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PREPSYCHOTIC AND EARLY STAGES OF SCHIZOPHRENIA

by

Albert H. Fechner

PREPSYCHOTIC AND EARLY STAGES OF SCHIZOPHRENIA

It has been said by Strecker and Ebaugh (22) "that each year not less than 30,000 to 40,000 individuals (including all cases) soon after adolescence or in the first flush of manhood or womanhood fall victims to the dread disease of schizophrenia." Annually 75,000 new patients are admitted to state hospitals and at least one fourth are schizophrenic.

There has been a continuous accumulation of schizophrenic patients in the institutions as they enter early in life and many remain there to old age. As a result they now constitute the largest single institutional problem in this country. They outnumber patients with all other forms of mental diseases combined. They are twice as numerous as persons in hospitals for the treatment of tuberculosis. They exceed the total population of all institutions for the feebleminded and epileptics and state prisons. Furbush (9) has further estimated that the annual economic loss to this country on account of this disease is over 123 million dollars.

It is not only the economic and social sides that is of importance but it is also the life that these individuals are condemned to lead - as stated by Strecker and Ebaugh (22) "they are condemned to a veritable living death, devoid of emotional life and unable to participate in the normal activities and affairs of living."

Schizophrenia or dementia praecox is defined by

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Strecker and Ebaugh (22) as "a fudamental splitting between the emotional, the thought, and motor processes, is a chronic psychosis which has its greatest incidence in the second decade of life. It is scarcely a clear cut disease entity but a reaction type - a maladaptation. In a majority of cases the end result is one of deterioration which particularly involves the mood or affective responses." Bleuler (2) and Meyer (15) avoid the term dementia praecox. Bleuler in his text book states that "the disease may come to a stand still at every stage and many of its symptoms may clear up very much or all together, but if it progresses, it leads to a dementia of a definite character. As the disease needs not progress as far as dementia and does not always appear during puberty or soon after, the name schizophrenia should be preferred." Meyer for the same reason prefers the name schizophrenia as there are enough recoveries to justify the avoidance of the term dementia praecox.

Now comes the question - what can be done to reduce the extent of this disorder? Much research along various lines as anatomical, histo-pathological, endocrine disturbance, toxic agents, and physiological has been done, but still little is known as to the extent or nature of the disease. However it is known that many of these individuals show peculiarities for some time and many date back to childhood. Richmond (20). This group of potential cases should be identified before marked psychotic symptoms appears, because it is during this

stage that something may be done for them in bringing about an adjustment. As stated by Strecker and Ebaugh (22) "unless an adjustment is accomplished during the brief stage of incipiency, these individuals are condemned, " Sullivan (24) believes that many of these cases could be arrested before contact with reality is completely lost if they are detected during these early stages. Consequently it is our duty to learn to recognize these individuals before they become definitely psychotic and attempttto bring about at least a partial adjustment. It is best to try this while they are still in the prepsychotic stages for when they become definitely psychotic and have lost insight the prognosis is bad.

Many of the patients I had the opportunity of observing in the Hastings State Hospital showed a history of peculiarities such as a seclusive personality and anti-social trends long before they became definitely psychotic. If these patients could have been identified during these early stages, something might have been done in bringing about at least a partial adjustment for them. It is also of interest to study the early manifestations of the disease which are encountered outside of theinstitution as well as in. At times the early manifestations are not recognized as such, but they are treated for physical conditions. This delays proper treatment and allows the disease to progress.

As stated before that many individuals who develop schizophrenia give histories of previous peculiarities of

behaviour has become well recognized and that the existence of a shut-in or seclusive personality before the onset of the actual psychosis is considered to have considerable diagnostic and prognistic significance (Gibbs)(11). There is a close relationship between the personality and psychosis and an understanding of the personality and personality types will aid in the understanding of the psychosis. Sullivan (25) speaks of a personality as not a thing limited to an individual himself, but that his personality is a part of everything about him or has been about him. The study of the personality is a study of human analysis and dynamic inter relation with other persons and with personality entities such as culture, tradition, laws, beliefs, etc. Petry (18) states that personality is essentially a psychologic term. It concerns that which distinguishes or characterizes an individual in relation with his environment. Amsden (1) defines personality in terms of behaviour as the aggregate of those personal habits, which, by continuous employment have been ingrained in the individual that those who know him can rather closely predict what course of action, what mental attitude and what emotional responses he will display under given circumstances.

This brings us to a consideration of the relation of the personality to a psychosis and its prepsychotic stages. Kraeplin regards the abnormalities of personality as early symptoms of the same underlying disease process as causing

the psychosis and that later the same underlying disease will probably produce the psychosis. However when the psychosis developes the clinical picture will be greatly colored by the personality. Other authorities look up on the relationship from another viewpoint. Gibbs (11) believes that the psychosis is a behaviour or a personality reaction depending upon and growing out of faulty habitual reactions which characterize the personality and that the psychosis is the way that the abnormal personality eventually comes to react to difficult situations in life. Hoch (13) regards the peculiarities of the personality and the psychosis both as deviations along the same line and phenomena of the same nature, partly depending upon constitutional and partly upon the environmental or psychogenic factors. Harrows (12) believes the psychosis and the personality are the same thing and the psychosis can be looked upon as an extreme degree of difficulty of adaptation.

Regardless of what the exact relationship is between personality and psychosis, the personality type does enter in as a factor and does influence the psychosis in some manner as just shown by the various authorities. This will lead us into a study of personality types to see which ones have some bearing on the schizophrenic process. Personality types have been discussed by various authorities. Jung (14) spoke of the introvert and extrovert types of personalities. His introvert type is the one that is governed by subjective

factors. His interests are around himself and is to a large degree immune from external influences. He is unsocial, is seclusive and is contented by himself. He is unemotional. The extrovert is just the opposite type and tends to be governed by external factors. Persons and situations determine his thought and interests. He seeks company, is a mixer and is not content in solitude. The introvert type of personality is commonly found in the patient who later becomes schizophrenic.

