INTERPRETATION OF SCHIZOPHRENIA

The Diagnosis & Prognosis of Schizophrenia

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e-Book 2016 International Psychotherapy Institute

From *Interpretation of Schizophrenia* by Silvano Arieti

Created in the United States of America

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Diagnosis

Typical cases of schizophrenia are easy to diagnose. Difficult to diagnose are those belonging to that ill-defined group that includes so-called latent cases, borderline, character disorder, quasi-psychotic psychopaths, severe personality difficulties, and so on. The diagnosis made in these cases is apt to reflect more the classificatory criteria of the psychiatrist than the symptomatology *per se.* Even in a typical case the diagnosis may be difficult if the patient has been interviewed only once or twice on a consultation basis.

The first rule to be adopted in diagnosing schizophrenia is that an individual symptom or even a few symptoms should not be considered absolute proof of the condition. The constellation of symptoms should be evaluated in the general picture or gestalt they generate. Even symptoms that seem typical, like auditory hallucinations, delusions, or language disorders, should not be considered to be absolute proof of

the psychosis, because they may occur in other organic or functional conditions. Very often, seriously disturbed, but not psychotic, adolescents are often mistaken for schizophrenics.

In Chapter 3 we mentioned the changing aspects of the symptomatology of schizophrenia. We shall mention now a changing trend in diagnosing schizophrenia. Whereas until 1955-1960 the diagnostic ability of a psychiatrist was measured by his skill in recognizing the largest number of previously undetected schizophrenics, the trend is now reversed. It has gradually been recognized that the diagnosis of schizophrenia is made too frequently, especially in the presence of serious psychopathology. The competency of the psychiatrist is often measured by his ability to rule out from the classification *schizophrenia* many patients who present a schizophrenic-like symptomatology.

Differential Diagnosis from Psychoneuroses

Differential diagnosis from psychoneuroses, easy in typical cases, is made difficult by the fact that neurotic symptoms may have preceded schizophrenia or may actually be present. When the

personality as a whole undergoes a rapid decline or maladjustment, one must think of the possibility of a schizophrenic outcome, even though the previous symptomatology was neurotic. For instance, sudden scholastic decline, dropping out, or any drastic transformation of character should be viewed with suspicion.

When hysteria was much more common than it is now, schizophrenia used to be confused with it. It is possible that patients diagnosed in former times as hysterics were suffering from schizophrenia. Hysterical attacks occur more frequently in people with an extrovert personality and are characterized by conversion syndromes. The symptomatology is easily influenced by certain persons in the immediate environment and responds easily to hypnosis.

Typical obsessive-compulsive psychoneurosis is easily distinguishable from schizophrenia. The examiner must keep in mind, however, that many patients who develop schizophrenia go through an obsessive-compulsive stage. In some cases this neurosis gradually blends into schizophrenia. Obsessive thoughts in preschizophrenics or schizophrenics are more general in character; they may progressively

invade the whole life of the patient. Moreover, they have some characteristics that are more frequent than in neurotic obsessions—they have a particular meaning even at a conscious or manifest level, and this meaning has a spreading quality. For instance, the patient may either count, look at, or avoid a particular number; but the number has a contagious meaning. A patient felt she had to avoid number 8. She started to decompensate after the death of her grandmother, who died on September 8 at eight o'clock in the evening. The patient expected something bad to happen on the eighth day of any month. Up to this point the symptoms could be classified as a superstition or as a neurotic symptom; but soon the patient started to hate every number that included 8 (18, 28, 800, and so on) and brooded over the special foreboding meanings of these numbers. Eventually she developed acute delusional thoughts and experienced hallucinations.

Similarly, a typical phobic syndrome is easily distinguishable from schizophrenia. When the patient is afraid of dogs, horses, crossing streets, squares, or bridges, and special uniforms, it is easy to make the diagnosis of psychoneurosis. However, there are symptoms intermediary between phobias and delusions. In typical neurotic

phobias the patient intellectually knows that his fears are unfounded; seemingly the phobigenic element is an animal, object, event, or situation. If the phobigenic object is a human being, it is because he wears a special uniform, like a nun or a policeman, or has a special job, like a doctor or a dentist. However, in phobic syndromes that are close to schizophrenia, the patient is not sure of the irrationality of his fears. Not always, but often, the fears involve human beings. For instance, a patient expects a man to come out of the closet and strangle her.

Some phobias and obsessions that are *mistaken* for delusions occur in women who believe they may hurt, even kill, their child or children. Especially if these fears occur postpartum, they are likely to be mistaken for delusions as part of a postpartum psychosis. However, every psychiatric symptom, including phobias and obsessions, can occur postpartum. The existence of such fears in women who have just given birth is not sufficient to warrant the diagnosis of schizophrenia.

Differential Diagnosis from Manic-Depressive Psychosis

The diagnosis is easy in typical cases. Severe thought disorders, like illogical remarks, incongruous statements, bizarre delusions, or

ideas of reference, are rare in manic-depressive patients. When delusions occur, they are consequent to the mood with which they are congruous. For instance, a patient suffering from psychotic depression may feel guilty for having committed alleged crimes, but this thought is part of a self-incriminating attitude. An elated manic patient may believe he is a millionaire. Manic excitement may be confused with that occurring in many schizophrenics. The excitement of the manic is sustained as long as the manic phase lasts, whereas that of the schizophrenic is more acute and inconsistent. A catatonic excitement in particular may be confused with a manic state. However, in the manic state the mood is more congruous; the actions, although grandiose, are less inappropriate. The anger of a manic patient, when he feels hindered or misunderstood, may be confused with the paranoid attitude of the schizophrenic. However, it generally lacks the suspiciousness, the innuendos, or the carefully conceived persecutory framework of the paranoid patient.

