Lecture 23

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- Presentation of a case of anxiety psychosis
- Clinical picture, course, diagnosis, prognosis, treatment
- Delimitation from the area of anxiety neuroses
- An example of hypochondriacal anxiety psychosis

Lecture

Gentlemen!

Patient Sch., who you see before you, came only reluctantly to the lecture theatre. He looks around anxiously, comes closer, but hesitantly, and then greets me as an acquaintance. You see him as a 55-year-old, heavily-built man of poor nutritional status, with somewhat cyanotic discoloration of face and hands, and cool extremities, fearful in posture and facial expression. Again and again, he repeats in a rhythmic manner a low moan, and also interrupts his speech every so often, when he shows a great need to express himself. When I interrupt him to give you information, he resents it. He gives correct answers to my questions about his age, family situation, and home town, but you will notice that due to his Affective state, his concentration is impaired; and he introduces pauses, during which he looks around absent-mindedly, so that his answers to simple questions, which would otherwise be quite prompt, sometimes take a long time to reach their conclusion. He also repeatedly suggests that it is difficult for him to concentrate. The impression we gain from his prevailing Affective state is one of bewilderment, anxiety, and disarray. The fact that such Affective states complicate an orderly train of thought has long been known, and has frequently been shown to you. On enquiry we learn that the patient complains of unceasing anxiety. If the seat of the anxiety is in his heart: 'It wants to crush him' [W]. He is also breathless, and therefore is sleepless at nights. The patient therefore wished to be examined by me, and in his anxious and overhasty manner, made arrangements to undress. When asked why he is afraid, he tells me of his fear of being beheaded; he had also heard that each day he would receive 50 lashes, counted-out; he would be expected to eat a roll that had lain in a fellow-patient's spitting glass. On questioning, we hear that other patients lying in the same room with him made these statements. Therefore the patient is well oriented and knows he is in a clinic for the mentally ill. However, he has not judged the current situation quite correctly; and presumably his viewpoint was already rather limited, as we often find among country folk from his region. He knows me; he recognizes the audience as students, and thinks that I have granted them 'an hour' [W], but he believes that all men there want to be ministers of religion, like his son, who is currently a theology student and accompanied him to the clinic. On the ward,

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the patient also claimed that they would cut off his head; he would be taken to the place where corpses were stored. Incidentally, it is not primarily fear from these threats that dominates this patient; rather, we usually hear from him his complaints about the fate of his family. He believes that all his possessions were gone: His son would no longer be able to study. He heard the voice of his young son saying: 'For three weeks we have had nothing reasonable to eat' [W]; he had also seen his son standing in front of him, with a pathetic gesture. He believes that his family will all die of hunger; the children are all sickly; his son, the student, was refused life insurance due to heart failure. It was his fault; he had shamed himself by an immoral lifestyle and secret sins of his youth. He had become lazy. He had also harmed himself by chewing a lot of tobacco. The patient tells of an assault, during which he recognized one of his attackers and reported him. He had probably committed perjury at the time, because it had been night, and he could not see clearly. Earlier, when his anxiety was even greater, he also complained that his two youngest children had been poisoned, and his wife had taken her life. At the same time this patient, who has suffered a hernia, eats only meagerly, and says that he gets abdominal pain after a meal.

Apart from the hernia, no organic disease can be found in this patient; and in no way does he look older than his age, but rather younger. He has now been in the clinic for more than a month, and was ill for about 3 months before that. The 'external cause' [Ed] of his illness was said to be that the patient, proprietor of a village smithy and associated farm holding, sold his plot of land and the blacksmith's workshop in order to retire. Although this transaction turned out to be quite advantageous for him, with a smooth transition, the idea gradually came to him that he had ruined his family and would impoverish them. Gradually this idea was joined by anxiety, self-blame in reference to alleged perjury (see above), and the idea that he was a great sinner and was being persecuted by Satan. These autopsychic ideas of anxiety existed on their own in the initial period of illness, and only shortly before his admission were they joined by those of fantastic threats; and at the same time, there was an increase in the patient's restlessness, which became so noticeable that it was inevitable that he be transferred to an institution. At this time, he seems to have reached the most critical point in his illness and even to have moved beyond it. This is supported by a reduction in his somatopsychic ideas of anxiety. Moreover, the phenomenon had been present, of which there is now no more than a hint; his rhythmic moans, which had been much more pronounced early in his stay, had risen from time to time to monotonous repetition of the same phrase, 'I, a poor sinner' [W]. This was occasionally accompanied by rhythmic movements of his arms. Also, anxiety seemed to have reached its peak at about this time. Eating became difficult only at the time when there were these somatopsychic ideas of anxiety; and sleep had to be induced mainly through sleeping pills. His body weight of 78 kg at the time of admission fell to 72 kg, where it is at present; so his food intake has usually been quite sufficient.

