INTERPRETATION OF SCHIZOPHRENIA

# The Fourth, or Terminal, Stage

SILVANO ARIETI MD

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**Silvano Arieti, M.D.**

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# Table of Contents

The Fourth, or Terminal, Stage

I Primitive Oral Habits

II Perceptual Alterations

Bibliography

Acknowledgments

# The Fourth, or Terminal, Stage

## I
## Primitive Oral Habits

We have now come to the fourth, or last, stage of schizophrenia during which a new set of phenomena occurs. Some of the symptoms appear no longer as predominantly psychological but neurological. It seems as if the disorder has reached a level where psychology and neurology coalesce. The indefinite quality of some of the symptoms leaves ample space for speculation and makes their study difficult.

How and when does this last stage start? It is well known that decreased activity is one of the most common characteristics of progressing schizophrenia, though not a constant one. This motor reduction often interferes with the dietary requirements of the patient to such a point as to bring about a state of malnutrition, anemia, and, occasionally, avitaminosis. This inactivity, which is a part of the schizophrenic withdrawal, is noted throughout the long years of progressing regression and is interrupted only by occasional and

transitory partial remissions. In patients who continue to regress indefinitely, however, a more or less sudden increase in motor activity is noted at a certain point. As a rule such an increase is not transitory but lasts for the lifetime of the patient, or until a physical illness neutralizes its effects. It is when this partial increase of motor activity takes place that what I call the terminal stage begins.

In the patients whom I observed and whose clinical records I studied, the terminal stage started any time from seven to forty years after the onset of the illness, but it probably may start even sooner, or later. The increase in activity is only relative, because the patients somehow remain underactive in comparison with normal subjects. Their actions, which are now more numerous, appear sharply reactive or impulsive; they are reactive to certain habitual situations, which will be taken into consideration shortly, or impulsive, inasmuch as they appear to be due to sudden internal stimulation. The patients may be impulsively destructive, assaultive, and much more violent than previously. At this stage of the illness they do not seem able to experience hallucinations or to elaborate delusions. Verbal expressions are either completely absent or are reduced to a few disconnected utterances.

The most striking changes, however, are noted in the dining room. The patients who had always eaten so little as to have reduced themselves to a state of malnutrition now seem to have a voracious appetite (bulimia) and often gain a considerable amount of weight. The nurses often report that these patients have the habit of stealing food. In reality, closer observation reveals that the concept of stealing is not implied in the actions of these patients. They cannot prevent themselves from grabbing food at the sight of it, so that they are better termed *food grabbers.*

Observations in the dining room reveal other interesting habits. A few of these patients show preference for certain foods. No matter how many kinds of food are in the dish, they always grasp and eat the preferred food first. They do not alternate the various kinds, as normal adults do, but only when they have entirely finished the preferred food do they start to eat the others. Similarly, if they show several degrees of preference, they first eat the food that is the first choice; when this is finished, they eat the second choice, and so on. If there are desserts, these are generally eaten before anything else. It seems that the patients are obliged to react first to stronger stimuli. The preference for a certain food is not shown by all patients who are food grabbers.

On the other hand, such preference is maintained only for a brief period after the acquisition of the food-grabbing habit. After this period the patients seem to eat with avidity any kind of food. *Whatever belongs in the category of edibility elicits equal and prompt reaction.* Another characteristic that is often observed is the extreme rapidity with which these patients eat (tachyphagia). In a few minutes these food grabbers may finish the rations of several patients if they are not prevented from doing so. Often they do not leave any remnants of food in the dish but clean the plate with the tongue.

The patients may remain indefinitely at this level, which is characterized by the food-grabbing habit, but the majority progress more or less rapidly to a more advanced level of regression characterized chiefly by what I have termed the habit of "placing into mouth." At this level the category of edibility is no longer respected. Whereas the patients had previously distinguished themselves by grabbing food and food only, now they manifest the habit of grabbing every small object and putting it into the mouth, paying no attention at all to the edible or nonedible nature of it. If they are not restrained, these patients pick up crumbs, cockroaches, stones, rags, paper, wood, clothes, pencils, and leaves from the floor and put them into the

mouth. Generally they eat these things; occasionally they swallow them with great risk. Many patients, however, limit themselves to chewing these nonedible objects and finally rejecting them. When they eat or swallow dangerous materials, such as an inkwell or a teaspoon, they are erroneously considered suicidal. Closer observation reveals, however, that the idea of suicide is not implied in the action. They simply react to a visual stimulus by grasping the object and putting it into the mouth. They act as if they were coerced to react in this way. It is as though they were especially attracted by small, three-dimensional stimuli that seem to be distinguished from the background more distinctly than usual.

