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LONELINESS AS EXPRESSED BY SCHIZOPHRENIC PATIENTS IN THE EARLY REMISSION PHASE

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ABSTRACT

We examine the clinical and psychotherapeutic significance of the "emotion of depression," particularly "loneliness," focusing on the postpsychotic depression in one phase of the early remission phase and prolonged early remission phase according to the so-called "remission process theory" of schizophrenia (Nakai). We first present details of two cases representative among 30 patients who discussed "loneliness" with their chief therapist. Then, in the Discussion, we classify the expressions of "loneliness" into four modes, taking "loneliness as isolation open to the other." In this phase, the patient strongly seeks a "deeply significant other" as a "partner for even a little protection against loneliness," and the therapist often assumes this role. This role is extremely important to the patient's passage through the early remission phase. We stress that the presence of this "partner for even a little protection against loneliness" is of great significance for the problems of subsequent progress or stagnation in the remission process, and the issue of ongoing deterioration as well.

Key Words: Early remission phase of schizophrenia, Psychotherapy, Loneliness, Partner as significant other, Clinical course

INTRODUCTION

The emotions enveloping the schizophrenic patient have been one of our ongoing therapeutic concerns[1,2,3)]. It has been said that "there can be no cure without empathy[4)]," and "empathy," or "sympathy," is the most basic of psychotherapy processes to which we must give the greatest clinical consideration. This also holds true for a psychotherapeutic approach to schizophrenia.

However, dealing directly with the emotions of the schizophrenic patient must generally be approached with caution. Yasunaga indicated that "since many schizophrenic patients exhibit a schizothymic temperament, they find it difficult to openly express emotion, are often very sensitive and easily hurt, tend to be introverted and have grandiose illusions[5)]." He clearly pinpointed both the difficulty of dealing with these emotions as well as the treatment considerations in such cases.

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In this study, we examine the emotions experienced by the patient, especially the "loneliness" encountered in the early remission phase and prolonged early remission phase in the "process of remission from the schizophrenic state" according to Nakai[6]. We further examine the clinical and therapeutic significance of "loneliness" in treatment during the early remission phase. We here wish to mention that this loneliness should be considered not only from the perspective of psychotherapy, but also as in the vernacular sense defined in the Oxford English dictionary[7], *i.e.*, "lonely: 1) without companions, 2) sad because of this, 3) unfrequented, isolated, uninhabited." This loneliness has virtually the same meaning as the term "loneliness" used as a key word throughout this paper.

SIGNIFICANCE AND POSITIONING OF THIS STUDY IN THE LITERATURE

As positive symptoms disappear or fade in the acute stage of schizophrenia, loss of desire and power to act are seen, and many patients complain of being easily fatigued, forgetful, and feel a sense of isolation. At this stage, the patient enters a period of day-long confinement to bed and manifests excessive sleepiness[8] unless family or hospital staff force him or her to be active. In other words, a pathological picture built on negative symptoms becomes dominant with reduced activity across all aspects of verbal and physical behavior.

The symptoms of depression within this pathological picture especially drew the attention of the English-speaking world. Since Eissler proposed the clinical term "relative muteness stage" in 1951[9], many studies were made on the depressive symptoms of this stage, which is the aftermath of an acute schizophrenic episode. They described this period using various terms, including "anaclitic depression[10]," "depressive-neurasthenic phase[11]," and "postpsychotic regression[12]." In 1976, McGlashan *et al* [13,14]. devised a definition to cover the phenomena centering on depression as follows: "Postpsychotic depression refers to a phasic phenomenon manifest by depressive affect and/or quiet but severe social withdrawal following on remission of the more florid psychotic symptoms." The history of this pathological picture was traced to the use of the term "despair[15]" by Mayer-Gross. Since that study, the term "postpsychotic depression" has come into general acceptance in English-speaking countries. The emphasized emotion of depression includes sadness, feelings of isolation, powerlessness, loss of confidence, feeling of being criminal, and suicidal ideation. This concept was not adopted afterward by the DSM-IV[16] (but was included in the ICD-10 in 1992). It became one of the subclassifications of pathologic type, "post-schizophrenic depression."

