&E 291).

XI: DEMENTIA PRECOX. (White 210)

General Symptomatology.— ... The *memory* is usually defective,

especially for recent events, reminding us of the memory defect of senescence (W 218).

Knowledge acquired before the disease began, however, ... is often remembered with quite remarkable accuracy (W 218).

and ecstasy.

53:5.8 5. **The stream of activity,** the thinking and talking of these patients,

is characterized by incoherence, rambling, blocking, evasiveness, verbigeration,

negativism, mutism, neologism, and echolalia.

53:5.9 6. **Memory** becomes increasingly defective,

especially for recent happenings,

events of earlier years being fairly well remembered.

As the disorder progresses, there is more and more mental blocking—dissociation.

53:5.10 7. **Thought deprivation** is an ever-present symptom.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
The patients frequently complain that	These patients make frequent complaint that
	their thoughts are in flight;
their thoughts leave them suddenly when they try to explain themselves	that their thoughts leave them suddenly as they make an effort to answer a question;
	this form of characteristic blocking is
and we note in these cases, often in the midst of a conversation ... (W 219).	noted in the manner in which the patient will pause in the midst of making a statement or of answering a question.
	There seems to be a painful difficulty connected with the effort to resume the train of thought.
This *thought deprivation* we have learned from association work is the result of strong emotional content—the flow of thought being inhibited by the presence of strong emotion (W 219).	Undoubtedly this is accounted for by the existence in the subconscious of a strong emotional pressure
[?]	or in the consciousness of a very wide gulf of dissociation.
	53:5.11 8. **Disintegration of Personality.**—

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Schizophrenic Thinking and General Behaviour
(Henderson & Gillespie 203)

The peculiar qualities of schizophrenic thinking and behaviour generally are dependent principally on four conditions:

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
(1) the schizophrenic turns away from reality (introversion); (2) his thinking is dominated by complexes ... to an extent not seen in the normal; (3) he regresses to a childish or infantile or archaic ... mode of thought; and (4) his personally undergoes a progressive disintegration (H&G 203).	Disintegration is progressive.
	Regression to the infantile mode of thought sooner or later eventuates in these individuals who have fled from reality.
Fragments, so to speak, of the old personality remain with the corresponding conflicts and inhibitions (H&G 204).	Fragments of old personality remain, normal islands here and there.
Gradually the thought-content becomes more and more involved, so that a formal disorder comes, and incoherence, which may go to the extent of becoming a "word salad", is not uncommon (H&G 203).	This stage increasingly becomes punctuated with incoherent speech of the "word-salad" type.
The result of the mental disintegration is a widespread change in the patient's personality, which vividly impresses itself on his friends.	Ere long, disintegration proceeds to the point where
The patient loses his pride in his personal appearance,	the patient begins to lose pride in his personal appearance,
gradually becoming untidy and slovenly and needs constant attention (H&G 202).	and everything about him becomes slovenly and untidy.
	53:5.12 9. **Delusions and Hallucinations.**—
	As time passes, particularly in the paranoid trends, the patient becomes more and more subject to delusions,
Visual hallucinations, hallucinations of smell and taste, are also frequent,	hallucinations of smell and taste
but not so common as those of hearing.	as well as those of hearing.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
[1. Persecutory ideas, feeling of mistreatment, food tampered with, poisoned, "doped," etc. (Strecker & Ebaugh 291).]	They are being "doped," or their food is being poisoned.
[[T]he patient's attitude ... is one of increased sensitiveness and suspiciousness ... (H&G 202).]	Suspicion increases.
The striking feature about the delusional ideas is their changeable and transitory nature (H&G 202).	The characteristic feature of these delusional states is their changeableness and transitory nature.
VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)	
"Analysis of symptoms occurring in 200 cases of dementia praecox leading to prompt hospital admission." (S&E 292)	
Hallucinations: Were prominent in 130 cases, of these approximately 85% were in the auditory field,	In a study of 130 cases, hallucinations were found in 85 per cent in the auditory field,
12% in the visual field,	only 12 per cent in the visual field,
3% were hallucinations of smell, taste, and feeling.	while there are but 3 per cent of smell, taste, and feeling.
Ideas of Influence: Marked in 60 cases—	53:5.13 10. **Ideas of influence** are common.
	Such patients believe their thoughts are being read or stolen;
of these two-thirds were in the nature of hypnotic influence, the remainder being of a mechanical nature, X-ray machines, hypodermic injections, radio apparatus, electrical influence (S&E 292).	that they are being hypnotized;
[They take the form of a belief that the patient's thoughts are being read, or stolen from him, or that he is being influenced by wireless or by electrical machines.	that they are being influenced by wireless impulses sent out by distant power-generating machines;

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	and then, following delusions of persecution,
As a further development delusions of grandeur may arise (Henderson & Gillespie 203).]	there often occur compensatory reactions of delusions of grandeur.
	53:5.14 11. **Insight—Judgment.**—
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Symptomatology. (Henderson & Gillespie 201)	
	Sooner or later insight fails;
The judgment of these patients is, however, greatly interfered with,	judgment is early hampered
[[repeated from 53:5.11] (2) his thinking is dominated by complexes ... to an extent not seen in the normal ... (H&G 203).]	as the thinking seems largely dominated by the patient's fixed ideas or complexes.
and they have no proper appreciation of the serious nature of their illness (H&G 203).	They do not seem to appreciate the gravity of their illness.
VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)	
"Analysis of symptoms occurring in 200 cases of dementia praecox leading to prompt hospital admission." (S&E 292)	
	When schizophrenia once becomes established,
Insight: Totally lacking in 85% of these cases.	insight seems to be almost totally lacking in 85 per cent.
A prominent factor in the consideration of modifiability. (Prognosis.) (S&E 293)	Those cases in which more or less insight persists are to be regarded as more favorable from the standpoint of prognosis.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	The introversion, the flight from reality, is progressive in all these cases when the trends are once thoroughly established.
Paranoid Ideas:	53:5.15 12. **Paranoid Trends.**—
	It is interesting to note
Present in 118 cases, of which 34 were of religious type,	in the study of 118 cases of schizophrenia with paranoid trends, that 34 were of a religious type,
31 had ideas of being "doped," food poisoned,	31 had ideas of being "doped," food poisoned,
20 were actively homicidal	20 were acutely homosexual,
33 had poorly systematized delusions against various orders, Masons, Ku Klux Klan, etc.	while 33 had systematized delusions pertaining to various fraternal orders, such as the Masons and the Ku Klux Klan.
Paranoid delusions were marked in those who developed psychoses between the ages of 35 to 40 (S&E 292).	It seems that paranoid delusions are most marked in those cases which develop later in life, between thirty-five and forty.
Ideas of Reference: Prominent in 30 cases	53:5.16 13. **Ideas of reference** are common,
especially marked in early cases referred to Out-Patient Clinic and later admitted for hospital care (S&E 292).	but the majority appear among the younger group of patients or those recently afflicted.
Summary from the Viewpoint of Findings in the Mental and Physical Examination. (S&E 291)	
3. Mood and Special Preoccupation... (b) *Trend reactions, topical reactions projections*	
2. Ideas of Reference—feeling of being talked about,	They feel that they are being talked about.
people pass remarks that "refer," etc. (S&E 291).	People they meet pass remarks "referring" to them.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
"Analysis of symptoms occurring in 200 cases of dementia praecox leading to prompt hospital admission." (S&E 292)	
Bizarre Disorders Somatic Sensations: occurred in 43 of these cases.	53:5.17 14. **Somatic sensations** are common
These consisted in ideas of displacement,	and embrace ideas of displacement,
transposition of the organs,	transposition of viscera,
entrance of outside material,	presence of foreign materials within the body,
electric wires, snake in the stomach, etc.	snakes in the stomach, and so on.
These delusions were of special prominence in psychoses developed in later life (S&E 292-93).	These hypochondriacal tendencies appear among the group of patients who develop schizophrenia in later life.
	53:5.18 15. **Negativism.**—
II: CLASSIFICATION OF MENTAL DISEASES (Strecker & Ebaugh 21)	
CLASSIFICATION (Strecker & Ebaugh 23)	
15. **Dementia Praecox.** ... The following features are characteristic although, naturally, they do not occur in every case of dementia praecox....	
8. Odd, impulsive, negativistic conduct,	Many patients exhibit an odd and impulsive form of negativistic conduct,
usually without relation to emotional disturbance and often with a clear sensorium (S&E 29, 31).	often without relation to any observable disturbance and in the presence of a relatively clear sensorium.
	This negativism is often associated or alternated with
[contd] 9. Autistic thinking,	a type of autistic thinking,
dream-like ideas,	and this disorder tends to gravitate from the dreamlike ideation

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
feelings of being forced or of interference with the mind from the outside, physical and mythical influences, etc. (S&E 31).	to feelings of being forced or coerced from the outside against the sufferer's will,
	thoughts often of a disagreeable or erotic nature being forced upon the mind from the outside.
	53:5.19 16. **Physical Symptoms.**—
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Schizophrenic Thinking and General Behaviour (Henderson & Gillespie 203)	
Physical.—Numerous investigations have been made of the physical condition in schizophrenic patients. Few of these researches have yielded any suggestive results (H&G 207).	The majority of the surveys of the physical phase of schizophrenia have been negative.
Schizophrenics are commonly poorly nourished, ill-thriven people.	Many times these patients are poorly nourished,
During the period of their illness they often lose a great deal of weight, and their general physical condition is not up to the average level (H&G 207).	the more depressed often losing considerable weight during the earlier phases of the disorder.
[L]ewis ... has remarked on the lack of development, particularly of the circulatory system, the low blood-pressure and the well-marked vasculatory disorders, which one sees so commonly in the type of case (H&G 207).	There does seem to be a deficiency in the cardiovascular apparatus in many of these cases, accompanied by lowered blood pressure
	and deficient vasomotor tone.
There is ... a fairly general agreement that the basal metabolic rate tends towards the lower limits of the normal (H&G 208).	The vast majority show a subnormal metabolism,
	particularly those belonging to the catatonic category.

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

Physical Summary. (Nothing specific.) (S&E 293)

2. General vasomotor symptoms, disturbance of the sympathetic apparatus,

53:5.20 These people seem to have more or less disturbance of the vegetative nervous mechanism,

localized sweating, edema, dilated pupils, increase in salivation, etc.

as illustrated by sweating, edema, dilatation of the pupils.

Langfeldt finds that catatonic patients showed signs of vagatonia while hebephrenics gave sympathicotonic signs (S&E 293).

Langfeldt contends that catatonic patients are vagotonic, while hebephrenics exhibit signs of sympathicotonia.

6. Neurologically the patients show nothing pathognomonic (S&E 294).

53:5.21 The neurologic

7. Laboratory findings including urine, blood chemistry, complete spinal fluid examination, etc., usually negative ... (S&E 294).

and laboratory investigations of these patients are in the main negative.

VI: SCHIZOPHRENIC PSYCHOSES (Henry 65)

Course of illness. (H 68)

53:5.22 17. **Course of Illness.**—

The course of a schizophrenia depends much on the time and nature of the onset;

Paranoid forms tend toward slowly increasing mental disintegration.

the *paranoid* forms tend toward slowly increasing mental disintegration.

In the hebephrenic form the deterioration is usually more rapid and profound.

The *hebephrenic* type presents a more rapid and malignant deterioration.

Catatonic stupors and excitements may alternate or persist for months or years without marked change.

