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Schizophrenia: a case study

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Chaos reigned in psychiatry during the middle half of the last century. Descriptions of the different psychoses represented clinical pictures of individual men's experiences only. Kahlbaum began in 1863 to formulate his theories. (May). Between 1868 and 1874, he established catatonia as a clinical entity, a disease characterized by stupor and deterioration. In 1871, Hecker separated off a group of cases under the name of hebephrenia. In 1896, Kraepelin had collected a large group of cases which he designated as deteriorating psychoses and named the group dementia praecox. He had opposed them to a group of cases that tended to recovery. The latter group is what we now know under the name of manic depressive psychosis. This proposal of Kraeplin represented the most important step in scientific psychiatry after the beginning of the nineteenth century. The only really important step that had been taken before that time was the clear delimiting of the organic cases from the so-called functional insanities. In 1908, Bleuler substituted the name schizophrenia for the term dementia praecox. A newer term has more recently been introduced by Adolph Meyer, namely parergastic reaction type. (Hohman).

Thus, as the introduction of these terms imply, the concept of schizophrenia has changed since the modern study of this condition

began. It has changed because more has been learned about it. Our knowledge of this "disease" is still much in the dark, but that fact should tend to stimulate rather than subtract from the interest in it.

In presenting this case the purpose has been, to study the symptoms "in a setting that does not tear life and experience asunder into piecemeal symptom-catagories, but leaves mental disease a part of the natural history of a life and its experience." (Hohman). I propose to quote at length this clinical record for several reasons: schizophrenia, as may also be said in general of any psychotic disease, is very much an individual illness peculiar to the individual suffering from it. Our concept of schizophrenia is not that of a sharply defined disease entity, but rather of a symptom-complex. If we separate the symptoms from the natural "setting" in which they occur, indeed, they will have lost much of their meaning. By the natural setting we understand the whole individual personality, his condition at the time (mental and physical), circumstances and childhood history. Clinical syndromes are not of the first importance. The prime object is to understand the patient as an individual human being, and to understand his morbid reactions and his problems. It is with this purpose in view that we set out to study our patient.

The history presented is that of a case of a mental disease diagnosed as schizophrenia at the State Hospital, St. Peter, Minnesota.

The patient, a married woman, age thirty two, was readmitted to the hospital because she would see and hear unrealistic things, had

abnormal somatic sensations, had attempted suicide, was some what depressed and because she herself thought she needed to come back.

We will go back and follow her in her experience through life because, although the symptoms of schizophrenia may come on apparently suddenly, the mental disorder in itself develops slowly over months and years. The complete picture is obtained only if we regard the previous history and emphasize it as much as the present history. To understand the person as she presents herself to us now, we must search and find the "tangible psychotic elements" which lie hidden in the past. In their insipiency we call them traits; later we call them symptoms. The peculiarities and reactions of childhood should be studied with seriousness so that we may be able to decide which traits are likely to be followed by what we call symptoms. In the study of schizophrenia, more than in any other mental disorder, it is important to remember that "the child is father of the man." Every present experience is influenced and modified by past experiences. An experience, rather than being in itself a unit, is a resultant of older experience combined with present experience.

The patient grew up on a farm in Iowa. She was next to the oldest in a family of four. Her environment did not differ in the main from that of an average country raised girl. Her birth and early development were quite normal. There is a vague history of a fall and a head injury when she was three years old. Before the age of six, she was of the quiet and bashful type. At the age of six she

began school. After having attended one term, she refused to attend school for a year because "we had gotten a man teacher and I had heard say that he was once in jail. I was afraid of him and then too, I was very bashful." She stayed out of school a year following which she again was persuaded to attend. But she went back to school reluctantly. It was impossible to make her go alone, so the difficulty was met by having her older sister accompany her. If she was sent on her way alone she would stop along on the road and set in crying. She says: "Iwas always very quiet and bashful until abour four years ago."

The father was a strict man. He grew angry easily and was of the type which commands respect. He was often "unreasonable." "When angry he would scold and swear at us, - that always made me afraid. I am afraid of him yet when he is angry." Though she occasionally would talk to her father "he never was chummy with any of us children like mother was."

As a child she was often afraid in the dark. She was especially afraid of thunder. She got along well with the other children in the family. In school she was fairly bright, finishing the grades at the age of twelve with high marks.

At the age of eleven her first experience with the sex problem began. "We played dirty games." She relates how she and another girl, two years her senior, would play "man and wife." "We did that right along for about a year. Then we moved to Minnesota and so were

no longer playmates. I have not played that sort of games ever since." Her sister had participated in this sex playing also. The patient worried not a little that people, especially her mother, might happen to learn about these shady activities. At times, she says, they feared that their mother already did know about it and was keeping watch over them. "We could not find an opportunity to play that sort of game often, because we suspected that mother had an idea that we were carrying on doings which we ought not do."

Her menses began at the age of fifteen. They were irregular for the first three months. They then became regular and remained so until two years ago.

