TYPES AND ANALYSES OF THE CLINICAL PICTURES OF RECOVERED SCHIZOPHRENICS

BY OTTO KANT, M. D.

In attempting to determine the general characteristics of a group of 39 completely recovered schizophrenic patients* who had received no shock treatment and who at the time of reexamination had been out of the hospital for more than four years, it seemed advisable to distinguish five different groups among the recovered patients, there being several outstanding features common to all of them. The heredity as well as the personality type suggested strong cyclothymic admixtures. Manic-depressive taint was several times more frequent than schizophrenic taint in the hereditary background of the recovered patients, the majority of whom were characterized by extraversion of temperament. Certain psychopathic traits, such as emotional lability, lack of maturity (infantilism), and inclination to neurotic attitudes, were represented with about the same frequency. With the exception of one group (11), this personality makeup was in many cases associated with pyknic physique.

Characteristic for most of the psychoses was their psychogenic precipitation (most frequently in the sexual sphere); physical precipitating factors seemed to be of only subsidiary importance.

With the exception of the first group (gradually developing psychoses with depressive coloring), all the psychotic attacks represented some type of excitement, characterized by an acute or subacute onset and by a stormy course of an average duration of several months, leading to complete recovery. Some clouding of consciousness was present in most cases during a greater part of the illness.

The purpose of this study is to outline and analyze the types of clinical pictures, with the hope of contributing to the problem of the differentiation of the schizophrenia group into meaningful clin-

*The general characteristics of the recovered group are being dealt with in another paper. It may suffice here to say that the recovered group includes all those schizophrenic patients who, after having been admitted to the Worcester State Hospital during a two-and-one-half-year period (July 1, 1931 to December 31, 1933), were found to be recovered at the time of the reexamination in 1939. The clinical pictures considered in this study are therefore likely to be actually representative of those types of schizophrenic patients which tend to recover.

ical entities. The five groups which have been distinguished range from cases with close relation to manic-depressive syndromes on the one hand to cases with acute catatonic or paranoid symptomatology on the other. Although all patients might conventionally be diagnosed as schizophrenics, extraneous features are present in every case; the groups are named according to the features which are most outstanding in the clinical picture.

Group I. Cases Resembling Atypical Depressive States

This group comprises: (a) cases in which the depressive structure is that of a retarded depression, and (b) cases in which it is that of an agitated anxiety-reaction.

Clinical Characteristics of (a)

A gradually developing depressive attitude, apparent shallowness of affect, and tendency toward stuporous conditions are most pronounced. Some clouding of consciousness is very frequent. The contact between the patient and his surroundings appears greatly decreased. Ideas of reference and other paranoid trends, misidentifications, and auditory and visual hallucinations constitute the chief abnormal content.

The main peculiarities of this clinical group may be illustrated by the following case:

M. G.: This 20-year-old girl had grown up in a highly moralistic atmosphere. Her home life was strict; the children were not permitted to attend parties and associate with the opposite sex. The patient acted older than her years; she was reliable and felt responsibility for the younger children. She was a good worker and very religious. While her temperament was more of the extraverted type, her attitude toward the sex problem seems to have been one of strict repression.

After having been a diligent worker in a shoe factory for several years, she lost her job for 10 months because of lack of work. She worried a great deal about unemployment. She started working again two weeks before her admission to the hospital. At the same time she was disappointed by a boy who first had shown some interest in her and then had kept company with another girl. This boy used to tell "dirty stories" in her presence, but she at first did not get the point because of her complete lack of sexual information. When the meaning of these things was explained to her by another girl (this happened during the last week before

admission) she was deeply shocked. She became "hysterical" when told about petting parties, etc. At this time she frequently stated: "Even my father and mother are dirty." She became increasingly upset and thought that other girls were talking about her. During a dance at her club, when a man touched her by mistake she flew into a rage and said the whole crowd were trying to make a "bad girl" of her. Next day she confessed to the priest for laughing at vulgar jokes. She thought the sermon in church was directed at her. She felt condemned and feared she was going to hell. She stated that her whole family and her friends had turned against her to make her wicked. Finally she attacked her parents, and because of her violence and her unusual behavior had to be hospitalized. At the time of her admission she appeared somewhat dazed, depressed, agitated, and withdrawn. She was slow, monosyllabic, and misidentified other patients. She heard "voices" saying she was going to have a baby. Ideas of reference were marked; she believed people were watching her. She was impulsive; her mood varied; on the whole she appeared perplexed. Occasionally she was noisy and disturbed, at other times indifferent and relaxed.

Gradual improvement took place, with fluctuations in her condition. After about five months she was greatly improved, and one year after the onset of her psychosis she appeared to be completely recovered. During the eight years which have passed since her recovery she has been working steadily and at the present time appears much better balanced than before her attack. As she stated during the recent interview, she had been "quite foggy" in the period following her "breakdown."

The combination of depressive features and other psychotic symptoms in reaction to a psychic trauma is evident in this case, and the psychological development of the psychosis can be well understood. Already upset by worries over unemployment, the patient experiences a serious disappointment over her boy friend. The crisis comes when she, who so far has had no contact with the world of sex, learns the meaning of certain sexual jokes which the former boy friend has told in her presence. Her principal reaction is that of self-reproach and depression, but her neurotic ambivalence toward the sex problem is expressed in her delusional idea that everyone is trying to make her "a bad girl". Voices tell her that she is going to have a baby. Her aggression is directed against her parents: "Even they are dirty."

