The author summarizes the literature on the subject thus: (1) Many people, after influenza, experience an emotional depression with more or less general psychic depression for a greater or shorter period of time, but which is usually not severe enough to be regarded as a psychosis or even as a neurosis. It was ascribed thirty years ago by Church to cardiac incompetency, and since then by divers writers to various physical inadequacies, the most recent of which has been hypo-adrenalism. It is generally agreed that it consists in feelings of lassitude, weakness, fatigability, incompetence, irritability, and melancholy. (2) After the influenza epidemic of 1890–2 there were many cases of psychoses in which depression was a pre-eminent symptom, and although it is scarcely likely that all of the cases which were given the name melancholia wholly deserved it, it is possible that there were relatively more cases of ‘manic-depressive psychosis’ than have been observed following the recent epidemic. (3) Depression has not been a frequent symptom in the psychoses subsequent to the recent influenza epidemic, nor has the manic-depressive psychosis been even a relatively frequent form of disease entity. The great mass of literature agrees on this point.

He points out that depression is either a phase of the manic-depressive or cyclothymic psychosis, or symptomatic in such conditions as paresis, cerebral tumour, etc. He quotes eighteen cases, and concludes that: (1) The question of emotional pathology as the product of influenza is a point of much practical and theoretical interest. (2) Depression has been regarded as an almost universal sequela of influenza, but upon analysis it appears that three distinct types of depression should be recognized. (3) First, there are the mild syndromes frequently seen by the general practitioner in normal individuals for some time after the attack of influenza, and variously ascribed in the literature to cerebral toxæmia, cardiac incompetency, and hypo-adrenalism. These never, or rarely, become severe enough to be regarded as psychoses. Aside from these, the number of cases of post-influenzal depressions is remarkably small. (4) Secondly, there are severe depressions even reaching the frankly psychotic degree, and frequently terminated by suicide, which, because of more or less obvious dependence upon some gross physical pathology such as cerebral haemorrhage, tabes dorsalis, exhaustion, etc., might be adequately called reactive or symptomatic depressions. The literature would indicate that these were far more frequent after the influenza epidemic of 1890–2 than they had been in the recent waves of influenza. (5) Thirdly, instances of manic-depressive psychosis of typical forms (manic, mixed, and depressed) may be precipitated by influenza either as the first attack or as recurrent attacks in individuals with a history of previous episodes. (6) Cyclothymic depressions are more frequently precipitated than manic attacks, and are far more apt to be precipitated as first attacks; the manic or mixed forms, on the other hand, occur in equal
numbers as first and later attacks. (7) The occurrence of manic-depressive psychosis is, on the whole, relatively infrequent. Of 175 cases in his series of psychoses associated with influenza, only 10 belong to this group. (8) Depression as a symptom in the other influenzal psychoses was relatively infrequent in the recent epidemics.

R. G. Gordon.


Few observers have investigated the important subject of the syphilitic factor in psychoses other than paresis. Alfred Gordon, of Philadelphia, has studied 23 cases for an extended period. One group consisted of 5 cases in which the psychoses developed in the secondary stage, and the other of 18 cases noted in the tertiary stage. In 3 of these trauma was recent, and the writer thinks this factor must not be disregarded. In the traumatic cases there were no hallucinations, but only a mild confusional state with some amnesia and slight delirium in the evening. In one case Korsakoff’s syndrome was seen without any polyneuritis. The remaining cases of tertiary syphilitic psychoses were recorded as: 6 manic-depressives; 3 had paranoia; 2 showed involutional melancholia; 3 displayed progressive dementia. Manic-depressive insanity when due to syphilis is difficult to diagnose from paresis; but if the four reactions, the immobility of the pupils, and the loss of the patellar reflex are in evidence, paresis is present. If they are only partially present, the possibility of a syphilitic psychosis other than paresis may be considered. Lewis M. Gaines states he has seen idiocy, imbecility, mania, melancholia, dementia praecox, and paranoia all caused by syphilis, and he suggests that a satisfactory classification can be made on the pathologic anatomy of the lesions. The psychic symptoms depend on the type of lesion and its anatomical site. When the base is attacked, stupor is apt to be prominent, though well-developed psychoses may dominate the picture. Syphilis of the convexity presents a different aspect. Some of the suggestive symptoms of cerebral syphilis in its various forms are given, and the differentiation from paresis is discussed. It is pointed out that infection may be a psychic trauma, and thus may hasten an incipient psychosis or cause the development of such in those predisposed. Although there is no psychosis pathognomonic of syphilis as far as the mental symptoms are concerned, there is no psychosis which cannot be caused by syphilis. Thom believes that a cure can be effected if early diagnosis is made and intensive treatment with salvarsan and mercury at once undertaken; but the mental scars remain, and the patient is never as well mentally as he was before.

