PSYCHOPATHOLOGY

PSYCHOSES.


Heuyer and Borel have described a 'reverie psychosis,' largely following the ideas of Freud and Bleuler. Others since have dealt with analogous cases where morbid reverie and loss of contact with reality were paramount. Morbid reverie can be placed on the same plane as the dissociation of ideas or the ambivalency of Bleuler and can be included among schizophrenic symptoms. Its content, however, is quite another thing from reverie contributed by complexes. It is a question of a peculiar attitude. The writers conclude that schizophrenic attitudes should be studied apart from the essential symptoms and complexes. These attitudes are not found in every schizophrenic case and they serve to distinguish plastic forms from others. The attitudes can be provisionally divided into two groups: ideo-affective, and purely intellectual. A knowledge of them allows us to understand certain schizophrenies better and has therapeutic possibilities by more easily establishing an affective contact with these patients. A case is quoted at some length and it is pointed out that the same symptoms and complexes could have been presented in quite another way. This patient adopted a particular attitude and lived only in the past. This past appeared in his psychosis in the form of regrets, self-reproaches, and painful memories. The regrets seem the only way in which the patient can put himself in touch with the happenings of his inner life and reality in general. The regrets are fixed on certain points of his life and always return afresh in a monotonous and stereotyped manner. They do not tend to any real end, but become an end in themselves and seem to dominate the whole psychic life. They are fixed and sterile, and in them we note a special schizophrenic attitude. However through them and their investigation we can get into better contact with the patient and discover a common bond between his psyche and ours. We find a disaggregation of the idea of time-duration with a 'hypoplasia' of the past, so that the past entirely colours the present. The present does not exist for this type of patient, and future hopes and desires have no place in the mind. The difference between what is dead and living disappears in these states. The profound disaggregation of time-duration insensibly makes such a patient slip into delusional conceptions, which would be only a rational expression of it.

C. S. R.

[255] Late schizophrenia (La schizophrénie tardive).—G. Halberstadt. L'Encéphale, 1925, xx, 655.

It has been thought that dementia praecox is exclusively an affection of adolescence, but there are more numerous cases than are generally believed beginning in infancy and also in later adult life. Régis mentions the possibility of its onset at the menopause, while Rogues de Fursac, considering hebe-
phrenia exceptional above thirty years of age, states that catatonia is not uncommon at a later period and sometimes appears at the threshold of old age, especially in women. Clinically, however, the diagnosis is rarely made, and we are too liable to connect certain psychoses with certain times of life. We must bear in mind that late schizophrenia may appear under a melancholic mask, while there is still much to study in the presenile psychoses. One may often find earlier indications of such a mental reaction which only becomes patently manifest at the involutionary age. Involutional melancholia and certain acute anxiety psychoses may terminate in a state of intellectual enfeeblement, though Stransky speaks of a "late dementia" apart from schizophrenia. Zweig concludes that dementia praecox can appear at any age; that there is no essential difference between the truly precocious cases and the late ones; that the prognosis of cases occurring after thirty is generally better than of those starting earlier; and that there is no reason to differentiate a special late type. Sommer enlarges the domain of the late cases by including presenile cases which deteriorate, and believes that they may sometimes give a clinical picture like manic-depressive insanity. Bleuler recognizes late schizophrenia, but does not exclude the possibility of an earlier onset with an intermediate period of latency. Urstein has no doubt of the late form, but his conception of dementia praecox is very wide. Vermeylen, Nyssen, and Lamoens record four cases of catatonia at the menopause, and Medow describes a presenile type commencing with depressive phenomena, slowly progressing with the appearance of stupor and stereotypies, and passing into final enfeeblement without marked troubles of the personality. Kraepelin speaks of a schizoid patient who developed excited catatonic phases between the years of sixty-six and seventy, with imperfect lucid intervals, and he also has described an intermittent group of dementia praecox which has to be carefully distinguished from manic-depressive insanity. Lhermitte and Nicolas also recognize late catatonia. Kryspin-Exner regards the diagnosis of an involutorial psychosis as either manic-depressive, late dementia praecox, or belonging to inversion proper. He, nevertheless, with all his experience, states that many such cases are obscure and unclassifiable. The writer concludes that though late schizophrenia must be admitted, it is exceptional and must be differentiated from merely retarded forms. In the second place one must not include in this category cases where the outcome is intellectual enfeeblement without characteristic dissociation of the personality.