On the autopsy tables of state hospitals it is a relatively common experience to find spoons, stones, pieces of scrap iron, wood, paper, cores, and other objects in the stomachs or intestines of patients who died while they were in the fourth stage of schizophrenia.

As a typical example, the case of A. R. will be mentioned briefly. This patient entered Pilgrim State Hospital in October 1933 at the age of 32. On admission he had delusions and hallucinations but was fairly well preserved. The diagnosis of dementia praecox, paranoid type, was

then made. Subsequently he showed a steady downhill progression in his mental condition. He became negativistic, mute, manneristic, and idle. He had the habit of wetting and soiling and required a great deal of supervision. On frequent occasions it was necessary to tube feed him. He did not show any interest in his surroundings, appearing completely withdrawn and living an almost vegetative existence. In the dining room, however, he showed great interest, grabbing food and eating in a ravenous manner. On December 31, 1939, he died of acute intestinal obstruction. At autopsy fourteen spoon handles were found in his colon and two spoon handles and a suspender clasp in his stomach. In the terminal ileum there was a rolled piece of shirt collar, which was the cause of the obstruction. The collection of foreign bodies in the stomach of this patient is very modest in comparison with that found in many other patients.

The grasping and ingestion of the objects may be accompanied by a quick movement, as a prompt reaction to a visual stimulus, or by a slow movement, apparently not accompanied by any emotional coloring. If the patients are under some mechanical restraint, they may try to reach the objects directly with their mouths.

It is also not rare to see some patients grasping their own feces, chewing them, and eating them, at times with great pleasure and satisfaction (coprophagia). These coprophagic patients may put everything indiscriminately into their mouths and incidentally their own feces, but this situation is rather exceptional. As a rule, they show a marked discrimination in putting into their mouths specifically their own feces. Other patients often smear themselves with their own excrement.

Are these habits only manifestations of purposeless behavior of demented patients or are they determined by deeper causes? I feel that the latter viewpoint is correct and that a genetic approach may help explain these habits.

In fact, it is possible to interpret them not as newly acquired habits but as behavior manifestations of lower levels of integration. The food-grabbing habit reminds one of what is generally observed in cats, dogs, monkeys, and other animals. The animal is coerced to react to the food at the sight of it. The food does not stand for itself but is what Werner (1957) calls a “thing of action.” It is a “signal thing,” the sight of which leads immediately to a fixed action (Werner, 1957). The

animal cannot delay the reaction or channel the impulse into longer integrative circuits. Similarly, other habits previously described disclose the same syncretic characteristics encountered in more primitive organizations. It is well known that when monkeys, dogs, cats, and other animals are given different items of food at the same time, they eat first the preferred food (for instance, meat in the case of the dog, or banana in the case of monkeys), and only when the entire portion of the preferred food is finished do they start to eat the other foods. They cannot alternate the various kinds but are coerced first to react to the strongest stimulus. Similarly, a child between the age of 3% and 4, if not prevented, eats first the preferred food, and only when he has finished it does he eat the others.

When the patients become even sicker, this integration of the stimuli is even more primitive, so that they react to edible and nonedible objects in the same way, by grasping them and putting them into the mouth. The category of edibility is no longer respected.

This habit of regressed psychotics has some points in common with what is generally observed in children approximately 6 months to 2 years old. When confronted by objects of a certain size, children of

this age grasp these objects and attempt to put them into the mouth. There is no discrimination made between edible and nonedible objects; the baby places in his mouth anything that comes within his reach and licks, sucks, or eats it. “If the object is too heavy or cannot be grasped with the hand ... the infant brings his mouth close to the object and licks or, in the case of clothing or bibs or blankets, sucks at it” (Kanner, 1942). Rugs, cotton, leaves, worms, wool, wood, stones, and paper are eaten or at least put into the mouth. “The objects eaten are the objects accessible; accessibility and not ‘craving’ or ‘appetite’ governs their selection” (Kanner, 1942).