When she had completed her years in grade school, she stayed out of school till she was sixteen. During this time she worked home helping both in the house and field. When sixteen, she began highschool. She got along well in her studies. "I did not have to work hard because it was easy for me to learn. I obtained good grades."

She had begun to associate in a normal way with people of the opposite sex at the age of fifteen. But it was not often that she was in their company until she had reached the age of eighteen. "I was not so good looking as my sister. She could have a better time than I could." She relates that once she became friendly with a boy in school who was very obese. The other children would tease her because she "went" with him. To avoid being ridiculed she would often seek to prevent meeting him after school although she was desirous of his company.

At the age of eighteen she began teaching school. While teaching she met her future husband. They got along well together and her life during that period seems to have been happy and normal. She, however, became pregnant half a year before her marriage. This worried her a great deal. To escape "having children" she went to a doctor and had an abortion induced. Afterward she began to worry considerably about the abortion. She feared that people might learn about it. This happened at Christmas time. The following June she was married. She gave birth to a child fourteen months after the date of her marriage. She had been feeling more than usually well during the period of pregnancy. Delivery was difficult and instrumental. She became pregnant again a year after the birth of her first child. She and her husband both thought that they could not afford to have any more children, so they again resorted to abortion.

From this time on until 1926 her life seems rather uneventful and normal. The sexual life, however, was not satisfactory. Coitus interruptus was constantly practised as a means of preventing conception.

February 16, 1928 she was admitted to the State Hospital, St. Peter, Minnesota. The commitment papers stated that the "attack" had first manifested itself a year and a half previously by periods of depressions. She had expressed definite fears. She was afraid that she might become a sex pervert. She thought that people were mocking her. She had attempted suicide and often expressed ideas to the effect that the

neighbors were attempting to harm her. She had told her parents that she had a drawing power which caused them to become sick when they came near her. These symptoms had gradually increased until she had been sent to the Mound Park Sanatarium. It was while there that she more strongly began to worry about herself becoming a sex pervert. She developed the idea that the doctors were the cause of her condition. She said that when they would leave the room, they would touch her hands and feet with evil intentions. She thought that the neighbors at home had the doctors bring this condition upon her. She imagined that she had a sucking sensation that began in her stomach, sometimes in her womb, and traveled to her mouth. This caused her tongue to twitch and also caused muscles of her face to become adapted to sucking. This sensation manifested itself more strongly during her menstrual periods. She stated that this sensation had become so strong that it had caused her to attempt suicide. She actually had made suicidal attempts by taking a quantity of laudanum. She had felt her whole personality change. She said her skin had changed and that she at times had changed into a man. At certain times she had felt as though she was neither man nor woman.

When she came to the hospital, she heard voices from upstairs telling her to "turn over", "get up," and "go back." She had strange sensations of smelling. She had a "sexual smell." At times she could smell the presence of a skunk, at other times she thought she could smell "the fat meat frying." Awakening one night she saw her baby,

her husband, and her brother standing upstairs. She admitted that she at one time had considered killing her baby. She expressed delusions regarding her own health.

The day after admittance the patient was quiet. She was somewhat evasive in her answers to questions. It appeared that a number of sexual worries were behind her upset at that time. Recently she had worried about cunnilingus, abortions and the practice of coitus interruptus. She said that she never practiced cunnilingus, but that one morning she awoke with her lips puckered and that she could ~~not~~ feel that that was what it meant.

She was paroled November 15, 1928, apparently mentally improved. September 16, 1929 the following report was received at the hospital concerning the patient: "While the woman is getting along without any serious difficulty, she is probably still unstable. Living conditions are not very good. Physically she is well." She has been found normal physically and neurologically at the hospital.

The patient was again brought to the hospital August 8, 1931. She asked for re-admittance. She said she was not living right. She expressed delusions of persecutions. "People are trying to hurt me, and when they hurt me they hurt my boy." The somatic sensations previously mentioned were still present. She nourished the idea that people were trying to put her in men's clothing and that she changed personality from time to time.

It will add to the understanding of her present condition if we

resort to direct quotation of her statements and answer to questions. Where description and explanation can add anything, that will be used. With that plan we will attempt to present her as she reveals herself to us at this present time. It should be added, that what is set forth in the following is not merely something gleaned from an ordinary routine examination. It represents what has been gathered from six weeks of almost daily observation, frequent interviews, and close contact with the patient.