Boltz (4) speaks of the schizothymic and cyclothymic types of personalities. These terms have been derived from the prepsychotic study of the schizophrenic and manic depressed psychoses. The importance of these studies have been stressed by Meyer, Hoch, and others and it is through these means that psychiatry no longer limits itself to the asylums with its rigid classifications and dark prognosis.

Quoting from Boltz (4) "in the psyche of man one can theoretically differentiate what is given through anlage from that which is acquired in the course of life's destinies. Everything that man does or experiences leaves behind its trace and slowly alters the psychic constitution. Thorough self-training and bringing up, diverse experience and vicissitudes of life, persons of similar anlage (genotype) at birth may comeinto very different channels, and then once a line of developement has set in, return is possible.

Herein lies the personal responsibility of each and every experience. The capability for altering a given anlage, through circumstances, is quite varied in different individuals. Thus it is apparent that the tempermental make up becomes subject to a certain degree of change due to numerous experiences. This change may be manifested in an exaggeration of some component of that personality, but nevertheless the general pattern of the personality remains the same. It is probably for this reason why one individual will become psychotic while another with a similar make-up will escape. It is not only the number of experiences that count but more important is their nature and the way the individual reacts to them. Thus the magnification of the experience will depend upon the stimulus, situation and the emotional significance to that individual. Some individuals may be born with an exaggeration of the schizothymic trait as in case of both parents being of that temperment (boltz)(4). As a result it is difficult to say whether a psychosis is a result of the anlage, an emotional experience or both. Nevertheless one reaction to the schizothymic temperment to a certain important environmental and emotional stimuli experienced in childhood is the dementia praecox or schizophrenic psychoses. Of course the developement of the psychosis depends upon the nature, degree, and persistence of an emotional experience, his adaptive qualities and the precipitating factors."

The schizothymic individuals have something problem-

atic about them and they appear as question marks before us. They have a jerky tempermental curve; unstable and alternative moods of thought and feeling. The affectivity of this type of temperment is mostly abrupt and boundless. They do not appear hypersensitive nor cold, but are hypersensitive and cold at the same time and in most varied combinations. Ideas of emotional significance are not manifested normally but are bound, under strong tension they are released in sudden outbursts of emotions. They, like the cyclothymic who become emotional and them it is all over, have a tendency to take things without much outward display, but keep them to themselves and brood over them for awhile until something irritates them and then they have a sudden outburst.

Repression is common among schizothmics. Whenever their impulse is contrary to others they tend to repress it. They seem to lack ability of meeting the situation half way; it is either their way or no way at all.

Individuals with this type of personality have the tendency to be unsocial or only in a superficial manner, that is without deep contact with the environment. Boltz (4) further states that he believes it is this reason that schizothymes have a strong family attachment and in case of m males this is for the mother. In too many cases this is still farther fostered by the mother. This helps the individual to withdraw still further from society, lessens his chances for an adjustment to society and aids in bringing on a true psy-

chosis. It seems in a number of cases that in male schizophrenia the child is the mother's favorite.

There is another type of personality that may make up a part of the picture of a prepsychotic stage and that is the rigid personality as desribed by Muncie (16). This type does not only predispose to schizophrenia but other types of functional psychosis as well. It is compounded in no fixed preportions of many factors such as obstinancy, aggressiveness, pride, sensitiveness, a rigid code of personal ethics, an inability to make concessions, a 'one hundred per cent attitude', etc. To a certain extent these qualities are valuable, but they may also predispose to maladjustment and some eventually a psychosis. Due to his code of ethics, pride, sensitiveness, etc. he can not concede to others, he can not make a "come-back" and yet he can not lose and consequently it becomes easy for them to shift responsibility - paranoidal reaction. Muncie (16) states that the paranoic developement represents probably the best example of the rigid personality in trouble. The presence of the rigid personality is of considerable importance in determining the prognosis of the psychosis. The inelasticity of the personality makes it difficult in many cases in treating and making a prognosis. Therefore a personality study is essential in each case as the psychosis is nothing more than the study of the personality.

The study of the personality is not of importance

because of any hope in changing it but these individuals with a "prepsychotic personality" should be recognized, watched and guided as to prevent the precipitation of a true psychosis. It may be that if many of these schizophrenic individuals could have been recognized during the pre-psychotic stages something might have been done in bringing about at least a partial adjustment and much of the grave results prevented. Gibbs (11) summarizes the personality as follows - "we can not change a pathological personality but it is our greatest hope to change the environmental and developemental factors so as to prevent the exaggeration of pathological personality in the individual personality."

This brings us to a consideration of the personality developement - when it begins and what factors influence it such as heredity, environment, associations and periods of life. Such a study has its beginning in childhood.

To begin with we have various classes and types of children to study. Burr (6) speaks of three classes of individuals. First those whose heredity is good and they go through life without any mental trouble regardless of the mental situations with which they are confronted; it is this class of individuals that we have no interest in at the present time. The second class are those individuals whose heredity is so poor or the congenital injury so great that they can not survive regardless how much consideration they are given. Their mental breaks

come on early and are lasting. They, too, are not considered in this paper. The third class is those whose heredity is of such a character that they will not survive the strain unless the environment is good and wise guidance is given until maturity is reached. This group of individuals may show behaviour problems in childhood or peculiarities of personality in early adult life. It is this group of individuals that we are interested in. By recognizing their peculiarities not only in childhood but in early adult life as well, studying their environment and by giving proper guidance and with careful watching these individuals will be helped in making an adjustment and possibly avoiding a mental breakdown at a later date.