During this whole period she is "dazed" and "foggy". Then she gradually recovers. Sexual ambivalence, anxiety, and disgust

expressed in aggressive trends toward her parents are the main psychological features of the psychosis. The psychotic content not only originates in a definite sexual trauma but remains completely centered on this theme until abreaction has taken place. The world is changed as in true psychosis, but the essential psychological aspect is that of a neurotic abreaction.

Analysis of the Clinical Pictures

In all cases of group I, affective disturbances of a depressive type are the outstanding feature. This means not only that the symptoms of depression are more numerous and more striking than any other symptoms, but that the basic structure of the clinical picture is that of a depressive state. What does this statement imply? The depressive reaction is the fundamental change penetrating the entire symptomatology so that every symptom arises from the background of a depressed personality. Thus the depressive change is the center of the clinical picture and all other symptoms are its periphery. The affective basis of the disturbance is illustrated not only by the clinical picture in cross-section but frequently also by the course of the psychosis in which manic episodes occur either in the process of recovery or as short interludes.

The affective disturbance, however, exhibits qualities which differ distinctly from those in a depressive state of the manic-depressive type.

Judging by the patient's expression, the degree of his depression frequently is shallow and somewhat in contrast to his depressive verbal statements. This has suggested to observers the presence of inadequacy; "apathy" and "indifference", therefore, were the terms often applied to characterize the patient's mood. Furthermore, definite signs of irritability, and outbursts of swearing and of destructiveness, deviated distinctly from the picture of depression. Stuporous states were often so pronounced that it was difficult to determine whether or not any emotional activity was hidden behind the placid surface.

"I didn't care at all"—this statement characterized what several patients recalled to have been their attitude. Every visit was "a waste of time". Nursing and therapeutic procedures were thought of as "ridiculous". This general attitude is much more

the expression of one who reacts to a crisis by "quitting" and resigning himself to his fate than that of a person in a state of true depression. In other words, all the depressive conditions in group I lack something of the vital depth which is replaced by the much more psychologically conditioned attitude of utter discouragement. This aspect of the "depression" may partly explain the contrasting irritability of these patients and their occasional outbursts.

Another factor contributing to the peculiarities of these depressed attitudes in the majority of patients was some clouding of consciousness during the greater part of the psychosis. While the clouding on one hand weakens the tendency of mental activity toward gaining a high degree of depth in the experiencing personality, it on the other hand helps to deceive the observer since it may hide an actually rich content behind a screen of perplexity and vagueness of expression. As many catamnestic discussions proved, not infrequently patients who had appeared dull and monotonous had at the same time rich, delusional, dream-like experiences. It was only the aspect of clouding and the lack of motion which had reached the surface and that could therefore be noted in the record.

It is principally in connection with clouding of consciousness that "deeper" psychotic symptoms such as misidentifications, symbolisms, delusions of a nondepressive type, and feelings of foreign influence appear in this group. It is not mere chance that several patients spontaneously used terms such as "dream state", "nightmare", and "fairy tale" to express that they had lived in a radically changed world during the main psychotic period.

After clouding of consciousness, the psychogenic aspect is most characteristic for the psychotic structure of this group. Centered upon precipitating difficulties, the psychotic content is well connected or at least on a uniform level and shows some relation to the basic depressive structure. The abnormal experiences, therefore, can much better be understood empathically than those in ordinary cases of schizophrenia.[1] The coloring of the depressive ideas frequently points to their psychogenic roots in the sphere of instincts. Cannibalistic and other algolagniac fantasies on the oral level remind one of similarly structured involutional melan-

cholias. Nourishment represents "ground-up flesh and blood"; one patient called food "flesh and blood of all the people" she has "murdered". She blamed herself for having poisoned her mother: "gave her an eggnog and it had soapsuds and urine in it."

The psychogenic aspect is, finally, not infrequently demonstrated by the superficiality of the psychotic experiences, i. e. the lack of reality which the patient attributes to them. One patient expressed all her delusional beliefs in such terms as, "I *think* this building is on fire . . . I *think* people have been saying I am pregnant . . . I *think* people have been treated as hostages." During the catamnestic interview, this patient stated she had "perhaps not been one hundred per cent convinced of the reality" of her experiences. There is a playful note also in the way another patient experienced symbolisms. The symbolic significance she attached to colors and patterns is definitely suggestive of obsessive mechanisms: "It was as if something would happen" to somebody dear to her if she finished the pattern on which she was working. Her symbolic interpretations differ distinctly from those of a schizophrenic patient who, for example, "knows" that the physician is in love with her because he wears a red necktie.

In some cases of this group, the psychogenic aspect of the clinical picture is even more striking than the basic depressive structure. Here one might actually be in doubt whether the psychosis, in spite of the associated depressive features, should not be classified as a psychogenic or hysterical state.

Clinical Characteristics of (b)

Acute persecutory experiences with great anxiety dominate the clinical picture: the patient is "framed", there is a "plot" against him. Definite depressive features are also exhibited. Agitation and clouding of consciousness are pronounced. Self-depreciatory ideas and fears are interwoven.

This clinical type differs from the majority of group I by the outstanding agitation and paranoid anxiety, and by the rather acute onset of the psychosis.