The patient has frequently expressed concern for her child son. She believes that some evil is going to befall him, and that she herself is the cause of that in some manner or other. The idea is closely connected with her somatic delusions and her delusion of persecution. "I feel lonesome for my boy, yet, I would be afraid to go home and take care of him myself. My condition will do him harm. I saw him hanging on a wire one day. He looked thin and skinny. It jerks in me when I think of it. It made me feel as if I was looking at a skeleton of my own child. But the next day I again saw him outside playing ball. It must have been a lie then; he had not died. Oh! such trash. Well, I might just as well tell the truth. I don't belong in this world. That is, I am here, but I am not here like other people are here." She was asked what she thought was going to happen to her boy, and she replied: "I am afraid that when he gets to be fifteen years old he will begin to masturbate because of the way I have lived. I once saw a man--it must have been my imagination--

who kneeled down in our garden and there abused himself--masturbated. My boy is not going to do such a thing, even if I have to pay the price and stay in the hospital all the rest of my life to prevent it from happening. But still, I am afraid that something like that may occur. He urinates too often. It is because my body is not all right. Why can I not have an operation? Why can I not have my womb and ovaries removed and be done with it? It is that which causes me all the trouble. I must either have that done or have someone make me stronger of mind."

Question: "Is there anything special which at the present time is troubling you?"

Answer: "Is there? Men are constantly bothering me. There is one in front and one behind me. I fight the one with my fists, the other I kick with my feet. They are trying to attack me."

Question: "Do you actually see these men?"

Answer: "I don't actually see them, yet they are there. They want intercourse with me. There really are not any there. It is only because my mind is not strong enough and because my body is not right."

Question: "Do you know who these men are?"

Answer: "I have names for these men. One I have named Edmundson. I saw one of the doctors wear his clothes one day to protect himself. I have to wear them myself at times. The doctors don't need protection. They are strong in their minds. Things can't be forced upon them like

like they can on me."

Question: "Is there anything forced upon you?"

Answer: "Are there? If, when I am menstruating, I am made to do certain things, like lowering my head and to look down, then I am forced to do that the rest of the month." (To her, the attitude or posture is an integral part of the event in question. It is a defense mechanism.) (Levin).

Question: "Do you feel like you had improved while you have been here in the hospital?"

Answer: "I am better today. That is, I think I am. The last time I talked to you, I saw you in a haze, as if you were in a mist. There is a lot of apple jelly in the air. I never stole any apples. It is floating in the air or something. I feel it. It gives me a sweetish taste."

Question: "Do you see anything else floating about in the air?"

Answer: "Lately I have seen something that looks like a cap floating about. It is made of jelly. If I take a hold of it and insert it into the vagina, it turns yellow."

Question: "What do you think that cap really is?"

Answer: "Oh! I don't know. Well--I guess I may as well tell you the truth, -I think it is the end of a penis."

Question: "What do you think is at the bottom of your condition?"

Answer: "I don't know. I know one thing: when my husband and I would have intercourse, he would reach the climax before I would. That made

me very nervous. Then it caused something to break in my body and that was what started this suction inside of me and way up in my mouth."

The patient relates how she gradually began to feel the presence of animals in her vagina. "First there was a Tomcat, then there came to be two cats. They would fight. Later I could feel that there was a pig in there and soon I felt a cow being there also. Finally there was a man in there."

The day following the above interview she was seen sitting by herself with her mouth puckered and blowing forcefully every few seconds. She replied that it helped her to keep her mouth clean of that foul stuff coming up into her mouth from her vagina and from her uterus.

A long interview had with the patient in the early part of September revealed no noteable change in her mental condition. She said she had no idea of leaving the hospital before she was well. "My husband must be angry with me. I have written him two letters. He has not answered any of them yet. Perhaps it is because he is busy. He perhaps thinks, that I am selfish for going to the hospital. Well,-- maybe I could pretend to be well and stay home and work. -- I don't like to stay in this room. (examining room). Last time after I had been in here I had to go to hell afterwards. To hell, that is what I call it. It is worse than hell. Even if I do stay in here they are going to hurt me.anyway. Something starts way down in my womb and goes up and up and up. It draws, draws and draws and gives me a horrid taste in my mouth. That is unless I am smart enough to drink some

water when I feel it coming on if I know it. It does not taste anything like I have ever tasted before. There is something that does not circulate. One's body is something like a car out of order, if your mind is strong enough you can fix it. -- Now it is getting all funny again inside my body. It smells like a drug store. -- I know what you think of me, you think I am a sexual pervert." -- Here the patient became very emotional. Tears came into her eyes and she could control herself with difficulty. But it was only a moment before she again looked cold and impassive. This incident marks one of the few times when the patient showed deep, unmistakeable, emotional disturbance. At such moments she appeared to become more human-like, as if she again had grasped the meaning of life and felt her connection and relation with the world about her.

On several occasions I would attempt to lead her into a conversation about her home and her family. Usually she would talk rationally about that subject for but a short time before again drifting into the unrealistic. At times, however, she would reveal that her emotional life was still present.

Question: "Have you written home lately?"

Answer: "I wrote my husband twice. He did not answer. To-day I am going to write to my boy. It is his birthday tomorrow. They are trying to make him into a negro boy because I am not living right. At home I was better than this. Here I don't urinate. I have urinated only once since I came. It does not make him a real negro, does it? -- Yes it does. I know it! If I knew how to live right, it would not

hurt him any. They make the place so big that two persons can sit in it at the same time--a man and a woman."