As for his prognosis, based on progress so far and other evidence, we are quite confident in viewing it favourably. The course of his illness showed an acute origin followed by increase in symptoms over about a week, in which parakinetic and hyperkinetic symptoms appeared in the form of verbigeration and rhythmic arm movements. This period corresponded with the height of his anxiety and production of somatopsychic ideas of anxiety. Since then independent motor symptoms and likewise his symptoms of hypochondria have ceased, and anxiety has subsided in intensity. Moreover delusions of relatedness, and disorientating phonemes with content to match have not increased. Thus the intensity of the basic phenomenon, namely anxiety, runs in parallel with the range of other symptoms; the decline of these phenomena is to be expected, in a similar sequence. (In fact the patient became healthy in the space of 3 months after the demonstration, and has remained so for 2 years since).

Gentlemen! This clinical picture described is typical of a large number of similar cases, given that we ignore a few anomalies which make this case not quite typical. Perhaps these are peculiar

to this individual, as I have suggested. In general, we cannot deny that the elementary symptom of anxiety provides the exclusive source of a disease, which in many cases produces no symptoms other than ones attributable to anxiety. We can summarize all such cases of illness as *anxiety psychoses* [W]. The basic symptom is anxiety, usually localized in the chest, especially in the heart and epigastrium; next most commonly, in the head; next in frequency to the entire body; and regularly, it has a fluctuating character, and, at the beginning, or as the illness abates, an intermittent character. Such anxiety regularly leads to the emergence of various ideas, which therefore deserve to be called 'anxiety ideas' [Ed]. They show grades of intensity such that the autopsychic ideas of anxiety correspond to lower intensity, and the allopsychic and somatopsychic ones to more severe anxiety. Somatopsychic ideas can sometimes be missing or even, as here, emerge only temporarily at the peak of illness. When the disease starts, and as it subsides, only autopsychic ideas of anxiety are usually present. In some cases anxiety persists, accompanied just by such ideas; far more often the ideas are 'dressed up' [Ed] as phonemes. At the height of the anxiety state, hallucinations can also appear temporarily in other modalities and, in some of the most acute cases, as in the example of anxiety in a case of epilepsy described above, can occur simultaneously in all senses, as combined hallucinations. Often, only autopsychic ideas are present, at a moderate level; or there may even be a combination of autopsychic and allopsychic ideas of anxiety, with added phonemes only at times when anxiety intensifies. Allopsychic orientation is retained but autopsychic orientation is usually permanently altered, in the sense of delusions of belittlement. On the other hand, disarray can expand to include the allopsychic area. Hints of delusions of reference are often encountered at times of intense anxiety; also, disorientating phonemes with such content occur. Common contents of autopsychic ideas of anxiety and matching phonemes express concern for family members, for the financial situation, and challenges to personal honour, and there may be ideas of belittlement, and self-recrimination, with corresponding abusive phonemes. The content of allopsychic ideas of anxiety is usually a threat to life, or of ignominious disciplinary actions, abuse, etc. Delusions of reference operate in the same way. The hallucinations whose intensity is most prominently linked with very high levels of Affect are those of smell and taste, because they are usually interpreted in terms of poisoning and lead temporarily to rejection of food.

Amongst the aetiological factors are alcoholism, epilepsy, and climacteric; and anxiety psychosis seems to be closely related to growing old.

As for the duration of such psychoses, they may last anywhere from a week to several months. The shortest course is seen in 'abortive' [Ed] cases among epileptics and alcoholics. It sometimes happens that *Delirium tremens* [W] will be replaced by acute anxiety psychosis, with its characteristic intense Affect, and with predominantly autopsychic ideas of anxiety. The psychotic state is then correspondingly short in duration and accompanied by tremors and symptoms arising in the projection system, as discussed later. In terms of symptoms, anxiety psychosis is not rare, especially in cases of poorly resolved heart failure; its time course then tends to be bound up with this situation.

An actual paranoid stage, reaching the point where insight into the illness is lost for a long time, tends not to develop.