In German-speaking countries, the "prolonged postpsychotic-asthenic stage[17]," "post remission insufficiency syndrome[18]" and "post remission exhaustion syndrome[19]" have been proposed as equivalent to "postpsychotic depression." Whereas the emotion of depression is underscored in English-speaking countries, exhaustion and fatigue are emphasized and generally regarded as the basis of the emotion of depression in German-speaking countries.

McGlashan *et al*. reviewed the studies of Wildroe[20], Roth[11] and Kayton[12] regarding psychotherapy for "postpsychotic depression" as follows[14], and the findings are related to the present study. The psychodynamics of "postpsychotic depression" includes: 1) a reaction to the psychosis involving severe blows to the self-esteem; 2) a mourning of the loss of old maladaptive (symbiotic) but comfortable ways of coping, and the loss of omnipotence in the self and significant others; or 3) a symptomatic reaction to facing the necessity to change, to individuate, and to take more responsibility for one's life. Psychotherapy for these aspects emphasizes the necessity of medical staff support for the patient, the importance of integrating the psychotic experience of the patient over the course of treatment, and analyzing patient resistance to pa-

tient independence.

Although we largely concur with the conclusions of McGlashan *et al*., we consider it important to meticulously study the possibilities of psychotherapy which adequately addresses the emotions of the patient while deepening understanding of the emotions of schizophrenic patients in the "postpsychotic depression phase" based on what transpires in the psychotherapeutic setting. Thus, in keeping with the remark of Nagata that "since this phase is related to the process of rehabilitation and reintegration into society, an even more practical description will be required[21]," we therapists must proceed to discuss the "postpsychotic depression" proposed by McGlashan *et al*., both from the clinical and therapeutic perspectives.

To comply with this requirement, the focus on "postpsychotic depression" in Japan began with a series of articles on the remission process in schizophrenia by Nakai[6,22]. This process, which starts immediately after the acute stage of schizophrenia, can be summarized by dividing the entire remission process into three periods: 1) the critical period, a variegated period of disturbance of the autonomic nervous system, with nightmares and transient periods of clarity; 2) the early remission phase, a period of exhaustion and inactivity, but with the recovery phase also taking place in incremental and quiet fashion; and 3) the advanced remission phase, a phase of pseudoneurosis and pseudoneurasthenia, yet with the potential for regeneration gradually emerging.

Nakai makes the important point that the "postpsychotic depression" of McGlashan *et al*. corresponds to one chronic aspect of the early remission phase[22]." This point became an excellent opportunity to reconsider "postpsychotic depression" from the perspective of Nakai's theory of the remission process, and depression symptoms in the early remission phase were later thoroughly studied by Nagata[8] and Mino[23]. These authors position "postpsychotic depression" as one stage in the early remission phase and prolongation of this phase according to the theory of the remission process, and the present study advances the concept from a similar perspective.

The purpose of the present study is to develop a working theory of the clinical and therapeutic significance of the emotion of depression, and specifically "loneliness," in "postpsychotic depression" from the perspective of interpersonal theory using Nakai's concept of the remission process in the light of the aforementioned research.

To further clarify the objective of the present study in the light of the argument to follow, thus allowing us to discuss the significance of "loneliness" in both clinical and psychotherapeutic terms, we first of all address the issue of the "loneliness" experienced by the schizophrenic patient as he or she enters the early remission phase throughout the critical period. At this time, it is our clinical experience that the patient is urgently seeking the "presence of a partner for even a little protection against loneliness." Secondly, we make the assumption that the feelings of "loneliness" experienced by the schizophrenic patient in the early remission phase, along with the longing for the "presence of a partner for even a little protection against the loneliness," persist but then stagnate in the course of the remission phase. This leads us to speculate that there may well be an association with the problem of ongoing deterioration.