Question: "To what place are you referring?"

Answer: "Any place--a chair or a car."

Question: "What makes you believe that your boy is to be turned into a negro boy?"

Answer: "I don't know. I saw a negro once coming down the road toward our house. He was not a real negro. I just thought I saw him coming."

These interviews reveal her condition much as she is. It is not to be understood, however, that the patient continuously would be occupied noteably by bizarre thoughts. She would appear quite rational to attendants. Yet, on interviews she would constantly drift away from the logical into the more disconnected thoughts and expressions. She would talk apparently rationally for a certain length of time, then rather suddenly a change would come over her, as if she had seen something coming out of a clear sky, suggesting to her all her misery and hopelessness. And once more she would be in the world of unreality.

The patient behaved commendably on the ward. She was cooperative and willing to help in her own mechanical way. When not occupied on the ward, she would most often be found sitting by herself, staring into space with an empty look in her eyes. Her expression was cold seemingly unemotional. She kept herself moderately neat.

Occasionally she would write letters home without it having been suggested to her that she ought to do so. A copy of a letter written by her to her mother is printed below. The content does not reveal the conflicts which a psychiatric inquiry would discover to be playing havoc in her personality makeup. --

"Dearest Mother,

Received your letter Friday. Guess it wasn't very thoughtful of me not to write for so long, but I had written Glenn. a letter for his birthday so didn't write last week.

Did Glenn get the clothes Gunval sent him and do they fit him? It was foolish for him to get him long pants and sweater, when he has a good suit, because if he don't wear it to school this year, I'm afraid it will be too small.

Just received Jean's letter today. Tell her not to bother sending me those magazines, as there are so many here, that I never get them read anyway. There are quite a few stories in the last McCalls that I haven't read yet. If she wishes, she may send the candy.

Surely was nice of Mrs. Ziehm to give Glenn a birthday present. Maybe I'll write her a letter some day, but I have written only home and to Gunval since I came, as I haven't had much to write about.

No, don't send me any embroidery work as I started going to O. T. last Friday. Then we always go for a walk afterwards. Perhaps later on I may embroider a dress for Baby Jeane, but not yet. Did

she get the yellow dress? Don't imagine she really needs new dresses as her Grandma sews so many for her.

Mother dear, will close now, and I'll try and not be so long in writing next time, but don't expect another letter this week.

With love,

From Hazel."

We have seen the picture. It represents her life. We see the background upon which are superimposed the important details. We can now approach our problem by using the facts in the patient's life history and viewing her as a totality. We will try to understand her abnormality in terms of known trends of normal and abnormal behavior. (Hohman). We will set out to deal with workable portions of the whole problem that is hers. (Haskins).

Our patient in her early childhood manifested definite fears. She was afraid of her teacher, father, darkness and thunder. It is here that we first recognize possible schizophrenic traits. If we study the schizophrenic group, we find that where the early childhood experience has been accompanied principally by definite fears, we can anticipate later manifestations of defense reactions. Our attitudes to persons has its provisional basis in interpersonal relations existing in infancy and early childhood. Our social tendencies have their origin in the interpersonal relations of the juvenile era. From these social tendencies come the problems of

adolescence and the maladjustments we see in the schizophrenic. (Sullivan).

One cannot be justified in forming any simple conception of causality at the present status of our knowledge of schizophrenia. (Haskins). In our case, however, we may note several lines of evidence that failure of adaptation played at least some role. She was bashful to such an extent that she even refused to attend school for a considerable period of time. She manifested definite fears. This early failure on her part to proper adaptation would seem to be due to innate weak vitality, because circumstances did not seem unduly hard. It is probable that the schizophrenic is suffering from a specific cerebral defect, making him morphologically imperfect. This fact might make him inadequate to cope with reality, and if the discrepancy becomes sufficiently great, he will automatically revert to modes of reaction belonging to a phylogenetic lower level, that is, to a level relatively comparable to the immature level of his own personality. (Levin).

The history of our patient reveals that she got along well in school and obtained desireable grades. This fact would rather tend to indicate that at that time there had been no deterioration. But it would by no means prove that she at that time did not have the traits. There is much disagreement among psychiatrists as to the learning ability of schizophrenic patients. Investigations carried out by mental tests show a preponderance of low I. Q's.

This statement is open to criticism, because it is possible that some degree of deterioration had already set in when some of the tests were being made. Thus it would become an acquired and not an inherited characteristic. (Gardner)[2].

It is possible that her resistance to the psychosis received another blow at the age of adolescence and that prevention could have been brought about by proper adjustment during that period. Evidence has been shown to support the belief that adolescence as a phase of personality genesis should be regarded as reaching its terminus in the incidence of a really satisfying adjustment to a sex object-hetero or homosexual. Until such sexual adjustment has been experienced, if only briefly, there are characteristics of the life process which identify it - regardless of chronological age--as adolescence. Once such experience has ocurred, the chance of schizophrenic illness seems to become nil. The history of our patient shows an unsatisfactory sex life. It is not beyond possibility that that fact has a very close connection with the development of her psychosis. (Gibbs).

