Thus the author claims that these experiments show that emotional experiences, whether their cause be conscious or unconscious, may cause alterations of the metabolic rate, and he believes that this is the first time it has been shown that shock from acute anxiety will produce a sudden and considerable fall in the metabolic rate.

M. R. Barkas.

**PSYCHOPATHOLOGY.**

[113] Circulatory ratings in mentally defective adolescent children.—


A circulatory rating test was used during the war to aid in detecting aviators who were unstable, and therefore were not in condition to fly at that time. In applying this test to a group of psychotic cases it was found that 82.61 per cent. of the hebephrenic and catatonic types of dementia praecox patients rated low and that only 26.9 per cent. of the paranoid types rated low. Also only 11.2 per cent. of the manic-depressive patients rated low. In 4,800 necropsies reported by Lewis he found that 71.55 per cent. of the hebephrenic and catatonic types had a small aplastic heart, the incomplete development involving also the capillary system. Furthermore 75.5 per cent. of these had hearts of less than average weight, while only 7.8 per cent. of the paranoids had such. A revised test was applied to 100 adolescent children and 15 were found to have a low rating; the principal of the school stated that all of them were 'problem children,' and the histories obtained from both the teachers and the pupils revealed the existence of many neurotic symptoms. On testing 100 adolescent feebleminded children, only two graded low. One of them had an organic heart disease, both were of the familial type of feebleminded, and neither was syphilitic. As a group, the mental defects graded high in the circulatory rating test. In reading the literature on the pathology of mental defect one finds very little concerning the cardiovascular system. The circulatory test seems a valuable instrument for detecting a certain type of individual.

C. S. R.

[114] Intestinal hepatic and renal lesions in cases of amentia (Lesioni intestinali, epatiche e renali in casi di amenza).—C. Mazzanti. *Riv. di pat. nerv. e ment.*, 1926, xxxi, 160.

Of twelve cases of mental confusion which came to post-mortem examination, eight showed macroscopic lesions of a hemorrhagic, congestive and degenerative type in the digestive tract. In another case of mental confusion which did not show macroscopic lesions the patient had suffered from intestinal derangement which continued till death. Three cases studied microscopically showed scattered degenerative lesions of the mucosa of the intestine and also in the liver and kidney.

These lesions suggest that in confusional states there is absorption of intestinal toxins and that the liver and kidney, essentially defensive organs, may facilitate the intoxication by concomitant acute lesions (probably secondary for the most part) and by chronic lesions of long standing which interfere with their functional equilibrium.

R. G. G.

The authors’ case is that of a man of 57, whose symptoms were those of mental deterioration, loss of memory and attention, and interference with speech, of a somewhat quickly progressive character, while affectivity and outward behaviour were for a long time but little involved. So-called logoclonia and agrammatism were present in moderate degree, and there was some apraxia. The diagnosis was made during life and confirmed by pathological examination, characteristic changes being found to be widespread in the cortex, whereas in the corpus striatum little alteration was discoverable.

There is a good bibliography appended to the paper.

S. A. K. W.

Criminality in cranial injuries (La criminalité des blessés du crane).—Porot. L’Hygiène mentale, 1925, xx, 205.

After briefly discussing the etiology and pathology of cranial injuries the author points out that in their general evolution one can distinguish (1) the period of immediate symptoms; (2) following symptoms marked sometimes by confusional and delirious episodes which may lead to medico-legal reactions (fugues); and (3) late symptoms with residual psychic troubles which may be still more important from the forensic standpoint. These latter may be reduced to two groups of manifestations (a) diminution of general activity, initiative, attention, judgment and memory; (b) disturbances of mood and emotions, characterised by change of character, irritability and instability. All these sequelæ may take part in the problem of responsibility. In discussing the frequency of criminality among those who have been concussed or trephined, opinions are shown to differ. Some deny that there is any evidence of relationship, while Vervaeck and Mazel estimate that crime is incontestably more frequent in cases of cranial injury than in others, especially crimes of violence and probably sexual offences. The writer in 60 cases found 12 acts of murder and assassination, 14 of violence, 24 of theft, and 3 of incendiarism. In the deeds of violence and murder, epilepsy appeared often to be the direct cause. It is extremely important to establish the medico-legal value of such commotional traumata. A most minute subjective as well as objective examination must be made. A retro-anterograde amnesia can conceal the criminal act of some subjects. It is difficult to judge the psychic condition existing at the moment of a crime through this mental screen. The author thinks that cranial trauma should be taken into account when the subject has acted under the influence of a mental disposition, momentary or permanent, arising directly from such injury. There are cases of total irresponsibility where the criminal acts are committed quite unconsciously or in a twilight state; cases where responsibility is attenuated to a variable degree; and those where there is
entire responsibility. In the last, though there may have been grave cranial injury, the acts are carried out with mental lucidity, without any intellectual or moral obliquity, or any morbid state interfering with volition. It is considered that the rôle of relating such trauma to the genesis of crime must be carefully limited and one must be heedful of the sentimental exaggeration of public opinion. In war cases such a type of injury became a precious talisman to some, which was used as a defence in any crime or delinquency. Vervaeck, on the other hand, states that it is very difficult not to admit in head injuries the existence of a more or less important diminution of penal responsibility for antisocial reactions, even where responsibility appears to be established. It is difficult in the present state of our knowledge to affirm that at the moment of the criminal act such an individual possesses free will or has perfect comprehension of the gravity of his act.

