THE RELATION OF ONSET TO OUTCOME IN SCHIZOPHRENIA

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Introduction

The writer will assume that the concept of schizophrenia has been stripped of an implication of inevitable chronicity and deterioration. He will not accept recovery as "remission" or "arrest," but instead will hold that an individual who has undergone a schizophrenic illness, ceased to show schizophrenic processes, and resumed social living with a gradual expansion of life-interests, has in fact to the limit of the meaning of such terms actually recovered from the schizophrenic illness. Having noted that such recoveries are by no means infrequent, he will then offer some tentative notions bearing upon crude observational factors seemingly sequents of the favorable outcome, and useful to the psychiatrist who cannot engage in any detailed study of his patients.

Review of Cases

In the seven years during which the research staff of the Sheppard and Enoch Pratt Hospital has been occupied with the problem of schizophrenia in males, about two hundred and fifty patients have been subjected to more or less elaborate investigation. To simplify this orientation, the discussion will be limited to the first hundred of whom fairly dependable correlations of the crude (non-statistical) sort can be made. This hundred occur in the first one hundred and fifty-five serial admissions. Fifty-five patients were eliminated from this study for the following reason: (a) defective information coupled with failure of the physician to establish satisfactory contact with the patient, 30 patients; (b) mentally defective patients coupled with defective information, 11 patients; (c) schizophrenic nature of the illness questioned (often in earlier admission elsewhere), 14 patients. In other words, there is useful data in 64.5 per cent of the consecutive male schizophrenic admissions. This higher percentage results in part from such factors as the hospital's policy and prestige, so that the patient-material cannot be held to be a representative cross-section of the general schizophrenic population. Many of the notions derived from this study, therefore, may or may not be of general application. The positive conclusions, however, which are the subject of this paper, must be accepted as only very modestly related to defects of the clinical sample, and as generally valid.

Of the one hundred cases on which comment is made herein, the onset of mental illness was insidious in twenty-two. In other words, in each of these twenty-two individuals, there was a life-course in which the patient underwent no dramatic separation from ordinary living, but instead became gradually more and more peculiar until finally, by reason of some more or less spectacular occurrence, his mental illness was recognized. In no one of these was the prolonged phase of insidious divorcement from approximate mental health a matter that was overlooked because of the indifference or stupidity of the persons making up the environment. The insidious characteristic of the change may be accepted as genuine.

Of these patients, a liberal figure for those improved is seven. That is, less than 32 per cent of these patients showed marked modification of the processes towards that state of approximate mental health. Of the seven, two patients are in perhaps as good mental health as is the general population, three are definitely paranoid states, one is a defective without psychosis; and one is decidedly reduced in the interest and activity range.

Of the basic one hundred patients, the onset of schizophrenic mental illness was acute in seventy-eight cases. In other words, in each of these seventy-eight individuals, there was a life-course in which the patient underwent a rather abrupt change in behavior and expressed thought such that the personal environment was emphatically impressed by his transition from a state of approximate mental health to one of mental disorder. Of these, forty-eight, or somewhat over 61 per cent, have shown marked improvement; in a considerable number, the change has amounted to a recovery from the mental disorder.

Of the thirty patients in whom the onset of grave illness was acute, but improvement did not follow, the following data may be of interest: four are dead, two having killed themselves; four are defectives, two of whom improved greatly under care, but relapsed to grave disorder under social pressure after discharge. In two instances, the illness appeared late in life; these are now both chronic paranoid states. Nine younger patients have progressed into chronic paranoid states from which recovery is not to be expected, since the disorder is preferable to the real situations to which the patient might hope to return. In five hebephrenic cases, deteriorating processes are evident -- one at least as a result of errors in the psychiatric handling of the patient. Another one progressed swiftly into a dilapidated paranoid state, but continued subacutely ill for some years, killed a bystander while on parole and was in turn killed by a policeman. This was the fifth death in the group. Of the remaining five, one has had recurrent waves of psychosis over a period of about eleven years, and is rather badly disintegrated; one has been in a subacute catatonic state with great hostility to the personal environment -- a form of paranoid state, according to a descriptive psychiatrist -- for about four years; one slipped into the acute psychosis owing to the extraordinary fragility of his personality, which had been held to some semblance of integration only by a quite bizarre disregard for ordinary standards, coupled with a wife willing to co-operate in his extraordinarily perverse modus vivendi; another is a subacute catatonic of several years duration, tending strongly to paranoid maladjustment, also the result of poor therapy on the part of the writer; the fifth is a man singularly handicapped by physical factors, who stumbled along until about thirty-six years of age before failure, and has little indeed to recover to -- he is progressing into a paranoid state.