Motor behaviour of patients is generally determined purely in psychological ways through Affective states, or the content of ideas of anxiety and of hallucinations. Usually, most patients can be treated in bed; however, as anxiety increases, a degree of motor restlessness is produced, initially as movements expressing anxiety, such as crying, sobbing, wringing of hands, kneeling down, and praying, according to the patient's individual manner. In many cases it may lead to tremors, gnashing of teeth, and outbreaks of perspiration. Should anxiety undergo a further crescendo, patients leave their beds, and walk restlessly up and down, probably also forcing themselves. Some expressions of movement—or at least borderline motility symptoms—are not psychologically motivated, such as rhythmic moaning or rocking movements of the trunk (usually both

together); endless uniform movements of hands, which are repetitive, if not rhythmical; fiddling around with the bed or pieces of clothing; rubbing the hands together, etc. There is almost always a strong suicidal tendency, or a wish to die, often expressed with comments such as 'Make an end to it. Strike me dead' [W]. At the height of the disease, even more severe motility symptoms are prone to occur, such as parakinetic behaviours, rhythmic movements, and verbigeration. On the other hand, at the peak of allopsychic disorientation, increase of sensory symptoms may occur, to the point of anxiety displayed even when approached, and as blind defensiveness.

As a particular form of anxiety psychosis, the so-called *Melancholia agitata* [W] deserves to be mentioned explicitly. In this condition, there is ever-present marked restlessness; movements are driven mostly, but not exclusively in psychological ways; sometimes, as described above, they are on the borderline of an actual motility disorder. Above all, increased production of anxiety ideas can lead surprisingly to pressured speech and flights of fancy, symptoms that we will encounter later in a very different clinical picture, where there can be no mistaking their sensory derivation. Also, it seems to be intrinsic to such cases of agitated melancholia that autopsychic ideas of anxiety outweigh by far any others in their content, even though allopsychic ideas may never be totally absent.

In *diagnostic* [W] terms, the assumption is that the illness will often develop further, forming no more than the initial stage of a more complex disease picture. Such development takes place in two ways: to a scenario of complex motility psychosis, characterized usually by the onset of akinetic symptoms, and to one of expanded sensory psychosis with disorientation. We should always suspect the latter when disorientating phonemes and delusions of reference make up more than a trivial part of the clinical picture.

Further development can also take place very quickly, so that the most acute medical conditions such as the so-called transitory psychoses [Ed] may result.

For differential diagnosis against Affective melancholia (see later), it is crucial to prove the presence of allopsychic ideas of anxiety or delusions of reference. Diagnosis of acute hallucinosis (see later) is likewise usually easily established. The symptom of anxiety predominates, from patients' accounts, and is also conspicuous objectively; and the dependence of phonemes on the fluctuations of anxiety, so often seen, is a usual characteristic. However, in acute hallucinosis a characteristic paranoid stage develops very early, which is not the case for simple anxiety psychosis. In the latter condition, allopsychic orientation remains intact, unlike the anxiety-laden state found in *delirium tremens* [W]. Likewise, disorientation tends to be found in generalized sensory psychoses. Therefore, many cases of anxiety psychosis are indistinguishable from progressive paralysis, because, from a clinical standpoint, one must accept the existence of a 'paralytic anxiety psychosis' [Ed]. While the Affective overlay often makes it difficult to establish those disturbances of thinking, judgment, and memory retention which can almost always be found in paralysis, the possibility nevertheless exists that key symptoms of paralysis or alcoholism, arising in the projection system, are still initially absent, only entering the picture later in the course.

Gentlemen! Very often you will come across cases of illness that you might call 'borderline' [Ed] cases, or cases of mixed *anxiety psychosis* [W] and *Affective melancholia* [W]. They are characterized by the fact that neither one nor the other clinical picture exists in pure or complete form. In their outward character, the picture of Affective melancholia is usually predominant, particularly because fluctuations based on anxiety are less pronounced, so that a more continuous and consistent clinical picture prevails. Subjective deficits, which befit Affective melancholia, are often absent, while prominent ideas of belittlement, self-recrimination, and other autopsychic ideas of anxiety are present. The dominant Affective state is a feeling of misfortune, but at the same time, a state of anxiety always exists, which can usually be localized. Expressions of anxiety usually restrict themselves to the simplest movements such as crying and occasional outbursts of despair, but agitation is generally missing. Allopsychic ideas of anxiety can almost

always be detected, but remain isolated, their importance falling away, so that one must often actively search for them. Likewise delusions of reference emerge entirely on their own. Forebodings of misfortune prevailing along with wider perceptions of anxiety often remain limited to circumscribed areas, as is found with pure melancholia. Phonemes play only a minor role.