C. S. R.

[117] Insanity and crime.—William A. White. Mental Hygiene, 1926, x, 265.

The writer, referring to Einstein's theory of relativity, surveys historically the concepts of responsibility, guilt and punishment, and emphasises the necessity for discarding antiquated legal methods in favour of methods in harmony with modern lines of thought. He believes that questions of guilt and personal responsibility (in which terms are embodied the ancient principles of hate and vengeance), should be laid aside in favour of the social concept of the social usefulness and assimilability of the individual; that those individuals who are socially dangerous should be segregated, irrespective of what particular crime may have brought them to public notice; and that their segregation should continue not for a definite, prescribed time, but for so long as they continue to be a social menace.

E. B. G. R.


In September 1924 a law became operative in Massachusetts calling upon the Department of Mental Diseases to make a psychiatric examination of all prisoners in houses of correction serving a sentence of over 30 days, and of all prisoners who had been previously committed to any penal institution. The first 1,500 prisoners thus examined were classified as follows:

Group I (281) consisted of 43 prisoners who showed psychotic symptoms, 7 who were feeble-minded, 79 diagnosed defective delinquents and 152 psychopathic delinquents. These prisoners were recommended for indefinite commitment in suitable institutions.

Group II (617) were alcoholics, 204 of whom were recommended for indefinite custody.

Group III (369) comprised prisoners who, on discharge, were likely to benefit by intelligent supervision and assistance.

Group IV included miscellaneous recommendations and cases in which no recommendations were necessary.

E. B. G. R.
[119] **Classification of idiocy and imbecility** (Gruppierung von Idiotie und Imbezillität).—W. **Weygandt. Münch. med. Woch.** 1926, 755 and 828. In these two lengthy articles the author discusses the lines upon which a classification should rest; in the absence of full etiological knowledge we must group these cases according to pathological anatomy, cause, and clinical features as best we can. For practical purposes in treatment other divisions are made, according to mental age, capacity for training, conduct, etc. Especially in the higher grade cases, and those of endocrine or other physical defect with little mental disorder, each case must be judged on its merits.

He first deals with historical groupings, such as those arising from defective upbringing, or from defect of one or more senses, and points out how these may or may not be associated with real defect of mind. His next group is that of endogenous disorders of the brain matter; he thinks the generally accepted proportion of these cases is too high (50 per cent.). In this category he places anencephaly (describing one case which Edinger reports, in which the patient lived to 3 years old), cases of partial absence of brain with idiocy, microcephaly, micrencephaly and congenital cerebral degenerations.

The third group is that of innate cerebral degenerations (he does not explain how these differ from those grouped above): amaurotic family idiocy, Merzbacher-Pelizäus aplasia, hypertrophic tuberous sclerosis, and mongoloid idiocy. The fourth comprises secondary disturbances of brain development with degenerative skull development: these are achondroplasia (though the patients are not always abnormal mentally) and pygrocephaly. The fifth group consists of the forms of idiocy due to exogenous causes, encephalitis, meningitis, hydrocephaly, metencephalitis (including defects of intelligence and character, athetosis, Little’s disease, torsion dystonia, and chorea, Sydenham’s and Huntington’s).

The sixth includes the syphilitic forms, idiocy, imbecility, epileptic cases, hydrocephalus, some forms of infantile paralysis and some of infantilism. The seventh includes endocrine disorders, cretinism, dysthyism, dyspituitarism, including dystrophia adiposogenitalis, and some cases ascribed to suprarenal and pancreatic defect. The eighth group is that of infantilism from a variety of causes, malnutrition, rickets, chronic diseases and circulatory disorders.