C. S. R.


The fact that there is a possibility of recurrence in true melancholia contributes to explain the view of Kraepelin, who regards all attacks of melancholia, nosologically, as forms of manic-depressive psychosis. The words 'melancholia' and 'depression' are synonymous to him: he does not recognize that the depression of true melancholia is a phenomenon secondary to the affective state of sadness, or that the symptoms of depression are
primary and essential in periodic melancholia. J. P. Falret in 1851 was the first to note the difference between melancholia 'ordinaire,' as he called it, and melancholia 'circulaire.'

By true melancholia the author means that form of melancholia which is motivated by a sorrow; for example, the loss of a love-object, or the reverses of fortune. On the other hand periodic asthenia or periodic depression is never determined by an external cause.

After a clinical description of four cases, the following conclusions are drawn:

(1) True or motivated melancholia, after recovery and freedom from an attack for a more or less long interval, is susceptible of return of symptoms under the influence of causes analogous to those which determined the first attack.

(2) True and recurring melancholia is always different, nosologically, from periodic asthenia, that 'depression melancholia' which comes on without any known cause and especially without any external cause.

(3) True and recurring melancholia is not very common; it was present in twenty-five per cent. of the cases of melancholia under the writer's observation.

(4) According to the writer's research, ninety per cent. of the cases of true and recurring melancholia recovered from the first attack.

(5) Confusion between true melancholia and periodic asthenia is explained by the possibility of recurrence in true melancholia, by the frequency of cures of the recurrences of true melancholia, and by the possibility of auto-accusations in periodic asthenia.

A. W. Young.


The case is described of a boy, age twelve, who had two febrile attacks which resembled epidemic encephalitis. Probably the initial attack was at the age of three and a half, for at that time he had an acute illness with fever, visual hallucinations, and diplopia. Following this, there was a gradual character change, the boy becoming increasingly difficult to manage. In his twelfth year he had another acute illness, similar in character, with fever, loss of appetite, insomnia and agitation by night and prostration during the day, with accentuation of the strabismus and diplopia. The child had periods of motor excitement which passed off quickly, not rhythmical, regular or present very often. Nocturnal agitation, however, began each evening at a certain hour and left off in the middle of the night.

In considering the two clinical types of change in encephalitis, viz., the form of motor excitement and the form of perverse changes of character, the author agrees that intermediary states exist, a fact which makes the separation of the two types difficult. The state of instability or motor excitement is transitory, bordering on the changes in character of a more profound nature, which transform the psychic constituents of the child.

A. W. Young.

Epidemic encephalitis may occur without the classical symptoms of the acute stage and this is often unrecognized. Such cases may develop physical and mental symptoms later that simulate those of other nervous diseases. Typical cases, apparently cured, may develop such symptoms after a varying period of health. The physical symptoms may resemble those caused by syphilis, neurasthenia and hysteria; the mental, especially those due to syphilis, alcohol and other toxæmias. Sudden changes in personality and behaviour, especially in children, should arouse suspicion as to the possibility of the condition being postencephalitic. It must be remembered, also, that the child may be apparently bright but manifest bad behaviour. Criminal tendencies may be so caused.

The question whether trauma of the head can predispose to the development of the acute attack and excite sequelæ in one who has had the disease must be considered.

Brief outlines of fifteen cases illustrating these points are given by the author.

