

A THESIS

ENTITLED

THE DIAGNOSIS OF THE PSYCHOSES OF YOUNG ADULTS

PRESENTED BY

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PREFACE.

Close coöperation between psychiatry and general medicine is advocated with renewed vigour from time to time. This is a wholly desirable thing, provided that the essential differences between disorders of the individual as a whole and disorders of his several organs are kept clearly before one.

At the present time, psychiatry is regarded as being but a small portion of the vast ground covered by the general physician; and the psychiatrist is but a minor officer in the army of specialists - this, at least, if the proportion of medical teaching allotted to mental disorders be any guide.

With things as they are, it is natural that psychiatry should borrow from the field of general medicine methods of approach to its problems which have stood the test of time. He would be brave indeed who would cavil at medicine taking the lead with psychiatry meekly seeking such crumbs of wisdom

as it can. Thus does it come about that people are attempting to solve most recondite problems of human behaviour by studying the bodily excreta, to the exclusion of other less concrete and more elusive factors. It is not denied that derangement of the physical mechanism of the individual may produce aberration of behaviour. Yet, how desperately ill a human being may be: sick to the point of death, while his intellect remains unclouded and his emotional state one of serenity, fortified by hope whose physical basis it would be hard indeed to locate.

What a contrast to this picture are many mental hospital patients of long standing: suspicious, deluded, estranged from their closest friends, yet apparently robust and in good health.

Does it not seem that there must be a wider creed than mere mechanism and the consideration of ponderable things? Should there not be more interplay of all the forces which the human organism is called upon to meet; less artificial effort to

separate the 'physical' and the 'psychological' and to 'pigeon-hole' human nature? In this thesis it is sought to show that a wider method of approach to psychiatric problems is needed. This view has been advocated by Clouston and many others since his day; but the fascination of modern biochemical methods is so strong that the tendency at the present time is to attempt to explain behaviour in chemical terms, and to neglect the more personal and essentially vital as opposed to the mechanistic aspects of the individual.

Our thesis, then, is of an essentially clinical nature, and deals primarily with the methods of approach to certain problems of clinical psychiatry rather than with the minute technicalities of biochemistry and academic psychology, on the one hand, and the nosographical quibblings of descriptive clinicians, on the other.

The old descriptive methods of Sydenham, so firmly entrenched in the field of general

medicine, must be only part of a wider scheme in solving the problems of behaviour which we see exemplified in the psychoses of young adults.

September, 1929.

SCOPE OF THE THESIS.

Proposition.

The diagnosis of psychoses occurring in young adults is possible only when the individual case is viewed developmentally in all its aspects - physical, psychological and environmental.

Definitions of Terms.

Diagnosis: the word is here taken in its literal sense - 'to know through' or 'to understand' - and not in its commonly accepted sense of merely attaching a name to a group of symptoms. In speaking of the diagnosis we mean the 'understanding' of 'rendering intelligible' of the psychoses.

(1)
Psychosis: Hack Tuke defines 'psychoses' as "the name for mental affections as a class"; but in later years the word has come to have a more limited meaning.

(2)
Stoddart says, "The psychoses are the true insanities", and indicates that the principal

criterion of this class of mental illness is that the patient fails to recognize he is ill; for example, he accepts hallucinatory experiences as real. It is in this latter restricted sense that the word psychoses is used here, although we do not entirely agree with Stoddart's definition of it. It is used because it is intended specifically to exclude such conditions as are now commonly called 'neuroses' and 'psychoneuroses', and also states of mental deficiency.

Young Adults: it is not intended to adhere with absolute rigidity to a particular age-group, but the subjects under consideration are taken as those between the approximate ages of 15 and 30 years. At this period of life one has a greater chance of seeing psychoses uncomplicated by such conditions as alcoholism, syphilis, arterio-sclerosis and other diseases of middle and later years. It is easy to speculate on physiological lines how these conditions may, by their action

on the brain, bring about changes of behaviour; but what of the apparently baffling changes of character, the exaggerations of mood, appearing like a bolt from the blue in young, apparently healthy, subjects? To render them intelligible will be the true test of our methods of approach to such problems.

Plan.

The thesis, then, resolves itself into the following parts:-

- (1) Historical Survey: a study of the methods of approach used by past and present schools of psychiatry.
- (2) The Argument: a defence of the dynamic viewpoint in psychiatry, consisting of a critical review of the method of approach of certain schools of thought described in Section I; and formulation of terms which are capable of rendering intelligible the psychoses of young adults.
- (3) Clinical Applications: the formulation of a concrete scheme of approach to the individual

case; selection of suitable nomenclature;
illustration with reference to actual cases.

PART I

HISTORICAL SURVEY.

The modern period in psychiatry began with the work of Pinel and Tuke⁽³⁾ at the end of the 18th. Century. They, however, approached mental illness largely from the administrative point of view; and their work does not, therefore, concern the primary objects of this thesis, except in so far as it paved the way for better management of all types of psychiatric cases. The nosography of psychiatry at that time was extremely loose, but even then it was believed that mental illness was some kind of misunderstood disease. Pinel and Tuke placed psychotic patients in such an environment that physicians were able to approach them armed with the methods which Sydenham a century before had applied to pure bodily disorders; namely, the careful tabulation of symptoms: in a large number of cases; delineation of clinical types and the labelling of new individual cases according to their conformity

with one or other of these types. As was to be expected, the application of these methods resulted, in the course of time, in the delimitation of certain clinical types of mental disorder. So far as young adults were concerned, one of the first groups to be differentiated was that known as katatonia.

(4)
Kahlbaum in 1874 described a series of cases in which mutism, refusal of food, motor phenomena, peripheral cyanosis and salivation were prominent features. In regard to prognosis, however, the substance of Kahlbaum's statements is that "the patient may recover; or, in an unfavourable case, the disease terminates in general confusion, and at last in actual dementia". The only criterion which he chose for his prognostic guidance was whether or not the motor phenomena were accompanied by other symptoms, such as "excitement of the maniacal kind", in which case he regarded the prognosis as bad.

Kahlbaum's work was challenged by Séglas and

Chaslin, who upheld Falret's opinion that katatonia was a symptom or a group of symptoms rather than a distinct form of mental disease⁽⁵⁾ .