Analysis of the Clinical Pictures

As it has been clearly brought out by the catamneses, definite depressive content had been present in each case. One patient had

"lost interest in everything"; she had been "ashamed" of herself and thought she was "not as good as others". Another patient was self-reproachful in addition to his paranoid fears and believed himself to be "the cause of a lot of trouble". In a third case, general retardation at the end of the agitated period pointed toward an underlying manic-depressive element, which achieved expression in a slight manic period preceding final recovery.

In every case clouding of consciousness, associated with a state of panic, was most marked. Only on this background of clouding, and nourished by the anxiety affect, do the paranoid notions arise. In two of the three cases it seems likely that the involutional age of the patient contributed to the anxiety-coloring of the clinical picture.

Although the precipitating difficulties could not be clearly determined in all cases, their psychogenic coloring was obvious.

As in (a), occasionally the slight reality value of the psychotic experiences became apparent by the way in which they were expressed: "It is as if my body has a kind of motor in it which makes it walk. . . "

An important feature in the paranoid experiences of this group was the close relation which invariably could be revealed between the origin of the delusional ideas and some reality situation. One patient's idea of being on a ship was precipitated both by his previous experience of dizziness and by the uniform of the male nurses which, because of the stripes on the sleeves, actually resembled a naval uniform. An attack of indigestion set off the idea of poisoning in another case. In the case of a third patient, fear of being "framed" by the police followed a joking remark of a police officer a few days before the onset of the psychosis.

Group II. Cases Resembling Atypical Manic States

Clinical Characteristics

After a more or less marked period of depression, an acute excitement-state with manic coloring and tendency to incoherence develops. Striking is the apparent shallowness of affect. Grandiose, religious delusional ideas are frequent; ideas of reference, misidentifications and hallucinations are also pronounced. Clouding is definitely present in some of the cases.

Analysis of the Clinical Pictures

The clinical pictures in some important respects are a distinct counterpart of those in group I. The affective change, which is here one of elation with diminished inhibition, is the basic element. The emotional alteration is all-embracing and every other symptom, including the grandiose religious experiences, is more or less closely related to it.

The "manic" elation lacks vital depth as did the depressed mood in group I. The cheerfulness frequently appears "empty"; excitement prevails over actual elation. The lack of genuineness therefore impressed many observers more than the manic attitude itself. All these psychotic states are preceded by some sort of depressive period from which the patients emerge "elated".

The compensatory nature of the manic attitude is to a high degree responsible for the impression of shallowness. The elation is not convincing, and the observer feels that the manic exaltation is a thin cover which may break at any moment. Psychological motivation is much more transparent here than is the case in the typical manic excitement. A similar differentiation was made with regard to the first group also. In conjunction with this peculiarity in both groups, the accessory symptoms such as ideas of reference, slight persecutory trends, and auditory hallucinations, tend to become more prominent than in typical manic or depressive cases.

The compensatory nature of the manic attitude is frequently expressed in a special type of delusional ideas: the overcoming of all difficulties through the personal intervention of God. But whatever the content may be, it corresponds to the basic manic structure. The abnormal experiences revolve about the precipitating conflict and are meaningfully connected in each case.

It is noteworthy that the religious delusional content, whenever outstanding, appears in accordance with the cultural background of the patient: theological training and the atmosphere of certain religious sects form the basis of the religious "revelation".

As in group I, the "reality value" of abnormal experiences frequently appears slight, i. e. the symbolisms lack the immediateness of typical schizophrenic symbolism. The patient declares that he "thinks in symbols" instead of actually *living* in a world of symbolic significance.

Where clouding of consciousness is most marked, the psychotic experiences are changing, vague—in short, of a dream-like character. In the symptomatology magical-prelogical mechanisms appear. There is less centralization in the dream-like content and the connection with the precipitating problems is much looser. The symptomatology in this variety is unified, however, by the pervasive background of clouding. Furthermore, the psychotic content, although it is frequently fantastic and confused, lacks truly bizarre features.

Group III. Cases with Outstanding Manic and Depressive Features

These psychoses are characterized by alternating periods resembling those described in groups I and II respectively. The single periods are frequently of a mixed type and the clinical pictures, therefore, more disintegrated. Confusion and incoherence are pronounced, excitement states predominate. Clouding of consciousness is distinctly present.

Remarkable is the low intelligence level in two-thirds of the patients in this group, a proportion which is much higher than in any other group.

Analysis of the Clinical Pictures

Alternating manic and depressive affective changes are the basic features. All other symptoms occurring in this group are, like those in groups I and II, more or less intimately connected with the manic-depressive alteration.

What distinguishes this group from groups I and II is not only that both atypical manic and atypical depressive features predominate, but that the single phases frequently resemble the "manic-depressive, mixed type" (e. g., depressed mood is associated with loosening of the inhibitions and excitement; manic elation appears without the corresponding overactivity, etc.). In addition, the clinical pictures exhibit those deviations from the typical manic and depressive states which have already been described in detail under groups I and II, thus further blurring the configuration which otherwise would impress the observer with its manic or depressive character. Consequently the single periods are less integrated than in groups I and II.

Dullness and apathy again frequently replace the "depression", and the excitement consists more of resistiveness, destructiveness and combativeness than of manic elation. Incoherence and irrelevance are more frequent and more pronounced than flight-of-ideas. The manic origin of the incoherent talk, however, is often betrayed by the overproductivity, by distractibility, and by a tendency toward punning and rhyming. The seemingly irrelevant talk not infrequently has some "dramatic" quality; more detailed knowledge of the patient's psychological situation may reveal more sense in his rambling monologue than at first is recognizable. He is "performing" the rôle of a famous actor or of a mounted policeman and this performance forms the topic of his rambling talk. The psychogenic aspect, which was highly pronounced throughout the entire group, came clearly into the foreground when decrease of excitement brought greater coherence into the verbal productions.

