On Schizophrenic Disease which Showed Very Good Prognosis

—Report of Two Cases—

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INTRODUCTION

Schizophrenia is one of the most important disease as a subject of study in psychiatry because its incidence is high, because the pathological picture presented is very peculiar, and also because it is difficult to treat. And yet, the cause of schizophrenia still remains unknown today despite the efforts made by many researchers. In diagnosing patients visting the clinic as schizophrenic, we have no effective and reliable means other than to examine the psychiatric symptoms and to study the history previous to their visit.

In any case, we make a diagnosis of schizophrenia by this method and begin treatment. While making long-term observations, we find quite a number of patients who do not show any advance of the disease peculiar to schizophrenia or personality defect which could be considered as the result of those. That is, a diagnosis on the basis of clinical course is made. Then, we face a question: Was our first diagnosis, or horizontal diagnosis wrong? Or, does psychosis of a type other than schizophrenia in the strict sense of the word exist? That is, we face the difficult question of what schizophrenia is --- a question which has been debated throughout the modern history of psychiatry and which has not yet been solved.

In the present paper, we have reported and reviewed two cases which started with symptoms indicating schizophrenia and whch followed a clinical course quite different from that of schizophrenia.

CASE REPORT

Case 1: Male, 20 years of age at the first visit.

Hereditary history: Not remarkable, except that one of his maternal cousins committed suicide at age 23.

Family history: The parents are living and well. He is the youngest among five siblings, his four elder sisters are all married.

Past history: Not remarkable.

Present illness: He was silent and unsociable as a child. Although he was the youngest child, he had not been particularly pampered. He graduated from senior high school with excellent achievements and entered the university of his choice. From around the time he was a second-year student, he started thinking that life was meaningless and ceased to attend lectures. Not getting enough sleep, he started to take a hypnotic habitually and began to drink whisky almost every night. After he flunked an examination and attempted suicide, he was referred to the Department of Neuropsychiatry for medical examination and treatment. On the first examination, he showed a careless attitude, merely mumbled away in reply to questions, sometimes put on a feigned smile, and there was an observed "Praecoxgefuhl." Slovenly dressed, he would not take a bath for a month and kept on wearing soiled underwear.

Along with these we observed in the patient delusion of reference, delusion of persecution, a dialogue type of auditory hallucination, and ambivalent feelings saying, "In making a decision, I don't know what to do because I come up with two answers, 'Yes' and 'No' simultaneously."

The patient was diagnosed as hebephrenic schizophrenia, and hospital treatment was initiated. As the patient showed a strong tendency to reject medicines, ECT and subsequently insulin therapy were performed. In the course of the treatment, however, impulsive excitement and stupor were observed, and he was placed in a protective room, though for a short period of time. After having stayed in the hospital for four months, he had remission and was discharged home.

After that, depersonalization and derealization persisted for about a year, but improved gradually. Abnormality in EEG was not observed. After returning to the university, he had no paticular trouble in studies and graduated.

Fifteen years have passed since he was employed by a major manufacturer. Holding a responsible position as an able manager, he is now leading a happy home life.

Case 2: Male, 19 years old at the first visit.

Hereditary history: Not contributory.

Family history: Both parents are living and well. The youngest of

four siblings, his two elder sisters and one elder brother are all in good health and independent.

Past history: Not remarkable.

Present illness: He was obstinate and liked to play alone with a pet animal in his childhood. He graduated from a senior high school with above average results. He could not enter the department of a university he desired but was transferred to the department of his second choice. He intented to wait for another chance in the next year, but persuaded by his father, took the necessary procedures for admission.

For the initial two months after admission to the university, he attended lectures like the other students. From the beginning of one summer vacation, however, he would no longer talk to members of his family but only lie in bed all day, taking a walk around his house at night or piling up dozens of literary books on his desk and often remaining absent-minded. After having behaved so irregularly for about a month, he suddenly disappeared and his whereabouts were unknown. A request for a search was submitted to the police, but there were no clues. Twenty days later, he returned home unexpectedly. Wearing soiled clothes and a lifeless expression, he looked like a vagrant and gave only meaningless replies to whatever questions were asked of him. Diagnosed as hebephrenic schizophrenia, he was admitted to a mental hospital at once.

On admission, the patient would say "Yes, yes" in a stereotyped manner and sometimes put on a meaningless smile, and "Praecoxgefuhl" was observed. Since he refused to take psychotropic drugs, ECT was performed ten times. The pathological condition was largely responsive to this treatment, and after completion of the third ECT, the condition was improved to the point where he would talk to the attending physician.

His running away from home was "guided by an electric wave from the Great Bear." He said, "I believed that the number '7' represented an ill omen to me." It was further made known that he had heard voices criticizing or deriding him from the time he entered the university (auditory hallucination). In the ward, he was sometimes talkative and sometimes silent, and often loitered about the corridor while talking to his auditory hallucination. After completion of ECT, he regained composure and no longer showed a hostile attitude toward those around him. However, he still said something contradictory: "When I think about something pleasant to me, for instance discharge from the hospital and resumption of college life, I feel uneasy. But when I think about

something gloomy, for instance death, I calm down."

He was discharged home after he had stayed in the hospital for five months. Members of his family said that he became sociable and was getting alone well with his siblings. Three months later, he resumed college life, while he continued to attend the out-patient clinic for one year and six months. EEG showed no abnormalities.

He graduated from the university and advanced to the doctorate proram. And now, 18 years hence, he is bringing his abilities into full play as a branch office manager in a profession which requires him to meet many people. His family life is also peaceful.

