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 deliriant 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 rôle 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 oligophreny 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
ABSTRACTS

power of understanding, and form quantitatively different modifications of a qualitative complex which is identical with the normal human intelligence. The work of Stern moves in this domain.

Part of the mutes and deaf-mutes appear to be of the group of the imbeciles.

In this way therapeutic possibilities are given for this group. They appear to respond to normal human learning methods. The way of learning of the idiots is that of trial and error. In some of them this can be combined with power of imitation without understanding. In this way of learning, certain objects or sounds get a certain "meaning" which gives rise to a selective reaction. This can perhaps be adapted in teaching them simple work which can be carried out without intelligence, and to react in some way—without understanding naturally—to the spoken word.

R. G. GORDON.


The psychotic picture is subject to considerable variation in its evolution which is dependent partly on the causative agent, partly on environmental factors, and is occasionally altered by emotional happenings. Under the stress and strain of war-time conditions, men developed psychoses with the symptom-complex of dementia prevæcox; yet they made unexpected recoveries on their returning to their normal environment. Dementia-præcox-like reactions frequently confuse the picture in an acute psychosis. The difficulty in making a diagnosis is especially great in early and atypical cases of dementia præcox and manic-depressive insanity. The mere presence or absence of hallucinations or delusions does not speak for or against dementia præcox. The actual content of the delusional idea may be of less significance than the mechanism back of it. Even the personal history may carry us astray. Where dementia-præcox traits are of sufficient prominence to suggest themselves in an early diagnosis, a guarded prognosis is indicated. In passing judgments on types of conduct and reactions which suggest dementia præcox, it is necessary for us to inquire into types of reactions and adjustments which the individual made in his normal prepsychotic period. So often our impressions that a certain case will not do well are founded upon traits which superficially appear to belong to the præcox group, but searching analysis later reveals them to be but atypical reactions depending on factors in the upbringing, environment, the inherited make-up, and beliefs and superstitions. A few brief case histories are given, illustrating the difficulties in diagnosis and prognosis the writer speaks of.

C. S. R.


Syphilis as a causative factor in relation to insanity is not believed to have any relation in this respect to dementia præcox, though Kraepelin states that it is common in this disease. Out of 495 cases of dementia præcox investigated by the author, only 12 were found to have positive
Wassermann and negative spinal fluid. Some of these might come within the group described by White and Jelliffe as syphilitic psychoses simulating paranoid types of dementia praecox. In none of the cases did there appear, at any time, any suggestion of mental aberration characteristic of the neurosyphilis. The evidence is definite that we must not rule out possibility of neurosyphilis because our patients are apparently dementia praecox. On the other hand, we may not always find that clinical and neurological evidence of tertiary nerve syphilis is to be relied upon if we are to use the spinal-fluid findings for a criterion.

C. S. R.


The author here presents the results of an inquiry into the possible importance of chronic bacterial infections as a factor in the causation of dementia praecox. For the purpose of the inquiry he studied, by appropriate bacteriological methods, the intestinal flora in thirty-two early cases of dementia praecox, in as many cases of other forms of acquired insanity, and in some three hundred cases of nervous and other disorders of the general population.

Every case of dementia praecox investigated was found to be suffering from serious bacterial infection particularly involving the intestinal tract, and though the infections were not special to this disorder, each having been found in many other mental and nervous conditions, yet they were all associated with neurotoxic manifestations, and were all such that their presence was incompatible with health.

While the infections in all cases of dementia praecox were mixed, three main types were distinguished in which the dominating organisms were, respectively, the pneumococcus, the neurotoxic diphtheroid bacillus, and the anaerobic streptothrix types. The most important associated infections were by the *Streptococci pyogenes* and *anginosus*, the Friedländer bacillus, staphylococci, influenza bacilli, and anaerobic strains of the *Micrococcus catarrhalis*.

Illustrative cases are quoted, and the author gives as his conclusion that these chronic bacterial infections are the most important of several factors that determine the mental disorder. Every form of bacterial infection shows a wide range of effect in any group of individuals; differences in the inherent resistance of the patient colour the clinical picture produced by the bacterial attack. In dementia praecox this defective resistance would appear to be especially on the part of the nerve-cells of the most highly developed areas of the brain, namely, the association centres.

Basing his remarks on the results he obtained by employing methods of therapeutic immunization against the particular organisms he has isolated in each particular case, the author concludes by stating his conviction that “it is along such lines that a great measure of control will be established over the large group of the acquired forms of mental disease, which includes dementia praecox, acute insanity, and the affective psychoses.”