All parents have observed this particular behavior when their children have reached this age and attribute it erroneously to various causes. Most of the time they attribute it to incipient teething or to increased appetite. Generally the people in charge of the child remove the object from the child’s mouth with their own hands, fearing it may be swallowed. But the child, if let alone, will test the object and often reject it if it is not edible or if it has an unpleasant tast. Only relatively seldom is the object swallowed with serious consequences. It seems almost as if taste discrimination, or at least oral discrimination by means of the sensory properties of the oral cavity, supersedes the

visual one. In pathological conditions this habit persists to age of 3 or even 4 and is erroneously called perverted appetite, or pica.

In a series of papers Klüver and Bucy (1937, 1938, 1939) described interesting observations on trained monkeys after the extirpation of both temporal lobes. The extirpation included Brodmann's areas 22, 21, 20, area 19 being left untouched. The removal of both lobes constantly caused typical manifestations, whereas the ablation of only one lobe or of an entire lobe and a part of the other did not bring about characteristic results.

The authors found that the monkeys, after this surgical treatment, showed an irresistible tendency to grasp anything within reach. They placed the grasped object in the mouth, bit it, touched it to the lips, and finally ate it if it was edible. If inedible, the object was rejected. All objects, edible or not, were grasped indiscriminately. Every one of the monkeys manifested this particular type of reaction, environmental changes having apparently no influence at all. It seemed as if all previous learning had no influence whatsoever on their behavior. As a matter of fact, the established reactions to visual and weight differences were superseded by the constant grasping and

placing-into-mouth reaction (called by the authors “oral tendencies”). In addition, it seemed to the observers as if the animal were “acting under the influence of some compulsory or irresistible impulse. The monkey behaves as if forced to react to objects ... in the environmental stimulus constellation.” It seemed to be dominated by only one tendency, namely, the tendency to contact every object as quickly as possible, any visual object immediately leading, whenever possible, to a motor response.

A different kind of forced ingestion of inedible objects is reported in another field of investigation. Members of primitive tribes are in the habit of eating some inedible substances (geophagy). They are almost forced to eat these objects, because they cannot avoid eating them when they see them. This habit is highly discriminatory for a certain substance in a given tribe but retains almost a compulsory characteristic.

The above-mentioned examples, taken from different fields of investigation, have some features in common, namely, the picking up of objects from the immediate environment and the placing of them in the oral cavity, with no discrimination as to their nature and no

consideration of the fact that they are not edible. These actions, in all the cited instances, have a more or less compulsory characteristic.

It could be objected that such similarities are only apparent or very superficial, and that we ourselves disclose paleologic thinking in connecting these various instances. Somebody else could emphasize the differences in the situations taken as examples. For instance, the geophagic habit found in some tribes may be part of a ritual and may be exclusively cultural in origin. On the other hand, in all the other cases that we have mentioned, the differences may be due to various factors acting contemporaneously with the common factor, which may be an expression of a certain level of development. The differences could be explained without difficulty. The precise movements of the monkey contrast with those of the child, because the monkey has acquired voluntary movements very well, whereas the child, whose nervous system is not yet completely myelinized, has not.

Unlike the child, the bitemporal monkey of Klüver and Bucy can indefatigably continue to grasp every object, to react repetitiously in this way to every visual stimulus. This reaction is probably due to the fact that the damage or the lack of cerebral areas causes the animal's

hyperactivity or the state of "being forced by the stimulus," similar to that which is observed in human cases with extensive cerebral defects (Goldstein, 1939). The fact that regressed schizophrenics presenting the described behavior grasp objects not in such number and not with such rapidity as the Klüver and Bucy monkey, or not at every opportunity, as the child, may be explained if we take into consideration the other aspects of the schizophrenic picture. The withdrawal and the emotional impairment of the schizophrenic may be responsible for such difference.

Klüver and Bucy give an interesting preliminary interpretation of some behavior characteristics of their bitemporal monkeys, in considering the latter as "psychically blind," or suffering from visual agnosia. Because in their tendency to approach their mouths and place all objects in them "without hesitation" the animals show no discrimination, no preference for food or for learned reactions, and no ability to concentrate on particular objects, the authors consider these monkeys to be psychically blind. If I have understood correctly, these authors come to the "psychic blindness" conclusion in view of the fact that the animal, after the removal of both temporal lobes, grasps and uses each object indiscriminately, even though it had learned before

the operation to distinguish the objects and use them discriminately. But is that behavior really due to "psychic blindness" or to that "compulsory or irresistible impulse" that forces the monkey, as well as the child, and at times the regressed schizophrenic, to grasp any object within reach? It could be, in fact, that the need to respond immediately does not permit any cognitive elaboration of the stimulus, beyond the most primitive senso-perceptual experience.