It is noteworthy that the above-mentioned disintegration of the clinical pictures in this group was limited to states of high excitement. During the quieter periods, the basic manic and depressive structures became better recognizable. In this group also, clouding of consciousness seems to be the basis on which some of the schizophreniform symptomatology arises. It is probable that the low intellectual ability which was found in two-thirds of the cases also is responsible for some blurring of the clinical contours and the activation of "deeper" symptoms.

Only in the case of one patient with low average intelligence were definite experiences of foreign influence upon the mental activity rcorded.

Group IV. Excitement-stupor States with Manic-depressive Trends

In the three groups so far described, the basic structure was akin to that of the affective psychoses. Apathy and stupor on the one hand, and incoherence and excitement on the other, were but subsidiary features. In the next group this proportion has been reversed.

Clinical Characteristics

Excitement and stupor states alternate, the former being more impressive. Manic-depressive trends, which are present also,

range second. Incoherence and destructive activity are marked, but the excited patient continues to appear in some contact with his surroundings.

Analysis of the Clinical Pictures

Excitement is the prominent feature. The patient is overactive and usually destructive. Pressure of speech is high; the talk is usually so incoherent that it remains incomprehensible. Scolding and swearing are the main elements of verbal production; the mood is difficult to evaluate and apparently varying and labile. Irritability is pronounced. The patient resents not only orders but all intrusions into his world, but he is not really autistic as is one who behaves without reference whatsoever to his surroundings. He has his own kind of contact with the environment and his attention is easily diverted by external stimuli. He snatches at everything which lies or comes near him; he moves furniture about and tears up rugs and clothing. He may grab the physician's coat and deliver his rattling monologue as if he were talking to him, but he does not wait for an answer and soon his attention is drawn to something else. Singing and dancing are performed, and the patient's conduct often impresses the observer by its "dramatic" tone. At the height of excitement the patient is completely uninhibited; denudation and other exhibitionistic behavior are frequent; but still there is a definitely playful note in the patient's uninhibited and regressive conduct. In spite of the explosive irritability and the threatening talk, actually brutal actions hardly ever occur and within a second the wildest swearing may change to an outburst of hearty laughter. The emotional expressions are explosive and high-pressured, but they lack depth and continuity. Occasionally posturing occurs, and other features of the catatonic syndrome, as waxy flexibility, may be present during interpolated stuporous periods. The still more specific peculiarities of catatonic motor behavior are, however, absent: gestures and other movements still have expressive quality; there is no disintegration of the psychomotor activity. Regression to a more primitive level of motor behavior, stereotypies, and incomplete movements are not observed. There are also no true mannerisms noted. Instead, the clinical pictures are interwoven with various features of

the manic-depressive syndromes. The incoherent, rambling talk in some parts exhibits distinct flight-of-ideas, and the tendency toward punning and rhyming may be pronounced. Distractibility and a certain contact with the surroundings—although of a destructive nature—are other features. The playful and (despite the displayed irritability) generally good-humored appearance of the patient's excitement and grandiose attitudes completes those features which permit a differentiation between these clinical pictures and true catatonic states. At times the excitement becomes even more markedly manic in every respect. In most of the psychiatric notes, the patient's behavior at some period is classified as "more manic than schizophrenic". Some relation of group IV to the manic-depressive entity is furthermore demonstrated by the occurrence of previous depressive episodes or interspersed periods of depression in the course of the excitement-state. Visual and auditory hallucinations, misidentifications and paranoid trends (poisoning, persecution) complete the symptomatology which at least partly arises from the background of clouded consciousness.

Of even greater structural importance than the clouding of consciousness is the high degree of incoherence of mental activity which at the height of the excitement results in complete fragmentation of the mental content.

In these periods no connectedness remains. When the excitement, however, recedes, the psychogenic coloring and a "dramatic" tone in the patient's behavior become more obvious. Borderline intelligence also may have been contributory in several cases in this group to the coloring of the clinical picture.

In two cases the periodic recurrence of similar excitement states of the type of group IV without distinct psychogenic or physical precipitation was outstanding.

Group V. Cases with Predominant Schizophrenic Symptomatology

The first four groups presented clinical pictures in which either affective changes or incoherent excitement-states characterized by clouding of consciousness and psychogenic aspect predominated. The "schizophrenic" symptomatology so far was mainly limited to lack of depth of the affective disturbance and to such symptoms

as incoherence, confusion, misidentifications, paranoid experiences, hallucinations (most frequently of the auditory and visual types), and slight cataleptic phenomena. Infrequent experiences of physical influence and of mental control originated obviously in the background of clouded consciousness.

Group V, however, contains those six recovered cases in which the psychotic syndrome approximates most clearly the schizophrenic type. Five cases (a) present a catatonic picture, while one case (b) demonstrates an acute paranoid reaction.

Clinical Characteristics of (a)

Excitement and stupor states occur, characterized by a high degree of autism. These states are associated with hallucinatory and delusional experiences of a specific type (struggle between good and evil, between God and the Devil). Signs of deeper psychomotor disintegration are not evident.