Kahlbaum and Hecker differentiated a further group of mental illnesses in young adults, which they called hebephrenia. Hack⁽⁶⁾ Tuke states that the essential feature in this group of cases was "the intellectual disturbance occurring at puberty or immediately after. It is more prevalent among girls than boys and may be hereditary or caused by masturbation or over-work".

Clouston's "Adolescent Insanity".
(7)

Clouston sought to describe a distinct form of mental disease which he called "adolescent insanity". It would appear that this name "adolescent insanity" covered a heterogenous group of clinical material which has since been subdivided into various clinical

types by later writers. Clouston describes first of all a condition of "defiance of parental and school authority with morbid self-will... .. They" (the patients) "will not get up in the morning, nor will they do any work or they even do daring acts of destruction, tear books, break furniture, threaten violence to themselves and others... .. take to purposeless deceit and lying... .. and yet all the time are not delirious or maniacal...". Later - speaking of the form which adolescent insanity assumes - he says, "All cases are not alike, but in 78% of them the symptoms are those of mania while in the other 22% the prevailing symptoms are melancholia^c, delusional or stuporose".

Describing the actual symptoms he says, "... .. the ideation is fanciful tending to hypochondriacal notions and morbid self-consciousness. Both sexes sometimes think themselves in love, the

object of their affections being strangers or nearly so... .. The acute part of the attack usually commences with a sense of 'bien être'... .. They are impudent to an insane degree, use bad language, and soon their habits change for the worse... .. The next stage is one of acute mania, when the speech becomes incoherent, the conduct outrageous and violent and the habits filthy and degraded... .. This acute stage lasts about a week... .. but the patients have repeated attacks... .. subsiding into a lethargic, anergic condition that is of the nature of stupor and sometimes simulates secondary dementia".

"... .. the 22% of cases which do not present any symptoms of morbid mental exaltation... .. are cases of melancholia, delusion or stupor from the beginning and remain so... .. There is often a confusional, resistive character in the melancholia."

Speaking of prognosis, Clouston says that

65% of cases of adolescent insanity recover under proper treatment, an exceedingly small proportion die, and 15-25% become incurable. The ending that is most common, if recovery does not take place, is "typical secondary dementia with more or less periodic exacerbations of maniacal attacks for the first few years. A few end in chronic mania, a few in 'folie circulaire' and a few in delusional insanity".

Clouston appears to have been the first psychiatrist to make a real attempt to understand the psychoses of young adults; and to him must go the credit for stressing the importance of approaching each individual case in a really comprehensive way. Although he believed in the neuropathological basis of mental disorders, he recognized that environment, personal, ethical and emotional difficulties, upbringing, physical health and occupation all played their part in determining the onset of the psychoses of adolescence.

He says, for example, "The insanity of adolescence cannot be properly understood without reference to the normal physiology and psychology of that period of life ...

... At adolescence the reasoning faculty first acquires backbone, the conscience then only assumes real dominance... ..

The emotional nature for the first time acquires a leaning towards the other sex...

... The events and possibilities of the future are reflected in vague and dreamlike longings that have much bliss in them, but not a little of seriousness and difficulty... ..

These subtle, complex, and all important mental, emotional, volitional and instinctive qualities cannot be developed but through corresponding structural and trophic development in the brain. The higher the function the more delicate the structure, and the more liable to derangement, therefore... .. The machinery has been preparing during child-

-hood, but does not come into actual and full working until adolescence. Therefore, this period must be a trying time to the brain ...
... a real crisis, just as birth is... ... The physiology of adolescence, its psychology, its neurology and its psychiatry must all hang together, being explained and unified by the facts of the development of the capacity and desire to propagate the species, then going on".

This, then, was the first attempt to formulate an explanation of the problems under consideration.

Since Clouston's day, a tremendous mass of work has been done. Much of it has come from two schools. The one founded by Kraepelin is still indulging in nosographical complexities, and is making a painstaking effort to explain mental life in terms of chemistry. The other, founded by Freud, is restricting itself to the purely psychological investigation of the inner battle of the individual with his instinctive tendencies. By adopting such restricted modes of approach to

a subject which deals essentially with the individual as a whole, each of these schools lacks a sense of perspective, without which an intelligible explanation of the psychoses of adolescence is impossible.

In spite of the tremendous following which these two schools have, the wider mode of approach as formulated by Clouston has been upheld in more recent times by Bianchi (who, like Clouston, was at heart a neuropathologist); and (along rather different lines) Adolf Meyer (also, at one time, a neuropathologist). Meyer contents himself with using broad, biological terms in which to explain his cases, and is content to keep an open mind as to the ultimate, academic, physical basis of such disorders; while Bianchi, although wide in his views, tries to reduce all psychoses ultimately to neurological terms.

Before proceeding with the present-day

exponents of the wider methods of approach, it is necessary to deal with Kraepelin and Freud and their followers.

Kraepelin and the Physiogenic School.

Kraepelin's position in psychiatry may be compared aptly with that of Sydenham in the field of general medicine. Dealing, to a considerable extent, with types of cases which Clouston had designated "adolescent insanity", he introduced a much more orderly subdivision of this mass of material than Clouston had done. By the careful tabulation of symptoms, he was able to delineate several clinical types, which he elevated to the position of disease entities. His first subdivisions were into dementia
praecox⁽⁸⁾ and manic-depressive insanity⁽⁹⁾.

Into the former category he put all cases which ended unfavourably. He found that cases which ultimately became demented showed a variety of symptoms in their early stages; so

he subdivided them into four types: namely, simple dementia, hebephrenia, catatonia and dementia paranoides, of each of which he gave a masterly clinical description. As his experience widened, he found that not all cases which ended in dementia necessarily conformed to one or other of these types, so he introduced another class, which he called "mixed forms". Further, he found that not all cases presenting early symptoms of what he called dementia praecox necessarily ended in dementia; in fact, some of them recovered. The essential features upon which Kraepelin made his diagnosis - or, rather, labelled his cases - were the presence of hallucinations and delusions of an odd or bizarre character, together with a giggling, silly, emotional state, possibly accompanied by curious motor phenomena, such as stereotypy, "schnautz krampf", peripheral cyanosis, resistance and negativism. Because a patient presented certain symptoms, he was, therefore, suffering

from a certain disease, irrespective of the setting in which such symptoms occurred, the conditions which led up to their appearance or the type of personality concerned.