Catatonic stupors and alternate periods of excitement may persist over long periods without producing marked intellectual changes.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Ultimately there is more or less mental deterioration.	Even in these cases there eventually appears more or less mental deterioration,
	with disintegration of personality.
In some schizophrenic psychoses the dementia may reach such a level that the individuals are described as living a merely vegetative existence,	Sometimes the deterioration quickly reaches such a level that the patient maintains a purely animal, even vegetative, existence.
i.e., one devoid of the essential characteristics of a human being or even of an intelligent animal.	
On the other hand the deterioration in many cases is so slight that it is possible for the patient to live at home	In still other cases these changes are so slow that patients live at home for years
and be engaged in a comparatively simple occupation (H 68).	and are often able to engage in comparatively self-supporting activities.
	53:5.23 18. **The symptomatology** develops in accordance with different types and the individual trend of the patient. One seeks to escape reality by wrecking himself—suicide; another, by wrecking the situation, as in the cases of the less intellectual female victims of the disorder who resort to prostitution. Others make a complete and rapid escape into the psychoses. A few cases, those receiving early help, make an adjustment and experience a more or less complete cure by learning to face reality.
[!]	
[!]	

XI: DEMENTIA PRECOX. (White 210)

I. SIMPLE DEMENTIA (HEBOIDOPHRENIA). (White 223)

[contd] In accordance with the conception of dementia precox outlined above, which regards it as primarily a deterioration upon which various psychotic symptoms may be engrafted, this variety would constitute the typical, fundamental form of the disease, showing the development of the deterioration per se,

with few if any of the extraneous symptoms found in abundance in some other forms (W 223).

[?]

[In this type there is an absence of any definite trend (Henderson & Gillespie 208).]

[?]

[contd] The origin of this variety is insidious,

and it may be quite impossible to fix its date,

largely because at first the beginning symptoms were not appreciated at their true value.

I. Simple Schizophrenia—Heboidophrenia

53:6.1 Very likely this type of dementia praecox represents the basic form of primary constitutive deterioration with which various psychotic symptoms become associated,

subsequently to present the clinical picture of the various schizophrenic groupings.

The diagnostic character of this phase of the disorder is the *absence of any definite trend.*

Of all forms of schizophrenia, the etiology of this one is the most obscure

and its onset the most insidious.

As a rule it is impossible to fix the date of its beginning

because the atypical early symptoms are not indicative of the grave disorder which later appears.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
The young boy, or girl, as the case may be, quite commonly was, previous to the onset of symptoms, getting on nicely in school,	53:6.2 Most often in this type the boy or girl is doing well at school,
perhaps unusually well, was quite a favorite with the other pupils,	sometimes being a favored pupil,
took an active interest in school life,	
and was going on with the young people of the neighborhood,	is getting along satisfactorily with young people in the community,
being in every way considered a bright and normal child.	in fact, is perhaps brilliant, above the average;
The fire may have burned brightly but it was built of straw (W 223).	but the brilliant cycle is destined to be short-lived.
[contd] At first the patient begins to show a lack of interest in things,	53:6.3 *The first indication of trouble* is usually a rather sudden lack of interest,
	especially in school work.
ceases going out and associates less and less with other children.	These youths begin to associate less with those of their own age,
[[S]uch individuals seem to lack ambition (Henderson & Gillespie 208).]	and there is a definite lack of ambition.
There is a general listless, apparently lazy	They become listless, apparently lazy,
and tired-out attitude towards life assumed,	and complain of *constant fatigue.*
lessons are neglected and not learned,	They resent studying,
	dislike going to school,
and in school the patient shows a failing ability to assimilate new facts—to acquire knowledge (H 223).	and teachers report an increasing inability to acquire knowledge.
[The memory is well retained, and the chief feature is the extreme apathy or emotional dulling (Henderson & Gillespie 209).]	There is definite intellectual dulling, associated with increasing emotional apathy.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
[contd] This state of affairs is associated with insomnia	53:6.4 Very often at about this time insomnia puts in its appearance,
and often headache, sometimes with hysteriform attacks,	frequently associated with headaches, sometimes with hysteroform attacks.
and not infrequently is mistaken for neurasthenia,	These patients are often early diagnosed as neurotic or hysteric.
or, if the patient is quite inactive,	When indifference and apathy are more marked,
this inactivity is taken to be an expression of the depression of melancholia (W 223).	the case is sometimes mistakenly regarded as a type of melancholia.
	53:6.5 *As the disorder progresses,*
[contd] Transitory delusions may occur, which are fully expressed,	transitory delusions,
and fleeting hallucinations may at times occupy the field.	together with flitting hallucinations, are not uncommon,
[?]	but the latter are rare.
These manifestations are usually disagreeable, voices are heard saying disagreeable or insulting things,	The delusions usually take the form of voices which are "heard" making disagreeable, offensive, and insulting remarks,
visions of the devil occur and the like (W 223).	while grotesque visions and dreams may put in an appearance at about this time.
[Even from his own family he becomes estranged (Henderson & Gillespie 209).]	There is a tendency more and more to become estranged from the family,
	to retire within a dream world of the inner life.
[contd] Not infrequently these patients show themselves to be quite irritable,	53:6.6 Many of these patients early show *great moodiness* and irritability,
and partly as a result there may occur transitory excitements.	and since they are sensitive and touchy, they often experience brief periods of emotional excitement

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	and marked resentment of something in their environment.
If, in addition, peculiarities of conduct and strange habits develop, the desire to be alone,	Increasingly they develop the desire to be alone,
some mannerism,	acquire bizarre mannerisms,
or slight evidences of muscular tension and the simpler manifestations of negativism,	and often exhibit slight tendencies toward negativism.
the close relation between these and the more frequent and more fully developed varieties is shown (W 223-24).	
	In the early stages
He goes from one position to another unable to fulfill even the simpler duties because of his lack of continuity and interest (W 224).	they frequently change jobs and gradually gravitate toward subordinate positions.
[contd from two rows up] It is in this group that	53:6.7 This type of schizophrenia,
	more than the others,
we find the mild and abortive forms that being arrested give one the impression that the peculiarities of the individual are inherent character anomalies.	impresses an observer with the thought that the peculiarities of the disease seem to be inherent, constitutive.
Not a few criminals, hoboes, prostitutes, pseudo-geniuses, cranks, and eccentrics	There is no doubt that many vagrants, criminals, hoboes, prostitutes, cranks, agitators, and eccentrics, odd geniuses of the present and past,
if their history could be accurately traced would show an episode of distinct precox coloring which separated a period of relative efficiency in their lives from a following period of relative inefficiency (W 224).	belong in the category of these mild types of schizophrenia.

The fact that many such individuals, when observed later, gravitate into definite schizophrenic involvement, lends proof to this belief.

II. Catatonia

III. CATATONIA. (White 228)

[contd] Like other forms of dementia precox which have been described this form is usually a subacute or chronic onset,

53:7.1 Catatonia very often begins as a subacute or chronic malady

being preceded by symptoms of insomnia, confusion, headache, loss of appetite, emaciation and the like.

and is not infrequently preceded by insomnia, headache, confusion, loss of appetite, and loss of weight.

[See 53:9.1, below.]

In many ways the onset is not different from that of hebephrenia;

The disease, on the contrary, is sometimes of sudden onset,

but the condition is more likely, in exceptional cases, to make its appearance suddenly,

in which case it is apt to be the result of a suddenly depleting cause like the loss of blood or some severe emotional shock or fright.

as when it follows infection or some emotional shock.

In these cases the patient may become at once profoundly stuporous (W 228).

Occasionally the onset is characterized by a profound stupor.

[contd] The initial stages are usually marked by a mild grade of depression, as in other forms, giving the appearance of melancholia.

Many times the initial stages are accompanied by mild depression,

Hysterical attacks and in some cases epileptiform convulsions may occur during this period (W 228-29).

although hysterical attacks and sometimes epileptiform convulsions appear at the very start in the more acutely developing group.

[contd] Following the more or less vague symptoms of the prodromal period

53:7.2 After a longer or shorter period of these more or less vague preliminary symptoms,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
occur the typical symptoms of the disease which group themselves into two stages which irregularly alternate, viz. *catatonic stupor* and *catatonic excitement* (W 229).	the clinical picture begins to take shape as an irregular alternation between *catatonic stupor* and *catatonic excitement.*
[contd] In *catatonic stupor* the principal symptoms are *stupor, negativism* and *muscular tension.*	In the stuporous stage, the characteristic symptoms are negativism and muscular tension.
In the extreme cases the patient lies perfectly still, without making any movement whatever and not reacting at all to stimuli.	In more marked involvement, the patients will lie perfectly still, making no muscle movements and reacting to no stimuli.
No attention whatever is paid to questions, absolute *mutism* being the rule,	They often become mute, refusing to answer any question.
while sensory stimuli of very considerable strength may be applied without eliciting any response (W 229).	
[contd] The mutism is one of the manifestations of *negativism* which usually shows itself in various ways.	This mutism is merely a phase of the *negativism* of this type of the disorder,
The patient not only refuses to eat,	which may proceed, not only to the place where the patient refuses food,
but pays no attention to the calls of nature,	but also to the point where no attention is paid to the calls of nature.
permitting the bladder and rectum to become overloaded with urine and fœcal matter, often to a serious extent;	Bladder and rectum often become overloaded,
he likewise allows the saliva to collect in his mouth for hours at a time until putrefactive changes have occurred,	and such patients not infrequently allow saliva to collect in the mouth for such a length of time that it becomes highly putrefactive.
and then only perhaps as a result of insistence by the nurse belches forth this mass of stinking fluid.	