Impervious barriers generally keep one from establishing rudimentary interpersonal relations with the unfavorable patient of insidious onset. This is probably a direct result to be expected from consideration of the environmental personal situation in which the personalities had their development. In the seven cases of improvement after the insidious onset, to which reference is made above, a rather good superficial contact was established with six of them. One proved to be of extraordinary intellectual equipment, who had had only a small number of truly schizophrenic processes in the course of an insidious deviation from conventional life, towards a life of extreme radicalism. He underwent partial psychoanalysis and is now studying medicine. Another was of decidedly superior intellectual equipment, had very few schizophrenic processes, but early retired from active social life and efforts towards achievement. He has been gainfully employed for two years or so. Another is a seriously defective boy in whom the onset had been acute, but in the course of such chronic maladjusted living that the change did not impress the personal environment. He made a "transference cure" of low grade and has been working for about a year. He thus comes to belong among those cases of acute onset, but is reported here because of the apparently insidious onset.

The Significance of the Type of Onset

In brief, an insidious onset of schizophrenic processes is of much more grave omen as to outcome than is an abrupt onset. Two theoretical considerations may be advanced in this connection. Either the insidious disorder is different

from the acute, or the personality distortion underlying the insidious onset is more severe, although of similar nature to the distortion underlying the acute onset. Moore (2) has presented some evidence derived from statistical operations with tetrad differences, pointing to the existence of a syndrome of "cognitive defect" positively related to so-called praecox conditions. This author finds that "cognitive defect" has positive correlation with "what are probably two phases of dementia praecox: the uninhibited and the catatonic." This is taken to move the "praecox" disorders off into the realm of neurologically founded maladies. It is easy to divide the material under consideration into "praecox illnesses based on organic pathology and "schizophrenic" illnesses based on functional pathology. The division, however, is irrational and unprofitable, for some of the former cases recorded a good measure of mental health just as did most of the latter. In other words, in frankly defective patients, undergoing severe and relatively typical schizophrenic processes (in other words, not typical "psychoses with mental deficiency,") nothing fully distinctive from extraordinarily talented individuals suffering schizophrenia, has appeared in this investigation.

Moore's syndrome includes the "shut-in" personality factor. This inclusion results from mathematical operations, and not directly from descriptive psychiatric procedures. How does the material under discussion bear on the "shut-in" factor? Taking the forty-eight patients in whom the onset was acute and recovery considerable, there are, roughly, thirty-six clearly negative and twelve more or less positive. Taking the thirty of acute onset without material recovery, there are, again roughly, ten showing what might be described as a "shut-in personality." Of the seventy-eight acute onsets, then, fifty-six did not impress the writer as occurring in personalities to be placed under the rubric of "shut-in." The question arises as to those showing insidious onset. Of the twenty-two, there were fourteen distinctly "shut-in"; these did not include any of those that actually improved markedly. (If all defectives are to be accepted as by definition "shut-in," then these figures are subject to revision, for several of the mentally defective patients did not impress the writer as having shown a "shut-in" personality.)

Conclusion

Very briefly, quite in keeping with the work of Edward J. Kempf and with the other findings of the Sheppard study, a crude correlative study such as that any hurried psychiatrist might make, indicates that an acute dramatic divorcement from more or less commonplace living is of good prognostic omen in schizophrenic illnesses. This sort of psychotic onset implies a personality that has grown farther towards adulthood than is the case with insidious illnesses. In this is the factor of promise. The acute onset means that one is dealing with a personality integration that has gone on a long distance in spite of the dissociated homosexual cravings or the masturbation conflict from which the illness has finally taken origin. It, therefore, includes a good deal that can be re-integrated into a "going concern." The insidious onset means that the growth of the personality has failed long before the hospital admission, and that there is relatively much less that is useful for a re-integration of anything like an average life-situation. Disregarding all the factual material which can be elicted in psychopathological study of individual patients, one is justified in prognosticating on the acuteness of the divorcement from reality in the schizophrenic illness, and may give a heavy favorable weighing to the dramatic outcropping of the psychosis. The chances for "recovery or remission from dementia praecox" are alleged to be in the neighborhood of one in four or five of the younger patients. This may be amplified by saying that the chances for recovery are twice as good in the patient of acute onset as in the one insidiously separated from reality.

Discussion

DR. STRECKER: In Mr. Sullivan's excellent presentation, I was particularly interested in the fact -- and I take it this is the point of the paper -- that what has been designated as an acute stormy onset is a relatively favorable prognostic sign. It is an old observation and one which I think is well borne out in clinical practice.

The other point is that I do not think we should be too much disturbed about what might be called the criteria of restitution. I wonder if some of our disturbed frame of mind about the matter is not due to the fact that we tend to lean over backwards in regard to the possibility of favorable outcomes. In discussing a presentation at the meeting of the Association when this subject was previously presented (1), Dr. Jelliffe put it very well when he said that every one of us, not only these restituted patients but every one of us found it necessary to carry a mental crutch with which to get on in life. Now, when we ourselves need that sort of help, which we extract from our environment as best we can to meet our individual needs, it seems hardly fair that we should expect the ex-schizophrenic patient to get on without anything at all. Therefore, I should like to point out that we should not be too rigid in our definition of what consitutes restitution.

