PARANOID SCHIZOPHRENIA IN A MONGOLOID DEFECTIVE: SOME THEORETICAL CONSIDERATIONS DERIVED FROM AN UNUSUAL CASE

By

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IN the past thirty years a great deal of attention has been paid to the problems of differentiating mental deficiency from psychosis, and recognizing the distorting effects of mental defect and deprivation upon supervening mental illnesses. The incidence of psychotic syndromes in mental deficiency hospitals has been variously estimated as 5 per cent (Greene 1933), 8 per cent (Vanuxem 1935), and 11 per cent (James 1939), while a survey made by Hackbush (1935) on a very large number of patients on the waiting list for admission to mental deficiency hospitals, suggested a figure of 10 per cent. James considered that three-quarters of his psychotic group were schizophrenic, and Bergman *et al.* (1951) agreed that schizophrenic illnesses were very common in mental defectives. Whereas the incidence of schizophrenia in the general population is 0·85 per cent (Mayer-Gross *et al.* 1954), it occurs as much as nine times more frequently in certain mentally defective groups.

This differential incidence does not imply that a mentally retarded patient has, *ipso facto,* an increased vulnerability to schizophrenia. Mental deficiency hospitals tend to admit and retain those patients who are the most socially incapable, and the double handicap of defective intelligence plus a supervening psychosis clearly will call for long-term care. Moreover, the ranks of schizophrenic mentally defective patients may be swollen by those who developed schizophrenia in childhood and whose general behaviour simulates primary feeble-mindedness (Neuer 1947), particularly after the acute phase of the psychosis has subsided (or been forgotten) and been succeeded by a functional dementia. It may be objected that many apparently schizophrenic patterns occurring in defectives are basically severe neuroses, but it seems unsound to class as psychoneurotic such symptoms as grossly deteriorated behaviour, delusions and hallucinations. Even should the high rate of schizophrenic illness in mental deficiency hospitals not represent accurately the incidence in the total mentally retarded population, it seems remarkable that paranoid schizophrenia complicating mongolism has not up to now been described, although mongoloid defect is a condition that can occur as often as once in 700 births (Penrose 1949), and accounts for between 5 and 10 per cent of patients in British and American mental deficiency institutions (Wallin 1949).

Because of its apparent rarity, the interesting considerations raised by its pattern, as well as the encouraging response to physical treatment, the following case is reported.

CASE REPORT

Maurice, a 32 year old male mongoloid defective, was referred by his general practitioner in January 1957 because of severely disturbed behaviour over the previous five months. The patient's mother was an intelligent and reliable informant who gave a clear description of his illness.

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History of present illness

Until August 1956 Maurice had been an affectionate, compliant mongol who lived with his mother in a comfortable home, obtaining a great deal of pleasure in playing with his toys, listening to the radio and watching television, and by visiting relatives and the cinema. He had loved his grandfather who had taken over the paternal rôle after the death of Maurice's father when the patient was a child. Following his grandfather's sudden death Maurice became anxious and depressed, and insisted on viewing the body. He remained depressed for two days; on the third there was an abrupt change in his behaviour. Formerly he had been timid, averse to strangers and the dark, mildly hypochrondriacal, and desirous of winning approval and affection. Now he became truculent, abusive and disobedient, and lost his shyness. He began systematically to destroy playthings that he had once cherished. Sleep was disturbed by initial insomnia and frequent waking; nocturnal masturbation that had occurred infrequently in the past now ceased. At times Maurice was discovered eating soap and paper.

He complained that "daft people" were insulting him and making mocking faces at the windows, that he was being whipped and pricked, and that his mother was plotting to put him in a "Home" and was giving away his possessions. Fears were expressed of wolves lurking in shadows and in cupboards, and of gangsters and "space-men" who were out to kill him. In response to fears that he was changing into a hairy animal or a "plastic man" Maurice began constantly examining his body for evidence of change, and washed his hands and face so often that eczema developed.

Despite the terrifying nature of his fears the patient's emotional state appeared generally calm and self-satisfied, but spells of weeping or laughter occurred at times without obvious cause.

Personal history

The patient was conceived when his mother was 22, and pregnancy was uneventful. Birth was by forceps delivery, the weight at birth was 7 lb. Although his general health was satisfactory, development was grossly retarded. He was deemed ineducable after attending school for a few weeks when five years. Until he entered hospital for treatment of his psychosis Maurice had never been parted from his mother for more than a few hours in the day. In view of Connell's findings (1958) that amphetamine intoxication may result in paranoid psychotic reactions, it should be remarked that this patient had never received amphetamine medication in any form.

Family history

This contained no relevant information.

Findings on examination

Maurice was a short pyknic mongol with a scaly dermatitis affecting hands and face. His rain-coat was worn inside out, and he brandished a toy pistol. He was suspicious and unco-operative, although his face was expressionless, and spoke in a monotonous American accent and with an assumed idiom. "Up with them mitts, Chief. Put 'em up. The game's up. I'm not getting a rubber face like you, Mister, I know you, Chief. Jim Darke, double-wise special space agent. Right? Right? Chief special scout, space-ways gang. Planet X. One peep out of you, Jim Darke, and you get this. Are you special agent 1234 . . .? Take off those glasses. They are my dad's glasses. They are my glasses. Let me see your face. What are you doing to my face? Take off that face. Now, off with it! What are you doing to my face? Are you a plastic man, Chief?" He accused the psychiatrist of turning him into an animal by means "of the needle", of mocking at him, and variously mis-identified the doctor as one character or another derived from crime and science fiction. His confusion extended to his own identity, and he seemed unable to distinguish reality from garbled memories of film and television entertainment. He knew his address and the day of the week, but described the clinic as "a police station, a space station". He covered pages of paper with stereotyped scribbles indistinguishable from the manneristic writing of schizophrenics with normal levels of intelligence and education.