A typical development may be illustrated by the following abstract:

A. V.: For several years this patient, in whom a strong urge for "perfection" was a dominant personality trait, had suffered from obsessive thoughts, denying the immaculate conception, etc. Being a faithful Catholic, he had been troubled with religious scruples and had himself noticed the resulting growing tension. For four years he had punished himself for his ideational sins by sleeping without a pillow and restricting his diet. His mother's death, which occurred about one month before the apparent onset of his psychosis, highly upset the patient, who feared he would contract cancer (cause of mother's death). Economic insecurity, overwork, and lack of sleep seem to have been subsidiary precipitating factors. Two weeks before admission the patient, who was already in poor physical condition and undernourished, appeared depressed and discouraged, and refused to talk. He was admitted in a state of semistupor, being mute, negativistic, and resistive. Usually he lay in bed, his eyes closed or gazing at the light, shouting loudly at times. As he later revealed, he was "guided" during this period by "voices of the Virgin Mary." He relived his experiences regressively in the different periods as man, adolescent, small child, and infant, finally "vanishing into nothingness." He was "recalled by the Virgin Mary" and experienced a new development: baby, child, adolescent, man. His parents were "God and the Blessed Virgin." After less than two weeks he improved rapidly and appeared hypomanic. He was boastful and gave medical advice. Two weeks later he showed good

insight and was discharged. After recovery he worked again fairly steadily. A little less than three years later he experienced a second attack after a period of hard work and insufficient sleep. The onset of this attack is characterized in the record as "hysterical condition of unconsciousness." The clinical picture was similar to that of the previous attack. The patient was "the second Jesus," had "supernatural powers." Again he soon recovered after a short hypomanic period. At the time of his discharge, he expressed the belief that there were two possibilities for him, either the religious way or the founding of a family. Choosing the latter course, he married four years ago. He passed a civil service examination and is now employed as a mechanic. He is getting along well in every respect. During the catamnestic interview the patient, an intelligent man, whose juvenile, slim figure contrasted with his gray hair, and whose "lecturing" manner of talking expressed some hypomanic energy, stated that he knew now how to keep his balance: All he needed was "taking good care of oneself, enough sleep, and a steady job." "It will never happen again."

Similar to the above manifestations are the precipitation, content, and course of the catatonic attacks in a second case of this group:

The patient has had three attacks of the same type, all centering upon sexual difficulties which he could not reconcile with the rest of his personality. He exhibited still more fantastic though well-connected and unitary experiences. He imagined the "regeneration of a new race"; "the sun was the father, the moon the womb, the earth the mother, and civilization was the testicle or seed of procreation." At times he felt that he was God; then again his father was Christ or he was the "third incarnation of God."

While experiences of cosmic dimensions appear most representative for this group, in a minority of cases the conflicts are fought out on an everyday-life level. In these cases the "dramatic" tone of the catatonic performance was most remarkable. The underlying conflict was clearly demonstrated in the psychotic behavior, and the psychogenic basis of the clinical picture was obvious. A verbatim excerpt of the monologue of a young male patient may demonstrate this peculiarity. During the entire psychosis of this patient, homosexual abreaction and heteroerotic wish-fulfillment on the one hand, self-damnations and attempts to overcome sinfulness on the other, were pronounced.

"Beatrice, I doubted you; I know I am happily married to you. I don't doubt you, Beatrice, bring me back home. Oh, I'll have to kill myself. Bea-

trice, appear to me in the form of a nurse. Boom, boom, ten times boom boom. Beatrice, I tried to make you queen of heaven . . . Son of God, judgement day, soon to be electrocuted . . ."

At this point, although still understandable, the monologue became more disconnected; he asked God to kill him for his sins and then again he appealed to his girl for help and forgiveness. Spontaneously he cried: "I've got to snap out of it . . ."

Analysis of the Clinical Pictures

In every respect the type of excitement and the abnormal experiences within this group must be considered as catatonic, although manic and depressive features are probably more frequently reported than in the average cases of catatonia.

The most general and most impressive characteristic of this group is the psychogenic aspect which is revealed in the dramatic performance of conflicts in the everyday-life dimension as well as in the fantastic-cosmic experiences of the religious level.

Experiences of mental influence are pronounced only in one case of partly exogenous structure in which "delirious coloring" is also noted.

It is remarkable that definite signs of psychomotor disintegration which otherwise are so characteristic of most cases of catatonic excitement have not been recorded in this group.

The most typical catatonic reactions of this group represent an attempt to overcome the gap between instinctive urges and the contrasting ideal-ego by reaching a new harmony on the highest possible level: "regeneration of a new race" . . . "unity with the saints" . . . "son of Christ and the Blessed Virgin."—These main themes are encountered in several variations. This type of psychosis reminds one of religious ecstasies; it is still a problem whether the two may be differentiated psychologically in spite of the grandiose and fantastic coloring of the psychotic experiences. In the two most characteristic cases, the psychosis occurred in a person for whom the Christian dogma always has had the greatest reality value. One of the patients, a Catholic, in spite of complete insight for the other features of his mental illness, even now believes that he had actually been in contact with the saints and he refers to the confessions of Saint Augustine and others. Asked

why the saints should prefer to talk to a person in an abnormal state, the patient replied that it might be because the psychotic person is so sensitized that he can receive messages unnoticeable to other people. He mentioned his own sensitivity to noises during his illness: "I felt everything in an exaggerated manner."