We must direct our attention to the fact that the ability to appreciate differences in lightness, size, shape, distance, position, and movement is not reported to be impaired in these monkeys. Therefore, we can reach the conclusion that the only bodies that are not "recognized" are the bodies with a definite, sharp, three-dimensional shape. Although the forced placing-into-mouth reaction of these monkeys is not explained by assuming the presence of visual agnosia, it cannot be disproved that the monkeys are really in a certain way psychically blind. As a matter of fact, in a certain sense even the child of one or two years of age may be considered partially psychically blind. The visual stimuli often do not lead the child to recognize the objects; his visual perceptions are still partially agnostic. By means of the mouth, more than by his eyes, the 1-year-old child explores what is

still unknown to him. Werner (1957) states: "The mouth is the primitive means of knowing objects, that is, in a literal sense, through the grasping of the objects. The spatial knowledge of an object results from a sucking in on the thing through the mouth and a consequent tactual discovery and incorporation." However, the child apparently grasps the objects and puts them into his mouth not in order to know them, but under a certain kind of primitive impulse. It happens that in doing so he starts to know the objects, and this behavior has beneficial results for him.

The demented schizophrenic in the terminal stage of regression may also be considered, in a certain way, partially psychically blind because the visual stimuli of the objects do not elicit cognitive and affective associations concerning their inedibility and the relative danger of putting them into his mouth and eating them. However, one must consider the theoretical possibility that the patient is conscious that these objects are inedible, but that he cannot inhibit the impulse to grasp them. Such a possibility cannot be ruled out. We may, however, advance the hypothesis that this behavior of children, bitemporal monkeys, and regressed schizophrenics is a primitive way of reacting, which is characteristic of a certain level of development

and is inhibited or transformed by higher centers. In other words, we may be dealing with one of those responses in which a short-circuiting takes place between the functions of reception and those of reaction instead of the usual response with participation of the higher centers. These reactions are intermediate between reflexes and voluntary acts, having some characteristics of compulsory acts. The placing-into-mouth reaction seems to belong to a much lower level than the archaic mechanisms described in other chapters, but it seems to be at a higher level than, for instance, the grasp reflex. The grasp reflex is found in infants from 1 to 3 months of age and in adults with lesions of the frontal lobes, although this reflex does not always appear as a true reflex but frequently as a prehension attitude implying some voluntary action. Schilder (1931), however, considers the taking of objects into the mouth "at least as primitive as grasping." This placing-into-mouth reaction is apparently not caused by any agnosia but seems to belong coincidentally to a level at which high apperceptions elaborating visual stimuli are not yet possible. This primitive reaction may have its early origins even in low vertebrates. It may have some connection with the feeding response of amphibians, reptiles, and birds, animals in which the temporal lobe is represented only by the hippocampal area.

Although its main purpose in phylogenesis is to contact food, it certainly is also a means of recognizing objects, especially in those animals whose visual centers have not reached a high degree of development.

Taking into consideration the coprophagic habit, the fact is worthy of mention that such behavior is usual in healthy apes. In 1940, while working in the Laboratory of Primate Biology of Yale University, directed by Robert Yerkes, I had the opportunity to observe the frequency of such a habit in the chimpanzees kept in captivity. Yerkes (1943) reported that the causes, controls, and prevention of coprophagy among captive chimpanzees have been searched carefully but with discouraging results. He felt that the hypothesis that coprophagy is induced by dietary deficiency finds no support in the inquiries conducted in his laboratories and concludes that this behavior is determined by complex underlying factors.

Kohler (1925) had previously described such peculiar behavior of primates. He reported that out of the many chimpanzees studied by him only one did not indulge in coprophagy. He states that the habit of smearing the excrement is also frequent among chimpanzees. Such

habits have not been observed in healthy monkeys. In mental patients this behavior is observed especially among catatonics and hebephrenics. Although it is a sign of advanced regression, it is not as malignant as the "oral tendency" described here, and probably belongs to a less primitive level. As a matter of fact, catatonics who have eaten feces or smeared themselves occasionally gain a temporary remission (Chrzanowski, 1943) or even an apparently complete recovery (personal observations).

## II
## Perceptual Alterations

The patients may remain indefinitely at a level characterized chiefly by the oral habits described above or may progress to a more advanced phase that is characterized by apparent sensory alterations.