Brill (5) has noted children with a psychotic tendency at such early ages as three and four years. There symptoms are varied - they may have outbursts of temper, have catatonic symptoms or appear anti-social and aggresive. Some are prepondingly schizoid in reaction and others are syntonic. He further states that he believes if these individuals under ten years of age will remain untreated they will probably break at puberty. The problem here is to stabalize their tendencies.

Sullivan (26) speaks of four eras in personality developement. These are the juvenile, pre-adolescence, mid-adolescence and late adolescence. The juvenile era is the period which begins in the early years at the time

the child begins to associate with other children. They do not choose definite friends but merely begin to associate together. This is the real beginning of personality growth and socializing tendencies. But this is also the beginning of the evolution of the schizophrenic process. It is through the inter-personal relations that personality growth is stimulated and the beginning of the personality type. Prohibiting these juvenile tendencies has a definite lasting influence upon that individual's personality. They develop fantastic ideas and do not learn to adjust themselves to others. By living in a life fantasy they come further and further away from reality. By failure to adjust themselves to others, the fantastic life is ushered on and they become more seclusive. Right at this point they are entering a realm that is peculiar to schizophrenia - withdrawal from reality. They may become a schizoid type of personality or develop a psychopathic personality which is not compatible with society.

The juvenile era ends with the beginning of the pre-adolescent period or homosexual period as Sullivan (24) speaks of it. This period is about the time of puberty and it is during this stage where the children make intimate adjustment with those of the same sex. They are shy of the opposite sex and have little to do with them. This period very soon passes over into the mid-adolescent period which is the very critical time. It is the beginning of true

sentiments of others - a definite feeling towards father and mother, towards religion and other higher and finer things in life. It is the time for adjustment of the sex impulse. Certain attitudes are set up in regards to the opposite sex and the same sex. Definite relations are set up. Certain ideas in regards to sex are adopted. Anytime during these two periods is an ideal time to start a mental conflict. Certain ideas may not be acceptable or things are not understood and fears and repressions may be the outcome. As a result these end in social maladjustments and personality warps,.It is these individuals which may later appear peculiar. However it would be incorrect to think that every one who has some such conflicts at this time of life will show abnormal traits and precipitate a psychosis. It depends upon the heredity, nature of the stimulus, degree of persistence, and ability of the individuals to adjust himself. But there are certain numbers of individuals who will begin to show peculiarities from this time on and it is these individuals that need help.

The late adolescent stages is that stage where habitual sex behaviour begins. It is probable that there is little chance for conflicts to begin here without causing and acute mental breakdown, but it seems more likely that this would be the stage where a psychosis would be precipitated in an individual with repressed ideas or an individual who is maladjusted and has shown peculiarities for some time.

Kraeplin states that certain proportion of schizophrenics show mental pecularities in childhood and that some have always been weak-minded. The child he speaks of is known to the teachers as the behaviour problem (Richmond) (20) and (Phillips) (19). It would be an error to say that every behaviour problem is a potential schizophrenic, but it is apparently true that many potential schizophrenics are behaviour problems. These behaviour problems may show senseless or even cruel conduct, no regard for punishment and will not reason about their problems or even profit by previous experiences. They are weak willed, easily lead, lacking in energy and appear lazy. Others may be mean, stubborn and highly tempered. These children are usually unsocial and have very few friends and associates. They appear queer and different not only to other children, but to the teachers and often to the parents. They may be and usually are problem cases at home. Children enjoy teasing them and leaving them out of their play. This only makes matters worse and makes reality less acceptable to them. As a result they look upon reality as something not to be adopted but rather to be avoided.

They differ from the psychopathic child in that the later appear bright, lazy and tricky while the schizophrenic appears dull, mentally defective and incapable of learning. However when the psychometric tests are applied it will be

found that he is not noticeably behind. He has the ability but seems too uninterested to make any effort to apply himself. At one time these individuals were spoken of as "potentially feeble-minded" but this is a misnomer.

In addition to the backward type of child just described Domingo (8) speaks of another type - the precocious type. These individuals have exceptional mental ability and appear much older than their actual years. They are ahead in their classes and do exceptional work. They appear little interested in childhood activities and in associations with otherx, but they are interested in books and spend much of their time in reading and study. They appear over serious, dignified, precise, prudish and as model children. Very often they show particular aptitudes such as remarkable memories, artistic ability, etc. As a result of all this these children appear and are different from others. Their accomplishments become crystallized in one particular thing. This sets them off in a class by themselves. In addition the parents very often spur on these children still further into their accomplishments in order to make them still more outstanding. As a result normal impulses are being crushed and the individual becomes still more peculiar. They feel different and adjustment becomes more and more difficult.

Regardless of what type child is dealt with both show a disturbance in the emotional field of life. There is a disturbance of interest in the so-called normal things in

life. The backward child is interested in himself or nothing while the precocious child has interests outside of the ordinary realm of children's affairs.

It is often impossible to differentiate the schizoid children from other children. There are no set standards by which the schizoid children may be separated from the others and branded as such. Bleuler (3) probably best states the situations "nowhere is the question 'sick or not sick' put so often in such an inexorable manner and with such weighty consequences as in the judgement of mental conditions. So far as the concept of insanity has become at all practical, it rests, not on medical or pathological criteria, but on the idea of social incapacity."

In judgimg these children the following conditions are used as a basis (Childers) (7): (1) child's social incapacity (2) his general method or pattern of meeting his situation in life (3) general conditions of how close his symptoms come to that of schizophrenia such as bizzare conduct, mental trends, influences, hallucinations.

The social incapacity is manifested in a number of ways. One of the most frequent is the inability to get along with other individuals and has no interest in their affairs. They would rather be alone and design their own amusement. As a result others look upon them as being different. Many of these children do not get along with the rest of the

family - especially with the other children. They either find it impossible to get along with them or the brothers and sisters find it impossible to regard them as playmates and eventually disregard them or tease them.