She began her sex play at the age of eleven. That in itself is not conclusive of anything. But we must speculate some without reading proof into something that does not prove. Youth, the springtime of life, is characterized by inconsequentiality and changeability of thought and conduct. Straying in either direction does not mark the individual of that age as abnormal;

it does that only if there is an absence of the swing back from any extreme to a satisfactory adjustment to practical life, which we expect from a normal biological evolution.

The period of adolescence is a difficult period. It is evidently therefore that schizophrenia so frequently becomes recognizable within that span of the life time. We cannot fail to recognize the extraordinary strain and stress the individual undergoes from the time of puberty, through adolescence and up to the time of adult life. Great changes, both psychological and physiological, are in progress during this rapid stage of biological evolution. These changes are of such nature as to fit the individual for the problems of his life and should keep pace with the ever increasing demands of self control and sense of reponsibility. The natural process of mental and physical growth is like the unfolding of a bud; the final outcome depends upon the pressure of the environmental factors and the innate characteristics. During this unfolding period of adolescence the organism is continuously modified. This modification constitutes a delicate adjustment to the natural process of growth and to the molding pressure of the environment. If the adjustment or adaptation of the individual is such as to impart to him a practical capacity for the realization and the obtainance of pleasure from life's continuous opportunities, then we look upon the adaptation as being satisfactory. If, on the other hand, the above condition is not fulfilled, we have an indivi-

dual with abnormal reaction and adaptation. (Gibbs).

In her late childhood and early adolescence our patient showed a tendency to be bashful and sensitive. Rather than being teased about her relation with her boy friend, she would avoid meeting him. We see here the tendency to avoid by retiring from, rather than meeting situations by decision. Such attitude is seem as a type of reaction arising from poorly developed habits of adjusting to other people and to new circumstances, it is seen as arising further from an underdevelopment and undertraining of adequate effective responses to situations and people. (Hohman).

We recognize periods of time in the life of our patient, which, as far as we can see, were free from schizophrenic manifestations. But, schizophrenia may come to a standstill at every stage and many or all of its symptoms may clear up very much or altogether. (Bleuler).

The patient's so-called first attack of mental illness manifested itself by depression. Of course, what is called her first attack means only that a stage had been reached where a layman could see a change had occured. But schizophrenics do show depression stages. This is one factor$ which may lead to error in diagnosis. But after all, as Bleuler points out, "it is not a question of either manic depressive insanity or schizophrenia, but rather to what extent the patient is manic depressive, and to what extent the patient is schizophrenic in type. One type does not necessarily exclude the other." (Campbell).

In what is called her first attack we also find the element of

fear. She was rather constantly occupied with the fear that in some way she was to become a sexual pervert and that she was too weak in her will power to prevent such a thing to occur. Such fears may come from sexual situations and the occurence of arousing of strong unconscious wishes. It is an eccentric or malignant reaction of the personality to a threatened or actual appearance in consciousness of a repressed and long forgotten desire. (Gardner).

She maintained that the doctors had brought the disease upon her. - Disease, for the schizophrenic, just as for the primitive, is often the work of persons of evil intention. (Storch). She also claimed that she had a drawing power which caused people about her to become ill. Likewise, she thought that the manner of her living and thinking would have a direct influence on her boy. This also is characteristic of the schizophrenics. They overestimate the scope of their own thoughts and wishes and ascribe to them a power which they do not possess.

Undoubtedly many of her symptoms are based on sexual factors. A large percentage of the schizophrenic patients presents a variety of symptoms that are definitely sexual in nature. It is being more and more recognized that consititutionaal and physiological factors, as well as those of environment and experience, enter into the formation of behavior reactions, attitudes and habits of doing and thinking. Most schizophrenic women have been more or less inadequate in sexual behavior. There is considerable evidence that the disturbance in sexual life which so many patients with schizophrenia present, both

before and during the psychosis, is not due to lack of sexual desire, disposition and inclination. Perhaps rather the opposite. After the psychosis develops, the sexual manifestations and ideas expressed continue to refer to desires and its accomplishment. The instinctive desire for normal heterosexual life is often fulfilled in dreams, hallucinations, and love fantasies. Previous sexual experiences and difficulties reappear in the mental content. It is on these presumptions that we best can explain certain behaviors of our patient. Her conduct is founded on emotions. It expresses a desire. (Gibbs).

She thinks at times she is a boy and says that people have attempted to put her in men's clothes. This transformation of personality is doubtless a condenced expression of wishes in various directions, the wish to change her sex for that of a man. With this may be a wish for children. The wish causes the change of personality.

The presence of hallucinations seems to be closely associated with or related to the primitive level. The average person has hallucinations, but they do not thrive. They do thrive in the schizophrenic. They are material of great value to his or her primitive-like mind and are utilized. The normal individual has no use for them.