Hallucinations occur very rarely in manic-depressive psychosis. They do not have the distinct perceptual quality that they have in schizophrenia. They are clearly related to the mood of the patient, and they occur at night, very seldom during the day.

A catatonic stupor may be mistaken for the depressive stupor occurring in severe depression. In the catatonic stupor there is no overt depression and no history of it.

The history of the patient is, of course, very useful. It may reveal a cyclical course typical of manic-depressive psychosis. On the other hand, it may reveal whether or not the present depression has followed a schizophrenic attack. In some cases in which the differential diagnosis is impossible to make because of the presence of both types of symptomatology, the diagnosis of schizo-affective psychosis is resorted to, as we have seen in Chapter 3.

Differential Diagnosis from Psychopathic Personality

Differential diagnosis from the psychopatic personality is important, often not only for medical reasons, but also for legal ones. From a medical point of view, the diagnosis is important because drug therapy based on tranquilizers, the type commonly used in schizophrenia, should not be given indiscriminately to psychopaths. Some psychopaths, in fact, under the action of medication, may lose any anxiety or restraint and may give vent to psychopathic behavior.

The diagnosis is important legally because, notwithstanding some controversial points of view, psychopaths are considered responsible for their actions by the law, whereas schizophrenics generally are not.

The differential diagnosis is easy in the presence of typical schizophrenic symptoms, like delusions and hallucinations. It is difficult when it is based only on the behavior of the patient. In fact, *antisocial behavior* may be the result of both schizophrenia and psychopathic condition. In the psychopathic personality the antisocial action has an easily recognizable aim: stealing, sexual gratification, revenge, and so on. Even when it could be demonstrated that the action had an unconscious symbolic meaning (for instance, stealing was a symbolic way to recapture the love of mother that a sibling had stolen from the patient), the fact that the patient was also motivated at a conscious level and obtained or sought to obtain gratification at a conscious level is indicative of the likelihood of psychopathic personality. On the other hand, if the antisocial behavior appears bizarre, absurd, and apparently unmotivated, the likelihood is that we are dealing with a schizophrenic psychosis, at times of a monosymptomatic type.

Differential diagnoses from paranoia and anorexia nervosa will be discussed in Chapter 44.

Differential Diagnosis from Organic Conditions

Many organic conditions have to be differentiated from schizophrenia, and all of them have to be taken into consideration by the examiner. We shall start with the two that in recent years have been most frequently encountered in clinical practice: minimal brain damage and drug-induced syndromes.

Youngsters suffering from conditions variously called minimal brain damage, minimal cerebral dysfunction, hyperkinesia, may be difficult to differentiate from child schizophrenia or adult schizophrenia. Approximately half the patients who presented these conditions in childhood are sufficiently recovered by the end of adolescence to escape psychiatric attention. A considerable number of them, however, continue even later in life to manifest constant or periodic excessive motor activity, at times slightly inappropriate behavior caused by restlessness, by the need to move, or by lack of attention, and delay in the normal development of intellectual and

emotional maturity. On account of their excessive mobility, these patients were difficult to take care of in childhood, caused disruption of family life, and fostered conflicts inviting rejection. Because of the strained relationships with their parents and because they have been left behind scholastically and otherwise even though they at times had unusual potential endowment, they present deep feelings of inadequacy. This symptomatology is sometimes wrongly interpreted as regressive and as indicative of an insidious development of schizophrenia. Of course, schizophrenia may occur in these patients, too, perhaps because of the mentioned superimposed psychological difficulties. However, this is the exception, not the rule. Generally if they are properly recognized and are treated symptomatically in a family that understands the problem of the patient, these patients do well later in life and may regain the lost ground.

History of hyperkinesis in childhood, presence of restlessness, absence of delusions, hallucinations, ideas of reference, and realization that a tendency toward maturity exists, although manifested with considerable delay, will lead to the correct diagnosis. Unfortunately, amphetamines, Ritalin, or similar products used diagnostically in children because of the prompt therapeutic effect in these conditions

cannot be used in older patients, because they are not so effective later in life and may promote addiction.

The differential diagnosis between schizophrenia and psychoses due to drug abuse has recently become necessary. The use of lysergic acid diethylamide (LSD) may bring about clinical pictures similar to schizophrenia, during the immediate reaction to drug intake as well as in conditions caused by a prolonged adverse effect of the drug. In the presence of a history of LSD intake, the diagnosis is easy. Visual hallucinations, with red, yellow, and blue predominating, occur much more frequently than in schizophrenia. There is an uncertain sense of wonderment, which may be unpleasant or pleasant to the point of conferring an aesthetic and mystical quality. The patient may feel that he has reached the absolute, the universal, the sublime, that he has come to understand God. There is difficulty in focusing on objects, but there is a sharpened sense of hearing. Auditory hallucinations are very rare. The pupils are dilated, and the reflexes are exaggerated. There is increased muscle tension and slight incoordination and ataxia. The reappearance of overt psychotic symptoms, seemingly schizophrenic long after the intake of LSD, may lead to a wrong diagnosis. Panic, or at least strong anxiety, often accompanies these recurrences.