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Any effort to get the patient to do anything is immediately met by a response diametrically opposed to the desired act (W 229).	Any and all efforts of nurse or physician to get the patient to do anything are met by an immediate negative response.
Attempts to move the body are met by marked resistance and elicit the condition of *muscular tension.*	53:7.3 If an attempt is made to move these patients, they respond immediately with their *characteristic muscular tension,*
The limbs are quite rigid, often stretched out stiffly, the fist perhaps tightly clenched, or, again, the extremities of the body as a whole, perhaps may rigidly occupy some peculiar position.	stiffening the limbs, clinching the fists,
This muscular tension is often shown in *grimaces,*	and often indulging in grimaces
certain facial muscles continuing in contraction and giving strange and peculiar expressions to the countenance.	and other facial contortions as a part of this generalized muscular reaction.
Thus we find that the patient maintains a constant expression of scowling,	They are wont to maintain a scowling facial expression,
or keeps the eyes tightly closed,	keeping the eyes tightly closed,
the cheeks puffed out, or perhaps the lips closed and protruded, producing the condition called by the Germans "Schnauzkrampf" (W 229-30).	sometimes with puffing-out of the cheeks.
In *malignant stupor* reactions there are, in addition to the fundamental stupor, ... indication of fantastic thoughts, displacement of affect, anomalous symptoms such as inexplicable giggling and outbursts of rage ... (W 231).	53:7.4 In *malignant stupor* all these symptoms are aggravated,
[?]	except that the excitement-state intervals are curtailed,
	and the patient sometimes becomes so melancholic,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
[Then a state of dull stupor develops... the whole aspect being that of a mummy (Henderson & Gillespie 217).]	acquires such a vacant expression, as to assume a *mummy appearance.*
	53:7.5 During the major part of the time
The condition of the catatonic stupor alternates with *catatonic excitement* (W 231).	the catatonic stupor tends to alternate with catatonic excitement,
[*Note:* Sadler seems to be confusing the agitation of a malignant stupor with catatonic excitement.]	associated with causeless laughter
[?]	and a flighty attitude toward the environment, together with an ever-present urge to go somewhere or do something.
The noisy incoherent talk of these cases might readily be thought to indicate flight of ideas	53:7.6 The *incoherence* and rapid, thoughtless speech of these patients often suggest a flight of ideas,
but the incoherence is much greater than that found with an equal grade of agitation in manic-depressive psychosis,	but the incoherence is much more marked than that observed in the agitation of the manic-depressive disorders,
and there is no trace of a guiding thought in the form of a goal idea.	and there is no absence of any main stream of thought—idea goal.
The patient, too does not show distractibility to the same extent, being, on the contrary, quite inaccessible,	*These patients are quite inaccessible,* are not easily distractible,
paying no attention whatever to what is being said or done by others,	pay little attention to what is going on around them,
not even making any pretense to answer questions, though often repeated (W 232).	and show little inclination to answer questions.
[contd] This illustration shows well the *perseveration* in the field of speech.	The tendency toward perseveration in speech is shown by the manner in which
A single motor impulse gets the field and holds it; the same word or phrase is repeated over and over again.	they will grasp a single word and continue to repeat it over and over.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
A quite similar disturbance is seen in the various types of *sterotypy* (W 232).	In other forms of the disorder there is also a tendency to develop this sort of stereotypy.
Quite characteristic of this condition, too, are the *impulsive acts* of these patients.	53:7.7 Every now and then these patients exhibit marked tendencies toward *impulsive acts.*
They will suddenly and with absolutely no warning whatever	Suddenly, without warning and without provocation,
commit some act of violence, such as assaulting another patient or breaking out a window, and quite as suddenly lapse into their previous state.	they will seize some small object and throw it through the window or at someone in the room.
[During this stage he may not only be homicidal, but impulsively suicidal (Henderson & Gillespie 218).]	They are very definitely *homicidal and suicidal at times.*
It is quite impossible to get any adequate information as to the cause for their acts.	I have never been able to arrive at any satisfactory explanation for these sudden, impulsive acts.
The patient is inaccessible to a degree and either gives some senseless reply to the questions asked,	To all questions regarding such conduct they give you only that stereotyped response,
a puerile reason, perhaps, or retires behind an "I don't know" or complete silence.	"I don't know," or greet your question with complete silence.
These attacks come out of the clear sky, cannot be foreseen, and make these patients at times very dangerous (W 233).	
Physical Symptoms. (W 234)	
	53:7.8 *During prolonged catatonic seizure*
Slight differences in the size of the pupils are common.	there is often a difference in the size of the pupils.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Pupillary unrest (hippus) is sometimes observed;	Pupillary unrest, "hippus," is occasionally observed,
quite frequently a marked degree of mydriasis is present, while the phenomenon of Piltz is sometimes found.	and not infrequently there is a considerable degree of midriasis.
The tendon reflexes are usually exaggerated.	The tendon reflexes are usually increased,
The cutaneous sensibility is lowered.	while cutaneous sensibility of all forms is decreased.
Vasomotor disturbances are often seen,	There is marked vasomotor instability;
giving rise to cold, cynosed extremities in the stuporous cases.	the extremities may become very cold, even cyanosed in cases of stupor.
With this condition may be associated dermographia.	Dermographia is often present.
The secretions are disturbed,	There is marked fluctuation in many secretory activities,
the sweat and saliva may be increased, the urine scanty or increased,	such as sweating, salivary action, urination.
and constipation may prevail (W 234).	Constipation is nearly always present.
VI: SCHIZOPHRENIC PSYCHOSES (Henry 65)	
CATATONIC TYPE (Henry 66)	
[contd] This form is manifested by peculiarities of psychomotor functions (H 66).	53:7.9 Catatonia represents the schizophrenic process functioning at the psychomotor level
	and is especially characterized by disconnections of conduct.
[The excited phase] consists of impulsive, odd, stereotyped behavior which is sometimes associated with vivid hallucinations (H 67).	Hallucinations are often marked and vivid.

Negativism, fixed attitudes, and stereotyped movements are especially in evidence. The motor symptoms of catatonia and catalepsy predominate. There is often observed an alternating state of excitement and stupor. There is a characteristic *disconnection* in intellection, exhibited in irrelevant speech; in emotional control, shown by giggling and impulsive acts; in conduct, as manifested in catatonia—even catalepsy.

III. Paranoid Forms

IV. PARANOID FORMS. (White 234)

[contd] There has been a great deal of discussion as to just what cases should be properly included under this heading (W 234).

53:8.1 It is sometimes difficult to know just what, or how many, forms of the paranoid tendencies should be included in the category of schizophrenia.

When the patient presents all the classical symptoms of dementia praecox involvement, and when the paranoid trend is present, the case should be included in this classification. While paranoid trends may appear as a part of the clinical picture of other forms of psychosis, and while paranoia can and does exist as a separate and uncomplicated psychic state, nevertheless, the majority of cases of paranoid tendency met with, at least in most institutional practice, belong to the schizophrenia group;

and I believe this to be the more practical and helpful attitude to assume toward paranoia,

In the last edition of his Psychiatry KRAEPELIN, however, has ... removed the group of dementia paranoides as well as all other cases which show a disturbance preponderantly in the intellectual field

notwithstanding Kraepelin's later move to regroup certain types of paranoid tendency which show a preponderance of involvement in the intellectual field,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
and fail to show the affection of the will and affect	but which fail to show marked involvement of will and the emotions,
with the serious dilapidation of the personality characteristic of precox,	although they exhibit serious dilapidation of personality (all of which symptoms are so characteristic of schizophrenia),
to a new group which he designates paraphrenia.	into a new group which he designates paraphrenia
This group he splits up into four divisions ... (W 235).	and then proceeds to subdivide into four main divisions.
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Paranoid States (Henderson & Gillespie 221)	
[contd] The paranoid types tend to develop at a later period of life than the other forms.	53:8.2 The *paranoid types of dementia praecox* tend to develop in later periods of life than do the other forms.
The patients affected are usually between 30 to 35 years old.	The patients so afflicted usually manifest the disorder in the decade from thirty to forty.
The delusions which are expressed are multiple,	The delusions, when they first make their appearance, are generally multiple,
unsystematised, changeable, usually of the most fantastic and illogical nature	unsystematic, changeable, and are often most fantastic and utterly illogical,
and accompanied by hallucinations.	and not infrequently are soon accompanied by hallucinations.
These ideas may be of any type; they may be persecutory, depressive,	The more typical form of delusions may be described as persecutory and depressive,
or grandiose, and will be illustrated by the case records (H&G 221).	but presently there is likely to appear a compensatory reaction of grandiose delusions and hallucinations.
[contd] This type of schizophrenia runs very much the same course as the other varieties,	53:8.3 Paranoid schizophrenia in its clinical course follows very much the general trends of the other forms,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
and ends usually in a state of dementia,	usually ending in a state of dementia
characterised by	which is characterized by
	the intellectual, emotional, and personality symptoms already noted, in association with
mannerisms, stereotypes, incoherence and a total lack of interest (H&G 221).	characteristic mannerisms, stereotypy, lack of interest,
	and progressive disintegration of personality.
	53:8.4 Projection is the essential mechanism of these paranoid states, an interpretation of other people's actions in the light of the patient's own personal motives. Ideas of reference are prominent. These patients indulge in all sorts of bizarre fabrications—believing themselves the victims of vast persecutory conspiracies. There is marked incongruity between their delusional systems and their adaptation to actual environment. They often describe their troubles with a smile.
	IV. Hebephrenia.
XI: DEMENTIA PRECOX. (White 210)	
II. HEBREPHRENIA. (White 224)	
[contd] This form of dementia precox is usually of more abrupt onset than the last [*i.e.* simple dementia],	53:9.1 The hebephrenic form of dementia praecox usually makes its appearance more abruptly than the simple or apathetic type,
although here we may also find that the prodromal period extends over several months,	although, even in this case, the prodromal stage,
during which time the patient suffers from insomnia, headache, anorexia, and perhaps some loss of flesh (W 224).	which yields no more marked clinical symptoms than headache, insomnia, anorexia, and slight emaciation,

may extend over many months or even years.

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Hebephrenia (Henderson & Gillespie 210)

The people who develop a hebephrenic disorder have in their earlier days shown an unstable emotional condition;

However, many of these cases early in life afford a definite history of fantasy tendencies, alternating moods,

they may give a history of tantrums, and have often been of the over-pious, ultra-conscientious type, apt to be idealistic, and to brood on obscure topics. Their acquaintances generally have looked upon them as queer (H&G 210).

while others are merely queer, perhaps overpious and sometimes highly idealistic.

XI: DEMENTIA PRECOX. (White 210)

II. HEBREPHRENIA. (White 224)

[contd from four rows up] The symptoms of the onset of the attack

53:9.2 This form,

in common with others,

are quite generally confusion and symptoms of depression

often begins definitely to manifest itself by states of *intellectual confusion* and symptoms of *emotional depression.*

which have an outward semblance to the symptoms of a depression (W 210).

[This type is very difficult to differentiate, because often in it there are some symptoms pointing more to a katatonic and others to a paranoid reaction (Henderson & Gillespie 210).]

Sometimes mild catatonic tendencies early appear.

However confusing the initial manifestations may be,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
The characteristic retardation of manic-depressive psychosis is, however, absent,	the very characteristic retardation of the manic-depressive psychosis is absent,
and hallucinations and delusions occupy a much more prominent place in this picture.	while delusions and even hallucinations, as a rule, are much more manifest.
The hallucinations are numerous and involve more especially the auditory and visual fields.	The *hallucinations* of this type are more concerned with auditory and visual involvement,
Both hallucinations and delusions are disagreeable.	and both are usually of a disagreeable and tormenting nature.
[Kraepelin particularly remarks on the changeable, fantastic, bizarre nature of their delusions ... (Henderson & Gillespie 211).]	It is characteristic of this phase of dementia praecox that the delusions are changeable and fantastic.
Voices are heard calling vile names	These patients hear voices calling them violent names,
	pouring filth into their minds,
and accusing the patient of immoral practices;	and accusing them of manifold immoral practices.
delusions are	The *delusions* are
	usually gloomy
self-accusatory and in harmony with the depression,	and, as a rule, self-accusatory.
	During the initial phase
the patients thinks he is lost for having masturbated	many of these people brood inordinately over the dire results of masturbation
and the like.	and other minor infractions of the social code in early life.
[The hebephrenic patient often suffers greatly from ideas of reference ... (Henderson & Gillespie 211).]	They suffer from many ideas of reference