C. Stanford Read.


This is a most interesting and instructive study of the hallucinatory phenomena in a remarkably communicative and intelligent subject of schizophrenia. The hallucinations are auditory in character, and are believed by the patient to emanate from a set of personal entities which
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he terms the 'Strengths' because of the controlling influence which they possess for him. The essential history of the case is to the effect that the patient fully realizes that he possessed certain tendencies of a cruelty or sadistic nature, against which, in the course of his life, he had had to exert a considerable degree of self-control; and, though he admits that on several occasions he had gone out of his way to give himself a partial gratification of these desires, he never gave way to conduct which was totally incompatible with the rest of his cultured ideals.

At the age of 35 he began to experience the hallucinations. According to him, the 'Strengths' are individuals of diabolical ingenuity and of great power and resource; they know all his past and throw it all up against him, particularly his thoughts, his suppressed but self-acknowledged unpleasant desires, and his little gratifications which he believed were known only to himself. They command him to perpetrate acts in accordance with his disorderly tendencies, they twit him with what he has done in the past, and they command him to do penance for his misdeeds or mis-thoughts by the performance of endless acts of expiation. They command practically his entire field of attention, and his will is powerless to withstand their influence.

Dr. Devine regards the case as being one of an isolated cruelty trend (or possibly one of an abnormal 'will-to-power' trend) in a personality built up upon a basis of highly-cultured ideals. The isolated trend had no outlet through the conscious personality, though it was, and still is, within the awareness of the personality. As Dr. Devine points out, there is the possible method of relieving the struggle by means of a phantasy development; but here the energy content of the trend was too intense to permit of peace with only a phantasy gratification, for the subject always realizes that the phantasy is unreal; consequently a true dissociation occurred, with the production of the authoritative auditory hallucinations. These, by reason of their complete objectivity, so far as the patient is concerned, came to dominate the personality entirely, and so achieved the complete gratification of the abhorrent desires.

THOMAS BEATON.


INVOLUTIONAL paranoia was described by Kleist in 1912 as characterized by a distrustful state of mind with manic-depressive fluctuations, and by misinterpretations and memory falsifications in accordance with this affect. In addition, there existed a peculiar intellectual disturbance, a combination of thought retardation and fixation with flight of ideas. Some of his patients suffered from hallucinations, preponderantly auditory in nature. The delusions that were present were the resultants of all these processes.

The disease developed insidiously or advanced with acute outbreaks, each of which left the patient worse. It began during the period of sexual involution, affected those with a "hypoparanoidal constitution" by exaggerating their morbid traits, and was much more frequent in women than in men.
He ascribed it to the metabolic displacement resulting from failure of the sexual internal secretions. It was not due to a destructive organic process, for he found defect phenomena (slight attention weakness) in only one-third of his cases, and in these the disease had already been present for periods varying from nine to twenty years. Two cases only had demonstrable arteriosclerosis producing symptoms. Kleist was inclined to consider the organic basis as one analogous to the physiological processes of growth and arrest of the brain which are constantly occurring throughout life. He emphasized the relationship of this involutional paranoia to the manic-depressive disease group, particularly to the depressed conditions of later life.

Dr. Bohnen describes here four cases which tallied exceedingly closely with the above definition; three were women, one a man. In all four of them delusions were present, linked to a conviction of injury and an exaggerated idea of their importance.

The last case developed rapidly, and his delusions were confined to the field of his personal rights, a querulant. Where erotic delusions were present, the loved one was also the persecutor. The delusions were in the main plausible, and related to persons in the patient's immediate environment. But stranger convictions could develop—as in one patient who felt herself in secret communication with her beloved, and interpreted every happening to her as a message from him. These patients showed no intellectual deficiency, and their personalities were fully developed, so that paranoid defect psychoses and schizophrenia were out of the question.

Isolated incidents were first misinterpreted, and then later these were brought together, although contradictions could co-exist in this fusion, which varied in degree. If the delusional formations were stripped of their externals of circumstance, the affect of mistrust was seen to be present in all, associated with irritability, sensitiveness, scorn, or sense of rights in the several cases. These delusions were accompanied by strong feeling; incidents were distorted and related to the patient's self. Physical disturbances due to illness or incidental to the period of life were sometimes starting-points of delusions, but played only a minor part. Memory disturbances occurred, but rarely free fabrication. Two of the cases had auditory hallucinations. Intellectually there was found excessive productivity in relation to the delusions; elsewhere retardation of ideas. Delusions tended to repeat themselves in stereotyped manner, and to break in upon associations to other topics.

Arteriosclerosis was hardly perceptible in three of the cases; but the last one had remains of a slight hemiplegia, which had come on seven years after the beginning of his mental trouble. Near relatives of two of the other three cases had died of apoplexy. The three women became ill at the climacterium, and the disease reached its height about ten years later. One of the women had been sexually prudish; the man was querulant before his breakdown; in both of them these traits were exaggerated by the disease. Some relatives of these patients showed evidence of manic-depressive disturbances, and involutional paranoia is probably related to this psychosis.

H. W. Hills.
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