Chronic users of LSD may be difficult to distinguish from schizophrenics. They may appear sloppy, dull, and with a flattened facial expression. They may present unusual mannerisms, like unusual motions of the tongue. Memory disturbances, slow thinking, difficulty in organizing ideas and in reaching conclusions suggest organic impairment. These patients, however, are socially more adequate than schizophrenics who are regressed to the point of showing equal disorganization in thinking. Generally they are able to give an account of the beautiful original trip experience (Blacker et al., 1968). Many authors have reported the longlasting adverse effects of LSD (Fink et al., 1966; Ungerleider et al., 1968). Diagnostic difficulties arise when one suspects that the LSD experience has precipitated a potential schizophrenic psychosis. I have seen many patients in whom I felt that a potentiality for schizophrenia would have never reached clinical actualization if LSD had not been used. Similar symptoms, simulating schizophrenia, although less pronounced than those caused by LSD, are seen after use of mescaline and psilocybin (Hollister, 1968).

Amphetamine-induced psychosis is to be suspected in paranoid states accompanied by tachycardia, mydriasis, anorexia, loss of weight, and aggressive behavior, occurring especially in those groups that are

likely to use drugs. Ellinwood (1967) has reported an accurate description of amphetamine psychosis. Visual hallucinations are the most common. Thinking disorders and body schema distortions are indistinguishable from those occurring in schizophrenia. Because five of the twenty-five patients whom Ellinwood treated continued to experience psychotic symptoms long after amphetamine withdrawal, he suspected an underlying psychotic process. He did not know whether amphetamine contributed permanent effects to the psychotic process. I have seen the disappearance of psychotic symptoms after withdrawal of the drug in all patients who had not shown psychotic symptoms prior to the addiction.

Moderate marihuana use does not produce conditions likely to simulate schizophrenia. However, I have seen many patients presenting acute schizophrenic episodes after excessive use of marihuana or a combination of marihuana and hashish. My impression was that the excessive use of these drugs had actualized a potentiality for schizophrenia. Whether the disorder would have eventually materialized even if the patient had made no use of marihuana or hashish is a matter of speculation.

Other organic conditions to be ruled out are epilepsy, brain tumors, general paresis, Huntington's chorea, mental deficiency, alcoholic hallucinosis, and several neurological syndromes.

Epilepsy presents no differential diagnostic problems when there is history of grand mal or petit mal attacks. The relations between schizophrenia and epilepsy will be discussed in more detail in Chapter 30. Here we shall mention that occasionally so-called twilight states of psychomotor equivalents are confused with schizophrenic behavior. However, they are generally of shorter duration and are accompanied by a state of disturbed consciousness. Schizophrenic behavior may coexist with epilepsy. It is a controversial issue whether these patients should be considered as suffering from epilepsy with schizophrenic symptomatology or from coexistence of schizophrenia and epilepsy.

Like many other psychiatrists, I have seen a considerable number of cases presenting at times a seemingly typical schizophrenic syndrome, episodic or of short duration, in patients who had dysrhythmia of the temporal lobes, especially the right. Often these patients present also attacks of depression, more prolonged than in schizophrenia, and unpleasant behavior. They are belligerent,

antagonistic, rebellious, without presenting, in the majority of cases, a clear or definite picture of psychopathic or antisocial behavior. Violent behavior and suicidal attempts, however, occasionally occur. When some of these patients hallucinate, they seem to be aware that they do so.

I am reluctant to make the diagnosis of schizophrenia when psychotic behavior occurs in patients who have dysrhythmia in the temporal lobes. These patients show no psychotic symptoms between psychotic episodes. However, some peculiarity of character may persist.

Petit mal attacks may be confused with schizophrenic blocking phenomena, but they occur suddenly and are of shorter duration.

Mental deficiency may be mistaken for the simple type of schizophrenia, or confused with Propfschizophrenia. Generally, in mental deficiency the defect was apparent in childhood, whereas in the simple type of schizophrenia and in Propfschizophrenia the disorder manifested itself at or after puberty.

Occasionally we see patients who are diagnosed as

schizophrenics who presented symptoms from birth other than those of child schizophrenia. These youngsters cannot be considered mental defectives, as some of them have an I.Q. as high as 120-130. Their behavior is unusual, given to irritability, anger, and occasionally to aggressive impulses. They cannot be considered cases of minimal brain damage, as the picture is different and more striking. If they had pyramidal or extrapyramidal symptoms, they would be immediately recognized as cases of birth injury, but the neurological examination does not reveal gross pathology. The electroencephalogram is also negative. They often present minimal incoordination of movements and some visual difficulties, like refractive errors, stabismus, and poor visual motor perception. Many of them present speech defects, such as dysarthria or dysphasia. I personally call these patients cases of intermediate brain damage, that is, with a pathology intermediate between minimal brain damage and usual cerebral palsy. The factors which operated at the time of birth and immediately afterwards either passed unnoticed or were soon forgotten. They might have been anoxia, the use of forceps, or traumata occurring during the passage of the head through the birth canal. Because of the peculiarity of their behavior, especially their appearance, and because of the unusual way

of talking, these youngsters are the object of ridicule from their peers. When they complain that people are talking about them, or laughing at them, there is more than an element of truth in these statements, which are mistaken for delusional and lead to the wrong diagnosis of schizophrenia. Rehabilitation, milieu therapy, and sedation rather than depth psychotherapy are necessary.