Thus a fairly common clinical picture can be characterized adequately in both directions. It seems to occur preferentially among very young persons and in old age. The diagnosis is therefore not unimportant, because the prognosis of this illness can be stated more securely not only than in cases of anxiety psychosis, but, in itself, is also far more favourable. Cases of this type that I know all had a favourable outcome.

The *prognosis* [W] of anxiety psychoses *per se* [W] would be designated as favourable, since by far the majority of cases such as those outlined above have progressed towards full health. This favourable judgment is hindered by the difficulty in making a firm diagnosis until some way into the course of the illness. Only when, as in the case I just presented to you, the patient has already gone through the critical point of the disease, can we assume it as likely that a transition of the clinical picture to a more complex one will no longer take place; and in this too, our hopes may sometimes be dashed, because, after a stage of apparent recovery, development of psychosis with a chronically progressive course may ensue. Such was the case, for example, in a case of senile anxiety psychosis in a 73-year-old woman who I could present to you after a 1½-year course, as a typical example of a chronic psychiatric patient with so-called hypochondriacal delusions of persecution [Ed], in the stage of allopsychic disorientation [1]. In this case the clinical picture was unfavourably clouded by numerous disorientating phonemes and delusions of relatedness.

Treatment [W] of anxiety psychoses has the special task of fighting the symptom of anxiety. We cannot humanely ask any patient simply to endure a high level of anxiety, any more than we can for analogous symptoms of pain. In general *Extractum Opii* [W], to be injected subcutaneously in doses of ½ to 1 dcg, is a reliable remedy. Along with this, a combination of hyoscine with morphine proves itself to be valuable: half as many milligrams of the former as centigrams of the latter. With that dosage one can increase the daily dose progressively from ¼ mg:½ cg up to ½ mg:1 cg. For anxiety attacks in epileptics it is preferable to administer a sleep-inducing dose of amyl hydrate internally or by enema. Incidentally, treatment of anxiety psychoses gives outcomes just the same as those for psychoses generally, so I refer you to my comments on the subject at the end of these lectures [2].

Gentlemen! In no other area of mental illness are there so many points of contact with the functional disorders of the nervous system as the one we deal with here. However common the anxiety psychoses may be, there can be no doubt that states of anxiety to be classed with the neuroses are far more frequent. This raises the following question: Are there any sure criteria by which one can distinguish *anxiety neurosis* [W] from an anxiety psychosis? This question is of great practical importance, for it is precisely anxiety psychoses for which doctors are obliged to provide timely security, by committal of patients to an institution, sometimes involuntarily. Such interference in the personal liberty of another fellow human would never be tolerated in the case of mere neurosis. Fortunately the clinical picture I described now offers more reliable and easily identifiable indicators in its complex of symptoms, such that a positive diagnosis of anxiety psychosis can be made easily, and any doubt about the appropriate course of action is thus excluded. However, without doubt, as everywhere else in Nature, there are borderline cases, where there is justified uncertainty about the wisdom of such a measure. Here, a physician will be tasked with ensuring the greatest possible reassurance while monitoring the patient privately. For this, there is no better way than strict adherence to bed rest. This is the way in which the symptom of anxiety itself, as shown above, is to be treated. The well-being of the patient precedes all other considerations, and so the focus must be on practical implications that the patient infers from his feelings of anxiety, and from subsequent unhappiness and anxiety about his own actions.

Always remember that although a single symptom such as anxiety is never sufficient to produce psychosis, nevertheless, at least as much value should always be placed on actions of patients, as on what they say. Where there are attempts at suicide, safeguarding a patient by internment in a lunatic asylum is imperative even in borderline cases.

Gentlemen! I have begun describing specific types of illness by choosing anxiety psychoses because, on the one hand, cases of such illness are relatively easy to understand, and on the other, because their points of contact with many other acute psychoses are so varied that they soon lead us right into the centre ground of our practical tasks. I need hardly point out that practical knowledge of mental illnesses in itself has nothing to do with theoretical assumptions. Therefore the series of our demonstrations is set up mainly for teaching purposes, these being subordinate to practical needs. The patient who I shall now present to you still belongs, in a practical sense, within the area of anxiety psychoses, but, as you will soon see, will continue into the topic of our next lecture.