Mention of the religious ecstasies leads us to an examination of the state of consciousness of these patients. They were able to recall many of their acute psychotic experiences, for which they did not claim any "fogginess" or "haziness". The lucidity of the rather coherent psychotic experiences was not actually diminished (the experiences were well connected). It therefore seems justified to assume that there was no clouding of consciousness in the usual meaning of this expression. Nevertheless—even if the "hysterical condition of unconsciousness" recorded in one of the medical certificates is disregarded—there is no doubt that these patients lived in an entirely different world from that of their real surroundings. This is confirmed by numerous catamnestic statements: "I was completely out of contact with reality . . . I recall putting an arm around my father's neck but I did not know it was my father . . . It was a complete lack of consciousness with flashes of light in between . . . I have some recollection of everything that happened but I did not know at all what really happened . . . "

In summary, the state of consciousness of most patients in this catatonic group permits the extensive formation and coherence of colorful new experiences. The psychotic content, however, is so impressive and exclusive that it completely embraces the patient's attention and cuts him off from contact with the reality situation. As one of the patients later stated, the illness started when he became more and more absorbed in ideas of which he finally lost all control.

The different structure of the newly-formed psychotic world does not permit its expression in the abstract logical manner of reality experiences. One patient, whose urge to express himself at this period was great, well realized the difficulty. Although his speech appeared fairly coherent, he stated that his thoughts were

"confused and mixed . . . but I am not making myself clear . . . I can't seem to think."

There is thus present an *ecstatic change** of consciousness which reminds one of certain types of confused states of psychogenic nature. The "war-neurotic" who relives a scene from the battlefield is an example. He also is out of contact with the reality situation and because of some emotional strain builds up an imaginary situation suited for abreaction; but his condition is still more related to an "everyday" situation and his usual way of expressing himself is more adequate, therefore his ability to express himself appears less impaired. To illustrate the chief difference between the "ecstatic" state and the usual clouded state with fogginess and amnesia, one might say metaphorically: in the clouded state the lights on the stage of consciousness are dimmed; in the "ecstatic" consciousness a different switch is turned on and brilliant lights illumine a new and strange scenery.

As has already been mentioned, not all pictures in this group refer to the "ecstatic" type; in others, clouding of consciousness and dramatic abreaction on the "everyday level" prevail; but some symbolic expression of the moral conflict (struggle between good and evil) is also present, justifying the classification of these psychoses under the catatonic group.

In one case in which the delirious element was pronounced, the occurrence of an at least partial exogenous precipitation could be assumed.

Clinical Characteristics of (b)

The only case of acute paranoid psychosis may be illustrated by the following abstract:

G. J.: This 30-year-old patient, who was known as a capable business man, had to be hospitalized three days before his intended marriage. He had for some time been under emotional strain provoked by certain conditions in the factory he directed. One month before the apparent onset of his psychosis his uncle (who had acted as a sort of foster-father to him) died and the patient became depressed.

Nine months before his breakdown he interpreted a harmless remark as a homosexual hint. After he became officially engaged (half a year be-

*This term is applied because in accordance with its Greek origin (i. e., "standing outside") it characterizes the actual change in a person's contact with reality.

before the onset) he worried: his fiancée might think him immoral if she heard "anything wrong" about him. A few days before admission he expressed fear lest his fiancée be taken away from him. He interpreted the priest's sermon as a homosexual hint referring to him. He was suspicious and wanted to see a nerve-specialist. On the day of admission, early in the morning he tried to telephone to his fiancée, went out on the street in pajamas and was apprehended by the police.

On admission he was well oriented, restless, his conversation at times relevant, at times disconnected. He talked about religion, defended himself, said he had always been honest and decent. Later he brought up a homosexual episode in which he had participated. His mood was indefinite. Hypochondriacal ideas were expressed. He believed that his thoughts were being broadcast; he expressed the idea that his body was being painted with grease. Before a lumbar puncture, he was afraid he was going to be castrated. He talked aloud to himself; he "resisted seduction" by nurses and attendants to keep his bed "sacred" for his fiancée. On being questioned he said he was going to die: there was "nothing to live for." A few days later he showed some insight, saying that he must have been "off the trolley;" he dated all his troubles from his last church visit where he had "been excommunicated." At times he was excited and resistive. Ideas of reference were indicative of homosexual content. After seven weeks he had quieted down and was less negativistic. The following month he showed interest in home affairs but still referred to "strange happenings around the hospital." "The whole routine is like an initiation." "Weather conditions" had "some relation" to his case. "Electric disturbances center around me." He spoke about being "in a fog." "Who has charge of weather conditions around here?" He felt "quite confused."

Two months later the patient was much improved but still inclined to "read meanings." After his release on visit (about four months after admission) he got along well in spite of a serious disappointment caused by his firm's failure to keep its promise to reemploy him. His fiancée broke off relations with him. He went abroad for another firm and since has become a successful independent business man. One year after his discharge he married; he now has a seven-year-old boy; a second child is on its way. The patient seems to have fared consistently well since his recovery nine years ago and during the interview showed himself to be proud of his success. He has good insight with reference to his previous breakdown. A little "queerness" in his behavior may probably be explained by his embarrassment, as the examiner happened to call while guests were present.