All of these social incapacities have a very bad influence on such children. They begin to feel different and consequently become still further away from society. Instead of accepting the blame themselves, they blame others and as a result have a paranoidal trend. By feeling different it becomes still more difficult to make associations and as times go on they become more and more maladjusted.

These children or young adults may react to the situation in three different manners. They may reform to a certain extent and to such an extent that their actions are within acceptable limits to social requirements. The second reaction is one of aggression or attack - they make at least an attempt to cope with reality, and make somewhat of an adjustment. As long as an individual will cope with reality there is hope, but when they once retreat the problem is of another nature and constitutes a third type of reaction. They withdraw from reality and begin to live within themselves. As they become older, meet more responsibilities, and must live within social limitations they may become still further removed from reality and may eventually develop a true schizophrenic reaction.

The study of fantasy life reveals interesting facts.

All children and adults have a certain amount of fantasy as well as schizoids and schizophrenics, but here comes the difficulty - where is the line between what is considered normal and what is considered abnormal. In short it may be said that in normal individuals the fantasies are passing, of short duration and are subordinant to reality. In the schizoid individuals they are more permanent, become realistic and offer the child more pleasure than real life - a true withdrawal from reality. The fantasies may take the schizoid back to earlier periods of life or replace individuals of influence or live in another world altogether. Very often dreams will be similar to their fantasies. These fantasies serve to escape from reality or from parental or social demands and the like. All this adds to a difficulty of adjustment.

Hallucinations may be present in varying degrees. The schizoid individual is usually between ten and sixteen years of age. The love band between child and parents and particularly the mother is usually strong. The child seems to feel insecure and withdraws from outsiders and seeks satisfaction with the mother. Upon looking back the parents amy be able to see pecularities but they have not been sufficient to attract a great deal of attention. At this age the child must make an adjustment or withdraw from society.

There is one period of life that deserves particular

considerations in studying the evolution of the schizophrenic process and that one period is that of puberty (Gibbs)(7).

In following the evolution of behavior it has been observed that a definite change in behavior and personality occurred at this period of life even though the psychosis did not develop until some years later. Various manifestations have been observed as aggressiveness, antisocialism and seclusion. In some instances these changes have occurred so suddenly and extensively as to be remembered by the parents.

There are two major sources for the peculiarities rising at puberty. The first are external, environmental and psychologic factors. The second are internal, physiologic, constitutional and heredity factors. The first refers more to nature and intensity of the stimulus while the second refers to mechanism and capacity to respond.

At puberty the individual and organism are especially susceptible to the influence of these factors. The individual is easily and more or less permanently influenced by his environment and in addition to this there are profound biological changes taking place within the body.

It is well recognized that the personality undergoes at puberty a marked transformation and refinement and that in the process the behavior of many boys and girls is considerably disturbed. They become restless, difficult to manage, aggressive, seclusive, antisocial, etc. Fortunately many outgrow or weather this condition. On the other hand

a few do not. Now why should these few fail? This is a problem not understood.

Concerning the constitutional factors, Marro of Paris (11) emphasized the importance of two factors - (1) disturbance of growth and metabolism and (2) heredity defects. He pointed out many of these individuals at puberty show rapid growth or subnormal growth and disturbed metabolism. In regards as to cause and effect, little is known as to the physiologic relationship between puberty and behaviour. It is known that the fundamental and essential changes at puberty are biologic in nature and behaviour changes which characterize the psychopathic personality relate to emotional and instinctive factors. It seems quite apparent that these biologic processes of growth and metabolism must carry on the organism to physical maturity before socialization of emotional and instinctive behaviour can be obtained. Consequently abnormalities in the biological factors would then tend to show its effects in some abnormal behaviour manifestation. Since the biologic changes envolve the gonads and the behaviour effects envolve the gonads and the behaviour changes envolve the instinct of reproduction, it seems no wonder that there should be sex coloring in the clinical picture of the psychosis of many patients (Gibbs)(11).

By permission the following four cases have been taken from the files of the Hastings State Hospital. The first illustrates the change which may follow puberty: Case 1. G.G. Single

girl. Age 16 years. Colored. Entered Hastings State Hospital August, 1932.

Personal History: Early developement was normal. Menstruation started at 13 years and is regular. She got along well with other children and was a follower. She was an average student in school. A marked change was noticed in her personality and character right after she started to high school at the age of fourteen. She learned poorly and made little progress in school. She failed in several courses and eventually quit school before the year was over. She quit playing with other children, devised her own amusement and became very seclusive. However, she did enjoy teasing the little children about school. She would make various excuses, write false excuses, or simply stay away from school. Because of her refusal to go to school and her pestering smaller children, she was sent to a reformatory for a year. The last two or three months at the reformatory she showed marked changes. She would become unresponsive and then explosive. Shortly after her admittance to the hospital she made one attempt to jump down an elevator shaft as the spirits told her to kill herself. Mental Status: Patient has had delusions for several months and believes she is going to die. She also has auditory hallucinations. Spirits tell her she is a bad girl and to kill herself. She has no interest in anyone or in happenings of the world. She displays some mannerisms. Diagnosis: Schizophrenia, Simple Type.

Many of the individuals will not become psychotic until in their twenties or even later. Numerous prepsychotic manifestations are found in these individuals. Those that are in high school began to lose interest in their work and before this time they may have been good students. The work of some may be such as to result in failures and they leave school by request while others simply quit on their own accord for no apparent reason. After quitting school some may go to work on their own accord while others are forced to. This soon becomes uninteresting to them and they will try something else for awhile. Frequently changes of jobs are common in the histories of schizophrenics. Some quit for no apparent reason while others lose their jobs because of ineffeciency as some will not put forth enough effort to make good. Still others will find it impossible to get along with others or other employees.

