
The concept of hypochondria is defined as a persistent preoccupation with the bodily health, out of proportion to any existing physical justification, and with a conviction of disease. No other effect than the belief involved in conviction need be apparent; the conviction (like all convictions) defies direct attack.

This concept gives the basis for the nosological isolation of hypochondria as a clinical reaction-type in its own right. The course is chronic but not (over a long period) deteriorative intellectually or emotionally. The patients are nearly always men, so far as the present series goes. This preponderance of the male sex is in accord with the traditional description of hypochondria. It is perhaps explicable on a psychopathological basis. The ages of the present series extend from 19 to 60. Inaccessibility to therapy is the clinical aspect of the firmness of the conviction. This also is illuminated by the psychopathological analysis. Exact nosological definition enables a distinction to be made from what can now be called pseudohypochondrias—hysterias and anxiety states. It also enables us to speak of a hypochondriacal development of an abnormal personality; thus it is accurate to speak of hypochondria in a schizoid personality. Other cases, however, make it necessary to consider the hypochondriasis simply as part of a schizophrenic syndrome.

Psychopathologically, from the content of the hypochondriacal complaints (their localisation, etc.), and from the patient's other utterances, an anal-erotic basis for some hypochondrias is strongly suggested. It is considered that the strong, usually unconscious, feeling of guilt is in some cases the component which clinically makes the conviction of disease so profound, and produces the therapeutic inaccessibility. The homosexual aspect of anal-erotism may serve also to explain the preponderance of men among hypochondriacs. Homosexuality in men undergoes much more repression than the same component in women.

The consideration of the indications, in certain hypochondriacs, of the possible unconscious trends involved helps therefore to explain not only the fixity of the hypochondriacal beliefs, but their nature (damage to the bodily health) and, in some instances, the actual localisation of the physical complaints. Incidentally a contribution is suggested to the theories of the etiology of perianal pruritus, which appears in some instances to be an anal-erotic masturbation.

The differences in the response to treatment in the series of cases discussed are of interest and importance. The first patient improved symptomatically for a time with any form of treatment except direct psychotherapy, which he resented, only to relapse again very soon; the second case, with a definitely material basis, recovered completely when the latter was removed; a third
patient ("essential hypochondria"), had never shown a therapeutic response and clinical impressions gave no hope that he ever would. Three cases all recovered in response to psychotherapy (investigation, explanation, and persuasion). These cases were considered psychoneurotic on symptomatic grounds. A similar case improved slightly several times but has always relapsed. In other cases the preexisting personality must be held responsible for therapeutic failure.

Author's Abstract.


The author, a pupil of Pavlov during his experiments on conditioned reflexes in dogs, attempted to establish a response consisting of a facilitation to the first stimulus immediately followed by an inhibition in response to the second stimulus. This was beyond the dog's power; he completely failed to achieve the response. At first his response took the form of considerable excitement, with restlessness, barking and howling, followed by a marked depressive stage in which he exhibited all the characteristics of a whipped cur. The analogy with patients who when presented with a conflict involving inhibition of a powerful inherent impulse develop a manic-depressive reaction is obvious. This interesting paper illustrates once more the great importance of Professor Pavlov's work for modern psychopathology. R. G. G.


By the expression "interpsychology" Dupré referred to the reactions between the insane patient and his entourage; this present communication deals with a common type of centripetal reaction, whereby the patient suspects the members of his family, his colleagues—or even a large collection of persons—of insanity. Veiller was the first specifically to describe this phenomenon under the title "le délire de la folie d'autrui." The authors here give numerous examples taken from personal cases. Delusions of insanity in others are common in the chronic systematized psychoses and result from a sustained and boundless confidence on the patient's part in his own judgment and intellectual processes. In the early stages the other members of the family have probably adjusted their behaviour or habits in order to comply with the demands of a slowly developing psychosis. At a later stage, when the nature of the patient's behaviour is realized, the attitude of the friends and relations will again undergo a change. Both these reactions will be noted by the patient himself and interpreted as madness upon the part of his entourage.
The authors give an apt illustration in the reaction of a university student who, unknown to himself, was slowly developing myopia. He would constantly complain that the handwriting of the lecturers was deteriorating and that the epidiascope pictures were out of focus. He became impatient with his colleagues when they did not associate themselves with his protests. This peculiar psychism terminated suddenly by the accidental discovery that a concave lens held before the eyes corrected the faults which he had previously ascribed to others.  