Analysis of the Clinical Picture

In this case the clinical picture is perhaps the most clearly schizophrenic of all those of recovered patients. Ideas of reference and symbolic interpretations centering on alleged homosexual accusations are outstanding. The patient's "thoughts are being broadcast"; he "resists" the "temptation" by nurses and attendants in order to keep his "bed sacred" for his fiancée. "Electrical disturbances center around" him; "the whole routine is like an initiation"—all this without ecstatic remoteness, signs of clouding of consciousness being present apparently only for short periods. Still there is one feature which separates this case from most similar cases: the distinctly psychogenic foundation of the psychosis, which in every regard represents a homosexual panic precipitated by impending marriage.

Despite certain prodromal symptoms, the psychosis in general presented an acute paranoid picture which in its beginning to some degree reminds one of the paranoid anxiety-depressions in group I.

Interesting is the recovery and the achievement in business of this patient in spite of untoward conditions in his career. Remarkable also is his successful marriage one year after recovery.

Comments and Conclusions

As the previous descriptions and analyses show, five types of recovered schizophrenics might be distinguished. The first three of these may be grouped together because of their relation to the manic-depressive entity.

In spite of some obvious overlapping, each group is marked by definite characteristics. All five groups have one important trait in common, i. e. their "psychogenic" aspect. Psychic precipitating factors are clearly present in the majority of cases. The psychotic experiences for the most part are definitely centered upon the precipitating conflicts and (except for group IV, with its fragmentation of mental activity) the psychotic experiences are all well connected and at a fairly uniform level. In the first three groups, some of the psychotic experiences reveal their superficial rooting by their close connection with reality experiences as well as by the low degree of their reality value for the patient. The "dramatic"

quality of the psychotic performance in many cases is another trait which increases the psychogenic coloring of the psychosis.*

Consistent with this characteristic of the recovered schizophrenics is the fact that, excepting again group IV, in no case has a true disintegration of the psychotic personality taken place even temporarily. When the patient was acting the part of a mounted policeman or of a cinema star or when he was fulfilling some "cosmic task" as a "divine missionary", his personality was always unitary and consistent in itself. This peculiarity is in accordance with the apparent lack of deeper psychomotor disintegration in the recovered states.

Whenever some "deeper", i. e. more schizophrenia-like, symptomatology arises in one of the recovered groups, there is (with the exception of one case in group V) some distinct lack of contact of the patient with his surroundings. As opposed to many other simple, hebephrenic or paranoid schizophrenics, most of these patients did not produce "deeper" psychotic symptoms as long as they were in good contact with reality. As was demonstrated in the analyses above, the lack of clear apperception of the surroundings was in each case due to one of three different factors respectively. While clouding of consciousness** was most pronounced in the first three groups, the fourth group was characterized by general fragmentation of mental activity caused by an incoherent excitement state. In the fifth group the so-called ecstatic consciousness seemed to be of major importance. Thus an interesting development is revealed in the succession of groups classified by the degree of their clinical relation to schizophrenia as generally conceived.

*In an earlier paper (2) it has been pointed out that such features as coherence of the psychotic content related to precipitating conflicts and expressive quality of the psychotic behavior have a negative significance in the differential diagnosis of schizophrenia. It is remarkable that these features were found to be outstanding also in the various groups of recovered patients, whose general symptomatology led to the diagnosis of schizophrenia. Important features thus seem to be common to the clinical pictures in cases of schizophrenia leading to recovery and those in other abnormal conditions which can readily be distinguished from schizophrenia. The psychological characteristics mentioned refer to a localization of the psychotic disturbance in a "higher" (the so-called "psychological") stratum of the human organism than does the typical schizophrenic symptomatology. The conclusion, therefore, can be drawn that recovery in schizophrenia depends largely upon the prevailing involvement of the psychological stratum as opposed to the involvement of the "deeper", vital, stratum in cases of schizophrenia tending toward deterioration.

**Because of the importance of dream-like experiences in certain clinical types, Mayer-Gross (3) has elaborated on their characteristics in his description of the dream-like form of experiences (Oneiroide Erlebnisform).

The first three groups, in which manic-depressive features, i. e. the affective disturbances, appear predominant, show relatively good integration of their psychotic content, which is still close to the everyday-life reality. Whenever "deeper" symptoms are present, they generally appear on the background of clouded consciousness.

The fourth group, which represents the intermediate stage of clinical structure, impresses one by the disintegration of psychotic experiences and behavior. The stream of talk is highly disconnected. Excitement and stupor outweigh the affective reaction. Because of the fragmentation of mental activity, the contact with reality is highly diminished although autism is not yet marked.

At the third stage a new integration has been created. Unity and coherence are reestablished here on an autistic level, the experiences reaching far beyond the human boundaries into cosmic spheres. As this stage marks the last group of recovered schizophrenics, it may be assumed that the next level of disintegration which is characterized by disorganization of the psychotic personality and the psychotic experiences and by autism is that of those types of schizophrenics who do not completely recover.

It may, therefore, be noted as one indication of this clinical study that complete recovery in schizophrenia does not occur spontaneously if certain levels of personality-disintegration have been passed.

This statement does not solve the nosological problem of whether the different degrees of psychotic disintegration occur on the basis of the same disease process or whether they are pathognomonic of different disease entities.

The first three groups may be considered together, since affective changes are predominant in each and their structural patterns are closely related. In cases apparently similar to these, Langfeldt[4] speaks of "admixtures of manic-depressive, psychogenic (self-reference tendencies) and symptomatic (cloudiness, incoherence) trends . . ." and recommends the classification of these cases as "atypical schizophreni-forme states." In this analysis of the first three groups a further step has been made. It has been pointed out that the affective change is the basic structural element to which all other symptomatology shows some more or less

close relation. For this reason, one might seem justified in actually excluding the first three groups from the schizophrenia entity. The otherwise useful concepts of the "mixed psychoses" (Gaupp[5]) or of the "schizo-affective psychoses" (Kasanin[6]) cannot be profitably applied to these cases, since the assumption of a combination of manic-depressive and schizophrenic features would not entirely explain all their peculiarities.