The individuals who live at home or have some one else to look after them get along better than those who have to face the responsibility alone.

A number of these individuals become adventurous and roam about the country. They start with little or nothing and return with nothing. They work just enough to "get by". The family may know nothing about the where-abouts of them, but only to have them return unexpectedly.

Sullivan (24) states that some of these individuals who later become schizophrenic have psychoneurotic symptoms as

the first manifestations. They may be in the form of hysterical finding while others present obsessional symptons. These patients are often treated for a psychoneurotic condition which later turns out to be a schizophrenia. What percent show such manifestations is impossible to say at this time.

Another feature is their social maladjustment. Some are definitely anti-social. Others can meet social demands but make no effort to do so. All of these cases appear seclusive.

A number of the individuals in the prepsychotic stages do not get along well their families. As stated before this trait may date back to childhood and in others it may develop until later. They are problem cases-, hard to associate with and radical.

In some cases the family physician sees these individuals with complaints of physical troubles fatigue, undernourishment and weakness. They may be treated for some time without success. Overwork, fatigue, strain and malnutrition enjoy great popularity among individuals with this type of mental disorder.

The following three cases illustrate the prepychotic personality as well as the early stage of schizophrenia.

Case 2. W. M. Male. Single. Age 22years. Laborer.

Personal History: W. M. was brought to the Hastings State Hospital in June, 1932 because of mental confusion and threats toward father. He was born in Nebraska and his

early developement was normal. He went to school until 15 years of age and was in the ninth grade when he quit. Up to this time there was apparently nothing significant about his history - he was an average student in school, got a-long well with other children and was a follower. Upon entering the ninth grade W.M. began to lose interest in school and his work was inferior. Before the year was over he quit school for apparently no reason. He stayed home and did nothing until about sixteen years of age at which time he went to work on a farm. He did not stay at one place long but continually changed places. He had no particular reason for changing so often but only that he liked to be on the move. Later he lost a number of jobs because of shirking his duty when he had an opportunity. When he reached the age of eighteen he began to roam over the country. He bummed his transportation anyway that he could, slept outdoors, and would work occasionally to earn a little money for food. He roamed over many of the western and southern states. He would be away from home for long periods of timesand his parents would know nothing of his where-abouts. He would then return home for a short period of time. The last months he has been at home doing nothing. He had become quite confused mentally the last few months and has made severalthreats to kill his father with a butcher knife and it is for those reasons that he was brought to the hospital.

His parents recall changes in his personality and

character since leaving school when fifteen years of age. He became more irritable and did not get along well with his parents. He lacked ambition, lost interest in the world and became more seclusive. He became a heavy smoker and drinker and has been arrested once for vagrancy. Three years ago he began having moody spells.

Mental Status: He has had delusions for the past few months in nature of ideas of reference. He has had auditory delusions for some length of time - voices tell him he is bad and not to do that. He is still quite confused and displays some mannerisms.

Diagnosis: Schizophrenia, Simple Type

Case 3. E. G. Female. Single. Age 34 years.

Personal History: E. G. had a high school and business college education. Her occupation was that of a stenographer and clerk.

Her mother states that E.G. has always been a little different and had a tendency to be seclusive even from early childhood. She was a good student in school and graduated from high school at sixteen years of age. She was inclined to be sickly and just following her graduation from high school she had a severe attack of nephritis and was incapacitated for some months. Upon recovery the patient refused to go to college which both patient and parents had planned on for some time. She had no particular reason but just would not go on. She continued to stay at home until

eighteen years of age and during this time she was very narvous and restless. She then went to another state to live with an aunt and here worked as a seamstress. After being there several years she wished to return to her mother. Just at this time her mother was moving to another town and the town to which she moved did not suit the daughter and she absolutely refused to live there. Her mother then sent her to a business college and the patient worked very hard and completed her course in one year. She immediately found a position and changed positions quite often but each one was a promotion. She was earning $150 a month as stenographer and clerk in a trust company when she was discharged in 1929 because of her conduct. Her work was efficient but she became quarrelsome with other employees and began to demand that certain individuals be discharged and that certain changes be made. Sometime before she lost her position she was visiting a sister and brother-in-law when during the conversation her brother-in-law made a statement that did not please her, she immediately left the house and never again visited there, although the statement had nothing to do with the patient. After losing her position she decided to go to California and bought a through ticket. After riding a short distance she saw a man on the train that she did not like the appearance of and feared (she did not know him) and the next stop she got off the train, bought another through ticket to her destination and took the next train.

She did this several times. She stayed in luxuriant hotels and lived in an extravagant manner. After being in California for a brief time she decided to go to Chicago and again had to change trains several times because of some individuals she did not like or feared on the train. She spent nearly a thousand dollars (money she had saved) before getting home again. For the past six months she has been home and has to be watched as she attempts to run away.

Mental Status: She has had delusions for the past two years. She believes she is being persecuted and has ideas of reference. Auditory hallucinations are present but there nature has not been determined. She has been despondent, seclusive., and unsocial for the past few years. She has a far away look on her face.

Diagnosis: Schizophrenia. Paranoid Type.

This is a case of schizophrenia that has shown peculiarities and a tendency to be seclusive from early childhood. She has shown pecularities all through early adolescence and yet she managed to get along in society until thirty years of age.

Case 4. L.H. Female. Married. Housewife. Age 30 years.

Personal History: L.H. was brought to the hospital because she would not talk, was despondent, and did not act right at home ; she would get up in the middle of the night and search the house with a flash light.

The early life of the patient was not a happy one.

