DIFFERENTIAL DIAGNOSIS OF SOME EMOTIONAL DISORDERS OF ADOLESCENCE (WITH SPECIAL REFERENCE TO EARLY SCHIZOPHRENIA).*

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IN my student days, after the first world war, teachers and text-books still used the term dementia praecox. It was looked upon as a disease *sui generis*, and descriptions were entirely in terms of clear-cut asylum cases with the usual classification into simple, hebephrenic, katatonic and paranoid. There was no psychopathology worth noting, and no anticipation of the immense gap waiting to be explored between "normality" and complete mental breakdown. In effect this meant that there was no half-way house in diagnosis: it was either dementia praecox or nothing. The revolutionary change in diagnostic approach began with Bleuler's highly original conception of the disorder as a progressive splitting of the psyche, indicated by the name schizophrenia which he gave to it, and which now holds the field. Added to this there are the researches of the psycho-analytical schools (the Jungians in particular) which have succeeded in opening up a huge and fascinating borderland on the fringe of normality, with a corresponding enlargement of our notions of schizophrenic disorders.

I am afraid, however, that in many quarters even to-day the change from dementia praecox to schizophrenia is not much more than an alteration in nomenclature, with no corresponding change in understanding. It shows up on occasion rather painfully when the mental hospital medical officer without much extramural experience is called upon to take the psychiatric O.P.'s, say, at a general hospital. I feel that so often in a certain type of case he is still limited in diagnosis to schizophrenia or "nothing"—just a new wording of an old diagnosis.† Here is the sort of thing that can happen:

CASE 1.—A well-grown girl of 16½ was sent by her doctor to psychiatric O.P.'s because of her very poor and irregular performance at work, apparently due to long spells of day-dreaming. There were further complaints from home of "always a dreamy solitary girl, easily upset, needing constant urging to do anything . . . will lie in bed all day . . . reading comic papers or novels . . . no friends," and so on.

The psychiatrist, an M.O. from the nearby mental hospital, could only think of an incipient schizophrenia, though the patient was far from psychotic and her mental state did not warrant any such diagnosis. As she had been under my care at the Child Guidance Clinic a year or two previously he asked me to see her again.

* A Paper read to the Spring Meeting of the Northern and Midland Division at Lincoln, April, 1949.

† Under diagnosis Henderson and Gillespie write, "The principal condition from which schizophrenia has to be differentiated is the manic-depressive psychosis" (fifth edition, p. 241). There is no mention of the other states I will call attention to in this paper.

Our records showed that she had been referred to us at 14 on account of her withdrawn unco-operative attitude at school, an attitude which her mother told us had characterized her behaviour right through her childhood. We had found her to be dull and slow intellectually (I.Q. 88); emotionally she was anxious and depressed, being most concerned at her inability to keep up with the others in school. She attended over a long period for treatment with considerable benefit, being discharged just before she left school for work, a happier, more outgoing child.

At this second referral it was seen that she had relapsed to pretty much the same mental state as when first treated at 14. The picture was of a dull, slow adolescent being pressed beyond her pace at work, and defending by a passive obstinacy (very obvious at home) and a withdrawal into compensatory day-dreaming. Significantly, when questioned she gave as her principal fantasy "That I could do more than the other girls"—very much in keeping with her anxious depression earlier when she fell behind in school.

One thing stood out quite clearly: the continuity of her character and the identity of her reactions under analogous conditions. On each occasion she responded in the same characteristic way to the same kind of stress, and the diagnosis of simple maladjustment due to real inferiorities of endowment was borne out by her response when changed to easier and more interesting work. At no time was there any evidence of any schizophrenic thinking or symptom formation, nor yet of any schizoid background on which the disorder might grow.

The cry in medicine to-day is for early diagnosis and treatment. This is all to the good, but we must be alive to the difficulties of such a programme. Asking for patients to consult us early means we shall see more and more cases like the above from the vague borderland on the fringe of normality, and our powers of discrimination and differentiation must be accordingly increased. Again, whereas the therapeutic attack may be straightforward in the well-established case of schizophrenia, what does one do in therapy before the condition has unequivocally declared itself? (Too much of our "keeping cases under observation" means doing nothing till the diagnosis is obvious.) This altogether apart from how to handle those we attract to our clinics who are not, and never become psychotic, and have no place in mental hospital treatment. Early and preventive psychiatry must be largely extramural, and now that the (new) psychiatrist has peeped out of the seclusion of his mental hospital, he must be taught to meet many conditions for which his previous training has hardly prepared him. Even the "straight" psychoses in these early stages may look very different from their present text-book descriptions.

