THE BLOOMING MIND

Reframing the notion of psychosis, the group of schizophrenias, and hebephrenia

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INTRODUCTION

When you think of the group of schizophrenias what are the first images that come to mind? Perhaps auditory hallucinations, bizarre delusions, or maybe a violent criminal. These however are images put forward by the media and construed by the public over decades to achieve some end. It could be fear mongering on the public's part in an effort to stamp out 'madness' from their ranks. To be psychotic in the public's eye is to be schizophrenic yet this could be no further from the truth. Something went awry in the late twentieth and early twenty-first century which resulted in our notion of schizophrenia being shaped predominantly by social forces. Forces with an agenda—a sinister agenda—meant to outcast and stigmatise our most vulnerable. We're not madmen, we're just people that think, feel, and act differently to the norm. However, perhaps we are mad craving exactly that which we cannot have in this day and age: a sense of purpose, meaning, and connection.

REFRAMING PSYCHOSIS

Hallucinations and delusions are pervasive, non-specific phenomena. They are associated with other non-psychotic diagnosis and are present in healthy individuals of the general population as well. Psychosis should be likened to a fever as an accessory symptom. That is, a symptom of schizophrenia that is also found in other disorders (Loch, 2019). Albeit, these simple facts and this simple model of psychosis have fallen on deaf ears in the grander psychiatric community where diagnoses of schizophrenia are equatable to a diagnosis of psychosis; which by and large sounds obscene, how can a symptom be the disease itself?

For example, in the eleventh revision of the International Classification of Diseases (ICD-11) we have:

> Persistent delusions, persistent hallucinations, thought disorder, and experiences of influence, passivity, or control are considered core symptoms.

Which states that nearly all core symptoms are psychotic in nature and even classifies schizophrenia under the title *Schizophrenia or other primary psychotic disorders*. It even goes so far to effectively list Schneider's supposed first-rank symptoms; a major turning point in our currently poor conception of schizophrenia. The only semblance of the fundamental symptoms we get is that of thought disorder.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is just as strict as its counterpart the ICD-11:

> Two or more of the following for at least a one-month (or longer) period of time, and at least one of them must be 1, 2, or 3:
>
> 1. Delusions
> 2. Hallucinations
> 3. Disorganized speech
> 4. Grossly disorganized or catatonic behavior
> 5. Negative symptoms, such as diminished emotional expression

In which again lists the psychotic symptoms as core with only a token gesture to thought disorders through disorganised speech. This is an absolute farce with disorganised and catatonic behaviour, and negative symptoms—symptoms apparent in a previously atomic, non-psychotic form of schizophrenia—not even being able to constitute the disorder.

These two diagnostic manuals—the elegant weapon of the psychiatrist—put forward a psychotic model of schizophrenia with token gestures to the original conception of schizophrenia put forward by Kraepelin and Bleuler. To this end we will examine how perhaps schizophrenia could be viewed not as a psychotic disorder but one of thought disorders, blunted or incongruous affect, social withdrawal, and apathy with psychosis as an outstanding symptom.

THE GROUP OF SCHIZOPHRENIAS

It is in the latest revision of the diagnostic manuals, namely the DSM-V and ICD-11, that we find the subtypes of schizophrenia abolished. Subtypes that are as old as the group of schizophrenias itself. The subtypes defined by Kraepelin were the catatonic, hebephrenic, and paranoid with Bleuler adding a fourth subtype of simple indicating his stance on the issue of schizophrenia; that it is not inherently a psychotic illness, that the atomic form of the illness doesn't even put forward the

notion of psychosis. Each of these types of schizophrenia had an outstanding symptom:

> The outstanding symptom of the simple form is withdrawal from reality; of the hebephrenic is cosmic identity; of the paranoid is persecution; of the catatonic is physical expression of negativism or positivism (Hinsie and Shatzky, 1940, p. 151).

Each type within the group has its own outstanding symptom, each effectively becoming a disease entity in its own right. Yet we've dropped this notion for its inherent flaw: that one size—or box for that matter—doesn't effectively tell the story of an individual suffering from schizophrenia. So the diagnostic manuals should be applauded in one sense for not trying to fit square pegs in round holes, but they should be condemned in another for not effectively replacing the subtypes; rather they have just thrown these outstanding and telltale symptoms of "withdrawal from reality", "cosmic identity", "persecution", and "physical expression of negativism or positivism" out the window. Symptoms that are descriptive and disabling and elucidate the notion of schizophrenia efficiently. A lot can be learnt from these subtypes in the original conception of schizophrenia.

HEBEPHRENIA

While an exhaustive coverage of each subtype of schizophrenia might be fruitful, a detailed analysis of hebephrenic schizophrenia, or simply hebephrenia, has been chosen. We will go into this discussion with the notion that hebephrenia is not a subtype of schizophrenia.

It is schizophrenia.

That its characteristics are so well-defined and robust as a disease model that the notion of hebephrenia should replace the concept of schizophrenia entirely (Taylor et al., 2010, p. 173).