Her mother died when she was only a few years old. Her father married again but the patient and her step mother never got along well as she showed more favors toward her own children. The patient was an average student in school and went to the tenth grade, then quit because she could not concentrate any more and she enjoyed day dreaming. She then remained home until twenty years of age . She then married a farmer slightly older than herself and whom she had known for several years. They started on their honey moon and after being about half way to their destination, she suddenly changed her mind and wanted to go back which they did. Her husband stated that she gave no reason except that she had a sudden change of mind. About a year later a boy was born to her and this is her only child. Soon after this her husband began to notice certain pecularities. She would become very religious for short periods of time and could not go to church often enough and then she would be just the opposite and have nothing to do with the church. She would have long periods when she would want everything money could buy and then again she would be the opposite.

Her sex life varied as for long periods of time she would be frigid and then for a time she would be just the opposite. She would not get up in the morning and her husband always prepared his own breakfast.

The last few years she has shown marked changes - personality and character. She lost all interest in happen-

ings of the world and became seclusive. She appeared depressed and finally would not talk at all. She was very restless and shiftless. She fell in love with several neighbor men.

Mental Status: She had delusions that the world and her friends had turned against her, she thought men were secretly in love with her. She was indifferent and had no interest in her husband or son. She apparently had hallucinations but the nature of them could not be learned. She displayed some mannerisms, her face was expressionless and she showed no interest in any thing. She talked in a low voice.

Diagnosis: Schizophrenia.

This is a case of schizophrenia that has a background of an unpleasant home life. She begins to show changes at about sixteen years of age (when she was a sophomore in high school) and these mental changes have been progressive until she apparently became psychotic. Following her marriage and birth of her child the mental changes became more marked.

This brings us to a consideration of the problem of when is an individual definitely psychotic and when is he only considered prepsychotic.

Bleuler (3) states in regards to the onset of the psychosis "the beginning of schizophrenia is in reality usually furtive. Even though the disease often becomes obvious to the relatives through an acute attack, a good memory usually reveals certain previous changes of character, or

other schizophrenic signs. Whether the inclination to retirement, often noticeable in childhood, combined with a certain degree of irritibility, is an expression of a disposition or the actual beginning of the disease can not be decided. In many cases the disease itself makes itself felt by a gradual decline of acquired skill and capacity to work. In others, neurasthenic, hysteric, or compulsive neurotic symptoms are for years mistakes for the disease and treated unsucessfully. Anomalies of character and single immediate acts are much more conspicuous."

Boltz (4) states that "from a study of a number of cases he feels justified in concluding that schizophrenia, like the neurosis, usually has a definite precipitating factor or situation (there may also be numerous contributing factors) which has psychological significances to complexes in a state of repression in the unconscious, such as a precipitating factor occurring in the outer world may be an actual situation related to repressed ideas and impulses that are advances by a homosexual or a symbolic situation of some sort having now an apparent relation to repressed material and again merely a vague relationship which can only be appreciated by one who has had experiences with the psychology of the unconscious. From his observation a homosexual setting in the environment which offers gratification in a passive form to the unconscious or even supressed homosexual impulses (already under great tension) of the patient is

the most common precipitating cause of schizophrenia in males. Situations which refer to incest, castration or other elements of the Oedipus complex seem to precipitate a psychosis less frequently."

Hoch (13) states "As a matter of fact we are learning to describe, to a certain extent, what goes on in schizophrenia in mental terms because we can follow somewhat the steps of the deviation from the normal adaptation and see in the special forms of reaction in what way the adaptation fails. Above all we are learning how various situations in life, that is causes which can be described in mental terms, play an important role in these orders, just as they do in the neuroses.

This brings us to a study of the nature of the precipitating causes - whether they are psychical or physical. Rosanoff (21) in 1910-11 studied a large number of psychotic individuals (all types) in regards to the precipitating cause. Out of this group he had 62 cases of schizophrenia. Out of this group 56% the psychosis was precipitated by psychical causes such as business troubles, death or illness of relatives, love affairs, sexual episodes, domestic trouble, and various miscellaneous causes as assault, fright etc. Business troubles, domestic troubles, and death or illness of relatives are by far the commonest causes in this group. He also found that only one third of the cases were precipitated by "sexual causes" in the broad sense. Rosanoff's

findings differ from those of Boltz (4) who stresses sexual particularly homosexual experience. Rosanoff further states practically all the psychical causes of his cases are the out come of maladjustment in the "societal relations" as emphasized by Sullivan (25). He concludes "leaving aside the matter of complete separation of personal and environmental factors, the exciting causes of insanity here considered appear to be invariably of a psychical nature, and that the cases in which no causes are assigned do not differ essentially from others in etiological mechanism: it so happens that in their histories there is no spectacular event to be recorded as the cause."

Gardner (10) made a study of fifty female cases in regards to the major mental conflict manifested early in disease. He found in 28 cases the conflict to be of a sexual nature as homosexuality, faithfulness, unfortunate love affairs, masturbation etc.; 6 cases that made a failure in occupation or life plans; 12 cases of long continued vague feelings of guilt, inadequacy and fear, and 4 cases with no data. He concluded that the major mental conflicts manifested in the onset of schizophrenic patients are those concerned largely with feelings of guilt or inferiority in relation to attempts at satisfactory conscious sexual and occupational adjustment. Nearly 50% were emeshed in conscious sexual maladjustments and nearly 25% were envolved in economic and social failures.

Sex plays a big part in precipitation of psychosis but just to what extent, it is difficult to determine. Hoch (13) states that a number of conflicts represent plain sexual demands which the patient can not meet; others are the result of strong subconscious wishes. Boltz (4) stresses homosexuality in precipitation of psychoses in male subjects. Gardner (10) and Rosanoff (21) have shown in their limited number of cases that other factors are just as often the precipitating factor.