The patient's belief in her hallucinations does not seem to be very firm. This corresponds with the established observation that it is rather common to have the patients inclined to disbelieve or doubt in their own hallucinations. (Levin). She says: "The men are there, yet, I do not really see them. -There really are not any there." We

must think of hallucinations in the schizophrenic group as being closely related to the more primitive level of adaptation represented by the total schizophrenic reaction. (Levin).

This same holds true as regards their language. What formerly was thought to be without meaning may be full of meaning. (White). The language of the schizophrenic and its interpretation is not without analogy to the inscriptions of unknown languages and their final translations. This points to the regressive nature of the psychosis. In the symbolic tendencies we recognize "the germ of disintegration."

The development or evolution of thought and speech, the assumption of genetic levels, implies that there must be a law in accordance with which the development proceded. The law is that thought and language must be the reverse, on the assumption that schizophrenia is a regressive psychosis. (Storch). Language involves abstraction. Actual experience is normally replaced by symbols. We collect our thoughts; the schizophrenic makes gestures with similar meaning. Inner experiences find a much more immediate expression in the movements of the body and in action than in thoughts. (White).

Observation of the patient revealed on several occasions rather marked emotional states. Evidence points to survival of affective life in the schizophrenic patients. They have an affect, only the affective energy is frozen, as it were, but not dead. There is a lack of conformity of the emotional reaction and the idea contence. This is spoken of as affective dysharmony. This manifests itself not only

with reference to a given time but also in reactions of successions.

The dysharmony, however, exists only on the surface. The key to the situation lies in the unconscious. The affect which is out of harmony with what appears on the surface is really in harmony with what is going on in the unconscious. On can always find the emotions also, if he search long enough. They may be deflected to something, but they can always be brought back if one tries hard enough. (Brill). Emotional deterioration is only apparent, not real. There is no measureable loss of emotional capacity. (Hinsie). What actually happens is a withdrawal of emotional interest. At least the affect is not dead entirely. "Even beneath the hard and sterile stones of fixed catatonic reactions, the lifeless verbal and motor stereotypes, seethe and murmur the springs, often babely audible, of experiences now almost extinguished, which at one time carried the being higher and higher in the primeval bound, ever upward until in Promethean timerity he grasped for the highest of all - and fell." (Storch).

We have, on purpose, tended to avoid a classifying attitude, but have tried to view this psycho-pathological phenomenon as a complex of facts from which the personality and its immediate reaction to environment cannot be easily separated. We have not tried to create a type so much as to consider the symptomatology, its interpretation and concrete situations in life. Following, in order to conform to the requirements and limitations, is given a brief history of cases of schizophrenia representing some of the different types into

which schizophrenia usually is classified. The cases were all studied at the State Hospital, St. Peter, Minnesota.

L. E. C. Male, age 26, occupation, corporal in the army, high school graduate. As far as could be determined the family history was essentially negative.

When admitted to the St. Peter State Hospital on October 13, 1930, the history obtained was that on June 2, 1930 the patient was found unconscious when doing guard duty at the United States Disciplinary Barracks at Fort Leavenworth, Kansas. From that time until the time of admission the patient did not speak or move.

Physical examination on admission was normal, with the exception of sluggishness of the pupils in the reaction to light. The blood pressure was 78/58. Other reflexes were normal. Urinalysis normal, blood Wasserman reaction was negative, spinal fluid Wasserman reaction negative, cell count 0, protein 10 milligrams per 100 c.c., colloidal gold test 0000000000, Widal reaction negative. No diptheria bacilli were found in cultures of the nose and throat.

The patient remained mute in the Hospital, but he did apparently take some interest in the surroundings and would follow the movements of the physician and other people very attentively.

On January 15, 1931 the patient was given .7 grams of sodium amytal intravenously. This was given in the form of a 10% solution. The injection was given very slowly over a period of about an hour. After he had had about .15 grams tears came into his eyes, and he commenced to respond to questions. At first he said he had a peculiar

feeling and felt sleepy. At first he said he did not know where he was and that it was difficult for him to think. The whole thing seemed peculiar and it appeared to him as if he were continuously being pushed around. He said he remembered that he was in a hospital at Fort Leavenworth, but did not know why he was sent there.

He said he could not recall being sent here and could not understand why he was not at Fort Riley. When told that he was in St. Peter, he wanted to know whether it was St. Peter, Kansas or Minnesota. He talked fairly freely and on one occasion volunteered information that he saw double. He told about himself in a general way, but when questioned about any experiences he had previous to his stupor he would give no information.

After the injection the patient slept for a while and then he read a paper. The following day he was again mute, but seemed more responsive than he had been before. The second day there was no change in the condition. He remained mute until February 7, 1931 when he was given .5 gram of sodium amytal intravenously. The injection was given very slowly. The patient again responded and he remembered having received the previous injection. At this time he did not talk quite as freely as he did on the first injection.

The patient remained stuporous until the early part of the summer when he commenced to talk. There has been a gradual improvement in his condition. At this time he talks freely, but he is rather hesitant in giving information concerning himself.