Brain tumors, especially in the frontal lobes, but in all so-called silent areas, may simulate schizophrenic symptomatology. At times there is a decay of the personality and deterioration of behavior in absence of neurological symptoms. Ideas of reference may also occur. However, a history of seizures and headaches and marked change in memory, attention, recall, or reasoning ability should make the examiner suspect an organic syndrome, and recommend a neurological consultation, X ray of the skull, and an electroencephalogram. In doubtful cases, a pneumoencephalogram may be indicated. Brain tumors misdiagnosed as cases of schizophrenia were much more common in past times when these diagnostic methods were not available. Figure 2 shows the brain of a patient who died after twenty-seven years of hospitalization. In the hospital she lived a vegetative existence. Prior to her hospitalization,

she had complained of headache and had had two epileptic seizures. These symptoms were ignored because when she entered the hospital, she showed apparent schizophrenic symptoms, and no neurological signs were recognized. Strangely, during her twenty-seven years of hospital life, no epileptic seizure was observed. She appeared to be a typical regressed hebephrenic.

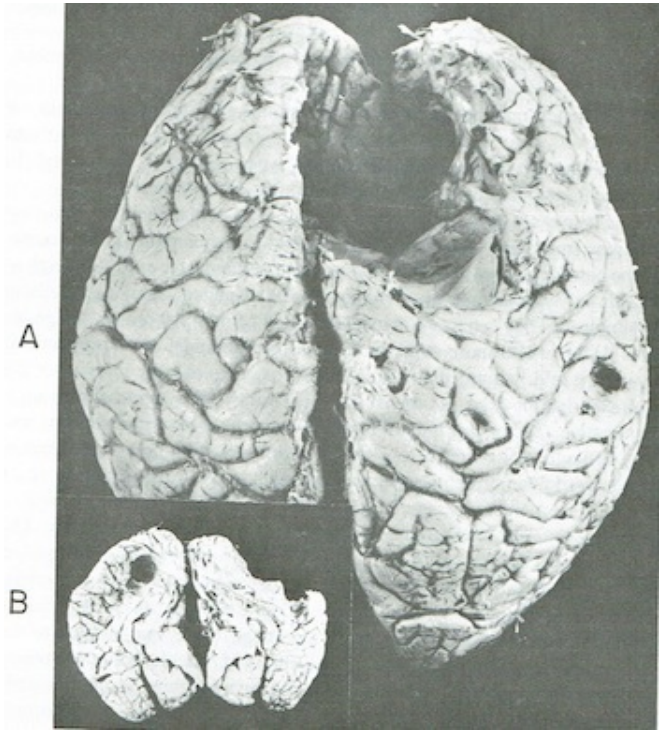

Figure 2

(a) Brain of a patient hospitalized for 27 years under the diagnosis of the hebephrenic type of dementia praecox. The brain is seen dorsally after a huge encapsulated fibroblastic meningioma and a small one have been removed. The larger tumor had replaced most of the right frontal lobe and, to a lesser degree, the left frontal lobe. (b) The same brain after the hemispheres have been separated. Notice the extension of the destruction of the normal tissue in the right hemisphere. The tumor extended from the right hemisphere toward the left frontal lobe, producing a well-defined cavity.

Early arteriosclerotic and presenile psychoses may be confused with schizophrenia, particularly when at first they manifest a paranoid symptomatology. The age of the patient, the presence of arteriosclerosis, and changes in the sensorium lead to the correct diagnosis. As we shall see in greater detail in Chapter 30, some aphasic patients show language and thought disorders that are at times difficult to distinguish from those of regressed schizophrenics. In these cases again either the history of schizophrenia or of the organic condition that caused the aphasia will lead to the correct diagnosis.

When general paresis was a common disease, many patients were misdiagnosed as suffering from schizophrenia, especially when they did not present the typical grandiose mood, and dysarthric and ocular signs. In the rare cases occurring today, the history of syphilis and the serological and spinal fluid examination lead to the diagnosis.

Cases in which a schizophrenic or schizophrenic-like

symptomatology accompanies a neurological condition are generally classified as psychosis with other cerebral conditions, such as encephalitis, degenerative disease of the central nervous system, and so forth.

Some cases of Huntington's chorea start with paranoid syndromes. In the beginning the choreiform movements may be mistaken for schizophrenic mannerisms and grimaces. The history of the occurrence of other cases of this hereditary disease in the family, especially when a history of previous generations is taken, will lead to the proper diagnosis.

Catatonic conditions are occasionally superimposed on organic syndromes. I have seen a few cases in which the patient was hemiplegic as a result of cerebral hemorrhage and totally immobilized by a superimposed catatonic condition. These cases present the most unusual combination, because the neurological symptomatology is covered by the catatonic symptomatology. Catatonic syndromes associated with organic conditions or suspected organic conditions, especially in children and adolescents, have been reported by several authors (Relfer and D'Autremont, 1971; Bemporad and Dunton, 1972).