Kraepelin applied the same methods in delineating his "manic-depressive insanity". This he did largely by following up the cases which were formerly labelled 'mania', 'melancholia' and 'circular insanity'. He found that in 'circular insanity' were certain symptoms also seen in 'mania' and 'melancholia', and that cases of mania often exhibited at another part of their course symptoms of melancholia, and vice versa. These findings gave rise to the conception of one disease group which he called "manic-depressive insanity". The essential clinical criteria on which he diagnosed this group were a mood of elation, increased activity, flight of ideas, and distractability, or their opposites. .

One of the most striking features in these

two groups (manic-depressive and dementia praecox) which Kraepelin demonstrated was that in many, if not the majority, of cases there was no gross impairment of the purely intellectual functions, such as orientation, memory and ability to perform simple acts of reasoning. For some time it had been recognized that disturbance of these functions was an essential part of the symptomatology of the psychoses associated with gross bodily disorders, such as general infections, states of exhaustion, disease or injury of the brain itself. Kraepelin demonstrated that psychoses did occur where - in the early stages, at any rate - there was no intellectual impairment, and he brought out more clearly this valuable point in differential diagnosis; namely, the careful examination of the intellectual functions. In practice, this meant that where intellectual impairment was a prominent feature of a psychosis, the major cause was to

be sought for in some gross bodily disturbance; whereas, if intellectual impairment was not present, then the psychosis was to be regarded, in 'Kraepelinian' terms, as a 'functional' one.

It is only just to note, in passing, that, although Kraepelin's conceptions of dementia praecox and manic-depressive insanity are widely accepted today as a working basis, they were not allowed to pass unchallenged by other psychiatrists. Thus, Bianchi regards the cases which Kraepelin calls dementia praecox as one of the possible end-results of 'sensory insanity'⁽¹⁰⁾ - a psychosis resulting from the gradual dominance of consciousness by a variety of hallucinatory experiences.

⁽¹¹⁾
Savage and Goodall, criticizing the conception of dementia praecox, say "it does not appear necessary to remove and group together under a special designation cases which exhibit such features, and which now appear under

other headings, such as melancholia, dementia stupor".

As time went on, Kraepelin continued to describe more and more clinical subdivisions of cases of "dementia praecox" and "manic-depressive insanity", until, in the last editions of his works, these have reached bewildering complexity. Thus, he came to alter his original classification of the early forms of dementia praecox, and finally spoke of two "depressive types of dementia praecox" - viz., "simple depression or stuporose deterioration" and "depressive deterioration with delusion formation". He spoke also of certain "agitated", "circular" and "periodic" types of dementia praecox, and finally a type in which "speech confusion" is the cardinal symptom. These are all in addition to his "simple", "catatonic" and "paranoid" forms. To formulate concisely, then, what Kraepelin did for psychiatry it may be said that:

(1) He produced extraordinarily detailed clinical descriptions.

(2) He attempted to delineate certain clinical types; and he - quite unjustifiably - implied that each type was a disease entity.

(3) As his experience widened, he demonstrated - although he did not formulate this concept explicitly - that there seems to be clinically a graduated scale of cases which, at the one end, show symptoms almost exclusively corresponding to his "dementia praecox" type, and, at the other end, corresponding to his "manic-depressive" type; while in between these extremes are cases showing certain features of both these alleged disease entities. It was these cases in the middle of the scale which led him to invent such names as "circular" or "periodic" types of dementia praecox.

Kraepelin did not, however, provide us with an understanding of the mental illnesses of

young adults. On closer inspection, it becomes clear that he actually pointed the way for his followers, away from the broad, well proportioned approach of Clouston's day; for his final legacy to psychiatry was his expressed belief that some form of toxæmia - then becoming a fashionable way of explaining the misunderstood in general medicine - was responsible for dementia præcox and the manic-depressive psychosis. On what clinical evidence he based this belief it is hard to tell. He describes enlargement of the thyroid gland, tremor of the fingers, pupillary anomalies, low temperature and blood-pressure and wide deviations in the pulse-rate; and presumably it was because of these changes that he suggested that some toxin was responsible for the disease. He connected this with the sex glands because the disease is so closely associated with adolescence. Later, he repudiated this hypothesis in favour of one in which a more general metabolic intoxication was the fundamental change. This, together with

the increase of scientific medicine at the close of the 19th. Century, and the attractive simplicity of the concept of some concrete, demonstrable substance being responsible for these psychoses, has led to a massed attack upon the subject from the chemical point of view. Comprehensive summaries of these studies into the possible physiogenic causes of mental illness have been given in recent years by Goodall⁽¹²⁾ and Langfeldt⁽¹³⁾, and it is unnecessary for present purposes to consider these researches in their technical details: it is more with the mode of approach as a whole that this thesis is concerned. It is necessary, however, to consider some of the outstanding results which have emerged from this mass of investigation.

One of the most serious criticisms which can be levelled at this ⁿpar~~ti~~-chemical attitude is that many psychiatrists with practically no chemical knowledge, training or experience, are tackling

the most abstruse problems of body-chemistry with weapons which they are ill-equipped to wield. In a few cases, however, a genuine biochemist or physiologist has applied his methods to cases of mental illness, with regrettably negative results up till the present time.

One of the first noteworthy efforts in this direction was the application by Fauser⁽¹⁴⁾ of the Abderhalden test to so-called 'dementia praecox'. It was positive in many cases, indicating that destruction of the sex glands was going on. This work was supported by the histological and chemical researches of Mott⁽¹⁵⁾, who demonstrated aspermatogenesis in the testicles of dementia praecox cases, and also regressive changes in the adrenal medulla, characterized by an increased number of nuclei, irregularity of nuclear forms and a deficiency of chromatin together with an increase of fibrous tissue. In the anterior part of the pituitary were found atrophy of cytoplasm and nuclear changes.

All these changes Mott correlated with chemical and histological changes which he found in the brain, such as swelling of the cell-nuclei with disappearance of Nissl's granules, destruction of cytoplasm and loss of dendrites, the appearance of lipoid granules in the cells of the cortex and basal ganglia, diminution of the number of oxidase granules and an increase of the neutral sulphur-content of the whole brain. Mott expresses the view that these changes indicate a general diminution in the oxidation processes in cases of dementia praecox.