CASE STUDIES

Thirty patients (15 males and 15 females) were the subjects of this study (Table 1). The period of initial expression of "loneliness" occurred in the early remission phase in all cases. We present two representative subjects among the 30 listed in Table 1.

Table 1 30 cases of this study

Case #	Gender	Current age	Initial Diagnosis	Age at onset	Age when “loneliness” first expressed	Mode of expression of "loneliness"	Duration of “loneliness” (months)	Current diagnosis
1	M	30	F20.1	17	22	a	6	F20.13
2	M	25	F20.1	17	21	a,c,d	24	F20.10
3	M	58	F20.0	27	36	a	<1	F20.02
4	M	45	F20.0	25	27	a,b	9	F20.51
5	M	24	F20.1	15	20	b,c	18	F20.13
6	M	54	F20.2	27	45	a,b	6	F20.23
7	M	28	F20.1	18	21	a,b	6	F20.53
8	M	40	F20.0	17	18	a,b	6	F20.03
9	M	25	F20.1	15	17	a	12	F20.12
10	M	30	F20.0	25	25	a,b	12	F20.03
11	M	35	F20.2	27	28	b,c	18	F20.22
12	M	41	F20.1	23	32	a,c,d	36	F20.52
13	M	30	F20.2	16	19	a,c	9	F20.23
14	M	22	F20.1	17	17	a	6	F20.13
15	M	28	F20.0	24	25	a,b	18	F20.03
16	F	38	F20.0	18	26	a,b	24	F20.03
17	F	29	F20.1	20	21	a,c	9	F20.13
18	F	40	F20.1	24	30	b	6	F20.53
19	F	36	F20.0	23	27	a	18	F20.53
20	F	42	F20.2	27	30	a,b,c	12	F20.12
21	F	54	F20.1	28	40	a,b	6	F20.13
22	F	47	F20.0	25	26	a	3	F20.52
23	F	45	F20.1	18	19	a	9	F2-.13
24	F	22	F20.1	17	18	a,b	3	F20.13
25	F	45	F20.2	22	22	a,b	6	F20.52
26	F	47	F20.1	30	41	a,b	9	F20.13
27	F	22	F20.0	17	19	a	12	F20.03
28	F	36	F20.0	21	34	a	18	F20.02
29	F	34	F20.2	19	19	a,b,c	24	F20.13
30	F	28	F20.1	16	19	a,c	6	F20.13

The criteria of ICD-10 (1992) were used for diagnosis (initial diagnosis and current diagnosis). The modes of expression of “loneliness” described in DISCUSSION 1 of the present study (categories a through d) were used. All subjects invariably expressed “loneliness” in the early remission phase, as described in the present study.

Subject #26, a 47-year-old female

The third-born of three siblings, the patient converted to a certain new religion after graduation from high school. Her life at age twenty was very indefinite other than for her faith in this new religion. She returned to live at the family home at 30 years of age, and was variously employed at a number of jobs, but never long term. At around the age of 32, she began to shut herself up in her room, and stopped conversing with her family. Gradually she no longer changed clothes or bathed, and she began an utterly forlorn lifestyle with a dog given her by an old friend from middle school. Her father died when she was about 39 years old. When she was about 40, her worried elder brother visited a psychiatric hospital for consultation where one of the present authors was a staff member, and the patient was then admitted for treatment for the first time.

As her sleep stabilized, the woman began to draw flowers on paper about 3 months after admission, and later began steadily knitting things by herself. After about 5 months, she began making paper roses with a female occupational therapist of about the same age, and eventually made exquisite roses. Her therapist stayed by her side as she did so in order to provide support. After 10 months, she stopped making the paper roses; she had frequent "dreams of meeting the friend from middle school who had given her the puppy," and she gradually spoke less and less. At this point, the onset of a critical period of increasing nightmares and mild fever was observed. At 11 months she entered the early remission phase, stayed in bed all day and remained alone most of the time. After 12 months, she sent her family a postcard. After 16 months, her chief therapist asked if she was sad, and the patient replied affirmatively: "I grew up without a grandmother. My mother worked, and it was very hard for me. That's why I want someone like a grandmother to utter words of comfort to ease my loneliness." The chief therapist was duly sympathetic upon hearing these words. The patient's relationship with staff became more stable during this period than previously. She first complained of being easily fatigued soon after admission, saying, "I'm tired, so I think I'd better lie down," and she would have a peaceful nap under the covers. After 16 months, the nursing progress notes indicated the patient stayed more and more in bed all day.