Diagnosis: Dementia praecox--catatonic type.

G. E. C. Male, age 52, single, committed to the St. Peter State Hospital on April 5, 1928. According to the history obtained, the patient was a graduate in law from the University of Minnesota. He graduated with honors.

Abnormal mental symptoms were noted in 1918. He has been committed to State Hospitals on different occasions. Following the first admission, he improved considerably and after his return, he helped to organize the municipal system at Anoka, Minnesota.

It appears that he escaped from the State Hospital at Rochester about four years before admission to this Hospital. He then went to California. He came back immediately before admission here. He became very abusive towards his mother who is an old lady, and struck her.

When admitted to the hospital, the patient had a long beard and long hair. Physical examination showed no abnormality. Urinalysis normal, blood Wasserman negative, spinal fluid Wasserman negative, cell count 3, globulin negative, colloidal gold test 0001100000.

The patient was quiet, but antagonistic in his attitude when committed to the Hospital. When the physician first saw him the patient suddenly exclaimed, "Did you ever stop to think that the circumference of a circle is radius times two Pi? The one is a commensurable number, the other is not." He then went on with mathematical speculations. This subject was introduced without any apparent reason and without any transition. He claimed that he was tried unconstitutionally, and thatthe judge who committed him was ignorant, corrupt, and had

a personal dislike to him. One of the physicians who examined him he said was superintendent of the State Hospital and was working for the English Government. The patient had proof for that and the physician was going to lose his job. "There are lot of people in this country who want to turn the government of the United States over to the British. Mayor Thompson of Chicago showed that there were a number in the Chicago school system." When questioned about his former commitments he stated that he was a janitor in the church and that several women were hanging around there. "From their actions I could tell that they wanted sexual intercourse. I asked one of them if she wanted me to assist her in becoming a mother."

At times he is suspicious that there is poison in the food. At times he talks freely and at considerable length. Again he will refuse to talk at all. On one occasion when questioned about the difficulty with his mother, he said that he had just come home from California where he had been for four years, and that his mother had put poison in his food. He said he told her that if she could not treat him better he would throw her in the river, and he slapped her.

Diagnosis: Dementia praecox--paranoid type.

S. B. H. single, male, native of Russia, Jewish, resident of Minnesota since 1902, clerk, high school education, age 24.

He has had several upsets before his admission to the St. Peter State Hospital on October 24, 1930. The history states that during

the past year he has had frequent outbursts of temper. He had attacked his father on several occasions.

He stated that he was unkindly treated at the hospital where he was previous to admission here, and complains that the employees were against him on account of his being a Jew.

Commencing October 1929, he had an attack lasting three months. He was at St. John's Hospital, St. Paul, at that time. At the age of 14 he had chorea. On admission the physical examination was essentially normal, the only abnormality being an undescended testicle on the right side.

Urinalysis was negative with the exception of a trace of indican. This disappeared after cathartics had been administered. Blood Wasserman reaction was negative, spinal fluid Wasserman reaction negative, cell count 17, protein 27 milligrams per 100 c.c., colloidal gold test 0000000000, Widal reaction negative. No diptheria bacilli were found in cultures of the nose and throat.

On admission the patient was restless. His temperature was slightly elevated, but returned to normal in the course of a few days. He was insistant that there was nothing wrong with him, and he attempted to escape on several occasions. Once he tried to take the keys away from the attendants. During the first month in the Hospital there was a marked improvement in the patient's condition. He commenced to take an interest in the surroundings and commenced to work, and was given partial liberty of the grounds. In the course of six weeks

he became more disturbed and refused to eat. He became uncommunicative and very irritable. As time passed he became more disturbed and irritable and frequently would refuse to eat. On Thanksgiving he refused to eat and finally did eat some at the insistence of the physician. He maintained, however, that it was necessary that he should keep his cap on when eating, as that was part of his religion.

Since that time he has been mute most of the time. He will lie in bed doubled up assuming an intrauterine position. It is a question whether we here are dealing with an expression of extreme negativism, or whether the attitude represents a strong wish to again inhabit the uterus. We may also speculate as to the possible relation it may have to retrogression. Sometimes he will eat a little, but frequently he has to be force fed or tube fed.

Diagnosis: Dementia praecox--hebephrenic type.

B. S. Male, age 41, farmer by occupation, native of Holland but resident of Minnesota since 1924. The patient has a third grade education.

This man was committed to the Minnesota State Prison at Stillwater on January 20, 1928 to serve a life sentence for murder in the first degree. On June 2, 1928 he became upset stating that he was hearing his wife's voice and also voices of other people, commanding him to do certain things. He was admitted to the Asylum for Dangerous Insane, St. Peter, on July 31, 1928. The family history was essentially negative, except that one sister has some sort

of mental disease and one sister died at the age of 45 from tuberculosis.