Because of the lack of cooperation and communicability of these patients, such alterations cannot be studied with the usual neurological technique, but much stronger stimuli, not ordinarily used, or observation of the patient's reaction in certain special situations must be resorted to. Therefore only gross alterations are reported here, and no claim to accuracy is made (Arieti, 1944a, 1945a, 1955).

It seems as though the patients who have reached the terminal stage are insensitive to pain. They appear analgesic not only to pinprick but to much more painful stimuli. When they are in need of surgical intervention and require sutures in such sensitive regions as the lips, face, skull, or hands, they act as though they cannot feel anything, even in the absence of any anesthetic procedure. Many times when I was working in Pilgrim State Hospital, I sutured wounds caused by violent and assaultive behavior without eliciting any sign of pain or resistance. Some patients seem to feel some pain, but far less than normal persons would. Only exceptionally is there a local withdrawal. The same anesthesia is noted for temperature. The patient may hold a piece of ice in his hands without showing any reaction. Pieces of ice may also be placed over the breast, abdomen, or other sensitive regions without eliciting any reaction or defensive movement. Such patients also appear insensitive when the flame of a candle is passed rapidly over the skin. They may sit near the radiator, and, if they are not moved, they may continue to stay there even when, as a result of close contact, they are burned. This state of insensitivity is, in my opinion, one of the chief causes of the large number of bums occurring in wards for regressed schizophrenics.

One may be induced to interpret this lack of responsiveness to pain and temperature stimuli, not as true anesthesia, but as an expression either of catatonic inactivity or of a certain kind of "inner negativism." Repeated observations, however, have led me to the conclusion that such an interpretation is not valid. Patients who show anesthesia for pain or temperature stimuli are not, as a rule, inactive; on the contrary, they show the aforementioned relative increase in activity that, together with the apparent anesthesia, is responsible for numerous accidents. The possibility that these patients do not react to dangerous sensations on account of inner negativism in my opinion is also untenable because many such patients do not show other signs of negativism. The phenomenon of negativism, although not absent at this stage of the illness, is much more commonly observed in patients who are at a less advanced stage of regression. On the other hand, the possibility that pain and temperature sensations are perceived, with only the affective components of such perceptions being lost, must be taken into consideration and will be discussed later. In a small number of patients this apparent anesthesia or hypesthesia for pain and temperature stimuli is only transitory. Even patients who have been insensitive to heat for several months to some extent may reacquire

capacity to perceive pain or temperature sensations or both. Occasionally, striking changes occur at brief intervals. However, I have the impression that some degree of hypesthesia is always retained. Partial hypesthesia is also found in many patients who have not yet reached the terminal stage. Tactile perception does not seem impaired in these patients. Tendon and superficial reflexes are not only present but often increased. The comeal reflexes are also present. On the other hand, many, but not all, of the patients who present anesthesia for pain and temperature stimuli seem also to have lost the sensation of taste. When they are given bitter radishes or teaspoons of sugar, salt, pepper, or quinine, they do not show any pleasant or unpleasant reaction. They do not spit out the unpleasant substances as quickly as possible, as do control mentally defective persons or deteriorated patients with organic disease; instead they continue to eat the entire dose without hesitation. Some of them seem to recognize salt but do not object to pepper or quinine. Others react mildly to quinine but not to pepper or salt.

In contrast to this lack of reactivity to pain, temperature, and taste stimuli is the normal reaction to strong olfactory stimuli. Patients who do not react at all to such stimuli as flames, pieces of ice, and

suturing, react in a normal way when they smell such things as ammonia and strong vinegar. They withdraw quickly from the stimulus with manifest displeasure. Such a reaction strikes the observer, inasmuch as many other strong stimuli from other sensory fields do not bring about any response or bring about only a mild reaction. It seems as though the phylogenetically ancient olfactory sense can better resist the schizophrenic process. However, the schizophrenic patient does not seem to make use of these olfactory sensations as well as he can, probably on account of his general withdrawal.

The aforementioned phases of the terminal stage (phases characterized by the food-grabbing habit, the placing-into-mouth habit, apparent anesthesia for pain, temperature, and taste sensation, and preponderance of the olfactory sense, respectively) do not always occur in the order given. A number of patients, especially but not exclusively those of the paranoid type, remain indefinitely at a less advanced phase. In others two stages of the illness overlap. For instance, a few patients who have the food-grabbing habit may retain the capacity to hallucinate. Other food grabbers may already have anesthesia for pain and temperature stimuli, and so on. However, the

order described is the one in which I have most commonly observed appearance of the symptoms. Occasionally a patient may improve and return to a less advanced phase or stage. Intravenous injections of sodium amytal do not produce any perceptible change in the picture of the terminal stage of schizophrenia.