Mott's work has been criticized on technical grounds by Morse ⁽¹⁶⁾ and others. It is not disputed that these changes occur, but attention has been drawn to the fact that they also occur in patients who are not psychotic, but who are of similar ages to Mott's patients and who have died of similar conditions, including a number of acute infections. It is certain that there is some clinical justification for the investigation of

the endocrine system in many patients. With the advance of endocrinology it has been shown that certain physical characteristics - such as type of hair, nature of skin, bony formation, and so on - are capable of being correlated with endocrine changes. Many so-called 'dementia praecox' patients show physical characteristics corresponding with those attributed to endocrine changes, as (17) Kretschmer has pointed out.

Pari passu with this extensive search for some endocrinopathy, certain observers clung to the former tenets of psychiatry - namely, brain physiology and pathology - but applied their methods to Kraepelin's clinical types. The most notable (18) of these are Alzheimer and Josephy, both of whom believe that dementia praecox is an organic brain disease because they invariably found degenerative cellular changes in the brains of dementia praecox patients. These changes are said to be of a non-inflammatory type - such as fatty degeneration, sclerosis and atrophy - and

are found principally in the anterior portions of the brain, frontal and temporal lobes, in the third and fifth cortical layers. Cell-changes in the basal ganglia are also found. Josephy does not claim that he can correlate these anatomical changes with the symptoms of dementia praecox. He believes them to be toxic in origin, and this brings his work into line with Kraepelin's concepts. The tendency of the majority of Kraepelin's followers has been rather to neglect the brain-pathology and devote themselves exclusively to the chemical aspects of the great clinical groups which he described.

Of all the extra-neural pathological work which has been done, there is little doubt that that of Mott and the endocrine school, as described above, has, up till the present, been the most productive of concrete objective results, which have at least some clinical justification.

The latest effort of the endocrine school is seen in the very comprehensive work of Langfeldt (19) ,

whose work on the autonomic nervous system and the endocrine glands, utilizes a system of pharmacological 'functional' tests made by injecting various drugs, such as adrenalin and pilocarpin, and observing their effects on pulse, blood-pressure, pupillary reaction, salivation, etc.

Apart from this work on endocrinology, however, there has been a widespread investigation, bacteriological and metabolic, of these cases.

(20)

Cotton, Hunter, Pickworth and many others have extensively investigated the bacteria of the intestine, nasal sinus, tonsils, teeth, etc; and some of the writers of this school go so far as to describe a "septic psychosis". These investigations are the application to psychiatry of a school of thought which was fashionable in general medicine for a time. It has been known for many years that gross infections and intoxications were capable of playing an important part in the

production of psychoses. These psychoses, however, as Bonhoeffer showed, were characterized by impairment of the intellectual functions. They were, in fact, "symptomatic psychoses", as he called them. So far as the groups designated "dementia praecox" and "manic-depressive insanity" are concerned, however, the 'focal sepsis' advocates have not been able to produce any convincing evidence that occult sepsis plays an etiological part.

In any case, the criteria of the normal bacteriology of the parts which these observers were investigating are admittedly unknown by competent bacteriologists.

At the present time, the question of the acid-base balance of the blood is arousing considerable attention; and, so far, it has emerged that many early cases of mental disorder in young adults are associated with a degree of acidosis. This work has been done principally by Shera ⁽²¹⁾, Mann ⁽²²⁾ and Goodall ⁽²³⁾.

The Psychological School.

Although the treatment of certain forms of illness in the far-distant past may, in a sense, be described as psychological, it was not until the middle of the 19th. Century that psychological conceptions were seriously put forward as an explanation of certain illnesses.

In 1843 Braid made a determined attempt to sift the good from the bad in the rather doubtfully scientific work of the French 'mesmerism' school, which had been flourishing for about a century ⁽²⁴⁾. He drew attention to a condition of "nervous sleep" - hypnotism - the phenomena of which are induced by "a continual fixation of the mental and visual eye upon an object with absolute repose of body and general quietude". As these phenomena may also be induced in the blind, Braid expressed the opinion that "it is not so much the optic, as the sentient, motor and sympathetic nerves and the mind, through which the impression is made". The phenomena which he was thus able to induce were closure of the eyelids,

with some vibratory motion; loss of normal consciousness; rigidity or cataleptic states of the muscles, and some anaesthesia. His explanation of the conditions was that "the equilibrium of the nervous system was destroyed", and that much of the effect was due to "the power of imagination, sympathy, and habit in producing the expected effects on those previously impressed". Although his work was done carefully and in an unbiased way, Braid's views did not find favour with the medical profession in this country. Hypnotism languished for about forty years, when interest in the condition was revived by Charcot and Bernheim⁽²⁵⁾, who, in 1884, put forth the contention that the phenomena described by Braid were due to suggestion. Braid, of course, recognized the importance of suggestion, but did not say so explicitly. Bernheim showed that suggestion was a universal factor in mental life, that it was called into play constantly in the normal life of a normal individual, and that it

could produce results, including therapeutic effects, without the intervention of hypnosis.

Charcot noticed that in persons showing certain nervous symptoms and signs after an accidental injury, the physical accident in itself was not the cause of the symptoms, but that a part was played by the memories of the accident. Finally, he propounded the view that certain symptoms of hysteria were due to "ideas". As Hart ⁽²⁶⁾ says, "with this view was laid the foundation-stone of the psychopathological conception of hysteria, and here also we see the beginning of a delimitation of 'psychogenic' from other diseases".

Janet, working from the propositions which Charcot had put forth, so strengthened the arguments in favour of 'psychogenic' illnesses as to render their position impregnable. He noticed that hysterical anaesthesia often had a peculiar distribution, quite out of accord

with known anatomical nerve-distribution, but corresponding exactly with the lay patient's "idea" of a certain part of his body (e.g., his hand).

He drew attention to another fact which widened and complicated the vista enormously. It was noticed that, whereas patients suffering from syringomyelia with small patches of anaesthesia frequently suffered accidental injury, patients with large areas of hysterical anaesthesia very rarely sustained any injury. The only conclusions possible from this were that the hysterical patient must 'feel' with his affected limb, which was anaesthetic on formal testing. In order to explain these facts, Janet devised the conception of "dissociation of consciousness". The mind of the patient was, so to speak, split into two parts; two independent streams of consciousness, each without knowledge or awareness of the other. Thus, the sensations arising from, say, a limb may be diverted into a current separated from the main stream of consciousness, thereby

producing an anaesthesia. This subsidiary stream is, as it were, a little personality or 'mind' in itself, which directs the activities of the limb independently of the main stream of consciousness, and unknown to it, thus enabling it to avoid injury. Such a hypothesis undoubtedly explains the clinical facts; it explains the apparent paradox that the limb is anaesthetic to formal testing; and yet it must be capable of feeling or it would not be able to avoid injury.