Schizophrenic disorders notoriously originate during adolescence, and it is amongst the emotional disorders of this period that we must look for the clinical onset of our early cases. It should be remembered, however, that adolescence is normally an age of emotional turmoil and instability, and much that would be classed as pathological in later adult life may prove to be but a temporary exaggeration of normal trends of character, and not necessarily the harbinger of a psychosis. The degree of mental pathology which may be exhibited with subsequent complete recovery is quite surprising.

CASE 2.—The parents of a young girl of 16 consulted me in a state of some alarm. The Head Mistress of the girl's boarding-school had written euphemistically that she was "not too well," and suggested she would be better for a week or two at home. On arrival she began talking queerly about "losing her memory" and "going mad"—a quite justifiable cause for the parental alarm.

The girl herself was an anxious, rather immature child of asthenic build. She described various inferiorities that had troubled her at different times since first going to the boarding-school some 12 months previously. But altogether she had managed to hold her own till a couple of weeks ago. Then, to use her own words :

" I felt a cold coming on . . . wanted to lay down . . . lazy . . . didn't feel like doing anything . . . just lay in bed . . . ridiculous thoughts passed through my mind . . . compulsive—' You've always wanted to know what its like to be dead, now you know.' . . . I thought I was going mad. . . . I was very frightened. . . . Next day in school I was in a daze and couldn't do anything."

The attack lasted the whole week, till she came home in fact, during which time she had restless disturbed nights and vaguely confused days. She had other complaints when I saw her, which included :

" I don't feel like other girls . . . I don't think I'm developing like them in mind and body . . . feeling out of it. I can't make up my mind about anything . . . I've no real feelings at all ! . . . I've lost interest, etc."

Altogether not a happy picture, and one demanding a guarded prognosis.

I saw her at intervals, some half-a-dozen times, for therapeutic conversations. The mental disturbance slowly cleared up and after about six weeks had disappeared. After another month of satisfactory stability she ceased attending.

Nearly two years later she asked to come and see me again, ostensibly for advice about her career. (She was taking elocution and music and getting on quite well.) Her complaints and doubts seemed objective enough, and, though there was some tension and a little undue anxiety, there was nothing of the nature of her previous symptomatology, and I reassured her parents accordingly. A fortnight after this she woke up during the night in an acute panic and wanted to speak to me at once. Her chief anxiety was about her masturbation, but as we had gone over all this before it could not have been the real cause of her extreme agitation (Before she could be calmed down *both* parents had to sleep with her !) The panic brought on symptoms reminiscent of her first attack though not by any means as pronounced, and after a week they gradually subsided and disappeared with rest and sedation.

I have not seen her now for about 18 months and, as she will be approaching 20, I am hoping she has achieved a reasonably stable maturity.

Here, by contrast, is a case that took the opposite turn :

CASE 3.—I first saw John, aged 17, in 1947. He had just failed in his school certificate, and I was asked primarily to advise about his further education ; there was a secondary complaint of attacks of awkward behaviour due to irrational fears on one or two recent occasions.

He was a tall, lanky youth who talked freely, but rather vaguely and with limited insight, about his pretty obvious retreat in the face of difficulties. His drawing (for which he had quite a talent) and his conversation revealed a decidedly introverted character, of a soft, easy, almost effeminate kind. More specific were his two recent attacks when his behaviour definitely overstepped the bounds of normality. The boy himself described ideas of reference with all the peculiar detachment of the schizoid :

' I couldn't sleep . . . thought people weren't friendly. . . . Not much to it. My imagination ran away with me—*I imagined people watching me*: not sure of my facts . . . things seemed peculiar . . . you get all muddled up."

He was taken on for regular psychotherapy, and in spite of the usual difficulties owing to his markedly introverted nature he co-operated well and with great benefit to himself. After about 6 months I was able to report great improvement ; he was attending the local Art School and doing well. Most unfortunately just about this time his father, to whom he was very attached, went down with a very serious illness and the boy relapsed completely. Psychological treatment was resumed but I was never able to get the same rapport again. He managed to carry on irregularly at school, and with odd patches at home, for another 3–4 months before he finally broke down completely with a frankly schizophrenic outburst which made me advise mental hospital treatment. When last heard of he was responding well to insulin therapy.