A rare syndrome that may be confused with catatonic schizophrenia is akinetic mutism, described by Cairns and associates (1941) in patients having lesions near the third ventricle. These patients cannot move or talk, but generally have other neurological symptoms and are affected by hypersomnia.

Alcoholic psychoses, especially alcoholic hallucinosis and alcoholic paranoid state, should be considered in the presence of an apparently schizophrenic syndrome in patients with history of alcoholic habits. In some psychiatric hospitals it is customary to diagnose as suffering from alcoholic paranoid state or alcoholic paranoia patients who drink excessively and who present intense jealousy and delusions of infidelity concerning the spouse. I have seen the same syndromes in many patients who abstained from alcohol completely, and therefore I am almost always reluctant to diagnose these patients as suffering from an alcoholic paranoid state.

At times, delusions, ideas of reference, and auditory hallucinations occur in patients suffering from myxedema. The condition may simulate schizophrenia. The thickened edematous skin, the puffiness of the hands and face, especially around the eyelids, the

large tongue, the obesity, the occasional deafness, low basal metabolism rate, diminished iodine uptake, and hypercholesteremia lead to the diagnosis. At times it is difficult to distinguish a psychosis due to myxedema from myxedema arising in patients already schizophrenic (Easson, 1966).

In untreated pernicious anemia, all kinds of psychiatric syndromes have been reported (Bowman, 1935), but in my experience paranoid conditions are the most frequent (Ferraro, Arieti, and English, 1945). The underlying illness leads to the diagnosis. The same could be repeated in reference to pellagra.

Confused with schizophrenia are those acute toxic-infective-exhaustive conditions, which are often referred to in Europe as Meynert's amentia. In addition to a general paranoid background, they show a fluctuating impairment of consciousness varying from mild confusion to complete disorientation. If an infection underlies the condition, fever is often present. The delirium, however, may persist after the febrile period. Thinking is disconnected, and hallucinations are predominantly visual. Specific infections may produce deliriums similar to schizophrenia. I have described them in the case of cerebral

malaria (Arieti, 1946).

Differential Diagnosis from Miscellaneous or Unclassifable Conditions

Occasionally cases of Ganser syndrome are confused with cases of schizophrenia. The Ganser syndrome occurs generally, but not exclusively, in prisoners who want to escape indictment. The patients often seem to have sustained memory losses. They appear bewildered, confused, and give answers reminiscent of the metonymic distortions of schizophrenics. For instance, they may say that a cat has five legs. When they are asked to identify objects, they give the name of a related object. For instance, upon being shown a spoon, the patient may say it is a fork. The history of the indictment and the need to escape responsibility by resorting to voluntary or to unconsciously produced mental deficiency and the rapidly occurring memory loss lead to the diagnosis of Ganser syndrome (Arieti and Bemporad, 1974).

A condition which in some cases is confused with schizophrenia is Gilles de la Tourette's disease. The patient presents jerking movements of the face and other parts of the body which resemble

schizophrenic grimaces and mannerisms. Some patients also present coprolalia (impulsive use of profane words) or make unnatural guttural sounds. A history dating the first symptoms back to childhood, and the absence of definite schizophrenic symptoms, establishes the diagnosis. However, I have seen cases of Gilles de la Tourette's syndrome in patients who subsequently developed a definite schizophrenic psychosis or in patients who were apparently in remission from a schizophrenic psychosis. Thus the picture is often confusing. It is possible that at least in some cases a connection exists between the two conditions. Differential characteristics from such controversial or exotic conditions as *boujfee delirante*, Capgras' syndrome, and *latah* will be discussed in Chapter 32.

Another condition which is to be differentiated from schizophrenia is the autoscopic syndrome, or Lukianowicz syndrome (Lukianowicz, 1958). The syndrome consists of the delusional experience of a double. The double is not a person from the patient's environment but the patient himself. The patient sees a person who looks exactly like himself, talks, dresses and acts as he does. Quite often this double seems exactly like a mirror image of the patient. He generally appears in gray, or black and white, like images in dreams.

Many patients experience the phenomenon only in the evening, at night, or at dawn. Although occasional instances of autoscopic syndrome have been reported in schizophrenia and in depressions, the phenomenon is generally not connected with these conditions. The majority of cases occurs in patients suffering from migraine and epilepsy (Arieti and Bemporad, 1974).

Strangely enough, a condition which occasionally makes some people suspect schizophrenia is *gullibility.* On rare occasions scared parents consult psychiatrists because their youngsters profess to believe in such things as flying saucers, interplanetary communication, reincarnation, communication with ghosts, etc. The possibility that such thoughts may be delusional has to be taken into consideration. However, it will be easy to determine that the would-be patient has been influenced by some special subculture groups or by what he has read in newspapers or books, or has seen in science fiction, movies, or television.

Gullibility may be the result of disparate conditions. Among the most common are the need to belong to, or to be accepted by, a group at any cost; or a state of anxiety and insecurity which hinders critical

faculties and promotes suggestibility and indoctrination. Less frequently a limited intellectual endowment is responsible for credulity. On the other hand, gullibility may even be a quality necessary for creativity. Creative people tend to keep an open mind to even hard to believe possibilities in order to let their thinking and imagination roam along new patterns. They dismiss the incredible idea only when it was definitely been proven wrong (Arieti, 1966a).