This period corresponds to the "cocoon period" described by Nakai[6], which he considered to be a part of the early remission phase. "In the hebephrenic type," he writes, "deep internal readjustment and reorganization are probably necessary in the remission process which must be compared to the pupal state[6]."

In group art therapy, the patient drew hydrangeas, and added what she called "my own touch, a snail," at one side. In the "landscape montage technique" of this period, the patient said she would not draw people. Although for some time she could draw quite a few farmers tilling and weeding, she said "I can't draw people." After 18 months, she commented, "I've no idea what to talk about. For example, you all get along so well with one another, right? Well, I don't." Although this was said with a dejected expression, several days later the patient met her elder brother's wife for the first time during an overnight pass from the hospital. The patient happily told the chief therapist, "My sister-in-law gave me some boiled eggs. I could talk to her right off." The chief therapist conveyed his own happiness to her upon hearing this. Dreams in this period sometimes manifested as "being with my close girlfriend up to my third year of middle school." The patient said, "My sister-in-law really helps me because she's my only friend." The chief therapist continued leisurely conversations with the patient concerning anyone to whom she had confided her feelings. Twenty months later, the patient confided, "When I look at the sky I see stars; before I believed all the stars had gone." She was discharged 23 months later. At this writing, it is about 5 years since then. The patient leads a quiet life, taking over the housework from her aging mother.

Subject # 3, a 58-year-old male

The patient is the first-born of three siblings, and has been of taciturn and meek temperament since childhood. Although he assisted his father in business after graduating from middle school, he felt ashamed of himself as the business declined, thinking he should be doing something as the eldest son, but could not. At 27 years of age, without consulting anyone, he began looking for someone to take over the business. Gradually, thereafter, he began to say "The police are tailing me" when he saw a passerby, and believed "gangsters have gotten into my house," and was soon admitted to a nearby psychiatric hospital. He was readmitted about four times in the next four years. The period of each hospitalization was relatively short at one to six months duration, and the patient was in remission upon discharge. However, this remission state simply meant the withdrawal of positive symptoms, a quick return to society without even ensuring adequate sleep. The patient invariably went immediately back to work after discharge.

This type of remission is referred to as the "poor early remission phase[3]." Compared to the "rich early remission phase" which ensures sufficient mental and physical rest, and provides peace of mind in the "cocoon period" that is therapeutically the most important, the "poor early remission phase" is one in which the protection of the "cocoon" is eliminated even without ensuring "surplus sleep" in the "cocoon period" after termination of positive symptoms when patients are forced to return to society.

The patient's symptoms deteriorated when he had to meet people frequently to conduct business, and he repeatedly readmitted himself for self protection. At 32 years of age, the patient was first admitted to a psychiatric hospital at which one of the authors was a staff member. Since positive symptoms such as auditory hallucinations critical of himself disappeared relatively rapidly after admission, the patient was discharged after 3 months. He was not conspicuous in the hospital ward, and returned to work soon after discharge. At the age of 34, he jumped into a canal in a suicide attempt, but pulled himself together on his own and diligently applied himself to business from then on without further incident. At 36, he again went into a paranoid-hallucinatory state, and was readmitted to the hospital saying he "wanted some rest." One month after admission, positive symptoms disappeared or grew faint, and the patient entered the early remission phase. After four months the chief therapist was transferred. When told by the replacement therapist that he was ready for release, the patient said, "I can't handle this. Since I was small, whenever I've had no one to depend on I've felt that I just can't go on." The chief therapist was unable to devote sufficient time to ward off this loneliness. The patient told the nursing staff he was "lonely," and felt "abandoned by the doctor." A few days after this conversation with the new chief therapist, the patient again experienced insomnia, and although his antipsychotics were increased, he continually awoke late at night and talked loudly to himself. He started eating less, and became physically weak. The chief therapist endeavored to provide physical care for the patient. However, his moods also became unstable, and his personality rapidly disintegrated as he continued to alternate dizzily between childish merriment and sullenness. Thereafter, he manifested pica, frequently attempting to eat inedible objects such as chopsticks, and was then unavoidably confined to a seclusion room for about 20 years.