DISCUSSION

In 1899 Kraepelin[1] identified a unit of disease called "Dementia praecox" as a counterpart of affective disorder. Establishment of this concept was of great significance in systematizing mental diseases, but it resulted in the confusion of the dualistic theory, according to which endogenous psychosis is deemed as either schizophrenia or affective disorder. This confusion continues up to the present.

To be sure, the concept of "Dementia praecox" is an epochmaking one. But it does not necessarily develop at puberty as the name implies and not all cases present "Dementia" either. And thus it was renamed "Gruppe der Schizophrenien" by E. Bleuler (1911).[2] He studied the mode of illness by the psychological characteristics of the disease, i.e. an analysis of psychiatric symptoms, while Kraepelin[1] studied it by the longitudinal course of the disease. Regarding the symptoms of schizophrenia he used as an index, he mentioned laxity of association, emotional disturbances and ambivalent feelings, particularly autism. As a result, studies on the cause and clinical course of schizophrenia were no longer conducted, and the concept of schizophrenia was expanded further in scope than that advocated by Kraepelin[1], and its constituent became very complex and diverse. Viewed clinically, however, there is no doubt that Kraepelin's "Dementia praecox" forms the nucleus of schizophrenia, and as for related psychoses, mention is made, for instance, of atypical psychosis (Mitsuda).[3] Some are of the opinion that atypical psychosis should be distinguished from schizophrenia since it is accompanied by EEG abnormalities.

Moreover, attmpts are being made to classify "affektvolle Paraphrenie" (Leonhard)[4] and "types déxperiences délirantes schizophreniques transitoires" (Laboucarie), which develop acutely but with good prognosis, into a group of diseases marginally related to schizophrenia. It may be

said that many of these attempts are based on the fact that there is a group of patients whose prognosis is good. Langfeldt[5] classified a group of schizophrenic diseases which showed no schizophrenic symptoms and for which prognosis was good as "schizophreniforme Psychose", as distinct from genuine schizophrenia. And he pointed out that the various shock therapies are effective for the former but not too effective for the latter.

Rümke[6] thought that only the schizophrenia showing "Praecoxgefühl "or praecox feeling is "echte Schizophrenie" and that the others are "Pseudo-Schizophrenie". In USA, all the different types of schizophrenia are sometimes called "the schizophrenic reaction" collectively, but there are many who oppose including "Dementia praecox" in it[7]. There are cases which are considered to lie on the borderline between neurosis and schizophrenia, and which are thus treated as "borderline cases" (Knight)[8]; they have been attracting attention recently.

M. Bleuler[9] made observations on the clinical course of 500 cases of schizophrenia for over 15 years, and classified them into six groups according to the prognosis. He reported that 25-30% of them were cured without leaving defects peculiar to schizophrenia. Patients belonging to that group were those who developed symptoms acutely and followed a cyclic course. This result is very interesting when compared with the report of Kurosawa[10] that among the cases of schizophrenia as classified in the broad sense of the word, about 30% belong to atypical psychosis.

The two cases reported here do not belong to the nuclear group of schizophrenia judging from their clinical course. They showed aggravation of symptoms only once each at puberty or in the second half of puberty, responded well to shock therapy, and were cured completely without impairment of personality which is the most outstanding characteristic. EEG abnormality, one of the standards for diagnosis of atypical psychosis (Mitsuda)[3] was not observed either. However, these two cases presented symptoms suggestive of autism and symptoms characteristic of schizophrenia such as ambivalent feelings and emotional disturbance, and they also had "Praecoxgefühl". Of course, it cannot be denied that "Praecoxgefühl" is an indefinable feeling or experience peculiar to schizophrenics, and that it is very subjective. As Rümke[6] himself maintains, it is not that "Praecoxgefühl" exists in all of the schizophrenics but that it rises and falls according to the conditions of illness. However, psychiatrists can sense it in the case when it consists mainly of negative symptoms like autism with positive symptoms hidden in the background. Our two cases were "echte Schizophrenie" in that they had

"Praecoxgefühl", but undoubtedly belonged to "Gruppe der Schizophrenien" under cross-sectional diagnosis, that is, according to E. Bleuler.[2] From the fact that our patients themselves found it difficult to make decisions on their futere, it may be surmised that immature personality or impairment of identity was partially accountable for that psychiatric symptom being presented. In this way our patients could be considered as "borderline cases". Though slightly different in nuance from those of Knight[8], these cases could possibly come under the category of "die beginnende Schizophrenie" (Conrad).[11]

Since the three classifications, namely "Schizophreniforms Psychose", "borderline case" and "die beginnende Schizophrenie" are not of the same origin, it follows that the two cases mentioned here partly agree and partly disagree with each of these. It would be more useful to link more similar cases than to establish a group of diseases anew simply because the cases are not in agreement with the concepts hitherto published. Otherwise, it may develop into the situation where each different type of the atypical group would have to be classified independently, and this would end up making the concept of schizophrenia more ambiguous.

SUMMARY

We have reported two cases which presented a pathological picture typical of hebephrenic type schizophrenia, responded well to shock therapy, became cured in a short time and showed no flare-up of symptoms after observations on prognosis for 15 years and 18 years. These two cases presented symtoms suggestive of the nuclear group of schizophrenia and were expected to take the course of "Dementia praecox", but in the end these symptoms were only transient and EEG showed no abnormalities whatsoever. These two cases can only be considered atypical judging from their clinical courses, although they could be judged as schizophrenia according to the cross-sectional diagnoses. We have stressed that the coordinates of these two cases in the system of psychoses cannot be determined in the current state of psychiatry.

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