Two other differential diagnoses, to be made generally in relation to legal implications, are *malingering* and *temporary insanity.* Malingering is to be considered in the presence of a history of psychopathic personality, especially in people who wish to avoid military service or a jail sentence. The patient who does not develop a Ganser syndrome will have great difficulty in simulating schizophrenia. The malingerer makes a conscious effort to produce the symptoms, at the same time that he tries to portray spontaneity. But the spontaneity arouses suspicion when the total picture does not fit the recognizable diagnostic categories. Faked delusions are not part of a delusional system as the patient could not fabricate such a system rapidly enough after having committed the crime. In the psychotic the delusion fits the personal history, or the psychodynamic mechanisms;

in the malingerer the delusion is often an isolated symptom. Stereotypy, bizarre behavior, is occasionally simulated. Again, the examiner must evaluate the totality of the picture. Catatonic mutism is very seldom simulated since the nonpsychotic has great difficulty in enduring mutism for a protracted period of time.

Temporary insanity, or isolated episodic psychotic dyscontrol, is a condition of more than doubtful existence. It is supposed to be manifested by irrational, often antisocial or illegal action, carried out by a person who prior to that act did not present any history of mental abnormality, and after the act revealed no psychiatric symptoms upon examination. Defense lawyers would like to believe that their defendant was temporarily insane when he committed the incriminating action. I myself have seen several patients who committed crimes during episodic exacerbations of psychosis. The so-called temporary insanity was part of an epileptic, schizophrenic, or manic-depressive condition which had not been recognized prior to the crime. After the crime there was often a period of remission. However, the whole history of the patient betrayed the presence of a subclinical or intermittent, but not “temporary,” psychosis, in the sense used by lawyers.

Many psychiatrists, in diagnosing schizophrenia, avail themselves of the help of clinical psychologists. Especially projective tests like the Rorschach may provide valuable information that is not available or deducible from the manifest symptomatology. Thus the value of these psychological tests is particularly high at the beginning of treatment. Because this book is aimed predominantly at the psychiatrist, clinician, and therapist, no description is given here of any psychological test. For a valuable discussion of the application of psychodiagnostic techniques to the differential diagnosis of schizophrenia, the reader is referred to the excellent book by Weiner (1966).

II
Prognosis

The prediction of the outcome of schizophrenia when the psychiatrist has been able only to observe the manifest symptomatology has been a matter of great interest since the early contributions of Kraepelin and Bleuler. Many authors have studied the prognosis of schizophrenia from a purely statistical point of view, without any consideration for the symptomatology. Typical of this type of research is the work done by the Finnish authors Niskanen and

Achte (1971), who have studied the outcome of first admissions for schizophrenic psychoses in Helsinki in 1950, 1960, and 1965. The percentage of patients who recovered or were socially recovered after a period of five years was 59 percent of the 1950 patients, 68 percent of the 1960 patients, and 64 percent of the 1965 patients. The findings also suggested that the proportion of those who were in need of hospital treatment after a period of five years decreased steadily: 22 percent of the 1950 patients, 14 percent of the 1960 patients, and 10 percent of the 1965 patients.

Most authors, however, have done a different type of research. They have tried to determine the prognosis by virtue of the characteristics of the manifest symptomatology, with the implicit understanding that the treatment to be administered later would improve the prognosis. Thus the majority of psychiatrists today do not agree with Bleuler, who stated that he or his contemporaries had "not discovered any correlation between the initial disease symptoms and the severity of the outcome of the illness" (1950, p. 261).

Typical of the group of authors who tried to predict the prognosis from the symptomatology is Vaillant (1967). He listed six criteria that

indicated a good prognosis: (1) Psychotic depressive heredity. (2) Symptoms suggesting a depressive psychosis. (3) Onset within six months before the fully developed illness. (4) Presence of precipitating factors. (5) Absence of a schizoid personality. (6) Confusion or disorientation. As a rule, the recovered schizophrenic presented symptoms suggestive of an affective psychosis and often possessed a heredity positive for psychotic depression.

In the first edition of this book I stated that although no one can be absolutely sure what course a given patient will follow, a certain group of symptoms and factors tend to occur more frequently in patients who recover; on the other hand, other symptoms and factors tend to occur in patients with a poor outcome. In this second edition I can reaffirm that certain characteristics to be mentioned shortly have a prognostic significance even when they are studied merely in their manifest aspect.

The *onset* of the illness is prognostically important. The more acute the onset, the more favorable is the prognosis, especially if characterized by a state of confusion. This criterion is not absolute. Every psychiatrist has observed very acute cases that were not

followed by recovery or improvement.

The *obvious occurrence of specific precipitating factors* (like loss of employment, broken engagement, childbirth) indicates a good prognosis. As we shall study in more detail in Chapter 8, the necessary occurrence or presence of these factors for the engendering of the psychosis indicates that the personality has a relatively better chance of reintegrating once these factors are removed. They also indicate that the underlying or more obscure part of the etiology was less prominent in these cases.