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
In this condition violent attempts at suicide are not infrequent	and in the earlier stages manifest *marked suicidal tendencies,*
and only go to add force to the diagnosis of melancholia so often made at this stage of the disease (W 224-25).	which explains why this condition is so frequently confused with melancholia when it appears later in life.
[contd] After the active symptoms of the first stages are passed the underlying and fundamental defect becomes more apparent.	53:9.3 With the passing of the acute or onset stage,
The hallucinations are fleeting,	the hallucinations continue as a flitting phenomenon,
the delusions not firmly fixed but changeable and fantastic or silly in content,	and the delusions still shift about, not firmly fixed but continuing to be altogether fantastic and silly.
though often with a paranoid tinge;	Though very early a paranoid trend may appear,
thus one patient believes the sheets stick to his feet, another that this is the "wandering planet."	
These delusions are not supported by reason or logic ...	these patients strangely make no effort to support their delusions by either reason or logic;
and existing much as do foreign bodies in various anatomical locations (W 225).	they seem to be present in the mind more or less as a foreign object.
The emotional deterioration is prominently in evidence.	53:9.4 The *emotional deterioration* is definitely present in the early stages.
One patient says enemies are following him,	It is not uncommon for these patients to insist, not only that they are followed by enemies,
and that he has been killed a number of times; another that the other patients are trying to injure him.	but also that they have already been killed a number of times.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
These facts are told with no show of emotion, in a decidedly matter of fact way (W 226).	They tell the most terrible things with no show whatever of emotion.
These patients, like the cases of heboidophrenia, often exhibit peculiar habits and mannerisms—	This type, like the victims of simple dementia praecox, tend to acquire *bizarre habits* and *peculiar mannerisms.*
a tendency to repeat certain phrases,	They often form the habit of repeating certain phrases.
suggestibility,	They are highly suggestible.
unusual attitudes,	They drift into queer and inexplicable attitudes—
or a certain muscular tension,	muscular tension—
shown by angularity, clumsiness, and restraint in their movements.	and are clumsy in their movements.
Among these symptoms is often noted a silly laugh which is frequently developed while the patient is talking to himself,	A characteristic symptom is a silly laugh, which often appears when the patient is talking to himself,
but which may occur at any time with absolutely no apparent cause.	but which may break out spontaneously without any apparent causation.
If the patient is asked for an explanation of why he laughed he will reply in a characteristic manner, "I don't know,"	If asked why he laughs in this peculiar way, the patient will answer, "I don't know,"
or else give some shallow, wholly inadequate, or manifestly false reason (W 227).	or he will volunteer some wholly irrelevant and unsatisfactory explanation.
	As the disease advances, the tendency to incoherence is greatly increased.
In conduct these patients usually exhibit a condition of listlessness, apathy and disinterestedness	53:9.5 As one observes these patients, one detects apathy, listlessness, lack of interest,
with little tendency to activity or to emotional expression.	and disinclination to engage in any physical activity or to indulge any emotional expression,

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	though it is true that
Alternating conditions of depression and excitement may and often occur	some cases are marked by certain tendencies toward alternation between depression and excitation.
and occasionally the disease is ushered in by an excitement which may lead to a diagnosis of mania,	In fact, in many cases of this type the onset is characterized by a mild excitation which could be easily mistaken for a manic tendency.
as the opposite onset we have seen may lead to a diagnosis of melancholia (W 227).	
	53:9.6 Hebephrenia represents the schizophrenic process operating at the emotional level
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Hebrephrenia (Henderson & Gillespie 210)	
This type is very difficult to differentiate,	and is a form sometimes very difficult to differentiate,
[The most prominent symptoms are the incoherence in the train of thought, the strange, impulsive, senseless conduct and the vivid hallucinations (H&G 211).]	being characterized by marked incoherence of thought, strange and inexplicable conduct, bizarre delusions, and vivid hallucinations.
because often in it there are some symptoms pointing more to a katatonic and others to a paranoid reaction.	The symptoms are often very similar to those of catatonia and the paranoid form of schizophrenia,
Hebrephrenia, however, seems to occur at an earlier age than either the katatonic or the paranoid varieties ... (H&G 210).	but they usually occur at an earlier age.

V. Mixed Forms

V. MIXED FORMS (White 237)

53:10.1 It is not always easy to determine that a given case of schizophrenia falls into one or another of the four principal forms described.

[contd] As previously mentioned the several forms described are not always clean-cut.

We are constantly meeting with mixed types in which the clinical picture is not clear-cut.

The simple, hebephrenic and paranoid often present symptoms that are more characteristically developed in the catatonic.

For instance, catatonic symptoms may appear in any of the four forms.

When one sees a large number of these cases,

These mixed forms are in reality very common indeed and in fact almost constitute the rule (W 237).

at least half of them will be difficult to place in either the simple, catatonic, paranoid, or hebephrenic categories.

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Varieties. (Henderson & Gillespie 201)

Nevertheless I believe we should withstand the tendency of

In the last edition of his text-book [Kraepelin] has added numerous other forms, *e.g.* simple depressive dementia præcox, delusional dementia præcox, circular dementia præcox, agitated dementia præcox, and so on. No useful purpose is served by forming so many subgroups (H&G 201).

our European colleagues to create such a vast and bewildering grouping as to render the clinical classification of a given case increasingly difficult.

It seems preferable, therefore,

Far better that

to use the term schizophrenia instead of dementia præcox, and to recognise only four main subdivisions—

the simple, hebephrenic, katatonic and paranoid forms (H&G 201).

we continue to regard the majority as belonging to one of the four categories now in general use,

and that we recognize the others as falling into the mixed groups, at various times showing definite trends toward one of the four well-recognized types.

VI. Diagnosis and Prognosis

XI: DEMENTIA PRECOX. (White 210)

Diagnosis.—The diagnosis of dementia precox, while comparatively easy in the well defined and advanced cases,

becomes a matter of great difficulty in certain instances (W 238).

53:11.1 There is little difficulty in making the diagnosis of the more typical and well-advanced cases of schizophrenia,

but in the earlier manifestations of this disorder the diagnosis is sometimes exceedingly puzzling.

[contd] Certain forms of manic-depressive psychosis present characteristic difficulties, particularly the mixed forms.

Here it is often necessary to find a history of repeated attacks with deterioration in order to feel sure that it is not dementia precox.

53:11.2 1. *Diagnostic confusion* occurs in certain forms of manic-depressive involvement of the mixed type.

In these cases the most helpful factor is the history of repeated attacks without deterioration.

This points definitely toward the manic-depressive condition.

The depression, which so frequently occurs as an early symptom in precox, may be readily mistaken for the depression of the manic-depressive psychosis,

It is very easy to mistake the depression which sometimes occurs in the early stages of dementia praecox for the initial depression of manic-depressive disorders.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
	It is a fact that
the retardation of this psychosis	the retardation of psychic and emotional processes in manic depressive psychosis
being very similar in its outward manifestations to the negativism,	sometimes very much resembles the negativism
the antagonism, the inaccessibility and particularly the lack of interest of the precox patient.	and accompanying inaccessibility associated with schizophrenia.
If there are delusions, however, the manic-depressive is more apt to have delusions of a self-accusatory type,	53:11.3 2. In *delusions,* manic-depressive patients frequently suffer from those of self-accusation,
while the precox type is more likely to have delusions of a grotesque character, and to refer the origin of his delusions to causes outside of himself.	while in schizophrenia the delusions are likely to be of a grotesque nature, more or less bizarre.
The pressure of activity of the manic-depressive has outward similarities to the excitement of the catatonic.	The overactivity of the exaltation phase of manic-depressive disorders in many ways resembles the excitation stage of catatonia.
In the former, however, the activity, although rapidly changing in its object, characteristically is addressed to some particular purpose,	However, in the former the rapidly changing forms of activity are usually focused upon something definite,
while with the catatonic the activity is more diffuse and has less direction.	while in catatonia they are diffuse
It is incoherent (W 238-39).	and accompanied by marked incoherence.
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Diagnosis.— ... Superficially, the apathy, listlessness and even stupor which occurs in schizophrenic cases are apt to be confounded with a state of depression. One or two questions are sufficient to elicit the fact that	

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
the schizophrenic does not have any subjective feeling of sadness, but, on the other hand, often feels happy and contented, and prefers to be left alone (H&G 230).	53:11.4 Dementia praecox patients are very *deficient in subjective feelings.*
	There is great discrepancy between the thinking of the patient and his apparent sadness.
The excitement of the schizophrenic is ...	Again, in dementia praecox, even during periods of excitement,
usually characterised by a blind impulsiveness ... Furthermore, the talkativeness which accompanies this excitement is merely a series of words and phrases which are repeated over and over again (verbigeration). In effect, there is a poverty of ideas as compared with the free production of the manic (H&G 230).	there is impoverishment of ideas,
	these patients sometimes indulging in just a flow of words—*verbigeration.*
VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)	
TABLE IV.—MAIN DIFFERENTIAL DIAGNOSIS OF DEMENTIA PRAECOX AND MANIC-DEPRESSIVE PSYCHOSES (S&E 338)	53:11.5 MAIN DIFFERENTIAL DIAGNOSIS OF DEMENTIA PRAECOX AND MANIC-DEPRESSIVE PSYCHOSES (AFTER STRECKER AND EBAUGH)* [*Strecker, E. A., and Ebaugh, F. G.: Clinical Psychiatry, P. Blakiston's Son & Co., Philadelphia, 1931.]
XI: DEMENTIA PRECOX. (White 210)	
Diagnosis.— ... In the early stages the mild depression of the precox may simulate that of the neurasthenic,	53:11.6 The early states of a mild praecox depression may have much in common with the onset of neurasthenia,
or the agitated depression may simulate that of the anxiety neurosis.	whereas the agitated type of depression many times simulates an anxiety neurosis.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
In both instances the precox is more apt to show grotesque delusions	In both cases, however, the schizophrenic exhibits delusions of a more grotesque nature.
and conduct disorders of a bizarre nature, such as tearing up his clothes, mutilating himself,	His entire conduct is thoroughly bizarre,
or, on the other hand, characteristic negative symptoms,	and in the advanced and typical cases, praecox patients show characteristic negativity,
such as retaining the saliva or the urine,	accompanied by such symptoms as retention of saliva and urine
withdrawing from all efforts to do for himself, refusing to coöperate in changing his clothing, the refusal of food and the like (W 239-40).	and refusal of food.
From paresis the differentiation can usually be made by	53:11.7 When in doubt as to the differential diagnosis of schizophrenia and *paresis,* the question can usually be settled by
the Wassermann reaction of the blood serum and the cerebrospinal fluid,	a Wassermann test of either the blood or the cerebrospinal fluid,
for both of which it will be positive in paresis, and by an examination of the cell content of the cerebrospinal fluid which will show an increased cell content ... (W 240).	the latter, in paresis, showing an increased cell content.
Oftentimes the question of diagnosis will arise as between an acquired defect due to precox and some form of inherent defectiveness.	53:11.8 Sometimes it is difficult to distinguish between some acquired schizophrenic defect and other forms of inherent defectiveness.
It must be remembered in this connection that precox may develop upon a defective basis,	Allowance must always be made for the fact that a praecox may appear in an otherwise inherently defective individual,
and that in such case the history will characteristically show the symptoms of this defectiveness,	but the history should clear this up by disclosing

such as poor progress in school, and inability to learn in the various occupations in which the patient has been engaged (W 241).

a poor record at school and inability to carry on in ordinary social situations

prior to the appearance of the more definite schizophrenic manifestations.

Nature of Dementia Precox.— ... Another and perhaps more fundamental difference is that

53:11.9 A point of value in differential diagnosis is the observation that

in dementia precox there is a very great restriction in the capacity of the patient to be interested in objects other than himself.

praecox patients are quite unable to interest themselves in anything outside their own personal situations.

Dementia precox is the type of *regression psychosis.*

Schizophrenia is essentially a *regression type* of psychosis.

In hysteria on the other hand

In the bizarre manifestations of hysteria

there is great ability to be interested outside of self,

the patient is abundantly able to take an interest in things outside of himself,

so much so indeed that hysteria is referred to as the type of *transference neurosis* (W 250).

the tendency in this direction being so marked that some authorities refer to hysteria as a "transference neurosis."