To complete a trio showing the uncertainties of prognosis in these cases, here briefly is one whose ups and downs have left me quite puzzled as to the ultimate outcome :

CASE 4.—Audrey was working at the telephone exchange, where she heard the girls talking about V.D. " I got an idea that I'd got it . . . I fainted . . . went home . . . I called myself hypocrite and coward." After staying in bed a few days she was a little better. But the ideas kept recurring each time she had a menstrual period. (The hospital doctor called it " hysteria " and it was left at that.)

A year later, now aged 17, she left the job and went in for teaching—training at a residential college. She was there only one week when she asked to be brought home because she had begun to think the girls were laughing at her. She was just 18 by the time I saw her (November, 1945), and at the first consultation she talked of—

" Ideas charging round inside my head—I've got it into my mind that they don't want me at home " (but knows this not true). " *My mind doesn't work in conjunction with my body.*"

There were other symptoms of an intermittent nature, the sum total of which was to make me prepare the parents for a schizophrenic breakdown.

Less than 3 months later the picture had changed with startling rapidity. She was bright, almost radiant, and had put on weight. All her " queer ideas " had gone, and she was so much better that she had begun as a help at an infants, school and liking it immensely.

Unfortunately it didn't last, and a bare two months after that I was consulted again for a recurrence of symptoms. This time she was quite dazed and confused and I could hardly get her to talk. At one point she echoed my laugh in the classical pathological manner. She still had some insight, viz., she agreed she has funny, ideas but added, " I don't know which are funny and which are not."

Again she recovered, and after 6 months, during which time she was allowed to vegetate at home, she was quite well again. Recently (August, 1948) I received, quite unsolicited, a charming letter from her reporting progress. After leaving me she had found congenial work in a bookshop. There were occasional setbacks but only very slight ones, and taken early, a day or two in bed put her right. She has now married, and according to her letter is happily settled.

These three cases should give us much cause for thought, and I should like to place them in their proper context amongst the emotional problems of adolescence, about which we are increasingly consulted nowadays, especially through the Child Guidance Clinic. I know of no previous attempt at classification of the cases (*cf.* note, p. 960), and would tentatively suggest a broad grouping as follows :

A. *Maladjustments Arising out of Personality Defects or Difficulties of Character.*

(1) *Real inferiorities of endowment.*—Intellectual or emotional dullness : severe emotional immaturity.

(2) *Extreme temperamental variations.*—The grossly introverted character.

(3) *Shy withdrawn characters*, with feelings of inadequacy or inferiority and evident internal conflict. Family tensions much in evidence, particularly with one or other parent.

B. *Psychological Illnesses of Adolescence.*

(1) The neuroses—mostly anxiety states of varying degrees of severity. Sometimes a continuation or a recurrence of the obsessional states of early childhood.

(2) Panic reactions.

(3) Early schizophrenia.

Before going further I want it to be understood that the classification above does not mean that we are dealing with some half-dozen clear-cut mental states rather like the diseases of clinical medicine. There is more even than overlapping on the various types. For the most part there is a continuous series in every direction, so that one passes insensibly from one type to the next, through the mixed and borderline cases. Nevertheless, it is useful to have in mind some theoretically " absolute " picture of the pure case as a kind of axis round which to group one's clinical material.

To take the items of the above classification in order. People there are with innate handicaps which reduce their performance and their capacity for adaptation. Case 1 briefly describes such a girl, whose limited mental endowment and general slowness was the source of her retreat from the severities of everyday life into the compensatory world of fantasy. In the event she was mistaken for an early schizophrenia.

Another common error is to mistake the grossly introverted (schizoid) character for the mental illness. The introversion-extraversion scale gives one dimension of personality, and at the extremes of the scale, particularly at the end of extreme introversion, one meets with people who by ordinary social standards are, to say the least, peculiar. But only in the same way that an unusually tall or very short person is peculiar ; eccentric they may be, but not psychotic. Here is an outstanding example :

CASE 5.—John R—'s parents described him as an " odd " boy with many erratic peculiarities of manner and behaviour. Solitary and asocial ; completely without friends or personal contacts ; only " external " interest is keeping rabbits. He would never respond to overtures from his parents or discuss his problems with them. He has spent hours in his bedroom all on his own. In company at home he is apt to 'act silly' instead of joining the conversation. He has always been absurdly faddy with food.

Nevertheless they saw no reason for serious complaint until he failed badly in his school certificate examination. On inquiry the school gave as the reason for his failure that he was " extremely slow in grasping new matter, in thinking, and in expressing himself at all " ; but not unintelligent.