Gardner (10) concludes that deep feelings of guilty, inadequacy and incompetency arising in connection with any of our multi-varied contacts with our fellow men - our "societal relations" - are the most general mental states concomitant with the onset of the schizophrenic disorders, the disease resulting in those individuals who have been endowed with the unfortunate personality make - up which is unable to accept frustation or defect from other human beings.

As stated before it is never easy to say just when the schizophrenic patients have crossed the line into actual psychosis. Sullivan (24) speaks of several cases in which there occurred a brief phase of marked psychotic condition some considerable time before the final break. Some of the cases had undergone operation and at which time they showed (right before or right after) definite psychotic symptoms as shown by characters of delusions and actions. They cleared up

readily and had gone sometime before the final break.

Some of the patients appear depressed just before the outbreak of a definite psychosis. The behaviour of these individuals reflect much unhappiness, but they are to be distinguished from the depressive psychosis. They differ in that they do not show up physically or mentally nor suffer with preoccupation with a certain idea. They differ in that they do not show up feeling that everything is lost because of sin, but that all is wrong for some reason or another which may or may not pertain closely to some individual inadequacy, pecularity or weakness. Sullivan (24) believes the situations are always a maladjustment to assumed personal liberty, but thus may elude the patient's awareness entirely. While the true depression is preoccupied with thoughts of the enormity of the disaster, of punishment, hopelessness and the like, the incipient schizophrenic is not the host of any simple content, but is burdened with pressing distresses and becomes more and more wrapped in phantastic explanation and effort at remedy. He further states that distinction is one fundamentally dynamic: pure depression is a most unhappy struggle. Instead of literal or figurative sitting still these people are striving to cut themselves off from painful stimuli, escape the situation by mystic and more or less extraordinary efforts and justify themselves by heroic measures. While the depression may end in suicide of a practical sort, the schizophrenic depression looks to fantas-

tic methods of self destruction often preceded by fear of being killed.

Fear states extending from phobia to terror and from anxiety to a full developed panic exist in many of the early schizophrenic.

Perplexity or confusion is almost a universal phenomena of the early state. Where influences from external sources affect the patient's perception of reality to such an extent that the patient becomes more and more mixed up. Insignificant notions interfere unpleasantly with mental processes. The state of confusion is well shown in Case 1 at the time just preceding and his early stay in the hospital.

A great proportion of these individuals just in the early stages of the disease believe that they are being referred to and talked about. The tendency to reduce others to a lower level than that adjudged to self is evidenced not only in the more direct behavior and thinking but indirectly by projection as in the persecutory trends and with any excuse this progresses into notions that one is being slighted, annoyed, or definitely wronged (Sullivan)(24).However similar mild delusions may be found in numerous individuals who are considered perfectly sane.

Fantastic ideas attached to the behavior of others or to one's own action are always found. Fantasies are also found in normal individuals but here they are subordinate to reality. Many of maladjusted after becoming psychotic believe

themselves to be under the influence of mental machines, radio machines, and the like. Their thoughts are not their own but are governed by these various devises.

In a study centering upon the cognitive features, there appears those processes and symbol elaborations which are commonly found in the dreams. These, like the dream figures, are representing the personal situation and for efforts at solving it. It is this stage that the patients believe they are being followed and watched. There are various hallucinations of which the auditory are by far the most common (about 85%) and visual hallucinations or about 12% of the cases (Strecker and Ebaugh)(23). The hallucinations are commonly of a threatening, robbing and degrading nature. They are called vile names and are threatened.

The general behaviour of the early schizophrenics may show many oddities. He may smile or laugh when there is nothing near him. He may at times be impulsive, others are antagonistic and even resistive. Some appear suspicious and at times alert. Mannerisms are generally present. There talk is often incoherent and without meaning.

Orientation, memory, retention, grasp of general information, calculation, speech, and writing are usually not impaired in the early stages but this is not alwaystrue as some patients are disoriented or show other disturbances in the sensorium and intellectual resources. Insight is usually absent and is a very important factor in considering the

prognosis. As long as there is insight one can expect adjustment possibilities (Strecker and Ebaugh)(23).

The schizophrenic patient may be classified clinically into the following types (17) (1) simple (2) hebephrenic (3) catatonic (4) paranoid. The simple type is one of simple deterioration. There is usually nothing marked about their behavior outside of indifference and some ideas of reference. Insight is poor and they nearly always go on to deteriorayion. The hebephrenic type show marked oddities of behaviour as silliness, laughing, etc. Talk is markedly incoherent and scattered. The catatonic type shows a disturbance of psychomotor activity ranging from deficient will power to catatonia where there is exhibited gross negativism and mutism and are resistive, unresponsive and rigid. The paranoid type have psuedo-systematized delusions. Their delusions are only partly systematized. The patient is usually indifferent in regards to them.

The following two cases are taken from the text, Clinical Psychiatry, by Strecker and Ebaugh, to illustrate the early stages of schizophrenia.

Case 5. Typical case of hebephrenic schizophrenia. K.A. Female 25 years. Single. Factory Worker. Admitted Oct. 10, 1922. Patient was referred to the hospital on account of her queer behaviour and odd delusions.

Onset of Present Illness: Began September 19, 1922, after a visit to a dentist's office. She talked irrelevantly. She felt that the dentist was in love with her. "He made me do things." She became careless of her personal appearance and

very untidy, at times exposing herself. Later she began hearing voices which made her confess onanism, which had been a source of wopry to her for a long time. She felt that people on the street were talking about her, claiming that she was a bad girl. She imagined that she must be making people crazy. She had prolonged periods of laughing and smiling to herself, and at other times was depressed. Relatives said that she threatened suicide. A week previous to admission the patient became very agitated, following a court proceeding against her older brothers for support of their invalid father. At one time she felt that she was facing death but stated that she was willing to die in order to "leave some pleasure in the world" and to"save the world". Voices asked her if she had intercourse with men and referred to other sex topics. She complained of seeing different animals, especially a dragon. She became very religious feeling that she should change her religion. There has been a gradual decline in her physical condition since onset of present illness.