II, I: THE PSYCHOSES (Ewen 33)

Prognosis of Schizophrenia. (Ewen 50)

Mauz (1931) distinguishes between the true schizophrenic process and situation psychoses simulating schizophrenia (E 51).

53:11.10 Mauz attempts to distinguish between true schizophrenia and certain situational psychoses which may simulate schizophrenic manifestations.

Varieties of Schizophrenia. (Ewen 43)

Differential Diagnosis of Schizophrenic Paranoid Series. (E 48)

A. Organic Mental Disorder. (E 48)

3. Epidemic Encephalitis. Febrile onset.

53:11.11 Epidemic encephalitis is characterized by a febrile onset,

Diplopia, ocular palsies. Parkinsonism (E 49).

diplopia, ocular palsies, and Parkinsonism.

[contd] 4. Post-epidemic encephalitic psychosis. Moral changes. Behaviour alterations

Postepidemic encephalitic psychosis exhibits definite moral changes and behavior alterations.

No delusions, hallucinations or negativism (E 49).

In this condition there are no delusions, hallucinations, or negativism.

[contd] 5. Disseminated Sclerosis. Neurological signs.

53:11.12 Disseminated sclerosis shows definite neurological signs,

In the emotional field disseminated sclerosis may resemble schizophrenia.

even though in the emotional field disseminated sclerosis may somewhat resemble schizophrenia.

Euphoria and eutonia may be common to both, and in both emotional control may be deficient.

Euphoria may be common to both, and in both emotional control may be highly deficient.

"Laughs and weeps without cause and smile when they relate their attempts at suicide" (Kraepelin) (E 49).

Schizophrenics laugh and weep without cause and "smile when they relate their attempts at suicide."

7. Alcoholism. Amnesia. Disorientated in time and place.

53:11.13 Alcoholics are disorientated in time and place.

Hallucinations may be prominent and common in both (E 49).

Hallucinations are common to both states.

B. Neuroses. (E 49)

[contd] 1. Hysteria. Emotional. Paroxysmal dissociation.

In hysteria the emotional phenomena are characterized by paroxysmal dissociation;

In schizophrenia continuous dissociation (E 49).

in schizophrenia, by continuous dissociation.

[contd] 2. Neurasthenia. Fatigue. (E 49)

Schizophrenics do not manifest the fatigue of neurasthenia

[contd] 3. Anxiety neurosis. Fear. (E 49)

nor the fear of the anxiety neuroses.

53:11.14 3. **Prognosis.**—

No longer must we regard schizophrenia as an incurable mental and nervous disorder. The prognosis is indeed poor if no treatment was early established, and if the personality is practically shattered. As a result of modern methods of approach and attack, many of these cases are turning out more favorably than in former years.

VI: SCHIZOPHRENIC PSYCHOSES (Henry 65)

Prognosis. ... After the definite onset of symptoms the outlook in the hebephrenic and simple forms is rather unfavorable.

53:11.15 When the hebephrenic type is once pretty well established, the prognosis is very unfavorable.

In the paranoid forms the deterioration in many cases is not marked

In the paranoid forms, deterioration in many cases is not marked,

and the individual may be able to make a fairly satisfactory readjustment.

and some of these individuals are able to make fairly satisfactory readjustment to life.

Catatonic forms are especially prone to remissions

The catatonic forms are especially subject to favorable remissions,

and even apparently recover during the early stages of the illness (H 68).

and many of these cases, when taken soon after the onset, appear to recover completely;

at least, they run along apparently normally for many years, but they are subject to recurrences as the result of shocks, infections, or other unusual experiences of mental stress and nervous strain.

[?]

53:11.16 In all forms of schizophrenia, *the more profoundly the emotions are blunted the less favorable the prognosis.*

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)	
Treatment.— ...We have come to recognise that there are many cases which under the régime of an institution do readapt themselves,	It is a fact, however, that many of these patients who achieve a practical recovery
but the recoveries do not usually occur with complete insight.	do not experience a full restoration of insight.
There is nearly always a certain falling away from the previous level (H&G 234).	Many times there is a definite retrogression of personality performance to a somewhat lower level.
Prognosis.— ... There are a larger number who make a social rather than a complete recovery,	53:11.17 Many such patients *achieve a social recovery* rather than a complete restoration of personality unification.
and there are still others who reach a quiescent stage so that they can be cared for at home.	Many others recover to a certain stage and then stop right there,
	the case remaining at a standstill for years.
The vast majority do gradually show a state of mental deterioration,	The vast majority, however, tend to show progressive mental deterioration,
which particularly involves the emotional field,	more particularly as concerns the emotional phases of the personality,
	and increasingly become misadapted to society.
and such patients are best cared for under mental hospital conditions (H&G 228).	Sooner or later, the majority of even the more mild types find their way to public or private institutions.

The emphasis must be placed more on an attempt to estimate how the individual met his difficulties in his pre-psychotic period. If he handled them for the most part in a satisfactory way, and if his general interests have been well maintained, then he has a very much better chance of readjusting himself than the shut-in, introverted individual (H&G 229).

53:11.18 Prognosis is more favorable if the schizophrenic made adequate adjustment to society before his mental breakdown,

The psychoanalytic school seems to believe that the malignancy of the reaction depends largely on the extent of the regression, and whether or not "archaic" material is included therein (H&G 229).

as it also is when the degree of regression is but slight.

There are also better prospects for improvement or recovery when

Treatment.— ... Our aim should be to get patients at the stage when they will co-operate in treatment, when they take advice and when they can be helped to grasp a new view of themselves (H&G 233).

the patient evinces a disposition to cooperate with treatment procedures.

XI: DEMENTIA PRECOX. (White 210)

Course and Prognosis.—The simple and paranoid forms are the slowest of evolution

53:11.19 The simple (apathetic) and paranoid forms of schizophrenia are the slowest in evolution;

and almost chronic in course,

that is, they tend to run a chronic course.

the paranoid forms often remaining in statu quo for two or three years.

Paranoid types will often remain stationary for two or three years at a time,

When the paranoid precox deteriorates it is because his compensation breaks down.

but sooner or later the paranoid compensation breaks down, and deterioration proceeds apace.

The hebrephrenic and catatonic forms are more acute in onset and course,

The hebephrenic and catatonic forms are more acute in onset

leading rapidly to dementia in the majority of cases,

and in many ways go on rapidly to actual dementia.

although the catatonic form has rather the better prognosis.

The prognosis of catatonia is, on the whole, much more favorable than that of the other three,

A certain few cases show a tendency to recur with sufficient regularity to result in a periodic course ... (W 237).

but some cases show a tendency to recur at regular periods,

even after apparent recovery.

The paranoid cases do not get well (W 237).

Permanent recovery of well-advanced paranoid schizophrenia is hardly to be looked for.

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

3. The Question of Modifiability and Adjustment (Treatment) Procedures. (S&E 294)

A. **Modifiability.** (S&E 294)

5. ... If the precipitating situation is innately significant and the psychotic content reflects its component facts, then the psychosis may be benign

53:11.20 *Prognosis is always more favorable if the precipitating factors have been very definite and outstanding.*

even though the symptoms in themselves have a somewhat sinister aspect (S&E 296-97).

That is, the more profound the causation, the better chance the patient has of achieving partial or complete recovery.

2. *Heredity* occasionally exerts an indirect effect

53:11.21 *Heredity* is definitely concerned in the prognosis of this and most other forms of psychosis.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
and the previous existence of chronic mental disease in a parent may apparently create an environment from which	Chronic mental disease of any sort in the parent may have helped to create an environment in which
a later developing benign psychosis in the offspring may take some of its unfavorable symptomatological aspects (S&E 296).	the ordinary mild type of personality disturbance tends to become more severe or malignant.
[contd] 3. A close study of the personality is often fruitful and furnishes helpful prognostic guides.	53:11.22 The prognosis largely depends upon the basic type and equipment of the patient's personality.
It is important to differentiate between a basic and constitutional seclusive make-up	It varies greatly, depending on whether the patient is constitutionally seclusive, markedly introvertish,
and one in which the withdrawal from socialization constitutes for the individual a somewhat logical defense and protection against definitely inimical surroundings.	or whether he has been retarded in socialization because of unfavorable surroundings or as a result of unfortunate experiences.
Catatonic manifestations during the psychosis may be occasioned by the re-appearance of	53:11.23 Catatonic manifestations may merely be glorified reproductions of
deeply ingrained dispositional "stubbornness" (S&E 296).	a constitutional tendency toward negativistic resistance or sheer stubbornness.
If the psychosis is in some sense an evolution of such peculiarities and no deterioration of personality is implied,	If a psychosis appears to be something of an evolution of certain preexistent traits of character,
then the outlook is not necessarily hopeless (S&E 296).	then the prognosis in most cases would seem to be more favorable.
6. The transition stage from reality or sanity to unreality or mental disease is an extremely critical period. Inhibition is decidedly lessened and extraneous, accidental happenings may be deeply impressed, and later elaborated into apparently malignant symptoms.	Many experiences of the transition stage from sanity to insanity may later be elaborated into apparently malignant symptoms.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
Other things being equal, an acute stormy onset is a favorable prognostic sign (S&E 297).	All things equal, an acute stormy onset is a favorable prognostic sign.
8. Toxicity or exhaustion may complicate a benign psychosis	53:11.24 *Toxicity* or some other form of *profound exhaustion* may often be associated with the early manifestation of benign psychosis,
and impart to it a deteriorating guise.	thereby causing the attack to appear to be much more serious than it is.
For instance, this may result when affective expression is masked or distorted by intercurrent clouding of consciousness.	In such cases, consciousness may be clouded
	and many symptoms may seem unduly alarming.
Both the pre-psychotic life and the psychosis should be carefully scrutinized for evidence of infection or bodily depletion (S&E 297).	A careful search should be made for preexisting infections and other evidences of physical exhaustion.
	The finding of these, if they have not been too long continued, should add a favorable element to the prognosis.
	53:11.25 It should be borne in mind that
[contd] 9. Catatonia has a wide-spread distribution and is not peculiar to dementia precox.	*catatonia* is a symptom complex appearing in connection with many disorders aside from dementia praecox.
It may be a response to toxicity and it then admits of a hopeful prognosis (S&E 297).	It sometimes results from chronic toxicity, and of course in all such cases the prognosis is hopeful.
[contd] 10. There are stuporous states, complete or partial, which do not meet the clinical requirement of benign stupor and yet they may not be looked upon as infallible signs of a deteriorating process.	The same is true of the stuporous states which are unassociated with schizophrenia.

The stupor in itself does not furnish a safe prognostic indicator

Prognosis, either favorable or unfavorable, should not be lightly ventured on the basis of any single symptom or group of symptoms.

and it must always be considered in its relations to the entire psychotic process (S&E 297-98).

After all, a forecast is much more dependent on *insight* than on any other single factor.

12. As long as there is insight one can expect adjustment possibilities (S&E 298).

If the insight persists to some degree, a favorable prognosis may be safely made.

VII. Treatment

IX: SCHIZOPHRENIC REACTION-TYPES (Henderson & Gillespie 191)

Treatment.—All medical men agree that the chief hope for success in treatment is earlier recognition of the disease.

53:12.1 The hope for success in the treatment of schizophrenia depends almost entirely upon its early recognition.

Not a great deal can be done for the average case if

The stumbling-block of psychiatric therapy has been that cases of mental disorder are not brought to the psychiatrist until the disorder is thoroughly established (H&G 232).

the psychiatrist is not called in until the condition is well advanced.

[All the strangeness and bizarre conduct, the tantrums, the difficulties of child-life, must be scrutinised much more closely ... (H&G 233).]

