patient in an attitude of relaxation combined with the assumption of a mental state involving the abeyance of the will in regard to the conscious determination of the thought processes, and this mental and physical attitude is that necessary to the course of the analysis. Secondly, suggestion may be applied informally by the establishment of a certain relationship between the physician and the patient, and the establishment of the so-called transference is again an integral part of the analysis. Bearing these considerations in mind, therefore, it is clear that the Freudian hypothesis which eliminates entirely the factor of suggestion in its explanations must be viewed with scepticism.

The author finishes with an appeal for the bringing to bear of a more general philosophic outlook in the treatment of cases, so that the patient may have a reliable and sound 'autognosis' upon which he may rebuild his personality.

**NEUROSES AND PSYCHONEUROSES.**


McDougall deplores the widespread and deeply-rooted prejudice existing against the more modern conception of functional disorder which has hindered the development of psychiatry, and especially so in England. He sees herein an aspect of the philosophical problem of structure versus function. The biological advances of the nineteenth century became dominant and popular, and seemed to settle the question in favour of structure. Other late discoveries seemed to confirm the point, so that research turned almost wholly to attempts to discover defects of brain structure in all mental disorder. Though some good results have accrued for psychiatry, it has been a period of stagnation. Thus organic neurologists and organic psychiatrists have existed, while the neuroses were neglected by all with a few distinguished exceptions. Through the influence of the war, which produced such an immense number of severe neuroses, and through the work of the psycho-analysts, such a state of affairs is being rapidly abolished. The claim of functional disorder to a place of equal importance with the organic disorders must be fully recognized. The human organism has to work under varying environmental conditions, and functional disorder arises when the environmental changes demand adjustments which exceed the organism's power of self-regulation. Purpose implies mind or mental activity, and such operations go on on very different planes of consciousness. Functional disorders are commonly the expression of subconscious purposes, or of the harmony of conflicting purposes which may be wholly or in part subconscious. It is therefore through mental influences that functional disorders are brought about; that is to say, they are psychogenie. In the emotional disturbances of the more chronic kind we tend to dwell on the bodily changes, losing sight of the essential fact that the mental change was the primary condition. It is in relation to the psychoses that psychogenesis is of greatest interest, and in dementia praecox the problem presents itself most definitely. Jung and
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David Forsyth are quoted as arguing forcibly in its favour, while Mott's deductions from his pathological work are severely criticized, McDougall giving evidence to show that Mott is blindly prejudiced to obvious facts. Exophthalmic goitre is taken as a good illustration of how emotional shock may bring about functional disturbance followed by organic changes. Cannon's work on the endocrines is quoted in confirmation. In such cases mental treatment may be the most essential and effective means towards cutting short the organic disorder. McDougall thinks we are justified in looking for functional origins in manic-depressive and epileptic insanities, and thinks that the most fundamental working conception for psychology must be purposive activity.

An excellent paper is concluded with the statement that "mind has a nature and a structure and functions of its own which cannot be fully and adequately described in terms of structure of the brain and its physical processes".

C. S. R.


FITZGERALD reviews his experience with the 'war neurosis' in the light of Freud's recent contributions to psycho-analysis, viz., narcissism, and Jenseits des Lustprinzips. Those cases where the constitutional factor is negligible and the breakdown is manifestly caused by the unparalleled ordeal of modern warfare are explained as due to the threat to the ego being so great as to throw the patient back to the position of an infant. This accounts for his deep-rooted sense of injury and injustice, and his desire that others should occupy themselves exclusively with his well-being. The regression motive is frequently seen in the dream, particularly in the recurring dream. Such dreams, which are often exact reproductions of the traumatic moment, are repeated even after the affect of the original event has been abreacted. It would thus seem as if the unconscious were powerless to deal with them, and as if the dominance of the pleasure principle was here mastered by the compulsion to repeat. Fitzgerald asks whether in the light of Freud's recent work the underlying motive in this 'widerholungszwang' may not be regarded as an attempt to gain mastery of the incident by repeated abreaction. In an overwhelming trauma all the defence mechanisms are gathered at the point to form a counter-charge of energy, which serves to bind the incoming stimulus. The dreams following an overwhelming shock seek to achieve mastery of the excitation by the development of anxiety, and may be regarded as attempts at cure. Abreaction therefore seems to be effective in so far as it aids the fixation process by the deliberate production of 'Angst' against which the patient has opposed the resistances of the (conscioius) ego. A physical injury received at the same time as the shock prevents the development of a traumatic neurosis by means of a narcissistic conversion, but as this transference weakens with the healing of the wound, a neurosis may develop. The resistance against cure must be regarded as an effort to protect against the results of the release of energy from its satisfactory fixation.