Personal History: Normal birth and developement. She showed the same oddities in children as later in life. She had the usual childhood diseases. She had a severe attack of influenza in 1918. Her school history was one of many changes showing poor adjustment at an early age. She has been working in a hosiery factory with practically no advancement. She was overstimulated by her associates who referred to her as an old maid, since she was extremely prudish and the girls enjoyed teasing her and talking about sex topics. She practiced self-

abuse during the past few years.

Personality Make-up and Situation: Patient has been very seclusive and reserved from childhood. She has always been overattached to her father and despite her long hours of work in the factory has waited on him day and night since his stroke. She has always been very much disturbed over sex-problems, especially since she heard a lecture on self-abuse several years ago. Patient felt inferior to the other girls and reacted poorly to teasing. She showed an inability to mix with people from an early age and was inclined to day-dream excessively.

Mental Examination: On admission the patient showed many oddities of behavior. She frequently smiled and laughed to herself. She was impulsive, antagonistic and resistive, at times abusive to those around her whom she accused of torturing her in various ways. Her talk was extremely irrelevant. At one time she spoke of the Catholics and Jews being against her and said she had to die. Spoke about electricity, self-abuse, various religious events. Mood and special preoccupation: Affect-inadequate and apathetic. She showed a tendency to laugh and be silly when asked about her father's condition. She had ideas od reference - "People talk about me and point to me and say that I am a bad girl. This has been going on for two years." At times she had an idea that her food had been tampered with and something put in it in order to make her sexually excited. Auditory hallucinations were present. She heard

voices that accused her of self-abuse and told her she must die. At times she reacted to visual hallucinations, stating that she had seen a dragon, which on close questioning she associated with the feeling of death. The patient also felt that she was under the control of electricity and also under a mental spell due to telepathy and thought waves.
Sensorium and Intellectual Resources: The patient was oriented regarding time and place. She recognized the examiner as a physician. Her memory showed no defect. She was able to describe in fair sequence different events of her past life. Retention, grasp of general information, and calculation could not be tested. She has no insight into her condition.

Case 6. Schizophrenia, simple type. D.J. Age 24. Clerk. Admitted August 26, 1922. Committed Septemberll, 1922.
Onset of Present Illness: In November 1917, the patient saw his uncle die and it seemed to affect him a great deal. He developed the idea that people were talking about him. He became very indifferent, listless, and refused to work. Soon after the onset the patient was sent to a private sanitarium where he remained for six months. At that time he seemed to have lost all ambition but was improved by his stay. Since his discharge he has taken several jobs but could not hold them and refused to work regularly. Three years later the patient realized that his physical condition was not very good so he began to take lessons in boxing, but continued to be a source of worry to his family. He left home February 28, 1921 and was not found until March 1922 when he applied at the

Hospital for a position as attendant and his mental condition was recognized.

Personal History: Normal birth and development. Had usual childhood diseases. Completed grammar school and later was graduated from High School with a very good average. He was very good in English but poor in Mathematics, showed little athletic interest. He refused to stay in a hosiery factory because he could not master numbers and so went from one position to another.

General Make-up: Patient was described as being very grouchy, obstinate, and stubborn. At school he apparently showed some ability in his English as he was Exchange Editor on the school paper. He seemed to be interested in the opposite sex but was too serious minded and distant. After leaving school he became very listless with no definite ambition.

Mental Examination: He showed no gross oddities of behaviour of any type. Appeared indifferent, listless, poor emotional tone. Paranoid Ideas: Vague and indefinite, he felt that his parents had never given him a chance. His parents could never understand him. He imagined that people were talking about him, referring to him as a loafer, as having a peculiar stare out of his eyes, etc. Hallucinations were absent.

Sensorium and Intellectual Resources: Well oriented for time, place, and person, with no defects of memory for remote or recent events. Grasp of general information was fair. He believed there was nothing wrong with his mind. He was willing to stay in the ward.

The symtomotology, reaction types, and differential diagnosis have been considered very briefly as this paper is not the place to discuss these factors in detail. This paper is limited to a consideration of the prepsychotic stages extending through childhood and early adolescence and the precipitation of a psychosis with some of the characteristic symptomotology of the early stages.

CONCLUSION

Schizophrenia, or dementia praecox, is a mental disease that has its greatest frequency in early adult life. Due to its frequency, the early onset and the bad prognosis it now constitutes the larhest single institutional problem in this country.

This disease usually occurs in those individuals with a seclusive or shut-in personality. It has become a well recognized fact that these individuals who become schizophrenic show peculiarities for months or even years before becoming definitely psychotic. It is during this prepsychotic stage that these individuals should be recognized and an attempt be made to bring about an adjustment, because when they once become psychotic and lose insight the prognosis is grave.

There is a precipitating factor or cause for the onset of a true psychosis and in the majority of cases the causes are psychic and not physical in nature. The early schizophrenic shows oddities of general behavior as mannerisms, rigidity, silliness and impulsive outbreaks and many others. Some are present in one case and others are present in other cases. The stream of mental activity and talk show changes such as incoherence, rambling, and catatonia. Ideas of persecution, reference or influence are present to some degree or another.

Auditory hallucinations are present in a very large percentage of cases in early schizophrenia.

Sensorium and intellectual resources are often not impaired, but insight is usually lacking.

Therefore as stated by Strecker and Ebaugh it is seen that "the importance of this group of psychoses from the Public Health (Mental Hygiene) view point need no further emphasis and preventive measures are of utmost importance."

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