The supposed idiosyncrasies, tantrums, and queer conduct of the young folks,

The misdemeanours and oddities which are often early manifestations

together with their temperamental oddities and early manifestations of misdemeanors,

are looked upon as childishness or as moral perversity,

and it is only later, when experience does not modify conduct, when reproof and punishment are found to be of no avail,

that the disorder is considered in terms of illness.

[*Compare:* [Psychiatry] seems to offer much greater possibilities at present than work on endocrine disorders, autointoxications, or what not (H&G 233).]

Even then, however, the psychiatrist is not called in. Recourse rather is had to the gastro-intestinal expert, or to the dentist, the Christian Scientist, or the osteopath;

and only after everything has failed

is the psychiatrist consulted (H&G 232-33).

[*Compare:* We have already remarked that there has been a reversal of opinion in regard to prognosis.

It is now generally recognised that although a schizophrenic type of disturbance is always most serious, there are certain cases which can, and do, readjust themselves (H&G 228).]

must no longer be regarded as nothing worse than freakish youthful behavior or mere moral perversity.

When ordinary efforts at correction and discipline have failed,

such manifestations of retardation, perversity, listlessness, or incipient delinquency should serve to bring such individuals to the notice of a psychiatrist.

53:12.2 Altogether too often these cases are looked upon as manifestations of glandular deficiency or moral perversity or else as resulting from some such physical disorder as autointoxication or focal infection.

Frequently the internist or the osteopath has been treating the case

before, after years of precious time have been wasted, as a last resort,

when the disorder has reached an advanced stage,

the psychiatrist is called in.

53:12.3 While schizophrenia has been long considered a practically incurable disorder, this prognosis should be changed.

Mild cases, when taken early, are undoubtedly curable, at least in a large number of instances.

"A STUDY OF THE SOCIAL READJUSTMENT OF ONE HUNDRED CASES OF DEMENTIA PRAECOX" (MacNamara & Read & Ettelson 93)

53:12.4 The Elgin (Illinois) State Hospital recently made a report of a study of the social readjustment of 100 cases of dementia praecox.

The following table shows the degree of adjustment for the various types of cases, in so far as could be determined by the social workers, without reference to psychiatrist's report (M&R&E 108).

The following table shows the degree of adjustment for the various types so far as this could be determined by the social workers without reference to the psychiatrist's report.

53:12.5 SOCIAL READJUSTMENT OF ONE HUNDRED CASES OF DEMENTIA PRAECOX

[TABLE]

[TABLE]

Summary and Conclusion:

53:12.6 *Summary and conclusions.*

We find that the highest percentage of excellent adjustments was among the catatonic type and they also have the lowest percentage of poor adjustments.

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The catatonic and paranoid showed the same percentage of re-hospitalization.

The catatonic and paranoid showed the same percentage of rehospitalization.

We find that the highest percentage of poor adjustments and re-hospitalization was in the hebephrenic group.

We find that the highest percentage of poor adjustments and rehospitalization was in the hebephrenic group.

The distribution of sex in relation to the various adjustments showed no significant difference, with the exception of group 4.

The distribution of sex in relation to the various adjustments showed no significant difference, with the exception of group 4.

We found only 4 per cent of the male cases had been re-hospitalized, and it had been necessary for 16 per cent of the female cases to be placed in other institutions (M&R&E 108).

We found only 4 per cent of the male cases had been rehospitalized, and it had been necessary for 16 per cent of the female cases to be placed in other institutions.

[contd] Dementia praecox is one of our greatest hospital problems.

53:12.7 Dementia praecox is one of our greatest hospital problems.

Statistics show that a high percentage of hospital readmissions are cases of this disorder—about 60 per cent of the residents of all state hospitals belong to this group—also that these cases remain in the hospital longer than any other classification.

Statistics show that a high percentage of hospital readmissions are cases of this disorder—about 60 per cent of the residents of all state hospitals belong to this group—also that these cases remain in the hospital longer than any other classification.

It is the general opinion that these cases are seldom able to make adequate adjustment in the community and are usually an economic liability (M&R&E 109).

It is the general opinion that these cases are seldom able to make adequate adjustment in the community and are usually an economic liability.

[contd] Therefore, it has been quite gratifying to find so many of the cases of this study in such satisfactory relationship to their environment.

53:12.8 Therefore, it has been quite gratifying to find so many of the cases of this study in such satisfactory relationship to their environment.

We were greatly pleased with the high degree of cooperation we received both from patients and their relatives.

We were greatly pleased with the high degree of cooperation we received both from patients and their relatives.

For the most part, even among the poor adjustments, great interest was shown in the study and the general attitude was one of appreciation of the interest shown by the hospital (M&R&E 109).

For the most part, even among the poor adjustments, great interest was shown in the study and the general attitude was one of appreciation of the interest shown by the hospital.

"THE USE OF SODIUM AMYTAL IN THE PSYCHOSES" (Ettelson 199)

[*Note:* I do not have access to the full article and therefore have been unable to trace this passage.]

53:12.9 The medical treatment of the disorder, whether by sodium amytal or other means, continues to prove disappointing.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
"MANGANESE CHLORIDE THERAPY IN DEMENTIA PRAECOX" (Haffron 114)	
Summary: Ten cases of dementia praecox were treated with intravenous injections of manganese chlorid over a period of ten weeks.	Recently a report has been made of ten cases treated with intravenous injections of manganese chloride over a period of ten weeks.
One case recovered and was paroled home.	One case seems to have been greatly improved and was paroled;
Two cases made a considerable improvement.	two others were considerably improved;
The remainder of the cases showed no improvement (H 116).	the other seven showed no advancement.
XI: DEMENTIA PRECOX. (White 210)	
Prophylaxis.—Preventive measures are dependent upon the ability to recognize in the child the possibilities of a future precox.	53:12.10 *Preventive measures,* as applied to schizophrenia, consist largely in very early recognizing in the child the trend in this direction.
The recent studies of character anomalies as found in the anamnesis of precox patients	The study of the history of praecox cases
indicates the possibility of foreseeing this result in a considerable number of cases,	indicates the possibility of anticipating many of them in early childhood,
particularly those presenting the "shut in" type of personality (W 255).	particularly in "shut-in," introverted personalities.

VIII: SCHIZOPHRENIC REACTION TYPES (DEMENTIA PRAECOX) (Strecker & Ebaugh 287)

3. The Question of Modifiability and Adjustment (Treatment) Procedures. (S&E 294)

B. **Treatment Procedures.** (S&E 298)

53:12.11 Strecker and Ebaugh* [*Strecker, E. A. and Ebaugh, F. G.: Clinical Psychiatry, P. Blakiston's Son & Co., Philadelphia, 1931.] have formulated the following very concise summary of prophylactic treatment procedures for combating schizophrenic tendencies.

[contd] 1. *Preventive Measures.*

53:12.12 1. *Preventive measures.*

Studies of childhood psycho-pathology. Mental hygiene in school.

Studies of childhood psychopathology. Mental hygiene in school.

Preparation for problems of adolescence, of emancipation from home, sex hygiene, etc.

Preparation for problems of adolescence, of emancipation from home, sex hygiene, etc.

Organized, state-wide neuropsychiatric examinations of school children showing behavior difficulties and of all school failures, with prompt treatment,

Organized, state-wide neuropsychiatric examinations of school children showing behavior difficulties and of all school failures, with prompt treatment,

as well as out-patient studies of prepsychotic individuals and of so-called normal individuals (S&E 298-99).

as well as out-patient studies of prepsychotic individuals and of so-called normal individuals.

[contd] 2. *Safeguarding Therapy.*

53:12.13 2. *Safeguarding therapy.*

Institutional care of patients.

Institutional care of patients.

Well- equipped observation psychopathic wards are therefore needed in all our general hospitals.

Well-equipped observation psychopathic wards are therefore needed in all our general hospitals.

Special psychopathic hospital care— clinic treatment (S&E 299).

Special psychopathic hospital care— clinic treatment.

[contd] 3. *General Internal Medicine.*

Careful elimination. Careful dietetic and tonic routine, endocrine therapy.

Removal of infection and proper treatment of accompanying disease (S&E 299).

[contd] 4. *Reconstruction Therapy—Establishment of Rapport.*

Frank discussion of patient's problems and assets (personality resources), and the situation he has to meet.

Establishment of an adequate personality in keeping with resources.

Establishment of reconstructive interests of diverse types, of insight and understanding (S&E 299).

[contd] 5. Occupational therapy to produce action is very advisable.

Colonization of all institutional cases where it is possible for deteriorated cases to become self-supporting.

Follow-up of all discharged patients for a number of years in order to arrive at definite statistical facts regarding adjustment.

Placement in private boarding homes (S&E 299).

[contd] 6. Careful psychiatric social service follow-up and vocational supervision may reclaim many of these individuals after they are discharged back to the community (S&E 299-300).

53:12.14 3. *General internal medicine.*

Careful elimination. Careful dietetic and tonic routine, endocrine therapy.

Removal of infection and proper treatment of accompanying disease.

53:12.15 4. *Reconstruction therapy—establishment of rapport.*

Frank discussion of patient's problems and assets (personality resources), and the situation he has to meet.

Establishment of an adequate personality in keeping with resources.

Establishment of reconstructive interests of diverse types, of insight and understanding.

53:12.16 5. *Occupational therapy* to produce action is very advisable.

Colonization of all institutional cases where it is possible for deteriorated cases to become self-supporting.

Follow-up of all discharged patients for a number of years in order to arrive at definite statistical facts regarding adjustment.

Placement in private boarding homes.

53:12.17 6. *Careful psychiatric social service* follow-up and vocational supervision may reclaim many of these individuals after they are discharged back to the community.

[contd] 7. *Treatment of Symptoms.*

Negativistic states and stupor: General hygiene and nursing care, ventilation, bathing, artificial feeding, change of scene, etc.

Excitement: Adequate supervision and observation. Continuous baths and other types of sedative therapy, such as packs.

Apathy: Useful occupation, games, entertainment (S&E 300).

53:12.18 7. *Treatment of symptoms.*

Negativistic states and stupor: General hygiene and nursing care, ventilation, bathing, artificial feeding, change of scene, etc.

Excitement: Adequate supervision and observation. Continuous baths and other types of sedative therapy, such as packs.

Apathy: Useful occupation, games, entertainment.

VIII. Illustrative Cases

Attempted Suicide

53:13.1 **Case 122.**—Age 35. Occupation, teacher. Chief complaint: Desires diagnosis. Was sent to psychopathic hospital two weeks previously because of waking up in the middle of the night in a confused state in connection with loss of emotional control. *Family history:* Father died of angina pectoris. Otherwise negative, except that subsequent to this, her sister, in the midst of an acute mental disturbance, committed suicide. *Personal history:* In every way negative, except that she was five years previously confined in a state institution with a tentative diagnosis of schizophrenia.

53:13.2 *Clinical history:* Patient was reluctant to talk about her former mental difficulties—in fact, it was not possible to secure much relevant data. She had had considerable difficulty in carrying on as a teacher, was overconscientious and overly thorough with everything she did, strove to be the best teacher in the school. The attack which led to her confinement in the psychopathic hospital for ten days seemed to have been associated with some sort of nightmare. Within twenty-four hours after being taken to the hospital she was apparently normal and was accordingly dismissed.

53:13.3 *Mental and emotional examination:* Patient was well orientated, had good insight, and aside from the peculiar impression conveyed to her examiners that she was overmeticulous and overconscientious—ultraidealistic—nothing abnormal was elicited at the time of this examination.

