believe a thing of little worth we soon curb our desire for it. Another way, however, in which we can get rid of unmanageable desires is by establishing a belief that we have attained what we desired, or that we shall attain it in the future. Normally we are prevented from being led too far from the truth by any belief, by the conflicting desires and beliefs which draw us in the other direction; also by the habitual love of truth founded on the instinct of curiosity; and lastly, the gregarious instinct prevents us from easily setting up our beliefs against those of the herd. Sometimes, however, these checks on the growth of any one belief do not predominate. This is seen temporarily under the influence of a burst of anger, which soon passes; but sometimes it is found that a passion will last for years, and dominate the mind so as to give rise to all sorts of false beliefs. If a man is poor in his habitual love of truth, or if his gregarious instinct is weak, he will more readily establish false beliefs; and it may happen that, as time goes on, the forces which tend to lead him astray gain in strength by making him withdraw from society, and so lose the steadying influence of the herd.

It has been seen, then, that beliefs are established according to their utility, and for this reason it may well be that 'intuitive' beliefs are more serviceable than logical belief. Inasmuch as a false belief is never ultimately a useful belief, we may claim that we are establishing a system of beliefs more and more closely approximating to the truth.

R. G. Gordon.

PSYCHOSES.


The writer tilts against the use of the term 'confusional insanity' as only being descriptive of a symptom which may temporarily occur in almost any form of mental disturbance, and deplores that in the official nomenclature no place for the infective-exhaustive group was found. In the etiology malaria took a prominent part, and other factors of considerable importance were 'heat stroke' and 'heat exhaustion'. Whether pure physical exhaustion can be regarded as of any importance in causation has been much debated. Farrar, Aschaffenbourg, and Bonhoeffer denied that there was any such evidence; but Henderson thinks that as a secondary etiological agent, following fever, the factor of exhaustion must still be seriously reckoned with.

Analysis of the author's group of cases confirms the view that the different toxic factors which played a part in their production have given rise to similar symptom-pictures. Delirium was the most frequent and most characteristic of all the symptom-pictures in this group of 115 cases, and comprised 36 per cent. The usual history was one of gradual physical exhaustion, with restlessness, sleeplessness, irritability, headache and giddiness, terrifying dreams, and a feeling of being mixed up in the head. Later, disorientation, illusions, and hallucinations appeared, fear was shown, and suicidal attempts were not uncommon. As fever subsided, convalescence quickly set in. Of the cases, 26 belonged to the irritable,
suspicious, deluded group; 19 to the group with depressive hallucinosis; 13 to the dull, apathetic, depressed group; 3 showed stupor; and 4, though placed under the heading of Korsakow's syndrome, are frankly stated to be really 'forgetful, wandering, amnesic states'.

Each patient reacted towards the situation by showing the type of symptoms which a study of his personality would, no doubt, have led one to expect, so that the malaria, dysentery, etc., were only exciting factors and had otherwise no etiological significance. No special predilection to attack the nervous system was noted; but it may be presumed that the affected individuals had inferior nervous systems which were liable to attack from any agent. The prognosis is excellent; in Henderson's cases the recovery-rate was 70 per cent.

C. STANFORD READ.


The author details the present circumstances surrounding the treatment of mental disorders in France, the law providing only for institutional treatment of certified cases. He states that the inadequacy of the Lunacy Law, which dates from 1838, has been strongly emphasized by the numbers of men suffering from the sequelae of nervous troubles contracted during the war, as, apparently, in France there is no provision such as the neurological clinics of the Ministry of Pensions in this country, and consequently these cases, not sufficiently serious to be certified—'les petits menteaux'—can find treatment neither at the general hospitals nor in the mental institutions.

Dr. Colin describes the formation of a Committee of Mental Hygiene of the Ministry of Health, and that of a more general body—'La Ligue d'Hypogène Mentale', which will include lay social workers, and will aim at the prevention of mental disorder on the lines of similar bodies in the United States of America. In addition, he warmly advocates the opening of the general mental institutions to the voluntary patient, and the commencement of out-patient clinics for mental patients. He holds strongly that the neurologist is out of place in handling the case of mental disorder, and maintains that such work should be done by the trained and experienced psychiatrist.