The boy himself presented the picture of a completely introverted character to such a degree that one could barely make contact with him, let alone make an impression. He was at first ill at ease, with a facial twitch and perspiring freely. At times his lips moved as if muttering to himself. There was a long pause before he replied to questions, and sometimes he completely ignored them. He preferred not to talk if he could help it : for example, when I asked about his school progress he just took some school note-books out of his satchel and handed them to me without comment. I asked him what he thought of his progress. " That's not for me to say " was his answer.

In general he was suspiciously on the defensive and refused to commit himself or give an unequivocal opinion. There was a good deal of verbal fencing and playing with words which he seemed to enjoy, but nothing of a concrete nature. The outer social world hardly concerned him, and as for his inner world he implied that was his own affair. " It's not a secret, but I've more sense than to tell." (After winning one such " debating point " he gave a peculiarly unhealthy self-satisfied grin.)

Altogether his preoccupation with his inner thoughts, which he refused to disclose, was taking him more and more inside himself, and I have no doubt but that he was steadily developing into an eccentric schizoid character.

Extravagant bizarreries such as the above are fortunately rare, as rare as the extreme of introversion from which they grow. But, as already mentioned,

adolescence is in the nature of things a period of emotional instability. Rapid development of new and powerful urges makes integration difficult; conflict with one or other parent (or both) is almost the rule rather than the exception; heart searching and introspection are inevitable, and the mental upheaval in cases suitably predisposed may come more or less to resemble a mildly schizophrenic picture, with which indeed it has close analogies and parallels. The usual story, and one very commonly heard, is of loss of self-confidence making for a withdrawal from social contacts and from work or school; such symptoms as awkward shyness and self-consciousness, with marked feelings of inadequacy and inferiority, are much in the foreground.

I will not give a case in any detail (everyone must have come across these children), but will pick out some significant remarks made during treatment by an intelligent secondary schoolgirl of 16+ suffering from this kind of disturbance:

CASE 6.—In essence Connie had just downed tools and given up her education in the year of her School Certificate. But that there was some internal conflict going on was clear enough from her erratic behaviour. She had gone back to school after one withdrawal and worked hard; then abruptly she walked out again one day. She was now becoming asocial and solitary. She had dropped all her friends, and at home would not help or do anything: she would just sit in a corner and read. She was irritable and resented interference, and hit back at her mother in her flashes of temper. (Incidentally a great deal of her problem was related to an open conflict with mother, who turned out to be a hard and unsympathetic woman.) None the less the girl was quite accessible and willing to be helped.

In the fourth session of psychological treatment she described a vague confusion almost like depersonalization ("It wasn't me—a queer detached feeling: most unpleasant"), and then proceeded:

"I get mixed up—there's so many of me.
"1. Wants to be a good girl at home.
"2. Cynical and bitter.
"3. Ranting and roaring person.
"4. Doesn't want to think at all.
"5. Utterly childish.
"6. Just desperate.
"7. Wants to be comfortable in luxury."

She finished off with "I will end up in the madhouse. I'll be out of everyone's way." In spite of this and much like it, she made an excellent response to simple psychotherapy, and ultimately an excellent adjustment to work as a Nursery School teacher.

Different and distinct from these maladjustments arising out of personality defects or difficulties of character development, I have separated out a second group of reactions which I look upon more as psychological illnesses.

Anxiety states with symptoms in the adult style may be encountered in the later 'teens, though fully fledged examples are distinctly uncommon. The personality behind the symptoms here is very different from those heretofore. One meets a mature, *over*-responsible young man or woman: intelligently self-critical, striving hard, but finding work or school—and life generally—increasingly trying to cope with. Having kept his troubles to himself (i.e. as far as he knows what they are), the breakdown is all the more surprising to the family, and may come on them quite unexpectedly. Fortunately, however, the latter in general are quite understanding and sympathetic, and able to

look upon the condition as the illness it is ; this in contrast to the previous type of case, where there is often a long history of barely concealed antagonism, working up to and culminating in the behaviour problem. The treatment is correspondingly different : whereas the behaviour problem can be handled by conversational methods directed to a reorientation of family relationships, the true neurosis needs a therapy more approximating to a proper psychological analysis (with free association, etc.). The same is true of obsessional states reappearing about this period.

For our purpose here, the important item to note is that in their heart-searching and self-questioning, cases of genuine neurosis may verbalize their mental conflicts in the manner of all adolescents without being at all schizoid. If this is borne in mind the true diagnosis is not likely to be overlooked. I must confess, however, that more than once in older patients I have been deceived in the reverse direction. What at first sight looked like a fairly severe anxiety state, later interviews showed to cover a latent schizophrenia, this particularly so in young adults in the early twenties.