Although statistical conclusions are difficult on account of this overlapping of symptoms, I have the impression that the number of patients presenting the habit of grabbing food or placing objects in the mouth is large in services for patients in the terminal stage. The number of patients presenting some hypesthesia for pain, temperature, and taste sensations is also large. On the contrary, patients presenting total anesthesia for pain and temperature sensations are relatively few.

Several authors have reported altered perception of pain in cases of early catatonia, and Bender and Schilder (1930) have discussed this subject in relation to the capacity to acquire conditioned reflexes. In my experience, the hypesthesia found in patients with early catatonia is generally not so severe as that observed in patients who have reached the terminal stage and often is not detected if, instead of

pinprick, one uses stronger stimuli. Anesthesia for temperature and taste stimuli is even more rare in patients with early catatonia and is not comparable to that encountered in very regressed patients originally diagnosed as suffering from the various types of schizophrenia. However, the possibility is not denied that the nature of the phenomenon may be the same. In many of the textbooks of psychiatry no mention is made of this analgesia encountered in some deteriorated schizophrenics. Bleuler (1950), however, reported that an analgesia, sometimes quite complete, occurs in schizophrenia not too rarely. He stated that this anesthesia is responsible for the fact that the patients readily injure themselves.

In agreement with the observations of Bender and Schilder on patients with early catatonia, I am inclined to believe that the real sensation of pain and temperature is not lost in patients in the terminal stage. The fact that the corneal reflexes are always retained may be a proof of it. However, these patients seem to be unaware of the pain and temperature stimuli and do not show any emotional reaction to them. They seem to be unable to perceive the stimuli. In other words, the rough sensation may be present but remains isolated and is not elaborated to the perception and apperception levels. The

patients are unable to recognize the emotional and cognitive value of the pain and temperature stimuli and therefore are unaware of the possible dangers that they at times imply. For this reason they often hurt themselves. These patients, for all practical purposes, have agnosia and may be compared to persons with sensorial aphasia who hear spoken language without understanding it.

Is this loss of nociceptive perception only an exaggeration of the general schizophrenic emotional indifference? Probably the basic mechanisms responsible for these derangements are related, but for all practical purposes these terminal patients are better described as having agnosia and may be termed “psychically analgesic” and not apathetic only. They fail to perceive pain and temperature sensation, not only from an emotional but from a cognitive point of view. That is the reason that they so often hurt themselves if they are not under constant supervision. At present it is a controversial problem whether these phenomena are due to loss of emotional capacity or to loss of perception of pain and temperature sensation.[1]

The fact that taste perception is often lost or impaired in these analgesic patients and that the olfactory perceptions are preserved

instead is also important to consider. The association of taste and pain asymbolias points to the conclusion that taste should be included among the general somatic sensations, as investigations by Boernstein (1940a, *b*) and by Shenkin and Lewey (1944) seem to prove. The striking survival of smell perceptions, which are phylogenetically very old, may induce one to think that the archipallium is less affected than the neopallium by the schizophrenic process. The olfactory sense, which is the dominant sense in lower vertebrates, in some regressed schizophrenic patients seems to reacquire a position of predominance among the senses, not because of increased acuity, but because of impairment of perceptions of stimuli coming from other sensory fields. However, contrary to what is found in lower vertebrates, these schizophrenic patients do not take as much advantage of the olfactory sense as they could. It is interesting to observe that the sense of smell in schizophrenic patients is not involved even in short-circuiting reactions, whereas it was involved in the monkeys of Klüver and Bucy.

## *Notes*

[1] The relation between emotional indifference and agnosia has been taken into consideration by Von Monakow and Mourgue (1914, 1928), who observed impairment of emotions in aphasic persons. The same authors considered the possibility that asymbolia may be due to disturbances in the affective sphere.

The findings by Penfield and Rasmussen (1952) prove that pain and temperature sensations are retained even when the cortical areas that supersede these sensations are completely removed. These findings make interpreting the pain and temperature anesthesia of the schizophrenic even more difficult.

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"The 'Placing into Mouth' and Coprophagic Habits." *Journal of Nervous and Mental Disease.* Vol. 99, 1944, pp. 959-964.

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