Janet also applied this concept of dissociation to hysterical paralysis, somnambulism and other phenomena; and he claimed that it fitted the facts. If this hypothesis is true, then there remains the question as to why dissociation should occur at all. If it is the result of psychological forces, then it must have some purpose; for purpose, as McDougall⁽²⁸⁾ has argued, is one of the characteristic marks of mental life. Janet, in his early works, formulated the "how", or mode of production, of psychogenic illnesses. It remained for Breur and Freud to

formulate the "why", or reason, for the production of such illnesses.-

(29)

In 1895 Breur and Freud described a case of hysterical paralysis, in which, under hypnosis, the patient recalled an unpleasant incident, which in her ordinary, fully-conscious state, she had forgotten. This incident had led up directly to the onset of the paralysis, and when recalled was accompanied by the unpleasant, emotional condition originally associated with it; after which, the paralysis ceased to exist.

From this time onwards, psychopathology began to take cognizance of the fact that emotion entered into processes, such as memory, which had previously been regarded entirely from the intellectualistic standpoint.

The patient forgets, or tends to forget, that which is unpleasant, because it is intolerable to his "better self".

Here, then, is a definite attempt to formulate the reason for the appearance of a hysterical paralysis - an attempt to make a symptom intelligible.

The case cited above was explained by the authors in a very simple fashion; there was an original "psychic trauma" or incident which resulted in an unpleasant, emotional state, and was, therefore, repressed or apparently forgotten.

With the growth of his experience, Freud's formulations grew more and more complex; and it is not intended here to discuss the intricate, psychological technicalities involved any more than the chemical intricacies of the physiogenic school. Rather is it our object to extract from the literature of both schools such facts as are established and such hypotheses as are likely to be fruitful in arriving at some understanding of the psychoses of young adults.

One of the most striking facts about the psychological school is that two investigators - McDougall, starting from the viewpoint of the

academic psychologist, and Freud, starting as a pure clinician - have, by very diverse methods arrived at conclusions which are fundamentally similar; namely, the large part played by the innate, instinctive tendencies in determining human behaviour - normal and morbid - and the fact that these tendencies are being constantly subjected to conflicts and inhibitions by each other, and by what McDougall calls the "self-regarding sentiment". It is held by the protagonists of this school that in individuals of a certain constitution these conflicts may be so unbearable to consciousness that they are repressed (i.e., forgotten), but not thereby exterminated or solved. They are merely "dissociated" from the main stream of consciousness, and they constitute the "subconscious" or "unconscious". Then, for some reason - it may be that the warring, instinctive tendencies are so strong, or it may be that the repressing forces (i.e., the "self-regarding sentiment" of McDougall or the "censor" of Freud) are weakened by some

external circumstance - the conflict bursts through into consciousness, but not in its naked, primitive form. It is disguised; its manifestation takes the form of a hysterical paralysis, a hallucinatory "voice", or a delusional belief; any of which, in some way, "symbolizes" the conflict.

The mechanism of symptom-production, then, according to the psychological school, may be formulated broadly as follows:-

- (1) A special constitution.
- (2) Unbearable conflict.
- (3) Dissociation of conflict from consciousness and repression of it into the subconscious.
- (4) Weakening of repressing forces.
- (5) Re-appearance of conflict in a disguised form in consciousness (i.e., symptoms).

It seems almost unnecessary to mention that the psychological school has been subjected to a storm of criticisms almost unparalleled in its bitterness.

A closer investigation of this criticism is necessary. In the first place, Freud has shifted his ground a good deal since he first propounded his theories. This has evoked much criticism; but critics have lost sight of the fact that, although Freud dropped the "psychic trauma" theory in favour of the "Oedipus complex", and that, in turn, in favour of the "castration complex", he adhered all through to the relationship between the instinctive tendencies and the symptoms. Such criticism as may be brought to bear on these grounds is valid only in so far as it applies to technical details of theory of the moment, and does not in any way attack the method of approach; namely, the investigation of the patient's "inner life".

Further, many of the criticisms that have been brought to bear are directed not against Freud's personal work, but against the work of

some of his followers, in the mistaken belief that these are synonymous with Freud for practical purposes. Nothing could be further from the truth, for it is notorious that few investigators have been so misquoted, so little read (in the original) and so subjected to exaggerated abuse by their followers as Freud.

One of the critics who has tackled Freud and McDougall, from the point of view of their mode of approach to mental illness as a whole, is Shaw Bolton, whose paper, "The Myth of the Unconscious Mind"⁽³⁰⁾, is largely a personal attack upon Freud, apparently on eugenic grounds, in part ridicule; and finally a denial that there can be any such thing as a subconscious mind because (a) no one has defined it; (b) its existence is unlikely.

In another communication⁽³¹⁾, Bolton criticizes Freud and McDougall in a mass of physical and metaphysical speculation, not unmixed with comparative

neurology and morphology, which does not seem to deal strictly with the contentions of these authors.

Others, however, have attempted to bring the essential Freudian principles into line with the psychoses with which we are dealing.

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Jung, for example, attempted to render the symptoms of dementia praecox intelligible in terms of psychology. It cannot be said that Jung has explained dementia praecox, but it is apparent that, in some cases at least, he has rendered intelligible symptoms which would otherwise be quite meaningless, no matter what their exact mode of production, be it physiogenic or psychogenic. Jung showed that some form of psychology which takes into account the patient's instinctive and emotional activities is an absolutely essential part of the psychiatrist's armamentarium if he would fully understand the psychoses of young adults. His attempts to formulate dementia praecox in psychological terms has its counterpart in McCurdy's "Psychology of Emotion"⁽³³⁾, wherein

he attempts to explain the manic-depressive psychosis and involitional melancholia in terms of the unconscious wishes and fears, whose emotional accompaniments appear in consciousness in an apparently false setting.

The Personality in Relation to Mental
Illness.