Using the ICD-10 we find some interesting tidbits regarding hebephrenic schizophrenia along with a definition:

> A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate and often accompanied by giggling or self-satisfied,

self-absorbed smiling, or by a lofty manner, grimaces, mannerisms, pranks, hypochondriacal complaints, and reiterated phrases. Thought is disorganized and speech rambling and incoherent. There is a tendency to remain solitary, and behaviour seems empty of purpose and feeling. This form of schizophrenia usually starts between the ages of 15 and 25 years and tends to have a poor prognosis because of the rapid development of "negative" symptoms, particularly flattening of affect and loss of volition.

In addition, disturbances of affect and volition, and thought disorder are usually prominent. Hallucinations and delusions may be present but are not usually prominent. Drive and determination are lost and goals abandoned, so that the patient's behaviour becomes characteristically aimless and empty of purpose. A superficial and mannerist preoccupation with religion, philosophy, and other abstract themes may add to the listener's difficulty in following the train of thought (1992, p. 80).

Interestingly the ICD-10 is reinforced by a reading of Kraepelin in his *Dementia praecox and paraphrenia*:

> The very great majority of cases [of dementia præcox] begin in the second or third decade; 57 percent of the cases made use of in the clinical description began before the twenty-fifth year. This great predisposition of youth led Hecker to the name hebephrenia, "insanity of youth," for the group delimited by him; Clouston also, who spoke of an "adolescent insanity," had evidently before everything dementia praecox in view. ... Hecker was even inclined to regard the issue of his hebephrenia just as an arrest of the whole psychic life on the developmental stage of the years of puberty. In fact, we find in silly dementia at least many features which are well known to us from the years of healthy development. Among these there is the tendency to unsuitable reading, the naive occupation of the mind with the "highest problems," the crude "readiness" of judgment, the pleasure in catch words and sounding phrases, also sudden changes of mood, depression and unrestrained merriment, occasional irritability and impulsiveness of action. Further the desultoriness of the train of thought, the half-swaggering, boastful, half-embarrassed, shy behaviour, the foolish laughing, the unsuitable jokes, the affected speech, the sought-out coarseness and the violent witticisms are phenomena which in healthy individuals, as in the patients, indicate that

> slight inward excitement which usually accompanies the changes of sexual development (1919, p. 223).

Despite the ICD-10 being written in 1992 and Kraepelin's work being written in 1919 there are definitely a lot of similarities. Perhaps the most striking similarity is that the ICD-10 states "A superficial and mannerist preoccupation with religion, philosophy, and other abstract themes …" while Kraepelin's work states "the naive occupation of the mind with the "highest problems,"…" which some might suppose is an interesting tidbit rather than an actual manifestation of the disease. However, we're going to assume this is an actual symptom considering that it's held fast in the description of the disease over 70 years of history. It also reinforces this idea that the outstanding symptom of hebephrenia is this notion of "cosmic identity" spouted by Hinsie and Shatzky. What's concerning is that it was as late as 1992 that these outstanding symptoms were still considered core to schizophrenia but went the way of the dodo in the latest revisions of the diagnostic manuals. Replaced nearly entirely with positive (psychotic) symptoms which as has been previously stated is weak ground to stand on. The ICD-10 and Kraepelin's descriptions of schizophrenia are not only descriptive but comprehensive. Not only comprehensive but evocative! It was only until recently that we had a solid idea of what constitutes a schizophrenic. In the most chronic form of the condition—namely hebephrenic schizophrenia—we have that "Hallucinations and delusions may be present but are not usually prominent," with not even a mention of psychosis in Kraepelin's description. This emphasises the case being put forward here that psychosis should never have been a fundamental symptom of schizophrenia. In fact, it should be considered an accessory symptom at best.

To continue our analysis of hebephrenic schizophrenia I would like to consult *Campbell's Psychiatric Dictionary* (2009) by Campbell. Most notably, this entry relates hebephrenia to schizoaffective disorder creating a clearer picture of the latter disorder:

> Some patients with the hebephrenic form of schizophrenia run, for some time, a course that resembles the periodic changes observed in manic-depressive psychosis. When the constituents of a depression appear in hebephrenia, the state is known as depressive hebephrenia. When there is similarity to a manic phase, it is known as manic hebephrenia.

This entry also states "See schizoaffective disorder" which neatly links the two up.

It's also interesting to note that in Japan, the diagnosis of hebephrenic schizophrenia is preferred over other subtypes with a rate of 30-50% over a long period of time over a wide geographical area. It's hypothesised that the Japanese held a unique concept of hebephrenia causing them to prefer this diagnosis; perhaps because of their culture. This is a result of Japanese psychiatrists viewing hebephrenia as the nuclear type of schizophrenia and preferring negative symptomatology in their diagnosis of schizophrenia (Inoue, 1993, p. 505). This preference of negative symptomatology could be a result of the *hikikomori* phenomenon found primarily in Japan. Hikikomori results in severe social withdrawal and is characterised by adolescents and young adults who become recluses in their parents' homes, unable to work or go to school for months or years (Teo and Gaw, 2010, p. 444). To this extent we're going to assume that severe social withdrawal is part of the notion of hebephrenia and continue our analysis.