T. B.

[22] Legislative restrictions in connection with the treatment of incipient insanity.—W. COROLEU. Jour. of Ment. Sci., 1921, lxvii, 470.

In a short article dealing with the treatment of cases of mental disorder in Spain, the author pictures a very deplorable state of affairs, ranging from inadequate asylum accommodation on the one hand, to extraordinarily hampering legislation on the other.

The ordinary process of certification of an insane patient in Spain is, apparently, a most complicated matter, and involves and requires the co-operation and payment of at least six medical and legal officials, none of whom need be specially qualified in the subject; whilst the retention
of a patient in an institution after a period of three months is practically impossible unless the patient is most refractory or dangerous, and unless the relatives are prepared to spend a great deal of money in further fees to officials. The author has seen cases of acute insanity die before the formalities of admission to a mental hospital could be completed, and, not uncommonly, such cases have to be admitted in the first place to the local gaol, or to a municipal dispensary.

Dr. Coroleu observes that, as a result of this legislation, "which embodies all the popular prejudices against lunatic asylums and mental institutions", the early case of mental disorder is never treated in the proper manner, and it is his experience that most cases are kept at home, shut up in one room, and are practically unattended.

T. B.


The users of moonshine whisky do not develop the type of psychoses ordinarily associated with alcohol, such as delirium tremens, alcoholic hallucinosis, or paranoid syndromes. Most commonly they develop a stuporous state in which the patient becomes more or less unconscious, and from which he either dies or recovers, and when he does recover he has an amnesia for that period. He may perform almost any act while under the influence of moonshine, but subsequently recollects nothing he has done. This condition is akin to pathological intoxication, or epilepsy, or its equivalent. If any hallucinosis does come about, it is mostly of the visual type, instead of the auditory in chronic alcoholics. Usually strange people are seen, with weapons, who are trying to harm them, and as a rule they have no amnesia differing from that of delirium tremens, where they see mostly animals and have amnesia. Lemchen thinks that this partly goes to prove that the form of psychosis a person develops depends more on the toxins circulating in his body than on inherited tendencies. Apparently different toxins attack different nerve-cells. While the non-volatile alcohol in bonded whisky seems to intoxicate the nerve-cell in the special centres, and we have in the majority of cases different forms of hallucinosis, the volatile alcohols in moonshine seem to attack the nerve-cells in the associated centres, and in the majority of the moonshine cases we have all degrees of unconsciousness, with impairment of judgement. Some cases are given in illustration.

C. STANFORD READ.


If we bear in mind (1) that for the production of delirium tremens there is required, besides chronic alcoholism, some other factor—probably a toxin whose presence is due to morbid alteration of function of the intestine; (2) that the liver of the drunkard, as the frequency of cirrhotic and fatty changes shows, is much exposed to damage; and (3) that one of the
liver's functions is an antitoxic function whose failure allows a flooding of the whole body with toxic substances, we can see how important it is, for an understanding of the pathogenesis of delirium tremens, to investigate the functioning of the liver. To do so by measuring the patient's tolerance of lactulose is, in his delirious state, hardly practicable. Hepatic insufficiency can, however, be shown also by the presence of urobilin and, above all, of urobilinogen, in the urine.

The presence of urobilinogen can be detected by addition of a few drops of Ehrlich's aldehyde reagent—a 2 per cent solution of dimethylpara-amido-benzaldehyde in 5 per cent hydrochloric acid. If urobilinogen is present in pathologically large amount, the addition of this reagent produces, even in the cold, a pronounced red colour. Traces of urobilinogen may occur in normal urines; the reagent having been added, a pinkish tinge appears on warming.