53:13.4 *Physical examination:* Slight anemia, anteflexed uterus, diseased tonsils, otherwise entirely negative.

53:13.5 *Diagnosis:* Potential schizophrenia, either simple or mixed type.

53:13.6 *Comment:* Patient responded fairly well to psychiatric training, went on with her work, doing it in a highly creditable fashion for about three years, whereupon her sister was taken with what appeared on the surface to be an acute and sudden anxiety neurosis, in a few weeks committing suicide; and yet this patient went through all this with exceptional fortitude. About six months thereafter, in leaving for school one morning, she took a bus going in an opposite direction, got off far from her school, wandered aimlessly in front of a freight train, and suffered the loss of both legs. The subsequent history suggests a gradual deterioration and confirms the diagnosis of so-called simple dementia praecox.

Recurring Catatonia

53:13.7 **Case 123.**—Age 23. Occupation, housewife. Married two and one-half years. Chief complaint: Nervousness, peculiar conduct, with apparent hysterical accompaniments. *Family history:* Practically negative—incomplete and in general unsatisfactory. *Personal history:* Practically negative, except for the fact that it disclosed she had not done well in school and had never been compelled to do very much contrary to her inclinations; when school was difficult, she was sent to an aristocratic finishing school.

Was later taken to Europe when she became dissatisfied with school and home environment. History revealed little information of value up to the time of her marriage and shortly thereafter.

53:13.8 *Clinical history:* Patient's family did not like her husband because of his drinking proclivities. Considerable tension existed. About two years after marriage a child was born, and the patient, after passing through fairly normal labor, began to exhibit symptoms of slight mental disturbance at the end of the first week in the maternity hospital. These symptoms appeared to be of little importance, however, and it seems that they were not taken as indicative of any threatened serious mental disturbance. On going home from the hospital with the baby, she was disinclined to assume any responsibility for its care. Increasingly for several months she took less interest in the home, particularly in the baby,

[See 53:7.5, above.] and finally began to manifest a peculiar mechanical form of laughter,

associated, for a few days, with mental depression

[See 53:7.5, above.] and then giving way to a desire to be on the "go," to be dancing, going to entertainments, and constantly active.

[See 53:7.2, above.] After this alternation of depression and excitation for three or four weeks,

she was brought to the psychiatrist, having lost all interest in her baby, at times refusing to acknowledge that it was hers.

53:13.9 *Mental examination:* Patient fairly well orientated, insight unsatisfactory. Highly nervous,

[See 53:7.1, above.] apparently hysterical, and exceedingly restless.

53:13.10 *Physical examination:* Rhinitis, diseased tonsils, slight retroversion of uterus, with cyst of left ovary.

[The vast majority show a subnormal metabolism ... (53:5.19, above).]

Laboratory data: Basal metabolism rate –12 per cent. All other tests negative.

53:13.11 *Diagnosis:* Catatonic schizophrenia.

53:13.12 *Comment:* It required five weeks for more definite schizophrenic symptoms to put in appearance, but at the end of that time it was plainly seen that the case belonged in the catatonic category. The alternations between excitement and depression began to disappear,

[See 53:7.2, above.]

and within three months the patient had become a typical catatonic, having to be tube-fed and paying absolutely no attention to herself or the calls of nature.

This catatonic state persisted for three months and was followed by two months of gradual recovery, which period was succeeded by the partial return of the alternating tendencies to depression and excitation. After running this course for about nine months, the patient was sufficiently recovered to undergo definite psychiatric training. With the help of a nurse she went through a course of domestic science, paying special attention to cookery. After spending a year under psychiatric training, about nine months in the rest home and three months in a hotel with a psychiatric nurse, this patient returned to her husband and her baby, *apparently* recovered.

53:13.13 All went fairly well for a year and a half, at least for a year. About this time financial reverses necessitated their giving up their home and her nursemaid, and she reacted to these reverses by manifesting less and less interest in her child. About this time her husband went away for a brief course of postgraduate study, taking his wife and baby with him. She did poorly under hotel life and very soon lost all interest in the care of her child.

She was sent away with relatives for a few weeks' rest, during which she entered upon a rather acute mental disturbance, not only giving up all interest in the child, but deciding that she no longer loved her husband. She began to indulge a fantasy love affair with a young married man she had met while visiting her relatives. She imagined having an appointment with this man in Chicago, came on to keep it, and was again placed in the rest home. She rapidly regressed but never developed the typical catatonic attitude characteristic of her former attack,

[*Compare:* January 5, 1921. Since the preceding note was made patient has not materially changed except that a week ago she began eating voluntarily and has not been tubed since (Strecker & Ebaugh 312).]

never had to be tube-fed,

but in other ways exhibited minor catatonic characteristics.

After six to eight months of this sort of behavior she began to improve, but more slowly than during the first attack. She has improved up to the present time—about fifteen months since the beginning of this second attack—to where she is oriented well and her insight is almost, if not quite, normal, but she refuses to take any responsibility about the house.

[*Compare:* February 1, 1921. ... She will sit in one position for long periods of time unless moved by the nurse (Strecker & Ebaugh 318).]

Will not do anything in occupational therapy unless the nurse stands right by her side and almost moves her hands.

She simply sits about, smoking up her daily cigarette allowance by early afternoon and refusing to take any interest in her environment. She will not read, except an occasional magazine story. Plays the piano some. Manifests no interest in her child and has to be urged even to write to her husband. There seems to be some evidence of real deterioration setting in.

Continuous Paranoid Type

53:13.14 **Case 124.**—Age 20. Occupation, student. Single. Chief complaint: Nervousness, insomnia. *Family history:* One case of apoplexy, one of pernicious anemia. General nervous tendency in ancestry. Father a bit peculiar, showing a tendency to fixation of ideas, but a thoroughly successful business man and conscientious citizen. Mother semi-invalid, lifelong sufferer from marked psychasthenia. Sister subsequently had "threatened nervous breakdown" but responded readily to psychiatric training. *Personal history:* Patient is a typical introvert, presents every appearance of schizophrenic type—mentally, temperamentally, and in physique. Has had no personal history of consequence. Recently had tonsils removed. Has done well at school, standing somewhat above the average. Very conscientious, of a religious type, given somewhat to worry. Is introspective, daydreams a great deal, very slow about dressing and eating.

53:13.15 *Clinical history:* This young man was brought to the psychiatrist because he had suddenly developed moody tendencies, sometimes sitting in a room with his head in his hands. Had become less talkative, more taciturn, a bit quarrelsome, and at the time of his examination showed definite tendencies toward "blocking"; but his mental examination and all psychologic laboratory tests were negative.

53:13.16 *Physical examination:* Aside from a tendency to anemia and slight underweight, the physical examination was wholly negative.

53:13.17 *Diagnosis:* Schizophrenia, paranoid type.

53:13.18 *Comment:* Within a very few weeks this young man became so definitely paranoid with religious trends, that he was sent to the rest home for further observation and treatment. That was eight years ago. This case is interesting in that it shows progressive development of a paranoid type of dementia praecox without the usual remissions being encountered. This patient has never been returned to his home. A year in a sanitarium saw him get gradually worse. Another year on a farm with a nurse likewise failed to produce improvement; then, with the threatened exhaustion of the family exchequer, he was sent to a state institution where he has been ever since, showing slow but certain signs of continued deterioration but always holding well to the paranoid trend. The paranoid manifestations followed the religions groove for five years. The past three years they have somewhat shifted from this and have begun to carry more of a sex tinge. After becoming an honor patient about the institution, he has twice run away, being now absent on his second escapade. (Since this was written, he returned to the state hospital voluntarily, regained his honor status, and has just been sent home.)

Paranoid-Type Recovery

53:13.19 **Case 125.**—Age 26. Occupation, draftsman. Single. Chief complaint: Mental worries. Suffers from a peculiar so-called "mental activity." *Family history:* Negative, except for a few cases of mild alcoholism and tendency of both parents to be nervous and to worry. *Personal history:* Wholly negative, except for the appearance, when eighteen years of age and while going to high school, of a very definite suspicion tendency. He began to feel that many of the happenings in his environment were highly personal and significant.

53:13.20 *Clinical history:* Patient finished high school but, because of the development of definite paranoid trends, got through only two years of college.

SOURCE	53: THE THEORY AND PRACTICE OF PSYCHIATRY
[See 53:5.13, above.]	At the time he was brought to the psychiatrist, he complained that people were *stealing his thoughts;*
[See 53:9.2, above.]	that there was a conspiracy on the part of some imaginary group of enemies to purify their minds by draining off the filth into his. Constantly he complained that these filthy words and ideas were being forcibly injected into his mind from these outside sources.
XXIV: SIMPLE PARANOIA (*The Mind at Mischief* 336)	
PERSISTENT DELUSIONS (*The Mind at Mischief* 338)	
I knew of one who had gone along for months, working in an office	He was able to work for a few weeks or a few months in some architect's or engineer's office,
under the delusion that he was being spied upon and followed and otherwise harassed by his fellow workers,	but he sooner or later focused his suspicions on some fellow worker, and as the result of his fears or because of some overt act, he would suddenly leave. He had resorted to violence only once.
but never giving intimation of his feelings until one afternoon he turned around to the man at an adjoining desk,	He turned to the draftsman working by his side about noon one day and said, "Will you stop that and stop it right now!" His fellow worker, in astonishment, replied, "Stop what? What do you mean? Are you going nuts?" And then the patient stepped over
and, figuratively speaking, "knocked him into the middle of next week."	and, figuratively speaking, "knocked the other fellow into the middle of next week."
Whereupon he went over to the closet, got his coat and hat, and walked out of the place.	Whereupon, he put on his coat and hat and left without his pay.

This is the only time this man has ever shown any tendency to become violent, tho he has been bothered for two or three years with these delusions (24:2.3).

This occurred early during his psychiatric observation and treatment.

53:13.21 *Mental examination:* Wholly negative, except for the presence of definite paranoid trends.

53:13.22 *Physical examination:* In every way negative.

53:13.23 *Diagnosis:* Schizophrenia, paranoid type.

53:13.24 *Comment:* The parents of this patient were frankly told of the diagnosis, and the young man himself, at times, was almost disposed to accept the psychiatrist's opinion regarding his trouble; but drastic treatment was attempted only after a strong appeal had been made by his mother that something be done for the boy, and after the patient himself had once said to the psychiatrist: "Maybe you are right. I have listened to all you have said and read the books you have given me. You ought to know your business. Maybe this whole thing is autistic. Maybe I do imagine these things. It is barely possible they may not have origin outside of my mind. If I believe you, what can you do to help me?"

[See the parallel chart for Chap. 24 of *The Mind at Mischief* (specifically 24:3.1), regarding the other apparent success.]

53:13.25 This is one of the few cases of paranoid schizophrenia that I have tried to help by "putting the patient out" with drugs, and it is one of my two apparent successes with this technic.

At the solicitation of his parents we finally decided to secure nurses, put this young man to bed, and administer luminal, bromides, and other drugs from day to day until we had put him out of commission for the time being. The patient was carefully watched, and after sixteen days of being "dead to the world" he was allowed gradually to come back.

No one was more surprised than I at his apparent clearness of mind. He seemed to have entirely recovered from all tendency to talk about his "mental activity." He went back to his position and worked faithfully for several months. That fall he entered a technical school and recently finished a four- or five-year engineering course. When last heard from, he was working satisfactorily, perhaps not 100 per cent normal, maybe a bit peculiar, but nevertheless fairly well socialized and reasonably well adjusted to his economic environment. Of more than a dozen experiments of this sort, this is one of two successful cases, and the only one that has remained apparently cured after five years. The other relapsed in the fourth year.