REFRAMING HEBEPHRENIA

With the abolishment of the subtypes of schizophrenia in the DSM-V and ICD-11, we're going to make the bold jump to declaring hebephrenia as its own disease entity separate from schizophrenia. To this end we're not going to consider hebephrenia on the schizophrenic (see psychotic) spectrum or as part of the group of schizophrenias. Rather, hebephrenia will foremostly not be a psychotic disorder but rather one that emphasises a cluster of symptoms that can possibly result in psychosis in severe cases.

Hebephrenia (literally "blooming mind") is a disease that strikes at youth. At the prime of their life—while blooming—an ever increasing fantasy life and a corresponding withdrawal of interest from the world of reality ensues (Ladell, 1951, p. 42). Hinsie and Shatzky state that the outstanding symptom is "cosmic identity" which could be related to the ICD-10 notion of a "preoccupation with religion, philosophy, and other abstract themes" with perhaps the fleeting and fragmentary delusions and hallucinations being based around these abstract themes. It's as if a crucial search for meaning, purpose, and connection at a pivotal time in their lives in a hostile world is invalidated by others. Then by a highly arbitrary labelling process the identity 'hebephrenic' is created by medical or quasi-medical agents (Cooper, 1970, p. 16). Is hebephrenia not just the name for a condition that psychiatrists ascribe to patients they call hebephrenic? (Laing, 1967a, p. 139) These tender souls do not need to be drugged up and banished, but rather admitted to and supported by a community where they can feel part of a greater whole.

Something that validates their existence rather than jeopardises their "cosmic identity."

It's common knowledge that hebephrenics are prescribed neuroleptics (see antipsychotics) for prolonged periods of time; it's not uncommon for neuroleptics to be part of a life-long treatment plan. However, recent evidence suggests that while neuroleptics are effective at reducing or eliminating flagrant psychosis in acute hospitalisations, we actually find that after the first three years neuroleptic treatment for hebephrenia is less effective, that after twenty years of neuroleptic treatment work functioning does not improve, and many non-medicated hebephrenics show adequate work functioning after the acute phase of the illness without neuroleptic treatment (Harrow et al., 2017, p. 267). This suggests that yes, neuroleptics have their place in the treatment plan of the hebephrenic but that they should not be the mainstay of treatment, and rather alternatives to the mass medicalisation of hebephrenics is proposed. The main alternatives to this medicalisation phenomena is classed under the term psychosocial treatment with the four empirically supported approaches including social skills training, family psychoeducation, cognitive therapy, and cognitive rehabilitation (Bellack, 2001, p. 136). Additional support such as case management, disability support workers, residential living arrangements, and disability pensions are also recommended. Hebephrenia is essentially a disease entity that has a multidimensional symptom profile and therefore should be treated with a multifaceted treatment plan targeting not just the psychotic—in acute cases—but deficits that ruin the functioning of the hebephrenic. It's recommended that there should be less emphasis on the acute (psychotic) cases of hebephrenia and more emphasis on the prodrome; the prodrome being a stage of hebephrenia in which fundamental symptoms of hebephrenia have appeared before the accessory symptoms such as hallucinations, delusions, and mania have become pronounced.

Hebephrenia's fundamental symptoms harken back to the initial conception of schizophrenia. These fundamental symptoms include disturbances of association and affectivity, the predilection for fantasy as against reality, and the inclination to divorce oneself from reality (autism in its original sense) (Bleuler, 1911/1952, p. 14). Accessory symptoms would include hallucinations, delusions, depression, and mania for example. Treatment for accessory symptoms is included in our current psychopharmacological profile in terms of neuroleptics, antidepressants, and mood stabilisers. Fundamental symptoms however cannot be medicated and are best addressed with psychosocial support in daily living skills and community participation.

CONCLUSION

Some audacious statements have been made. Firstly we noted that psychosis is not solely found in the psychotic disorders but also that of the affective and neurotic disorders. That psychosis is akin to a febrile symptom rather than part of the underlying disease process. That subtypes have outstanding symptoms and are valid constructs but abolished in the latest diagnostic manuals, and the notion that the hebephrenic subtype was the most outstanding and equatable to schizophrenia itself.

However, the most exciting conclusion that can be drawn from all of this is that hebephrenic schizophrenia, or simply hebephrenia, is not a subtype of schizophrenia but a disease entity or disorder that stands on its own. That as schizophrenia moves towards a psychotic, first-rank symptoms diagnostic criteria, there needs to be a disorder that exemplifies what schizophrenia previously stood for as conceived by Bleuler without the 'schizo-', or splitting, aspect to the disorder which was largely ill-defined.