At age 52, the patient's pica stopped, and his condition partly stabilized. At about this time, the patient spontaneously drew a picture when alone by himself in the seclusion room, in which there was a "lone traveler descending Mount Fuji with a setting sun in the background" (Fig. 1). This drawing might be taken for an expression of the "conclusion process[24]." However, the patient depicted himself as descending the mountain alone with no one to accompany him.

Figure 1

DISCUSSION

1. Characteristic expressions of "loneliness" in the early remission phase

The subjects of this study are 30 schizophrenic patients (15 males and 15 females) whom we treated in our capacity as chief therapist (Table 1). Their expressions of "loneliness" in the early remission phase were divided into the four modes described below. Subject #26 exhibited attributes a and b, and subject #3 exhibited attribute **a**.

a. Complains of "loneliness" to the chief therapist. Occasionally also complains to the nursing staff. When asked if s/he is lonely during medical examination, replies affirmatively.

b. More indirect than type a, looks for a partner with expressions such as "I want a friend," and "I want someone to talk to." Asks to meet the therapist more for examinations, frequently wants to see family members, talks to nursing staff with increasing frequency.

c. Engages those nearby with expressions such as "I want someone near me."

d. More direct than type c, looks for direct physical contact. For example, seeks physical contact with the mother, and sometimes father, such as requesting a massage from the mother.

In Table 1 we consider the following factors in subjects who had an age gap between the age at onset and age at which "loneliness" was first expressed. 1) Some patients experienced a prolonged acute phase of schizophrenia, and it took much time to reach the early phase of remission throughout the critical period (subject #5). 2) The unstable therapeutic relationships from the acute phase to the critical period had an unfavorable impact upon the therapeutic relationships in the early remission phase (subject #6, 18). 3) The patient has continuous patient support from family (subject #12, 21, 28).

Most subjects (27 subjects) expressed "loneliness" according to type **a**, and these factors are discussed in DISCUSSION 2.

The following factors are considered in patients who experienced "loneliness" of long duration. 1) The patient experienced temporarily strained family relationships in the early remission phase during which the patient spent more time with the family through meetings and overnight furloughs (subject #16, 29). 2) The patient was young at onset, left high school against his own intentions, and continuous hospitalization and therapy were required over a long period. For these reasons, the patient felt continuous regret for the loss of irreplaceable youth all through the early remission phase, due to hospitalization, saying: "I want to go to high school again and make friends," or "I never had any teens" (subject #5). 3) Some hebephrenic type schizophrenic patients had scattered critical periods during the early remission phase due to the structural characteristics of this hebephrenic critical period. For this reason, it was extremely difficult for the psychotherapist to proceed with the psychotherapy while focusing on the "loneliness" of the early remission phase.

Two subjects (#2, 12) diagnosed as hebephrenic schizophrenic patients conformed to type **d**, seeking direct physical contact. The expression of type **d** "loneliness" is referred to as "regression" in the literature[25]. Some patients seek physical contact from the critical period through the early remission phase. This phenomenon is described in the literature as follows: "It is at the level of 'basic fault' (per Balint) because there is no third person. Everything is a relationship between two persons, and either has skinship as his/her object without using adult language." However, these authors consider this to be a "benign regression allowing patients to discover a more suitable way of living than previously." Although it is possible to consider the expression of type **d** "loneliness" as "regression," we prefer to consider it a primary expression of loneliness.