DR. SULLIVAN: Dr. Strecker's comment, stating the point, if any, of my talk, requires reply. I shall also amplify my presentation; although I had intended nothing more than a crude prognostic indication for general use. As to the prevailing notion regarding the type of onset and outcome; not only does an acute stormy onset indicate a relatively good prognosis, but an acute stormy onset is frequently overlooked or unrecognized by members of the patient's family. It is the character of the onset as it actually occurred in the patient that bears on the outcome. Sometimes the outcropping of schizophrenic phenomena is very clearly reproduced by the patient and shows an abrupt appearance of the abnormal content. This may have occurred when his behavior was not observed to be seriously disordered. The prognosis in such cases is good. The consideration of the sufficiency of the exciting situation seem to me to be practically of very little value to the institutional psychiatrist. I have attempted in other studies to show that the sufficiency of the exciting situation is an almost irrelevant consideration; certainly one on which I would accept the patient's opinion rather than that of the investigating psychiatrist. Since the insidious onset does not arise out of an "exciting situation," this consideration is wholly irrelevant, in every sense, to the group of patients in whom, in my opinion, the prognosis is most gloomy.

As long as I am led to touch upon the dynamics of the schizophrenic break, I feel that I should mention certain considerations which have appeared to me to be valid and which I presented at a recent meeting of the New York Neurological Society. Study of the life history of a considerable number of people, including those patients mentioned in the present paper, has convinced me that the onset of schizophrenia can frequently be divided into two stages. A considerable number of people experience the first step towards schizophrenic phenomena a considerable time before the psychosis makes its appearance. The interval between the initial stadium and the appearance of psychotic experience may be a matter of moments or the matter of a lifetime. I call the first stage the collapse of the individual world synthesis.

Individuals come to a certain age with a body of what I suppose one might describe as implicit assumptions about themselves and the universe.

We all depend upon a large number of things that we are really not justified in depending upon, but we have never had any reason to suspect them. The sun rises pretty regularly and our alarm clocks work if we give them a chance, and so on and so forth. A great body of assumptions is the foundation upon which our life processes rest. In a remarkable number of adolescents, however, there comes a time when their faith in this background of implicit assumptions about their own abilities or about the consistency of the universe, and so on, is abruptly shattered. Then, instead of building the rationalizations as we do when someone points out that we have been an ass, these individuals go on feeling terribly upset about things. From that time on, instead of building the sort of rationalizations with which we heal the wounds to our self-respect, these people are different from what they were before. Perhaps I might mention three or four groups. In one case the individual becomes a superficial individual from then on; he deals with social contacts in what we call a sort of hysterical fashion; he has all sorts of enthusiasms and distresses and what-not, but acquaintance with him shows that this is just a sort of surface play. In another instance the individual becomes retiring, secretive, he seeks a much more restricted environment and avoids all social contacts. As a third case I might perhaps mention the resort to a wild compensatory program, this often leading to schizophrenia.

I believe we can isolate by further study a type of situation which I will call the first stage of schizophrenia (because it is so very frequently associated with the second or definite schizophrenia), in which there is a rapid loss of faith in the self and the universe without the remedial maladjustments or actual remedial processes which go on with most of us when we receive a severe bump in life. Such situations are not, however, in any necessary close association with the gradual separation of the individual from reality, of which I have spoken.

Briefly, the second stage of schizophrenia as it has become formulated in my mind is somewhat as follows. The individual, with serious impairment of the dependability of his self and the universe, progresses into a situation in which the dissociated parts of his personality are the effective integrating agencies. The factors which he experiences are then of two varieties. He lives the sort of life to which he is accustomed; this under the domination of the accepted egoistic structure. And he has from momentary to extended intervals during which the experience which he is having is dominated by the dissociated systems. The result is a condition which I cannot distinguish by any important characteristic from that undergone by an individual in attempting to orient himself on awakening in the midst of a vivid nightmare. To all of this condition I apply the term incipient schizophrenia. If it goes on, the clinical picture becomes that of catatonic illness. So far as I can see, an individual may remain in this state of difficulty almost indefinitely. On the other hand, he may, as a result of appropriate experience, undergo one of three changes -- this at any time in the course of a catatonic illness of any duration. An integration may begin between the dissociated and the dissociating systems of his personality,-- in which case all proceeds toward recovery. A massive transference of blame may occur, as a result of which he progresses into a chronic paranoid state, the particular type of which is related in a simple fashion to the conflicting systems. Or there may be a dilapidation of the dissociating system and a regression of interest and impulses to an early childhood or infantile level; in which case we see what is called hebephrenic dilapidation.

You will notice that my considerations imply that a gradual detachment from reality, occurring rather early in the evolution of personality, follows an ominous course quite distinct from that of the more dramatic type to which I have invited your attention. Further, that in the latter connection, it has appeared to me from study of the problem, that so-called hebephrenic and paranoid praecox illnesses are separate processes from the essential schizophrenia, incipient or catatonic.