The patient has been married twice. The first wife died from cancer. It is stated that in 1917 when "fooling" with a .32 pistol, he shot himself in the chest. He had some kind of "kidney trouble" in 1918. An appendectomy was performed in 1920. He also had a tonsillectomy and hemorrhoidectomy performed. He served in the World War.

Physical examination revealed no essential abnormalities. Scars were noted from the operations performed. He is of a tall slender type with elongated chest.

Neurological examination was negative throughout. Urinalysis normal, blood Wasserman reaction negative, spinal fluid Wasserman reaction negative, cell count 1, protein 43 milligrams per 100 c.c., colloidal gold test 0011000000.

The patient was fairly cooperative when admitted. He talks freely about his ideas and maintains that he has been persecuted, but when talking about it he shows no emotional reaction. He maintains that he is in poor physical condition and the reason for his difficulty in Prison he gave as being due to people hollering at him through the ceiling and through the walls. This continues in the hospital. He maintains that the letters he received from his wife are not written by her but by somebody else signing her name. He also complains of moving pictures being taken of him, and he talks

about his"emiges" being placed together with "emiges" of negroes, and he is opposed to that. These "emiges" he explains as somewhat like moving pictures that are duplicates of himself. Apparently they are some integral part of his personality.

He maintains that electricity is shot into him from the ceiling and the walls, and this causes him great pains. He believes that he has been swindled out of several patents he has. One of these he explains is a perpetual water fountain. He writes freely about his ideas of persecution, and will write letters to different offices such as the War Department, the President of the United States, the Governor, and the Chief Justice of the United States Supreme Court.

Diagnosis: Dementia praecox--hebephrenic type.

J. J. C. Male, about 39 years of age, married, native of Minnesota, farmer, Catholic. He has common school education. As far as could be determined there were no abnormalities noted in the family.

This patient was committed to the Asylum for Dangerous Insane at St. Peter, Minnesota on March 3, 1931. He was committed from the Minnesota State Prison at Stillwater where he was serving an indeterminate sentence, maximum 40 years, for the crime of robbery in the first degree. He was received at the Prison on January 18, 1929. He had previously been arrested for various crimes. On April 3, 1919 he was arrested in St. Paul for box car burglary. On September 12, 1916 he had also been arrested in St. Paul for box car burglary. On May 17, 1919 he was sent to the Minnesota State Prison

after having been convicted of grand larceny first degree. On May 24, 1924 he was arrested in Minneapolis for assault and attempted burglary. Disposition was not given. While in the Prison he expressed the idea that there was a machine influencing his mind. This was operated by others so that they could tell him all manner of things. The voices would come in through his forehead. The language they would use would be vile, obscene, and deriding. This machine would influence his stomach causing pain so that he is unable to eat, and it would act on his genitals. When admitted to the Asylum for Dangerous Insane, the physical examination showed considerable dental work with many gold fillings. The pupils were contracted, but regular in outline. They reacted to light very sluggishly. No cooperation was had to determine the pupillary reaction to distance. The chest is long and narrow. The lower abdominal reflexes were absent. The cremasteric reflexes were greatly delayed. The biceps, triceps, ulnar, and radial reflexes were sluggish. Other reflexes were normal.

Urinalysis was normal, except specific gravity which was 1.010. Blood Wasserman reaction negative. Spinal fluid Wasserman reaction, negative. Cell count 0. Protein 24 milligrams per 100 c.c. Colloidal gold test 0000000000.

Mentally the patient was antagonistic and somewhat hostile when first interviewed. He talked freely and immediately commenced to

tell about his machine that was working on him. He would foam saliva in the mouth and spit it out to show the physician that the machine put poison into his system. When telling about the persecution he showed no emotional reaction towards it except the irritability. It was explained to the patient that the physician knew little or nothing and that he was interested in getting the patient's side of the story. After that the attitude seemed to change to some extent and he became more pleasant. He then explained in detail that he thought he was all right up until June or July 1930 when he commenced to hear voices. These voices would talk about him. These voices would tell him that the Deputy Warden of the Prison was keeping the patient's wife and was sleeping with her. The machine, he thought, belonged to the Government, but there were some people in Stillwater using it. By the means of this machine they could tell what he was doing and all that happened around him. Thus he said that they knew all the patient and the physician were talking about. He further explained that by means of the machine they put some kind of "stuff" or poison into his stomach causing him to "rot away." The patient is oriented in all spheres. The memory both recent and remote is good as far as could be determined. He is fairly well informed as to recent events, although his knowledge of them is limited due to his stay in the Prison.

While in the Hospital there has been no essential change in his condition. He continues to have delusions he had on admission. At times he is fairly pleasant, but again he becomes irritable. The last

few months he has become more irritable towards his wife and relatives when they are visiting him.

Diagnosis: Dementia praecox--paranoid type.

Summary

1. A case of schizophrenia has been presented by quoting at length the clinical record.
2. An attempt has been made to interpret the symptomatology.
3. Five additional cases of schizophrenia have been presented by brief clinical records.

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