2. "Presence of a partner" and "loneliness" in early remission phase

Although the schizophrenic patient speaks of "loneliness" throughout the critical period and into the early remission phase, Nakai says "the isolation of this period is different from isolation in the acute stage; it is an isolation open to the other[6]." In this period, the patient urgently seeks the presence of a partner for even a little protection against loneliness. This "partner for even a little protection against loneliness" is the "significant other[26]," or "deeply significant other[27]." The "significant other" is a sociological concept advocated by Mead, according to which "essentially the other has an attached high significance in psychological meaning for an individual. The significant other provides an individual with a basis for self-esteem, having influence as a basis for evaluation, judgment, behavior and the like[26]."

Osodo proposed that the sociological concept of "significant other" can be applied to clinical psychiatry for schizophrenia as the "deeply significant other." She then noted that "the deeply significant other is a reliable friend and confidante of the patient as well as a protector even when this significant other is a person or provisional character in a fantasy or in make-believe[27]." The importance of the therapist and patient searching together for a "deeply significant other" is emphasized in the psychotherapy of schizophrenia. In our clinical experience also, schizophrenic patients find support in their "loneliness" first by the existence of a "deeply significant other" in the early remission phase. According to one patient (subject #8), the presence of a "deeply significant other" is a key factor for a "life worth living." Here it is extremely important for the therapist to always be at the patient's side, at least in spirit.

Here the "deeply significant other" most patients seek is very often their chief therapist. The patients spoke to their therapists of "loneliness," and mentioned urgently seeking the presence of a partner to protect them from "loneliness," and the expression of type **a** "loneliness" in Table 1 occurred in most subjects (27 subjects). For this reason we feel that sufficient time must be duly given to patients in psychotherapy, particularly in the early remission phase.

Among patients with a short course such as schizophrenic adolescents, in not a few cases they found it rather easy to find a "deeply significant other" in their own family (subject #14, 24). However, we believe that the presence of the chief therapist as a "deeply significant other" appears to have even greater importance the longer the case history of the patient, including long-term hospitalization and therapy. For this reason we believe it imperative to ask if the patient has a "deeply significant other" during psychotherapy for postpsychotic depression.

The patient (subject #26) we presented in section II entered the early remission phase 11 months after admission; and then, 16 months after admission entered the phase most important therapeutically in the early remission phase, the "cocoon period," in which one undergoes "profound internal readjustment and reorganization[6)]." During this period she spoke to the chief therapist about wanting someone like a grandmother to utter words of comfort to ease her loneliness, and of seeking a "deeply significant other" "for even a little protection against loneliness." The chief therapist spent much time in leisurely conversation with the patient discussing people who might alleviate her "loneliness." Gradually, the patient found words of comfort to ease her loneliness in the form of dreams about her close school friend and her sister-in-law, and she was discharged 23 months later. This is a process of beginning the two-person relationship characteristically observed in the critical period and then moving on to the three-person relationship of the early remission phase. After discharge from the hospital, the patient lived a quiet life and took over the housework from her aging mother.

In some cases the "deeply significant other" may be a loved one appearing in a fantasy or make-believe (subject #1, 27, 28). Even if the patient has a loved one in a fantasy or make-believe world, there is a great possibility of protection from direct confrontation with the reality of the "poor early remission phase[3)]" while adhering to social norms. In this sense, especially during this period, these patients look for the therapist to empathize with them in their need for such protective, wishful fantasizing.

3. "Loneliness" in early remission phase, "presence of a partner" and clinical course

The second clinical and psychotherapeutic significance proposed in section I is based on the assumption that the "loneliness" of the patients and the "presence of a partner for even a little protection against loneliness" are deeply related to the subsequent progress and stagnation of the remission process, as well as the further problem of ongoing deterioration. As Hoshino indicated[28)], the overwhelming number of schizophrenic patients follow the course of prolonged-type early remission phase with continuous unstable chronic clinical features, whether treated on an inpatient or outpatient basis.