ALFRED CARVER.

In his well-known graphic way, Janet gives a clinical description of a case he had followed without interruption for over sixteen years, to demonstrate the transition from an obsessional state to a deliriant condition. He endeavors in conclusion to throw some light on the solution of the problem.

The patient, now a woman of 36, had a very psychopathic family history, but apart from chronic stomach trouble seemed fairly normal until the age of 20, when, after the death of a sister, she showed symptoms of psychasthenia. She became constantly sad and worried, readily cried, and was dreamy and idle, but at other times would be restless, talked loudly of her tormenting remorse, but did nothing useful. Full of scruples and self-accusations of all sorts, she expressed the feeling that she knew what was right but had not the will-power to do it. Though wishing for advice and help, she felt she must struggle against others as well as herself, and though lacking initiative must do something wonderful to rid herself of her condition. She thought she was never clean, that she was constantly soiling herself, while her gravest fears centred round her modesty, and she felt her brain crowded with obscene and tempting sexual thoughts. These were, however, only obsessional thoughts, and no appropriate acts followed. She was for ever vacillating between statements of guilt and having done her best. From the age of 20 this state has constituted her normal life, but at three different periods of time, for five months, eighteen months, and two years respectively, she passed into a condition of delirium. She then puts into violent execution, and affirms, with the most positive conviction, all the ideas which previously she presented in the form of obsessions accompanied with hesitation and doubt. She starts actions of devotion which become absurd, cries out that she must impose her will over others, and fights for days and nights. She imposes privations upon herself, and gives herself the most filthy tasks to perform. The very ideas which were formerly repugnant to her, and of which she spoke with fear, are now those which she furiously puts into execution. She is now surprisingly vulgar and incredibly obscene. Revolting scenes are enacted night and day for as long as two years.

How can such a delirium be classified? There is no question of dementia or mental confusion. Her elementary intelligence is retained, and her acts are accompanied by at least apparent reasoning. In her lucid intervals all her past memories are fresh in her mind. The psychological characteristics of periodical manic states are not discovered here, even though this patient for weeks would be sad and depressed. There is none of the joy of the manie, but rather is she sad in thinking over all she believes she must do. She has not lost the faculty of desiring, believing, and willing, as found in melancholiacs. Both her forms of behaviour in her two phases are marked by voluntary action and belief, but at a different psychological level. Janet then states that will and belief consist essentially in a binding together of the spoken word and movement. There may be immediate assent as in suggestion; but at a higher level there is reflective assent, which expresses the average force of all the tendencies of
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the whole mind which is the starting-point of reality. It is the operation of reflection upon which all the disease of the psychasthenic rests. They seem to reason passionately, but cannot reach conclusions. It is this disease of reflection, this difficulty to apply a reflective decision, which characterizes the first phase of this patient. The delirant stage demonstrates the falling to a lower, more primitive level of psychological tension, in which reflection is completely suppressed and the patient gives immediate assent without hesitation, regret, or control. A delirium of this kind may play a considerable role in the delirium of persecution, and, where the depression sinks still deeper, we become involved in the problem of dementia praecox.

C. Stanford Read.

PSYCHOSES.


The author commences by investigating the behaviour of a four-year-old microcephalic idiot, and found that this corresponded to what is known in animal psychology as non-ideational behaviour. He describes his experiments on this and other patients at some length, and obtains the following results:

As in neurology comparative anatomy is applied, in the same way the application of comparative psychology in psychiatry gives good results. This comparative psychological method gives a means of investigation without language. In this way I discovered the lowest form of oligophrenia which is characterized by its lack of power of understanding. The representatives of this group are, as far as their behaviour toward their environment is concerned, comparable to sub-anthropoid animals. When we call this group idiocy, we make a distinction between idiocy and imbecility which is based on essential and qualitative features, and not on gradual and quantitative differences, as was the case till now.

In the experiments the possibility of imitation without understanding which had already been observed in animal psychology was again stated. The attention could be divided into essential and primitive attention—the former for new, the latter for stamped-in mechanisms.

The group which has been called idiocy can be divided into three degrees, with the following features:

Idiocy of the first degree: attention positive, power of imitation positive, power of understanding negative.

Idiocy of the second degree: attention positive, power of imitation negative, power of understanding negative.

Idiocy of the third degree: essential attention negative, power of imitation negative, power of understanding negative.

The features of imbecility are: attention positive, power of imitation positive, power of understanding positive. The different degrees of imbecility (and of debility) are characterized by gradual differences in the
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J Neurol Psychopathol 1922 s1-3: 188-191
doi: 10.1136/jnnp.s1-3.10.188

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