Now for the last and most perplexing type of case to be differentiated from early schizophrenia. I have already given two examples (Cases 2 and 4), and have labelled them, for want of a better term, the "panic reactions." Here more than anywhere else does one feel the absence of clearly demarcated boundaries in psychological medicine, and it is a moot point whether we are dealing with a disorder different *in kind* from established schizophrenia, or whether (as I am inclined to believe) there is not a continuous series of steadily increasing severity from the mildest and most temporary panic reaction to the severest schizophrenic. I should say it is a matter of degree, largely of success or failure of integration, and I do not think one need involve any special or new psychopathology in those progressing to psychosis. (Note, for example, the fluctuations of Case 4, who undoubtedly was psychotic on occasion, and compare the remissions and relapses in established cases of schizophrenia.)

This last compares with the point of view adopted by Adolf Meyer and his school, which looks upon schizophrenia as "the outcome of progressive maladaptation of the individual to his environment. Schizophrenia is not a 'disease' but a congeries of individual types of reaction having certain general similarities." But for a full psychopathology we must go a little further, and bring in Bleuler's now classical notion of "splitting of the personality." This, the unique form of his withdrawal and the internal repercussions of his maladjustment, is *the* characteristic psychopathology of the schizophrene, which in advanced cases can bring about the complete disintegration of the ego and permanent dementia. In the earlier stages, however, the failing may first show as a lack of capacity to integrate *new* emotional drives and experiences. (Integration is a faculty that is normally so automatic as to be taken for granted, and only its failure demonstrates how little we know about it.) Because of the turmoil of new feelings, adolescence stands out as a period of particular difficulty in this respect, and many a precariously established internal balance, say, in a young person not very tolerant of new emotional experiences, suffers an explosive disintegration under the impact of the freshly awakened sex drives and all their concomitants.

Significantly in most of my " panic reaction " cases I have noted a general emotional immaturity and dependence on parental figures. The smooth cherubic baby-faces of some of these patients are very typical (in strong contrast to the adult appearance and manner of the anxiety states), and one can easily foresee their fearful panic and retreat in the face of new emotional demands. There are also present the same poor (or unstable) socialization, the same passivity and lack of initiative and brooding inferiorities, that one finds, if one looks for it, in the *pre*psychotic histories of schizophrenics. One cannot help thinking that in this panicky withdrawal, coupled with an unstable *internal* integration in a suitably predisposed introvert, one has the key to the schizophrenic disorders. At any rate it gives a working hypothesis which fits the facts, and one on which to base a rational psychotherapy of the " early " cases quoted in this paper. My aim is primarily to work up a positive transference which will hold the patient, and give enough support to tide him (or her) over the critically unstable adolescent years. Essentially one helps patients to resolve their immediate conflicts, so making possible new integrations that would normally be too difficult for them to assimilate.

The prognosis is as a rule quite hopeful, though of course one is bound to come across patients who do not respond. I remember one girl of 18 who was under my care for over two years. I kept her going for 12 months on simple psychotherapy of the above kind. But after many vicissitudes a pronounced divorce between thought and feeling blocked further psychological approach. A later relapse was treated by E.C.T. (11 applications) with great benefit; it reduced the emotional force behind her delusory ideas so that she could and did ignore them, though they were still present. (I have not heard from her for over 12 months now.) Another one already quoted (Case 3) broke down and had to be admitted to mental hospital for insulin therapy.

This is my usual approach: psychological exploration first, and the more drastic physical methods if it fails. I know there are some psychiatrists who would advocate insulin therapy immediately upon diagnosis, on the principle that the early cases give the best results. I would hardly be disposed to agree, particularly in view of the vagaries and uncertainty of diagnosis I have tried to describe here. Some cases there are, dull, emotionally impoverished, inaccessible (the so-called slowly developing schizophrenia simplex), or, again, the more malignant types which cannot or will not co-operate, for whom it is the only course, but wherever possible I would suggest that some attempt be made at psychological exploration and readjustment.

Of course my material is derived largely from the early and milder private and " Child Guidance " cases; yours, being bound up with the hospital patient, may be very different. The field is wide and much of it fairly new to psychiatry; one's personal experience is bound in the nature of things to be limited, and an exchange of views is very helpful. I have given you mine, and would be very pleased indeed to hear yours.