This 69-year-old factory worker, Mrs L., as you can see, is a silver-haired woman, who walks with a slight stoop, with downcast, facial expression, easily made anxious, and with corresponding attitude. She answers questions that are directed to her promptly, albeit with a rather faint voice. She tells us her birthday, the date of her marriage, how long she has been married, the date of her husband's death, his illness, and the names of her children; she talks about her only surviving daughter, and tells of her grandchildren. Also, we learn directly from her the history of her illness. In the spring of 1896 she was diagnosed with a growth in her abdomen, which had subsequently been operated on. She had then spent 11 weeks in hospital and was subsequently quite weak but was otherwise healthy. In November she was diagnosed with shingles, and for 3 weeks was virtually unable to sleep. At the beginning of December the present illness started. She gives the duration of her stay in the clinic—from 24th February this year—which is roughly correct; she shows herself to be completely orientated about the way in which the institution functions, and about her fellow patients; and she knows that the gentlemen present are students who visit the clinic. I led her to a discussion of her illness. What kind of illness was it? She could not eat anything because her throat had 'grown over' [Ed] or, as she corrected herself, only very little would pass through. Her tongue had grown onto her palate. She felt with her hand, and also showed me that the upper surface of her tongue touched the palate. She also had a constant taste of 'bad luck' [W] in her mouth, and everything she ate lacked flavour. Anything she did swallow in her laborious way, she felt became stuck in her oesophagus. It piled up in the region of her stomach, and led to feelings of bloating. It had previously been impossible for her to pass any stools, and they now passed only by artificial means and insufficiently.

I asked whether things were not already improving, which she denied. I must comment here that she is actually already recovering well. She used to be so weak and feeble that she could answer only in a toneless, flat voice; and a demonstration like today's would have been totally impossible. Due to her severe malaise, at that time, she hardly ever spoke about herself, while now she sometimes does so; she had shown no interest in her environment, whereas now she takes some interest in it. At that time she also stated that the canal for passage of her food had grown over completely, and she had to be forcibly fed, whereas now she can take some nourishment spontaneously. We also learned, from her daughter, that she had earlier complained of not being able to breathe.

This patient cannot specify exactly the nature of her disease; at least it was something very bad, and totally hopeless. In the past she had given her view that it was plague, and that she was afraid of infecting others by contact. In this respect, too, she has clearly made progress because now she no longer believes this.

When we now ask the patient how satisfied she is with her treatment here, she replies: Good, but it is just not worth it. Why ever should she blame herself? She was bad and sinful through and

through; she had already attempted to take her own life; she was a monster, a spectacle amongst men; she deserved to be discarded. Other patients shouted out about her. She had brought her illness on herself by starving herself; during her last illness she had been reckless in treatment of her mother. As a further sign of a fantastic delusion of belittlement, I want to mention that the patient refuses to go into the visitors' room, because she should not be seen by others. When preparations were being made for photography the photographer would be so frightened at the sight of her that he would drop down dead. Furthermore, she believes that she cannot die, because she is too bad; and yet now she says she wants to die and, prior to her admission, she had made two attempts to strangle herself because she could bear it no longer. As for her grandchildren, the patient believes that they are very ill, perhaps dead, and she previously gave us the opinion that they would die on her behalf. She even claimed to be the cause of all misfortune, from which she heard, as an example, when a friend had burnt her hand. She likewise expressed the fear that she would be admitted to hospital because she was too evil. Although she gives quite coherent information, and conveys no outward sign of anxiety, she says on questioning that she suffers constantly from anxiety. Where is the root of the anxiety? In my head. The anxiety is precisely differentiated from a feeling of excitement in her epigastrium; but according to earlier information, the anxiety had been temporarily localized in her chest. With regard to this patient's conduct on the ward, she has always shown herself conspicuous as accessible and trustworthy. She always keeps herself clean, and the only hindrance to this is on occasions when, as a consequence of her delusions, she attacks her anus or touches her faeces.

Gentlemen! No other symptoms have been found in this patient. There remain only her delusions based on the abnormal notion she describes, restricted just to her body and her personality, and which thereby determine her behaviour. With regard to the conceptualization of this illness, it is very instructive to provide an overview of its course. In fact it turns out, beyond doubt, that the hypochondriacal complaints which still exist had been present right from the beginning, and had led gradually to the most severe emaciation of the patient—her body mass was 31 kg at admission—which had precipitated the need for admission to the clinic.

The other unusual ideas were added only when her illness reached a certain level of severity, after the isolated hypochondriacal complaints had been present for weeks. Tests of memory retention and attentiveness gave normal results. The information that we received from the patient came only as short answers to the questions directed to her.

References

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