We have addressed clinical issues such as the following elsewhere. Emotions such as feelings of isolation, emptiness, despair and desolation which close off the innermost mind of the schizophrenic patient have strong interactions in the lifestyle of the patient. Nakai says "patients who acknowledge loneliness when asked are far more apt to emerge from the chronic course than those who emphatically deny this feeling." Classical semeiology and knowledge of the course based on it have overlooked this viewpoint[1)].

After positive symptoms disappear, some patients (subject #4, 11, 22, 25) remain in a continuous, unstable and chronic pathological state, as well expressed in the drawing of the pitch black withered tree in the Baumtest. Repeated readings of the clinical records and progress notes of such patients, including a patient with ongoing deterioration (subject #3), made us feel that the therapists at the time might not have been aware of the "loneliness" which is characteristic of the early remission phase. This "loneliness" was either not reported, hardly any support was provided, or considered next to impossible to offer. Even in such cases there are many instances of conversations about "loneliness" between the patient and the nursing staff

recorded in the progress notes.

For example, one patient (subject #4) would sit alone in the community room during the early remission phase some 6 months after admission. Seeing the patient in this position, a nurse called to him and the patient replied, "I'm very 'lonely' with no one to talk to," and the nurse recorded the comment in the progress notes. The patient (subject #3) described in section II left the hospital and returned to work during the early remission phase 4 months after admission because the chief therapist was assigned elsewhere. At that time the patient himself said, "I can't handle this. Since I was small, whenever I've had no one to depend on I've felt that I just can't go on," and expressed great uneasiness in leaving the hospital along with his feelings of "loneliness." This was a cry from the heart that he was earnestly seeking a "deeply significant other" as a "partner for even a little protection against loneliness." However, it is quite possible that the patient's strong sense of abandonment by the transferred chief therapist, who was probably the only "partner for even a little protection against 'loneliness,' " produced an adverse effect on the course. He told the nurse, "The doctor has abandoned me." Mayer-Gross, who first described postpsychotic depression, mentions that a "patient reaches a state of despair after passing through a phase of psychotic symptoms[15]." This seems to fit the patient under study.

Tonomura reports[29] a "simple relapse" and "secondary outbreak" of schizophrenia in one period of the course of this patient (subject #3), and Utena proposed the term "deterioration in middle age[30]" compared to "remission in middle age." However, we speculate that among the schizophrenic patients thus characterized as "deterioration in middle age" there may well have been some who might have been predisposed to a poor course of deterioration and desolation but did not have such a course due to cautious psychotherapeutic intervention in the early remission phase. We conjecture that there were some such patients who, with more competent therapeutic assistance, were able to have a more favorable course.

CONCLUSION–FUTURE THERAPEUTIC ISSUES–

In this study we investigated the medical records and nursing progress notes of 30 schizophrenic patients for whom we acted as chief therapist in order to consider the clinical and therapeutic significance of emotions,especially "loneliness," in the early remission phase.

Loneliness in the early remission phase is not the "feeling of utter isolation" experienced at onset; it is characterized by a certain "awe for human beings," but contains a "yearning for human beings," a pervasive "longing for human beings" that is even stronger.

We do not assume that patients reach a stagnation point in the remission process or further deterioration simply because their "loneliness" in the early remission phase was not addressed and given insufficient therapeutic consideration. We believe many unknown factors remain, factors we never imagined possible. However, based on our experience, we consider the establishment of a hypothesis that "the course may change in no small measure as a function of loneliness and the presence of a partner for even a little protection against loneliness" is significant at least from the clinical and therapeutic perspectives.

Under closer scrutiny, we wonder whether the early remission phase, and especially the "cocoon period," may not be the warm place needed to nurture peace of mind. On the other hand, at times we hypothesize that the tearing away of the protective covering of the "cocoon" might be the first step toward the chronic state of schizophrenia. We are presently continuing this investigation at two hospitals to verify this hypothesis.

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