Another important piece of work done by Jung was to bring attention to bear on the sort of people who become mentally ill. The old classical types of temperament had stood for years, and did not seem to be of any practical value to the psychiatrist; but Jung, in his "Psychological Types"⁽³⁴⁾, developed this rough subdivision into definite, carefully-delineated personality-types, of which the main subdivisions were the now much misused 'introvert' and 'extrovert' type of personality; and this was the starting-point for the extensive personality studies which were presently to engage the attention of psychiatrists.

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Kretschmer made an extensive investigation not only of the personality or "mental make-up" of normal and psychotic personalities, but he attempted to correlate his mental types with characteristic physical features. He delineated broadly two types - the "schizothymic" and the "cyclothymic" - corresponding roughly to certain of Jung's 'introvert' and 'extrovert' types. The former he found liable to develop dementia praecox types of illness, and the latter the manic-depressive type of illness. Wisely, he was not arbitrary in drawing hard and fast distinction between his types; rather, he implied that there is a gradually shifting scale with pure schizothymes at one end, and pure cyclothymes at the other; and this, of course, is quite in conformity with what is seen clinically. Kretschmer's work, then, may be formulated as follows: individuals conform to certain types of personality, more or less; and when an individual breaks down mentally, he does

so along the lines of his personality.

Kretschmer, however, was at heart a Kraepelinian, and was very loth to give up the arbitrary, clinical types - dementia praecox and manic-depressive insanity - of his teacher. It was becoming apparent, however, that this distinction did not meet all the clinical facts; and it fell to Bleuler⁽³⁶⁾ to put forward a formulation which seems destined to fill a gap which exists in clinical psychiatry between the nosographical forms of Kraepelin and the psychological explanations of other workers. The formulation of Bleuler's method of approach is as follows:- when we meet with a case, we should not ask 'Is it a schizophrenic' (dementia praecox) 'or an affective disorder?' (manic-depressive insanity), but 'To what extent is it schizophrenic and to what extent affective?'.
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Bleuler introduced the quantitative as well as the qualitative factor to psychiatry. He recognized, and stated explicitly, that in any

individual there are potentialities for reacting to his environment along either of two lines. He may withdraw from reality into himself (schizophrenic) or he may make good contact with his environment, at times launching forth into, at times being overwhelmed by, it (affective or syntonetic or cyclothymic reaction type). In a case of mental illness it has to be determined to what extent the patient is reacting along each of these lines. Thus, Bleuler suggested a mode of approach to the psychoses which opened up wider vistas, more in consonance with observed clinical facts than any psychological method then put forward.

To bring Bleuler's work into line with the present enquiry, then, it may be said that he recognized two clinical types of psychosis, one at each end of a scale, whilst in between were infinite gradations and combinations of the two. One type was 'schizophrenia', so called because its characteristic feature was a splitting,

dissociation or disintegration of the functions which, in their coördinate whole, make up what we call the mind. The other type was the "affective disorder", characterized by an exaggerated mood or 'affect' "most appropriate to the situation of the moment". Each of these types occurs only in individuals of the corresponding type of personality.

In a further development of this theme it was shown that the doctrine "an individual breaks down along the lines of his personality" was true not only of the "functional" psychoses (dementia praecox and manic-depressive insanity of Kraepelin), but also of the organic.

For example: a patient with general paralysis will have, of course, the intellectual impairment characteristic of all organic conditions. In addition, he will have symptoms of disorder in the emotional field, affecting his moods and beliefs, and so determining, to a large extent, his behaviour. If he be of cyclothymic disposition, then we should expect him to be grandiose, expansive and full of

generous whims. If he be of schizothymic disposition ("Yond' Cassius hath a lean and hungry look, he thinks too much"), then we should expect him to be morose, suspicious and antagonistic - at any rate until dementia obscured the whole issue. It would seem that this hypothesis is a possible and reasonable, but incomplete, explanation of the diversity of symptoms seen clinically - these "atypical cases" which render so confusing the attempts of the text-book to "pigeon-hole" a subject which in its very essence must be as protean as humanity itself.

It is, however, only part of the explanation; and, pursued to its logical conclusion, would have to answer the question, "What are the forces which determine the constitution of the personality of the normal individual?". Its protagonists are quick to note this, and there is amongst them at present a determined effort to follow up their arguments by an intensive study of the "personality".

This account, then, summarizes the diverse

activities of a school of thought which has flown in the face of accepted medical convention, but which, in its fundamental principles, cannot be ignored.

It would be well in closing this section to make clear one point often neglected by its critics. It is this: the leaders of this school - Bleuler, Freud and McDougall, to name a few - have never stated that the "mind" is some sort of mythical entity. Many of them have expressed the belief that the phenomena which they describe have some - as yet undefined - ultimate, physical basis; but they do say that, in the present state of our knowledge, psychological and biological terms are the most convenient way of describing, thinking of, and explaining those problems of behaviour which it is our business to investigate.

The Works of Bianchi and Adolf Meyer.

Although not explicitly a follower of
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Clouston, Bianchi, in his teaching, adopts such

a wide method of approach to psychiatric problems that his work may be regarded as the direct continuation of Clouston's methods, enlightened by extraordinarily careful histological and physiological researches. Like Clouston's, Bianchi's work rests on the solid foundations of anatomy and physiology; but, realizing that human behaviour cannot be profitably and completely explained in these terms alone, he blends them with sociology, environmental considerations, adaptations spoken of in biological terms, and, finally, with what may be termed "individual psychology" - the hopes, desires, experiences, fears, breeding and upbringing of the individual. For example? speaking of the "methods and field of clinical enquiry", he says, "It is our aim to translate the facts and laws of general psychology into what is known as individual psychopathology, since in each individual case the task of the physician is to reconstruct in mental synthesis the diseased personality in front of him, taking into account the social grade of

each individual and the amount of instruction received. Such object... .. may be obtained by (1) the psychological examination... .. of the patient; (2) the reconstruction of the individual and family history; (3) an enquiry into the environment; (4) the anthropological examination; (5) the minute functional examination of the nervous system; (6) the examination of the entire organisms, taking into account the multiple, mediate and immediate relations existing between structure and function both of the cerebrum and of all the other organs inasmuch as all these in synthesis reflect the personality".