An attempt to relate these groups to one of the accepted clinical entities would need to consider the classificatory scheme proposed by Kleist.[7] This author tried to establish a large number of new clinical types which he characterized as "marginal psychoses" (Randpsychosen) of either the cycloid, the paranoid, or the epileptoid type. The first three groups here considered show some relation to Kleist's cycloid as well as to his epileptoid "marginal psychoses". It is interesting to note that Kleist also was impressed by the outstanding clouding of consciousness in a great number of acute psychoses leading to recovery which he therefore classified as "episodic clouded states" (Episodische Dämmerzustände). The fact that his procedure, in spite of many good observations, did not actually influence the differentiating attempts of clinical psychiatry in general is probably attributable to the impossibility of reaching a new solution in questions of differentiation merely on a descriptive-clinical basis in the manner of Kraepelin and his school. The writer believes that the outlined structures of his first three groups confirm this assumption as they can be understood only by means of a distributive analysis showing a certain personality type, definite precipitating conflicts, activation of manic or depressive changes and other psychotic symptoms, with the attack more on a psychological than on a vital level and veiled by clouding of consciousness or in some cases blurring of the clinical contours by the low intellectual capacity of the patient. Only the synopsis of these manifold features in this or a similar constellation can give us a real understanding of the structure of the first three groups in the sense in which it has been stressed by Adolf Meyer and his associates.

While affective features definitely outweigh all other symptoms in the first three groups, this is not the case in group IV. Here it seems even more futile to attempt a definite nosological classifica-

tion at the present stage of our knowledge of cause, nature, and boundaries of the functional psychoses. Incoherent excitement and stupor states characterize this group, the basic structure of which is neither an affective change nor an autistic-dissociative reaction. The writer would suggest that this psychotic type be differentiated from the other accepted forms at least temporarily as "excitement and stupor states," but without the pretension of having described a new clinical entity. What has been said above concerning the necessity of a distributive analysis is as valid for this group. It is probable that most of the so-called "benign stupors" as well as the so-called "periodical catatonias" fall into its realm.

One might say that the disintegration in the patients of group IV is as high as in any case of schizophrenia, but there is one substantial difference: it is the disintegration of an incoherent excitement state and therefore of a "superficial" and temporary type. When the excitement subsides, the former unity of the personality structure is restored.

As for the fifth group, finally, there can be no doubt with respect to the classification of its cases as schizophrenic states in spite of occasional manic-depressive trends. The great majority of cases present a clearcut catatonic picture, but the psychogenic and unitary aspect of the psychotic attack connects this group as much with the first four groups as it separates it from the average cases of catatonia. One might, therefore, be tempted to apply the term catatonic (schizophrenic) "reaction" to these cases (Popper,[8] Kahn[9]). The attacks are associated largely with an "ecstatic" state of consciousness and characterized by strong excitement. They thus reveal the extreme loss of contact with reality which was stressed above as an important factor in all recovered schizophrenics.

Of all recovered cases, one remains (group V) which has only a psychogenic aspect in common with the other recovered cases. Except for this one trait, the picture, which is that of an acute paranoid state, is most typical for schizophrenia. Even if an affective disturbance (panic-state) may have been present in the beginning, the further course of the psychosis shows a clear, well-oriented patient in an indefinite mood, who produces a large num-

ber of schizophrenic experiences. This case is unique in the writer's material; it will be necessary to find some similar case experiences before attempting to draw more definite conclusions.

Summary

Five clinical types of recovered although not specially treated schizophrenics, marked by definite characteristics, are described and analyzed.

While affective changes (manic and depressive features) are most outstanding in the first three groups, the fourth group is characterized by alternating states of excitement and stupor. The fifth group, with the exception of one case, consists of catatonic states. The remaining case exhibits an acute paranoid picture.

Strong psychological coloring with centralization of the psychotic content upon some precipitating conflict is common to all recovered cases.

Coherence of the psychotic experiences and preservation of personality integration are marked in all groups except group IV, in which the incoherent excitement causes general fragmentation of mental activity. "Deeper" schizophreniform symptomatology arises on the basis either of clouding of consciousness, of incoherence and fragmentation, or of the so-called "ecstatic" consciousness.

While thus the first three groups show good integration of the psychotic content and the fourth group, due to incoherent excitement, is marked by high disintegration, in the fifth group the third stage is reached: a new integration has been created on an autistic level. Next in this development, disintegration on an autistic level seems to be confined to those types of schizophrenics who do not spontaneously make complete recovery.

From the nosological point of view, it seems justifiable to exclude the first three groups from the schizophrenia entity because the affective change is here the basic element. The clinical structure of these groups can be understood only by means of a distributive analysis.

The fourth group stands by itself, as neither affective nor schizophrenic symptoms predominate.

The cases of the fifth group, with the exception of one, might be considered as catatonic "reactions".

In all clinical pictures of the recovered schizophrenic patients there are some features recognizable which deviate from the classical picture of schizophrenia.

Research Service
Worcester State Hospital
Worcester, Mass.

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