M. C.

[206] **Vagrancy in the young** (Le vagabondage infantile).—**Guy Néron.**


The examination of 250 cases of vagrancy, according to the author, gave the following statistical results. Social causes as the most evident factor, 22 per cent.; dementia precoex, 1-24 per cent.; epidemic encephalitis, 24 per cent.; epilepsy, 2-8 per cent.; simple intellectual defect, 19-24 per cent.; imbecility, 1-6 per cent.; instability, 20-4 per cent.; mythomania, 2 per cent.; paranoia, 3-2 per cent.; cyclothymia, 1-24 per cent.; instinctive perversions, 6-8 per cent.; cases where several psychiatric factors were present, 19-24 per cent.

C. S. R.

[207] **Some considerations of the significance of physical constitution in relation to mental disorder.**—**Herman M. Adler and George J. Mohr.**

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Among normal and psychotic patients we may recognize various physical forms that correspond to types as described by Kretschmer. There is evidence that these forms in no sense constitute types but that there is a normal distribution of physical characteristics that vary from those that define the asthenic to those of the pyknic build. Significant differences in performance of groups that are widely separated in the normal distribution, and that conform to the type criteria, are demonstrable. These performance differences are such as to associate the asthenic build with the so-called schizothymic temperament. Accumulated observations by many investigators apparently establish a relationship between pyknic build and manic-depressive psychosis. In the psychiatric categories here considered there are two elements: that of normal distribution of qualities common to all members of the group, and the characteristics not common to all the group but only to certain individuals affected by the various causative factors producing these characteristics.

C. S. R.

[208] **On the pathology and laboratory diagnosis of paresis.**—**F. Proeschel and A. Arkush.**


*After* reviewing Spatz’s work on the occurrence of iron in the Hortega and other cells in the brains of general paralytics, the authors review their own
observations based on the use of thiazin red as a stain. They have found iron present both in sections of the brain and in the spinal fluid and consider that these findings are distinctive of general paralysis.

R. G. G.

PROGNOSIS AND TREATMENT.


The points here dealt with are the individual treatment of offenders and the abolition of the jury trial of the question of mental disorder. The first has an important bearing on the defence of insanity, since there are many mental cases which could escape notice as such unless individually studied. The present procedure is based on the theory of making the punishment fit the crime instead of fitting the individual. This fails conspicuously as a deterrent to crime. In a number of large cities individual, sociological and mental study of the prisoner before trial and individual consideration of the punishment or other disposition have already been adopted, usually with the assistance of psychopathic clinics. The classification prison about to be placed in operation at Sing Sing will afford a careful sociological and psychiatric study of each new prisoner by the aid of which the newcomers will be sent to the particular prison and given the particular treatment or occupation which his case indicates. The introduction of a new socio-penal agency is suggested, to function after conviction and either to advise the court or to have the power to prescribe a to what disposition should be made of the offender after a careful study of each case. The commission should be composed of psychiatrists and criminologists of the highest type, and power of sentence would be taken from the judges and vested in this body. A logical result of such treatment of convicted wrong-doers would be the curtailment of the recidivist who would probably receive the much-talked of wholly indeterminate sentence.

A jury should never be charged with the determination of the mental state of an individual; he should instead be examined either by a commission of experts appointed by the court in each case or by a standing commission in the state department dealing with mental diseases, as is the case in Massachusetts. The jury would be called upon to decide simply questions of fact, viz., was the act committed, and was the act committed by the individual accused? The question of responsibility should not be referred to a jury. It is for the experienced psychiatrist to decide this. The report of the commission examining the accused would be submitted to the judge who, if so advised in the report, could commit to a hospital. If the finding indicated normal mentality, the case would go to the jury without comment. On the other hand, if partial responsibility on account of limited mental capacity was found this could be made use of by the judge in passing sentence or if some way of presenting it to the jury without the usual cross-examination could be found it could be used at the trial.

C. S. R.