T. B.
[64] The prognosis of involution melancholia.—August Hoch and John T. MacCurdy. Arch. of Neurol. and Psychiat., vii, 1.

This article is based on observations made by the late Dr. Hoch on 108 cases of involution melancholia between 1895 and 1905. They are now summarized by Dr. MacCurdy in the light of a work by Dreyfus which appeared in 1907. Dreyfus contended that a great many cases of involution melancholia, whose condition had been considered irrecoverable, finally recovered, although the favourable outcome might not appear for almost ten years. Moreover, he found that many gave a history of former attacks, and some passed from melancholia into a manic phase. The behaviour of the psychosis was therefore the same as that of the recognized forms of manic-depressive insanity. Dr. MacCurdy attempts to substantiate this with the material of Dr. Hoch’s observations. Of the 67 cases tabulated, 43 are classified as recovered, 20 as chronic, and 4 as doubtful cases. In general he regards the features common to the recovered cases as benign. They are: (1) Marked emotional reaction; (2) Anxiety with restlessness; (3) Delusions of death and poverty (most common). Peevishness and hypochondriasis are never outstanding features of this type. The average duration before commencement of recovery was nine and a half months. The average total duration was twenty and a half months.

He applies the term malignant to the features common to the 20 chronic cases. In them the frank fear reactions of the recovered cases are replaced by whining, moaning, and exclusiveness. The three malignant features are: (1) Peevishness; (2) Hypochondriacal ideas; (3) Restriction of interest or affect. One or all three of these features is found in all the chronic cases.

It will thus be seen that the features common to the recovered cases approximate to those which we associate with manic-depressive insanity, while the salient features of the chronic cases are distinctively of the type we associate with dementia praecox, viz., auto-eroticism, negativism, ridiculous hypochondriacal delusions, and perverse sexuality. The term involution melancholia would therefore appear to be applied to two markedly opposed psychiatric divisions. MacCurdy considers it probable that individual taste is likely to determine the classification adopted by psychiatrists; but in any case the recognition of the facts is very important from the point of view of prognosis.

To summarize: (1) Patients with involution melancholia recover unless they show as dominants: (a) Marked insufficiency of affect; (b) Peevishness (auto-erotic behaviour); (c) Ridiculous hypochondriacal delusions, usually concerning the alimentary tract; these latter, however, may be present in women at the menopause without prejudicing the outlook for recovery. (2) All who eventually recover show improvement within four years of onset. The others run a chronic course or die unimproved.

James Young.


This is a somewhat brief article concerning the administrative measures
taken to deal with the question of mental deficiency in the South African Union, the necessity for such action having arisen out of the fact that the work of the institutions under the departments of Education, Prisons, etc., was found to be much hampered by the numbers of the mental defectives who were accumulating in them. Thus in one industrial school 12 per cent of the girls were feebleminded and 17 per cent were on the border line, in one reformatory 25 per cent of the boys were defective, while in a prison for older habitual offenders more than 10 per cent of the inmates were found to be seriously defective.

The author emphasizes the importance of recognizing the fact that the problem could only be solved by identifying the defective at the earliest possible school age, and indicates how the difficulty is being surmounted, the onus being thrown upon the principal of the school for calling the attention of the school medical officer to the child who is backward for longer than a certain period without a reasonable cause, while the Director of Education is made responsible for notifying the Commissioner in Mental Disorder of all defective children whether attending school or not.

The Commissioner is then required to keep a register of all mentally disordered and defective individuals, and to see that they are under proper guardianship and care, this latter duty being carried out by the medical superintendents and officers of the various mental hospitals, whose sphere of activity is not confined to the attending on the inmates of the hospitals to which they are attached, but is extended to include the area in which the hospital is situated.

These measures, apparently, do not affect the native population. The author mentions the difficulty of applying any definite standard to the intelligence of the native. He points out that, though the native has been living in close association with the European for some years, he has made little or no change in the extreme simplicity of his life. Such a persistence of custom would indicate a lack of intelligence, and the author adduces various arguments to support his view that the native is of a markedly low grade of intelligence, and that no amount of education would effect any improvement in his mental state.

Apart from the deficiency problem, reference is made to the very broad-minded and modern legislation in the matter of mental disorder. Any term, such as the word 'lunacy' or 'lunatic', which might offend susceptibilities, has been omitted, central reception houses have been established, while one section of the special Act provides for the treatment of suitable cases in the wards of the general hospitals.

PSYCHOPATHOLOGY.


The author points out that a drunkard is not the same as an alcoholic. When he is not drunk a drunkard is normal; an alcoholic is never normal and seldom if ever is drunk. Indeed, under the influence of alcohol his