Not only did Bianchi formulate these essential principles of approach, but he recognized, although he used different terms to describe it, the importance of the "inner life", so much vaunted by the psychological school. Thus, he says, "The illuminated field" (i.e., of consciousness) "presents the conditions best adapted for maintaining the contact of the ego with the external world and for utilizing through these relations the whole

patrimony of the personality conserved in the non-illuminated part - that is to say, in the unconscious. In other words, the unconscious supplies to consciousness all the data of the individual history essential for useful adaptation of the personality to its environment. The illuminated field is also a place of preparation of instantaneous syntheses and of new reactions; but this work of synthesis is not unknown to the more profound and obscure departments of the unconscious."

Further: "It is in unconsciousness that the formation of delirium are prepared and organized, that they assume associative relation and raise the potential of the sensory zones, producing hallucinations as a result. ... The unconscious is the great architect of good and evil, of genius and folly and the majority of mental affections have their origin in it."

Bianchi fully recognizes the "conflict" of the pure psychologists and seeks to place it on a

physiological basis; and, further, he recognizes the "withdrawal from reality" also of that school. It may truthfully be said, then, that Bianchi was fully alive to all those facts which the pure psychologists claim to have brought to light, but he formulated them in terms of mixed psychology and physiology and - perhaps for that reason - his work has not met with the reception in this country which it deserves; nor have his methods been adopted to an extent which would certainly have proved profitable in a better understanding of the psychoses. Put concisely, then: Bianchi adopted the wide method of approach to the individual case, and attempted to reduce his ultimate explanations to physiological terms.

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Meyer is another psychiatrist who adopts a broad viewpoint in approaching his cases. To quote two of his pupils ⁽³⁹⁾: "This biological hypothesis regards mental illness as the cumulative result of unhealthy reactions of the individual mind to its environment, and seeks to trace in a given case all

the factors that go to the production of these reactions".

In this formulation there are, undoubtedly, the same essential features as in other wide methods of approach. We have the "individual" nature of mental illness, the dynamic conception of a "reaction to environment", and (implicitly) a "number of factors" which go to produce such reaction.

Possibly the most helpful point in Meyer's method of approach to psychiatric problems, and that which renders it unique, is what one may call his unification of all the functions of the individual. This is essentially the doctrine of integration, which is that the individual is something more than the sum of his parts. He is a hierarchy of functions, with something new emerging at each level until the highest of all is reached; viz., the mental level, which is the complete expression of the individual as a whole. This, once for all, does away with the

old dualistic controversy of "mind" and "body" as a necessary part of psychiatric philosophy.

Meyer's method of approach is to study developmentally the building up of the individual, to analyse and reconstruct the personality, and to consider it in relation to the situation which it is called upon to meet. This is the so-called psychobiological viewpoint. Be it noted that this method takes everything into account, including physical changes, and recognizes no incompatibility between "functional" and "organic" psychoses. Meyer does not regard the psychoses as disease entities, but as "reaction types"; and each case is essentially the outcome of factors peculiar to the individual, and, therefore, calls for a prognosis and management peculiar to itself.

This, then, closes an outline account of those schools and aspects of modern psychiatric work and thought which may profitably be brought into relationship with the psychoses of young adults. It will be our business in the next section of this thesis to show how, in practice, a judicious combination of some or all of them may help in the elucidation and management of these illnesses. Before doing so, a summary of this historical survey is presented, so that we may have our data in concise form.

SUMMARY OF HISTORICAL ACCOUNT.

1. Pinel, Tuke and others, by their reforms placed psychotic patients under hospital conditions, and enabled them to be approached by physicians in the same manner as other sick people.
2. The nosographical methods of Sydenham were applied to these cases, resulting some forty years later in the delimitation by

Kahlbaum of two clinical types of illness seen in young adults; namely, 'katatonia' and 'hebephrenia'. These were regarded by Kahlbaum as 'disease entities', but his views were much criticized (Falret and others).

3. Clouston regarded the 'insanity of adolescence' as an entity in itself. It might take one of several forms, and there were no criteria by which one could foretell the ultimate result. Clouston taught the importance of a wide viewpoint if an understanding of these cases was to be possible; and, while taking cerebral physiology as his fundamental basis, he pointed out that the psychology of the individual, his instinctive longings, his education and environment might all play a part in the development of a psychosis.

4. Kraepelin followed on Kahlbaum's work. He delineated 'dementia praecox' and 'manic-

depressive insanity', each with their subdivisions. He continued this method almost to the point of absurdity, so many and diverse were the types he described. It appeared that there were cases presenting mixed features of both these alleged entities. So far as young adults were concerned, he showed that almost any form of psychosis might occur in them; and each of these he sought to elevate to a definite disease entity. He believed that a toxæmia was responsible for the production of these conditions, and he produced a certain amount of clinical evidence in favour of this in some cases.

5. This led to the 'toxic', 'physiogenic' or 'chemical' era in psychiatry, characterized by a great activity in the search for some 'substance' which would account for the symptoms. Much of the work was done in an ill-controlled manner by unskilled observers.

The few positive facts which were arrived at by valid methods were: (a) Mott's description of degenerative changes in certain endocrine organs, evidence of disturbed metabolism and organic, neuronc changes; it has been pointed out by Morse that Mott did not take sufficient consideration of the clinical type of illness and its duration, the age of the patient, and the cause of death; (b) Langfeldt's clinical evidence of disturbance of sympathetic function; (c) the demonstration by Goodall, Shera and others of disturbed acid-base regulation in certain cases.

Gross infection and intoxication have been shown to play a part in the production of psychoses - the 'symptomatic psychosis' of Bonhoeffer - but no convincing evidence has yet been produced which would justify the theory that focal sepsis plays an etiological part in the psychoses designated 'dementia praecox' and 'manic-depressive insanity'.

6. Braid, Charcot, Janet and others demonstrated beyond all doubt that psychological factors are capable of producing psychological, or even physical, symptoms. Janet formulated the concept of 'dissociation of consciousness', and found that this hypothesis explained some symptoms in certain cases. Freud and McDougall drew attention to the part played by the instincts and emotion in the production of dissociation and, hence, of symptoms. Jung attempted to apply these concepts to dementia praecox, while McCurdy applied them to the manic-depressive psychosis; and each put forward a theory which rendered certain symptoms intelligible.

7. Jung drew attention to the two broad types of personality (introvert and extrovert), and showed that dementia praecox tended to

develop in the introvert type.