Psychological tests

Attempts to use psychometric and projective tests were unsuccessful. The pre-psychotic social age, as assessed on the 1936 revision of the Vineland Social Maturity scale, was 6·4 years.

Diagnostic formulation

On the basis of evidence of visual, aural, and tactile hallucinatory experiences, delusional ideas of persecution and self-transformation resulting in obsessive-compulsive rituals, inability to distinguish reality from fantasy, perseveration and stereotypy of ideas, and the impoverishment and incongruity of affect, it was considered that a florid paranoid psychosis had developed in this mongolian defective patient.

It seemed probable that the psychosis had been precipitated by the stress of losing a father-substitute, and a reactive depressive state; these were likely to recall painful

memories of his own father's sudden death and to awaken intolerable feelings of insecurity and threat. But the character of the ensuing psychosis did not suggest a basic depressive illness.

Treatment and progress

Maurice was admitted under the care of Professor Martin Roth to the Psychiatric Unit of the Newcastle General Hospital and given six electroplexies. A marked and sustained improvement followed in his mental condition, and he was discharged home after eleven days, taking 25 mgms. chlorpromazine hydrochloride t.d.s. This drug was continued for seventeen months, and then withdrawn without any recurrence of disordered behaviour. His present condition, over two years after the onset of an acute paranoid illness, suggests that remission is almost complete, and Maurice's behaviour at home is best described by extracts taken from a letter written by his mother.

"I have been in hospital myself, and I was surprised when I came home to see the affection he gave me. He often came and kissed me, and said "I like you." The only strange behaviour I have noticed is, if he thinks he is on his own, he will talk to himself and laugh just like one does at hearing a good joke . . . but all told he's very good and happy, and even sees a joke before me at times. He's on good terms with all the folks around . . . they always give him a word and have a joke with him."

Discussion

(a) *Character of psychotic syndrome*

Apart from its rarity, this patient's illness was noteworthy for its well-marked classical symptomatology, although it occurred in a patient whose pre-psychotic mental level was that of an imbecile. It is tempting to suggest that the floridity and systemization of his thought disorder reflected credit upon the rich variety of experiences that he had previously encountered in everyday life. Had the environment been less stimulating it is likely that a supervening psychosis would have been impoverished for lack of cultural material, and then would have, *faute de mieux*, presented atypically.

(b) *Schizophrenic illness, severe mental defect, and mongolism*

Kallman *et al.* (1941) concluded from their extensive studies on twins that separate genetic complexes existed for endogenous types of psychosis and mental deficiency, and that the occurrence of both conditions in the one individual resulted from his inheritance of two genetic groups. If this is so, the incidence of paranoid schizophrenia in adult mongols should be much the same as that in the general population. The rarity of the case I have reported may be more apparent than real, unless it be postulated that mongolism and paranoid states are antagonistic conditions. Whatever the aetiology of mongolism, it is difficult to conceive that the condition should protect against the appearance of paranoid psychosis in adult life, apart from its high associated death rate in early childhood (Penrose). I suspect that paranoid schizophrenia can occur in disturbed mongoloid defectives, but is not recognized for lack of well-differentiated symptoms. Pearson (1938), Hayman (1939), and Herskovitz *et al.* (1941) have described the difficulties of diagnosing psychotic syndromes when a patient's I.Q. is below 50. Since institutional mongols tend to have a range of I.Q. between 19 and 63, with an average score of 36 (Wallin), the paranoid mongol would be expected to display bizarre mental symptoms instead of a recognizable thought disorder.

If catatonic psychosis be considered (admittedly crudely) as a schizophrenic condition primarily affecting volition and motor behaviour, and endogenous paranoid psychosis as one in which perceptual and thought disorder predominate, then it might be predicted that a schizophrenic mongol, because of severely defective intelligence and lack of environmental, social and cultural stimulation in his experience of institutional life, would not possess an adequate

store of ideas and attitudes to furnish him with material for hallucinations, delusions, or a grandiose/persecutory frame of reference. His psychosis would tend to present as a catatonic state and/or a severe diffuse conduct disorder. The work of Rollin (1946) seems to support this contention since this author has succeeded in describing a "primitive" type of catatonic schizophrenia in a group of disturbed mongols.

Strickland (1954) suggested that mental functioning in mongols might be improved by a good and stimulating upbringing. Whatever the truth of this supposition, I think it likely that Maurice's paranoid illness owed its classical features to the excellent cultural opportunities that he had enjoyed in the past, despite his imbecile level. Without a substrate of ideas and a sufficient number of social experiences in the past, it is difficult to imagine how a thought disorder could flourish. Is it not possible that increased longevity and improved care of mongoloid defectives may result in further unequivocal cases of paranoid psychosis, and possibly of other forms of schizophrenia, being recognized in mentally-ill mongolian imbeciles and regarded as meriting as intensive treatment as is accorded the schizophrenic with adequate intelligence?

SUMMARY

A case of typical paranoid schizophrenia is described in a 32 year old mongoloid imbecile. Response to E.C.T. and a prolonged course of chlorpromazine was highly satisfactory.

It is suggested that the classical pattern of the psychosis reflected and resulted from the patient's excellent pre-psychotic social and cultural opportunities, and that typical forms of paranoid schizophrenia may be recognized more frequently in the future in mongoloid adults who have had adequate social stimulation.

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