Relapsing Paranoid Type

53:13.26 **Case 126.**—Age 49. Occupation, business executive. Unmarried. Chief complaint: Patient made no complaint, aside from irregular menstruation. Was brought by her sisters who said she was "acting queerly." *Family history:* Negative, except for a sister who had for years been confined in an institution for the insane in a distant state. *Personal history:* Negative, aside from an operation for appendicitis six years previously, typhoid fever when a young woman, and mental and nervous tendencies. Had had slight attacks of arthritis.

53:13.27 *Clinical history:* Patient had been a much inhibited, emotionally repressed individual. Had never had any active love affairs. Had for years been unusually interested in astrology and numerology. About five years before coming under psychiatric observation, she had become suspicious of some of her business associates; thought one married man was trying to flirt with her; believed another had made disrespectful remarks about her. It is more than likely that there was a basis for some of her early suspicions.

About this time she began to forecast her future in accordance with astrology and numerology, and between her suspicions, on the one hand, and her astrological leanings, on the other, she became increasingly paranoid and finally indulged in an outbreak to one of her superior officers which led to her summary discharge. For two or three years she lived with an unmarried sister but gradually grew worse. More and more was she upset and disturbed, and finally, as the result of the fears of her mother, who had come to live with these two sisters, she was brought to the psychiatrist.

53:13.28 *Mental examination:* Negative, except for the uncovering of suspicion and definite paranoid trends.

53:13.29 *Physical examination:* Anemic tendencies, mild arterial hypertension, slight hemorrhoids, and irregular menstrual function, suggesting menopause.

53:13.30 *Diagnosis:* Schizophrenia with paranoid trend.

53:13.31 *Comment:* This patient consented to being placed in charge of a psychiatric nurse and was willing to undergo a course of treatment. For six months this program was carried out, with regular work at occupational therapy, visiting museums and other public institutions, daily reading and study, and writing of assigned psychologic essays; the patient, from week to week, made very commendable improvement. After this period of treatment she seemed so normal that it was deemed best to allow her to return to her people, and they even entertained hope of her being able to work again, but there was one fly in the ointment. There were two things she would not budge on: One was that the initial basis of her suspicions was a real incident—and it is more than likely she was right in that. One of her business associates probably did say the very thing she insisted he said.

But the other and more serious and disturbing factor was that she absolutely refused to yield her belief in astrology, even though she had weakened considerably on numerology. This was her remark at the last conference before she returned home when I said to her, "I hope you will have no more trouble about this astrology and numerology business": "Well, Doctor, I will leave them alone as you have requested as long as I am your patient, but when you discharge me as being cured, I am going to take them up and get to the bottom of them."

53:13.32 To make a long story short: She went home, did well for a few months, entered heartily and cheerfully into helping to care for the house, and was a comfort to her mother; but she woke up at four o'clock one morning, carrying on in great fashion, rushed to the bathroom saying that she had killed her mother and, as she locked the door, made some remark about killing herself. This so alarmed her family that they not only called for help but had the fire department come with nets in case she should jump out the third-story bathroom window. Finally they gained entrance to the bathroom and, upon calling the doctor for aid, were directed to take the patient to the rest home for observation. She has been there ever since, about two years. Her paranoid trend remains undisturbed. She now thinks she is the wife of some English lord and pregnant with twins; assumes herself to be at the head of the institution and that all of the attaches are her servants. She raves one day about her fortune and the next about the "crown jewels." The paranoid trend remains unchanged. Its associated emotional status changes about every three months, swinging alternately from cycles of taciturnity and superciliousness to marked congeniality and an attitude that is overjovial and patronizing.

53:13.33 This case illustrates how difficult it really is to cure a paranoid trend when it has once become thoroughly established. The evident progressive deterioration prevents us from considering this case as manic-depressive.

Paranoid Social Recovery

53:13.34 **Case 127.**—Age 29. Occupation, none. Single. Chief complaint: Feels nervous and upset, worries about certain things. *Family history:* Thoroughly negative, except for one case of tuberculosis and a tendency on both sides of her ancestry to nervousness and worry. *Personal history:* Tonsillectomy and adenoidectomy ten years previously. History of mild sinus infection but, aside from childhood diseases, no complaint except of fatigue and constipation. Hands and feet, however, are habitually cold.

53:13.35 *Clinical history:* For ten years patient has been suffering from a mild paranoid tendency. It appeared while she was on the boat with her mother en route to Europe ten years ago, when she became suspicious she was being talked about by certain people on shipboard. This suspicion has continued during these years, never becoming focalized, shifting about from one individual or group of people to another. It has interfered definitely with her education and socialization, and she feels is preventing her getting married, which she moderately desires. She willingly consents to her mother's proposal to consult a psychiatrist. Her attitude seems to be unusually favorable as compared with the average victim of paranoid trends.

53:13.36 *Mental examination:* Negative, aside from the elicitation of paranoid tendencies.

53:13.37 *Physical examination:* Constipation, slight visual defect, slight dental defects, otherwise negative. Laboratory data: Basal metabolism rate –35 per cent.

53:13.38 *Diagnosis:* Incipient schizophrenia with paranoid trend.

53:13.39 *Comment:* This patient most willingly and almost heartily entered upon a year's psychiatric training. Within a few months after beginning this course, she accepted the idea that her trouble was psychic, a personality maladjustment. At the end of a year she was theoretically cured. She went to work, greatly improving her social activity, but still could not quite make the grade of full and complete psychic and emotional deliverance from her tendencies. She continues to improve even though treatment was not begun until the condition had been present for ten years. We have every reason to think that this represents a piece of prophylactic work in psychiatry. I really believe this woman has been saved from certain drifting into full-fledged schizophrenia. Of course, I shall follow the case in years to come with a great deal of interest, but it is typical of a number of others—more mild and gotten hold of earlier—that have responded to treatment with apparent cure; it is cited instead of cases treated at an earlier age because of its value as indicative of what can be done even when the paranoid trend has been in operation for as long a period as ten years.

53:13.40 It is interesting to note that thyroid and other ductless-gland medication seemed in this case to be without result.

Paranoid Suicide

53:13.41 **Case 128.**—Age 35. Occupation, clerk. Single. Chief complaint: Amenorrhea, but on further questioning, confessed to being "mildly nervous." *Family history:* Negative as far as obtainable, except in case of one sister who had "nervous breakdown" at forty and a more remote ancestor who became insane. She thought, however, that many of her relatives were more or less nervous. *Personal history:* Patient had had few illnesses aside from diseases of childhood and a slight nervous breakdown a dozen years previously; was away from work for a few months. Had since suffered from headaches and three years ago had her tonsils removed.

She made no physical complaint except as to constipation and her difficulties with menstruation.

53:13.42 *Clinical history:* The patient was sent to us by a welfare worker in a large corporation by which she was employed. She went to this woman one day complaining that the head of her department, a married man of good reputation, had secured a latchkey to her apartment and had been coming up in the middle of the night, slyly pulling the covers down to the foot of the bed, and standing there viewing her naked body while sardonically grinning. She had written him a letter explaining that, if he desired to pay her sexual attention, he should come forward like a man, even though he was married, and make an open-and-above-board proposal to her. She did not indicate in this letter what her attitude would be toward such a proposal, but she did most strenuously object to this underhanded way of his seeking to gratify his sex impulses. Of course, the welfare worker decided it was a case of paranoia and insisted that the woman see a psychiatrist.

53:13.43 *Mental examination:* Negative, except for overserious mental attitude and the exhibition of definite, well-focalized paranoid tendencies.

53:13.44 *Physical examination:* Slightly lowered hemoglobin, visual defect, leukorrhea, hypothyroidism (basal metabolism rate being –30 per cent). Thyroid medication for the short time she was under treatment was apparently futile.

53:13.45 *Diagnosis:* Schizophrenia, paranoid type.

53:13.46 *Comment:* The patient recited her story in a most innocent and naïve fashion. She seemed a bit hurt when she even suspected that the psychiatrist did not believe it 100 per cent. When, after a number of interviews, it was intimated to her that she might be suffering from some mis-apprehension,

that perhaps the man concerned really did not get into her room at night, she was a bit resentful and suggested that her medical advisers confine themselves to the treatment of her physical condition and allow her to manage her own mental program and psychic affairs. By this time a brother had come into the picture and insisted that she undergo treatment. This she pursued under mild pressure for a few weeks and then discontinued. In the meantime she became suspicious of her brother's wife and, after some words, took poison in her brother's house, attempting suicide. Prompt medical assistance brought her out, but within two weeks she was successful in ending her life in a second attempt.

53:13.47 While paranoids are in general more likely to be homicidal than suicidal, this case illustrates a certain leaning toward suicide, especially in these cases that come on acutely and seem to be so well fixated, so thoroughly focalized.

Hebephrenic Type

53:13.48 **Case 129.**—Age 35. Occupation, housewife. Married twelve years. Chief complaint: "Can't think right." *Family history:* Negative, except for history of mother's having been confined several years ago in a sanitarium for the best part of a year because of a "nervous breakdown." *Personal history:* Patient was of a very conscientious type, good student, devoted daughter, faithful wife, meticulous mother, had been devoted to two children, and had showed no mental trouble until very recently.

53:13.49 *Clinical history:* For the past two years this patient had been undergoing a severe and continuous strain due to sickness of mother, illness of another member of the family, and a very serious ordeal with one of her children.

On top of these troubles, or in connection therewith, she gave birth to a baby and about six weeks after this experience began to develop a psychic queerness. Following a week or ten days of manifestations of excessive energy, she became confused, talkative, quarrelsome. This condition progressed and led soon to her being placed under psychiatric care; at the time she was brought to the rest home, she presented a picture that was definitely hypomanic.

53:13.50 *Mental examination:* Patient very much confused, not well orientated, insight very poor, while responses to all questions were unsatisfactory or greatly delayed.

53:13.51 *Physical examination:* Negative, except moderate underweight and a slight mitral regurgitation. Laboratory data: Hemoglobin 75 per cent.

53:13.52 *Diagnosis:* Schizophrenia, hebephrenic type.

53:13.53 *Comment:* Patient progressed steadily into a rather typical hebephrenic state for about six months. After a status quo of three or four months she began to show slight evidence of improvement, but before this improvement could be regarded as at all encouraging, a combination of circumstances caused her to be put temporarily in charge of relatives, and what little improvement had manifested itself, rapidly disappeared. According to reports she became definitely worse and was removed to a state institution. This type of schizophrenia gives the most unfavorable prognosis of all forms of this dread malady.

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1. This is somewhat redundant, since Sadler had already mentioned the typical age-range of onset in 53:0.8, lifting from Henry.

2. Aside from this class of causes, direct heredity is frequently in evidence, and families are found with several cases of dementia precox, just as similar conditions occur in manic-depressive psychosis (White 212).

3. It is scarcely a clear-cut disease entity but a reaction type—a maladaptation (Strecker & Ebaugh 287).

4. This is redundant; Sadler already mentioned Cotton's theory about focal sepsis in 53:1.1.

5. Only a short time ago he was like us and now we wonder how he could have become so changed (Henry 72).

6. The most prominent symptom is the failure of affect, or emotional blunting, showing itself in apathy and indifference (Henderson & Gillespie 201).