Conscious anxiety is an important indication of good prognosis. Its presence indicates that more severe mechanisms of the psychosis are not present or have not eliminated the presence of this emotion. By being distressing, anxiety invites the patient to continue his search and possibly to return to reality. However, if the anxiety increases in spite of the treatment, more severe mechanisms of regression may develop. For instance, the hebephrenic may become more grandiose and disconnected, the catatonic more immobile. When the paranoid is forced by his anxiety to search for an increasing number of logical defenses, he may remain ill for a long period of time or permanently.

Thus anxiety may work in two ways. But without anxiety, no improvement is possible. Of course, we should not confuse the decrease in anxiety due to improvement with the decrease in anxiety due to progression of the illness. The latter is accompanied by more and more detachment from reality, whereas the opposite occurs in the former.

The type of prepsychotic personality is prognostically important. The *stormy* type indicates a more favorable prognosis, the *schizoid* type a less favorable one (see Chapters 6 and 7). Recent studies have confirmed this statement by concluding that a good "premorbid personality" generally indicates good prognosis and shorter hospitalization (see, for instance, Harrow, Tucker, and Bromet, 1969).

A *general attitude of defiance or compliance* is also another important prognostic characteristic. If the patient is compliant toward therapists and nurses, the chances of his recovery are much greater than if he is defiant (Seitz, 1951). This is particularly true about the paranoid. The patient who defies the therapist, wants to demonstrate at any cost the veracity of his allegations, and is uncooperative and unwilling to submit to the suggestions of the therapist has a more

guarded prognosis. He wastes his energies in the fight to retain his psychosis.

The *general affective condition* is also important. The presence of depression improves the prognosis. As we have already discussed, at times the depression is so marked that the syndrome has been diagnosed schizo-affective, or a differential diagnosis from manic-depressive psychosis has been difficult. The schizophrenic depression is not necessarily accompanied by a conscious feeling of unworthiness. The more adequate or richer the affective behavior is, the better is the prognosis.

A *state of hopelessness, not accompanied by congruous depression*, is an ominous prognostic sign.

The *content of the delusional or hallucinatory material* has important prognostic value. The more the patient projects toward others and exonerates himself, the more severe is the psychosis. If, on the other hand, he believes that he is persecuted because he is somehow guilty or responsible, the prognosis is better. The prognosis is much better if the delusions concern feelings of guilt and

responsibility. But here again the diagnosis may be uncertain, wavering between schizophrenia, manic-depressive psychosis, or schizo-affective psychosis. At times, the differential characteristics and the prognosis are difficult to evaluate, as, for example, when the delusions follow a schizophrenic pattern and the depression and the feeling of guilt present a manic-depressive picture. The following example is typical of this combination.

> The patient was a 32-year-old chemist, the youngest of five children. After the death of his father, which occurred when the patient was 3 years old, he was raised in an orphan asylum, where he stayed until puberty. He was a very shy, submissive person, fearful of authority, who gained some kind of security through intellectual achievements. In his youth he had been too shy to date girls; occasionally he would visit a prostitute. At the age of 30 he met a rather energetic woman who became interested in him and persuaded him to marry her. It is doubtful whether he ever loved her. He considered her physically unattractive and domineering. But still, she was the only woman who had ever paid any attention to him. Two years after the marriage, the wife became sick with a rather serious arthritic disorder, which made her appear even more unattractive to him. One day the patient was sent by his firm to a distant city on a business commission. While he was sitting in the lobby of his hotel, he was approached by a prostitute who proposed that he invite her to his room. He

agreed. They had intercourse, after which he promptly dismissed her. After she left, he started to worry. She had had a funny look on her face. Maybe she was sick. Maybe she had infected him. He became so disturbed that he returned to New York City sooner than he had planned. He visited his physician to find out whether he could detect any sign of infection. The physician did not find any pathology. A few days later the patient thought he saw some peculiar spots on his penis. This time he was sure he had syphilis. He visited two or three specialists who reassured him that he had no venereal disease. A blood Wassermann was taken and was found to be negative. Two weeks later he noticed some peculiar pimples on his wife's face, and he also heard that a neighbor's child, whom he had caressed on the street a few days before, was sick in bed. He became convinced that he had infected his wife and this child with syphilis. He also noticed that the workers in his firm showed some peculiar pimples on their faces, and he was almost sure that he had spread the infection to the whole company. He was not absolutely sure of all his apprehensions, but he was "almost" sure, and he tried to rationalize his anxiety. For instance, every two weeks he would take a new blood Wassermann. Although all of them were negative, he was not sure that he was not syphilitic. He had read in a book that the Wassermann reaction is accurate only in 98 percent of the cases. After all, he might belong to that 2 percent showing inaccurate results. He was very depressed and felt extremely guilty. He connected several events with his delusions. For instance, he had read in the paper that two or three people had committed

suicide. These people lived in a part of New York City that was crossed by a subway line that he used to take. He thought that maybe he had infected these people by touching them or by using the same seats. These people had contracted syphilis from him and consequently had committed suicide. He was very depressed and was so preoccupied with these thoughts that he had to stop working. He was seen by several psychiatrists who differed as to the diagnosis. Two-thirds of the group who had seen him emphasized the delusional system and favored the diagnosis of schizophrenia. One-third pointed out that the patient was very depressed, that he had strong feelings of guilt, and that the delusions were not projected, but somehow introjected, as regards, for example, his feelings of responsibility for the increase in the number of suicides. They felt the depression was congruous with the tremendous feeling of guilt and favored the diagnosis of the depressed type of manic-depressive psychosis. The patient had two or three psychotherapeutic sessions, during which the hostility for his wife came to the fore. But the awareness of this hostility increased his feelings of guilt also. Because it was not possible to arrange a prolonged psychotherapeutic treatment, the majority of physicians who examined him recommended shock treatment. After the first treatment a striking symptomatic improvement was noted. The delusions lost their strength, and after the fourth or fifth grand mal seizure, the patient was no longer delusional. This apparently excellent response to electric shock confirmed the opinions of those who had diagnosed the case as one of manic-depressive psychosis. Two years

