PROGNOSIS OF HEBEPHRENA*

A Study of Onset and Clinical Manifestations

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In investigating 100 cases of hebephrenic schizophrenia at the New York State Psychiatric Institute, attention was directed to symptomology, clinical course and clinical manifestations in search of factors which might be utilized advantageously toward the determination of prognosis. The cases selected had already been diagnosed by the staff of the Institute as "unmistakable" hebephrenia, in keeping with the standards of the American Psychiatric Association. Only those were considered who were native urban adults of high school education, free of physical defects. Only first admissions were included. Each patient was a resident of the Institute from 1929 to 1933, and each was followed for a period of five or more years.

The investigation disclosed that numerous symptoms made their appearance with regularity for varying periods prior to the usually accepted time of onset of the disorder. Inasmuch as the study was primarily one of prognosis, it became essential that all symptoms and the variations of the clinical course be considered with this in view.

It would be exceedingly useful if one could predict the prognosis of hebephrenic schizophrenia from the clinical symptomatology in the acute phase of the psychosis. In the monograph of Hoffman, reference is made to the investigations of numerous authors (Kraepelin, Stransky, Meyer) who have attempted to determine a single specific symptom in schizophrenia as of prognostic value. Mauz alone has apparently met with some measure of prognostic success, the clinical registration of the actual symptoms.

The schizophrenic patient is recognized by changes occurring in his emotional manifestations, in his activities, or in his intellectual performance. Often these are accompanied by carelessness with reference to the person. Further change may be evident in the

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presence of depression, restlessness and irritability which may re-
sult from the patient's realization of his inefficiency. Mental symp-
toms, although manifestations of specific safety devices adopted by
the patient, have little significance apart from the setting in which
they have developed. The ideas expressed are indicative of dis-
orders in thought content and in thinking. The patient as a rule
is not entirely aware of any defect in his thought, for much of it is
controlled by the unconscious; and the repressed material consti-
tutes an important part in the formation of the thought content.

The usual account of hebephrenic schizophrenia refers prom-
minently to the tendency to silliness, smiling and laughter which ap-
pear inconsistent with the ideas expressed; peculiar neologisms,
hallucinations, delusions, disintegration and deterioration. This
picture is just, but gives no insight into the sequence in which
symptoms occur, nor does it make possible the recognition of the
incipient hebephrenic schizophrenia. With this in mind, the "evo-
lution" of a hebephrenic is presented.

The disorder presents a prodromal period, an acute stage, a sta-
tionary stage, and a chronic stage.

Prodromal stage: The disorder usually begins insidiously. The
patient at first manifests a feeling of lassitude, weakness, fatigue,
loss of appetite and insomnia. There are numerous indefinite
physical complaints. Headaches, dizziness, palpitation and faint-
ing may occur. The individual becomes aware that something
is wrong with him. He becomes depressed, sad, downhearted, un-
happy, anxious, irritable, annoyed, agitated and apprehensive. Al-
though he is likely to have had a schizoid personality for a number
of years, he becomes even more shut-in, usually being concerned
largely with himself. He associates less with family and friends.
There is constant examination of the features, an outstanding
symptom being gazing in the mirror to detect changes in facial and
body features. The patient is unproductive, suspicious, somewhat
absentminded, and is forgetful or negligent of his duties. In con-
junction with the agitation and apprehension, he develops twitches
of the face and body. There is evidence of grimacing. Toward
the end of the prodromal stage, the patient becomes more seclusive,
loses interest in his environment, is withdrawn from reality, and
becomes deeply preoccupied with various ideas and thoughts. His