The ninth embraces cases due to exogenous toxins, such as alcoholism, whether in parents or in the child: the tenth—epileptics, idiopathic and spasmodiphilic. The eleventh class is that of psychotic disturbances of development, including infantile hysteria, dementia praecocissima, schizophrenia, cyclothymia; the latter usually in early puberty.

The twelfth includes cases of organic disease of the central nervous system, such as tumour, Friedreich’s ataxia, disseminated sclerosis, etc. The thirteenth includes traumatic cases, whether the trauma occurs during birth or later.
In all these groups the author goes into some detail, describing the type of case, post-mortem findings, and possibilities of treatment, and he urges the importance of trying to place the case with every means of diagnosis and exhausting all possible treatment before consigning the patient to an institution for training, and also the desirability of making full post-mortem examinations in all cases. He deprecates the lack of adequate institutions for these cases in Germany.

Finally he mentions that he has deliberately refrained from discussing the question of destroying worthless lives, as he thinks this is not the province of the doctor, who should do what he can for them and for preventing the occurrence of similar cases.

M. R. Barkas.


The differences between general paralysis and cerebral syphilis are quite definite and may be explained by the fact that in the former the spirochaete succeeds in crossing the boundary between mesodermal and ectodermal tissues. This is borne out by the discovery of spirochaetes in the cerebral tissue in general paralysis and the fact that the sheath of lymphocytes and plasma-cells surrounding the cerebral vessels is less dense than in cerebral syphilis. There must, however, be some change in the whole organism with lowered resisting power to account for the physical as well as the mental changes in this condition. The nature of this change has not been discovered, though metabolic changes, in the form of failure in nitrogen equilibration, in disposal of foreign toxins and the formation of intermediate products which circulate in the blood, are suggestive. The later development of general paralysis is a problem which awaits solution; the explanation may be sought in differences in the spirochaete or in the patient. Certain rather inconclusive evidence is adduced in favour of the former thesis. The evidence in favour of the latter contention is more definite. Differences in age, sex and racial incidence are very striking, and several other factors have been suggested in the same connection, such as the incidence of infectious diseases, alcohol, and the efficiency of treatment. Of these alcoholism as a contributory factor has the most evidence to support it. Several suggestions as to fruitful lines of research are given.

R. G. G.


The classification of mental disorder elaborated by Magnan was based essentially on etiology and clinical features, and was applied to hallucinatory delirium, which he divided into chronic delirium systematically developed, and
the polymorphic delirium of degenerates—apart from alcoholic and toxic delirium.

The second group, involving mental degenerates, includes clinically many divergent features. These polymorphic insane states are kaleidoscopic in their variability. They must be separated from chronic hallucinatory psychoses and from dementia paranoides. A curable percentage, however, were noticed by Kraepelin and Bleuler, who were inclined to put such cases in the manic-depressive group; but the author is of the opinion that their unique character calls for a separate category, hence he marks off polymorphic delirium in order to prevent confusion.

The author describes at length a case of delirium with rapid alternations of mania and depression. He analyses the mental state and gives full details of the somatic disturbances, particularly of the vasomotor disequilibrium—i.e., marked vagotonia. He regards such cases as arguments in favour of Magnan’s view of curability, as against Kraepelin’s view of chronicity of polymorphic delirium.

Bearing in mind, however, the somatic disturbances frequently found, intermittent digestive trouble, dysmenorrhoea and vagotonia, a chronic variety of polymorphic delirium has to be distinguished. The differential diagnosis from manic-depressive and periodic insanity, and from paranoid states, is fully considered, in order to emphasise the need for regarding polymorphic delirium diagnostically and prognostically as a separate clinical entity.

E. MILLER.

[122] **Psychoanalytic study of a case of organic epilepsy.—K. A. MENNINGER.**


A case is here presented of a typical epileptic syndrome arising upon a basis of definite structural cerebropathy which was studied by the psychoanalytic method. Although thorough systematic investigation was impracticable, the dreams, free associations, and clinical developments made it seem clear that the occurrence of convulsions was in part psychogenically determined. Relief from the intolerable pressure of unconscious conflicts was accomplished by the epileptic flight, a characteristic reaction type. The improvement was probably due to a combination of (1) transference, (2) catharsis, and (3) environmental alterations. The author believes that this study adds confirmatory evidence to the thesis that the manifestations of structural (‘organic’) pathology are associated with, if not determined by, psychic mechanisms which are accessible to study by the psychoanalytic method with, in some cases, objective clinical improvement.

C. S. R.