Pathological urobilinogenuria occurs in hepatic cirrhosis, in hepatic congestion, and sometimes in cholelithiasis—not, however, if the bile-duct is completely blocked. In cirrhosis, urobilinogenuria may be permanent; and to investigate by this means the functioning of the liver in delirium tremens we must choose cases in which it is not permanent. Urobilinogenuria is observed also in various infective diseases, especially typhoid fever, pneumonia, and erysipelas. It is noteworthy that these are illnesses which, even apart from alcoholism, often produce delirium, and which, in drunkards, are specially prone to set up delirium tremens. Urobilinogenuria occurs, moreover, after severe haemorrhages of every kind, in apoplexy, in the haemorrhagic diathesis, and after fractures of bones; and we know that, in drunkards, fractures of bones are specially apt to set up delirium tremens. In urobilinogenuria following haemorrhage there is probably no toxic damage of the liver; the hepatic function then fails merely because the elaboration of the resorbed blood-corpuscles makes too big a demand on it. Opinions differ as to whether fever alone can produce urobilinogenuria, but artificial raising of the body temperature in animals does not produce it.

The author has tested the urine for urobilinogen in twenty-six chronic alcoholics. Two of these were patients who, on account of pronounced tremors and restlessness, were sent into hospital as being threatened with delirium tremens; the urine in each case contained some albumin, but no urobilinogen; in neither case did delirium tremens supervene. Twenty-two cases of delirium tremens were examined, and in every one of them urobilinogenuria was observed. Fifteen of them were 'pure' cases, of which three were fatal. Two were accompanied by epileptiform fits. In one case there was erysipelas, in two a slight haemorrhagic diathesis, in one a fracture of the scapula, and in two cirrhosis of the liver. All the cases had more or less albuminuria. In thirteen of the cases the urobilinogenuria did not begin until after admission to hospital. In five of these it first appeared on the morning of the day in the evening of which the delirium began. In four cases it first appeared a day to a day and a half before the delirium, and in three cases two days before. Only in one case was its appearance delayed until after the onset of the delirium (two days
after onset). The urobilinogenuria was always of brief duration, varying from one to four days.

The author concludes that damage of the liver has probably a causal relation to delirium tremens. A temporary failure of the antitoxic function of the liver can lead to a flooding of the body with abnormal metabolic products, to which the brain, already damaged by alcoholism, responds with a delirium tremens. The failure of liver function is due to an acute exhaustion of the liver-cells, which have been overworked in consequence of the alcoholism.

SYDNEY J. COLE.


Though Bleuler has endeavoured to group the symptoms of dementia praecox and show their relationship, the underlying factors which bind them together into a diagnostic unit have not as yet been sufficiently defined. The several levels—vegetative, neurological, psychic, and social—should be synthesized. At present a formulation at the psycho-social levels meets the case best. Regression is the fundamental mechanism, and the symptoms are either regressive or efforts to escape from this tendency. Dementia praecox is a regression psychosis with a malignant trend, this latter depending upon the depth of the regression ontogenetically and the inclusion in the process of archaic phylogenetic material. It is because of this that the productions of the praecox seem so alien to us compared with other psychoses, and that the patient so lacks insight and fails to appreciate the personal source of his symptoms which tap the ultimate sources of psychic integration.

All through the symptomatology we see evidences of segmental over-domination, which are especially marked in the oral and anal zones, the skin areas, muscle segments, and respiratory zones, thus implicating organs and functions which are expressed at all the levels, and showing that the regression has gone deep enough to unloose bits of psychological mechanism. Though the archaic cannot be identified at the symbolic level, it must be there, and it is suggested that the unanalyzable residue of unconscious material represents what is phylogenetic. Herein, White would include delusions identifying certain excretions with the personality—delusions of food and air as impregnating material, cannibalistic symbols, water as a birth symbol, mythological animals, and certain delusions concerning the heavenly bodies. Dementia praecox is therefore looked upon as a profound defect of biological adjustment. There are other regressive states indistinguishable from early stages of praecox, so that diagnosis by outcome must often be resorted to.

The claims to cure praecox are not regarded as well founded. Treatment must lie in presenting to the patient a possibility for the utilization of whatever creative tendencies he may have, which will at any rate tend to obviate further regression.

C. STANFORD READ.