> later, however, the patient manifested open symptoms again. His mother had died of a cerebral hemorrhage, and again he thought that she had died because he had infected her with syphilis. A person who worked in the same firm also had died of apoplexy, and the patient felt responsible for his death too.

I could not treat this patient, and I do not know what has become of him. Unfortunately, this case could not be explored or treated dynamically in spite of the excellent possibilities. It has been briefly reported here as an example of the fact that delusions of guilt have a better prognosis and a better response to any type of treatment, at least as far as the single attack is concerned.

There are, however, other delusions connected with guilt and responsibility that do not have a good prognostic meaning. They are seen in the hebephrenic type of schizophrenia especially. For instance, a patient felt that if he went swimming in a pool or in the ocean, he would impregnate all the women who were in the water. Therefore he did not go swimming, because he did not want to be responsible. This patient had been told by his mother that he had been responsible for all her sicknesses, which had started from the time she was pregnant with him. Her “being pregnant with him” had symbolically become his

act of “impregnating mother,” and it aroused feelings of guilt. He did not want to repeat his original sin. By thinking of his own original sin, however, he magnified his power; he had the power to impregnate many women, and in a psychotic way he compensated for the inferiority feeling that his mother had engendered.

Hebephrenics and catatonics at times feel that they are, or may become, responsible for all the evils of the world. In these delusions, the feeling of power is more obvious than the feeling of guilt, which may not be apparent.

If the delusions involve members of the family, such as the spouse or the parents, generally there is an arrest of the illness, or very slow regression, but the probability of final recovery, without recurrences, is not enhanced or reduced.

The *state of insight* has important prognostic value. Opinions differ on this point, mainly because the word *insight* has been given several meanings. The “psychotic insight,” to be described in Chapter 22, has a negative prognostic value. When the patient feels that he fully understands what is behind the strange things that happen to him, the

prognosis tends to be unfavorable.

The insight the patient may have about the symbolic meaning of his symptoms generally has a negative prognostic value. The repressive forces are all destroyed, and the patient is in immediate contact with the sources of his disturbances. Of course, an exception is the symbolic insight that is acquired through treatment, because in this case the anxiety is also progressively removed.

The insight that makes one aware of being sick is, on the other hand, a good prognostic sign. It is reminiscent of the insight that the dreamer has when he is about to wake up from a dream and realizes that what he experienced was a dream, not reality. This type of insight has a particularly good prognostic value if it occurs after a period in which it was absent.

There are also patients who are generally in a borderline condition, with occasional outbreaks of transitory psychotic symptoms. These patients are usually aware that they are sick; at times they go as far as to diagnose themselves as cases of schizophrenia. In this case, the insight does not have a good prognostic

value as far as complete recovery is concerned; however, it somehow seems to indicate that the process of regression is prevented or at least slowed up.

The *ability to pretend, or to lie,* is a good prognostic sign. Delusional life is reality for a patient, not pretension. When he is questioned about his delusions, he cannot deny them or lie about their existence, even when he knows that admitting them will have an unfavorable result, such as the rejection of his demand for discharge from the hospital. He cannot lie or pretend because he cannot shift to an imaginary assumption.[1] The denial of delusions, which are so real to him, requires a power to abstract or to shift to a set of facts that from his point of view are unreal. At times, when he knows that admitting his truth would mean being kept in the hospital, he will try to be as evasive and defensive as possible, but he will not actually lie. When the patient is able to lie about his delusions, he is in the process of recovery. He will not have to lie for a long time, because the delusions will soon disappear.

This inability of the schizophrenic to lie should not be confused with the inability to lie that is present in certain obsessive-compulsive

patients. The latter cannot lie, not because they cannot shift to an imaginary assumption, but because they feel compelled to tell the truth in order to ward off guilt and anxiety.

Finally, the *acceptance of one's illness, or resignation to being sick,* has an ominous prognostic meaning. This trait belongs more properly to the second or advanced stage of schizophrenia. Other prognostic criteria have been considered by Rennie (1941) in an accurate statistical analysis of one hundred schizophrenics who recovered.

Notes

[1] Schizophrenics treated even with moderate amounts of tranquilizers often reacquire the ability to lie.

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Acknowledgments

I wish to express my indebtedness to the publishers who have permitted the reproduction in this volume of long excerpts and/or illustrations from the following articles of mine:

"Special Logic of Schizophrenic and Other Types of Autistic Thought." *Psychiatry,* Vol. 11, 1948, pp. 325-338.

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"Schizophrenic Art and Its Relationship to Modern Art," *Journal of the American Academy of Psychoanalysis,* Vol. 1, pp. 333-365. © 1973 by John Wiley & Sons.

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