E. B. G. R.


Psychoses in twins develop frequently on the basis of degenerative etiological factors, and the similarity or identity of the mental disorders finds its raison d'être in a consanguinity which surpasses the ordinary limits. There does not appear to be such a clinical entity as a 'twin psychosis.'

Two examples of psychoses in twins are given in this paper. In the first an identical mental affection of the dementia praecox type developed in twin brothers. The onset of the symptoms was nearly synchronous; they ran a similar course and ended in a similar manner. The second history is that of manic-depressive psychosis in twin sisters, who became ill only after they had separated and lived a different life from one another. The question of folie à deux could be excluded in both instances.

E. B. G. R.


An examination of a series of cases of primary dementia will reveal, amongst other more generally recognized characteristics, a deviation from normal in the colour of the hands. The mechanism of its production is but little understood. Immersion of such hands in water at a temperature of about 42° C. results in the production of an intense arterial erythema over the areas exposed. Mechanical stimulation by stroking these areas will be followed by a similar deep red and irregular blotching over the skin thus stimulated. A possible explanation of these results lies in the fact that heat and moderate pressure-stroking are both known to result in arteriolar and capillary vasodilatation. The excessive erythema thus produced in primary dementia is a direct consequence of the existence of capillary paralysis (either partial or complete), and is analogous in every respect to the erythema which is produced.
by similar stimulation of the healthy hands after their prolonged exposure to
cold. It should be remembered that the hand of a primary dement is cold,
not because of low external temperature, but because of excessive local heat-
loss secondary to enlargement of the capillary bed. Were this heat-loss due
to a need for heat excretion on the body's part (as in hyperthyroidism), then
there would be an accompanying dilatation of arterioles of the skin. The
hand is then red, moist and warm instead of cyanotic, moist and cold. There
is a capillary dilatation only in the latter, whereas in the former there is
accompanying arteriolar dilatation. It is clear that the superficial vessels
in dementia praecox respond poorly to external stimuli, and that the capillaries
at least do not seem to retain their tone or their capacity for regaining tone
after dilatation. It might be suggested that katatonia, by lack of muscular
movement, fails to assist the return of blood from the peripheral areas, and
would, in time, by mechanical back-pressure, result in a measure of paralysis.
Nevertheless severe vascular paralysis occurs with frequency in those who
lead a comparatively active life, and even in those who are excited. Dementia
praecox is not usually associated with definite subthyroidism, and the cir-
culatory condition cannot be entirely ascribed to a deficiency in that gland,
though there may be some dysthyroidism. There is no gross evidence of
dyspituitarism in primary dementia, though it is conceivable that there may
be some minor derangement of functional activity. In view of the cumulative
evidence of involvement of the sympathetic nervous system in dementia
praecox, it is suggestive that in this particular vascular manifestation we have
further evidence of derangement. The suggestion is that an inefficient
development of sympathetic fibres exists in this condition, and that, even
though the necessary hormone exists in the blood-stream, yet insufficient
tone persists, or, at all events, a tone insufficient to resist mild external
stimuli such as are provided by exposure to the average atmospheric condi-
tions in this country. It would be of interest to know whether circulatory
changes of this kind exist in warmer climates, and also whether the condition
noted is seen in the hands prior to the onset of mental symptoms.

R. S. C.

NEUROSES AND PSYCHONEUROSES.

and Rec., 1925, cxxii, 342.

The writer gives his conclusions as follows:—

1. Anxiety neuroses, phobias, obsessions, compulsions and transference
hysterias all have a closely related etiology and most of them have their
origin in sexual indiscretions and dissatisfactions.

2. These conditions must be distinguished from hysteria at the one end
and neurasthenia at the other end as having been intermediary processes
between the two conditions.

3. The symptom-complexes of these conditions are practically the
same, with but slight changes in mental reaction, and run the gamut from the
physical, through the sensory, to the mental.

4. They must be definitely classified as distinct entities, differing radically