8. Kretschmer enlarged this viewpoint. He demonstrated a gradually sliding scale of personalities, and showed that when an individual breaks down he does so along the lines of his personality.

9. Bleuler demonstrated practically the same facts as Kretschmer, and he formulated the question - to be asked in any given case - "To what extent is it schizothymic (or schizophrenic), and to what extent manic-depressive (affective)?" ; while he laid down certain criteria for each of these extreme ends of the scale.

10. Bianchi formulated his views in a wider manner. He sought in anatomy and physiology the physical basis of the psychoses; but he also emphasised the importance of the "individual psychology" - the unconscious, the environment, etc. He pointed out that the task of the physician was to "reconstruct in mental synthesis

the diseased personality in front of him".

11. Adolf Meyer also adopted the broad viewpoint and method of approach. The essential features of his teaching are (a) the doctrine of integration and (b) the psycho-biological viewpoint; and the psychoses are regarded in terms of "reactions".

PART II

THE ARGUMENT.

In this section it is proposed to produce evidence in support of our proposition, to formulate terms in which the psychoses of young adults may be rendered intelligible, and to pass in critical review the methods of approach of certain psychiatric schools of thought, extracting from each such facts and concepts as are likely to prove useful for our purposes.

As was pointed out in Part I of this thesis, the essence of the Kraepelinian method was careful description of symptoms in a vast

number of cases, division of cases into groups, according to the similarity of their symptoms, and the labelling of each of these groups.

Thus, a number of clinical types are delineated.

Kraepelin demonstrated which clinical types tended towards recovery; recovery with probability of relapse; and non-recovery. There were, respectively, the toxic exhaustive (acute confusion) psychoses, manic-depressive insanity and dementia praecox. In a word, he showed that there was a certain relationship between clinical type and ultimate result. He failed, however, to realize that a clinical type or group of symptoms is not necessarily the same thing as a disease entity. A disease entity implies a specific cause and a specific pathology. It has not yet been shown that any such specific cause exists in the psychoses of young adults.

The pathology of the conditions under consideration has not been reported as being

constant or specific, even by the most competent observers.

It has been shown that a variety of morbid physical changes occurs in many cases; but it has not been proved that these have any etiological significance; nor have the organs which show these changes been compared with the corresponding organs of non-psychotic persons of similar ages, and existing under similar conditions, to an extent which would justify our regarding them as specific. Conversely, it has not been demonstrated that there is any disease entity in young adults of which a psychosis is a constant symptom, with the rare exception of juvenile general paralysis. On the other hand, it has been shown that many psychoses occur in the absence of any specific disease entity.

Let us suppose, for a moment, that the Kraepelinian method has found some specific cause and has demonstrated some specific pathology: would that explain the extraordinary

diversity of clinical symptoms which we see? Emphatically, no; nor would it explain why some cases of apparent 'dementia praecox' end in recovery, and why some cases of 'manic-depressive insanity' end in dementia.

Let us take a concrete example; viz., dementia paralytica: here we have a specific cause and a specific pathology; we know that the spirochaete is destroying the brain; it is intelligible to us how this process leads ultimately to dementia - in virtue of our knowledge (such as it is) of cerebral physiology - but that does not explain why, in the early stages of the disease, some patients are elated, others facile, suspicious or hostile, why some have delusions of persecution, others of unworthiness, and others of grandeur.

Consider the case of a woman who develops a psychosis during the puerperium. We commonly find that confusion is a prominent

symptom. We have reasonably strong clinical and experimental evidence that this symptom is an indication of disturbance of the associative functions of the cerebrum. In other words, it is indicative of a definite physical disturbance. In addition to being confused, such a patient may be dull, irritable and suspicious of others; or she may be profoundly depressed, expressing beliefs of her own unworthiness, and attempting to commit suicide; or she may be elated, over-active, and full of expansive schemes for the improvement of the world.

To say that these things are the result of poisoning of the brain does not render them intelligible.

It is remotely, if fancifully, possible that cerebral localisation may become so exact, and our knowledge of the selective action of toxins so complete, that an understanding of the case along these lines might be achieved. In the light of our present knowledge, however, this is

not a justifiable conclusion; and it has the great disadvantage that it tends to make us think that we have explained the case, and to leave it at that, without utilizing all the means in our power of modifying other factors, which might have etiological significance and therapeutic value.

It is desirable to make clear at this point that we do not in any way intend to disparage the painstaking efforts of those whose work is directed towards the elucidation of the physical changes which take place in the psychoses; nor do we take exception to the search for some physical cause for such conditions.

We would point out, however, that such cause - if it exists - must operate on something; and that something is the living human being, in part or in whole, including that elusive aspect of him which we call the 'mind'. Now a human being is not a fixed, static thing. He is

living, ever changing, dynamic; and it is, therefore, valid to speak of the causes of a psychosis and that on which they operate as if they were forces. This being so, we may regard the phenomena which we call the symptoms of a psychosis as the resultant of these forces.

It is quite illogical to attempt to understand the resultant by studying only one of the component forces. No matter how minutely we study a single component, we cannot explain the resultant unless we study the other components also.

For this reason, the search for some single, specific cause of a psychosis, even if it be successful, cannot explain the psychosis. It is necessary to know the nature of the subject in whom the psychosis develops; and this is obviously an individual matter, not only as regards the 'mind', but also as regards the peculiarities of body-chemistry and constitution

generally.

The resultant (i.e., the symptom-complex), as we know from clinical observation, differs in detail in every case, so that, even if one component (causal factor) be shown to be constant, the others must be infinitely variable.

In each case, therefore, there is a different explanation of the symptoms.

Therefore, all cases must be approached individually.

The nosographical method of diagnosis is useful in so far as it enables us to communicate to others the kind of case we are thinking about; and, incidentally, to prognosticate in an empirical way. Such a method is essentially static. It consists in taking the symptoms as we find them at the time of examination, and comparing them with our concept of other cases showing similar symptoms. We are, however, dealing with the resultant of dynamic, ever-changing forces. Our aim should be to resolve the resultant into its

components. Clearly, if this be a valid metaphor - indeed, it is more than a metaphor, for we are aware of no other terms which are more nearly capable of rendering our subject intelligible - we cannot so resolve the resultant by merely studying it at any one point in its path. Nor, for that matter, would it be of much assistance to study any or all of the components at any one point.

We must trace the resultant and each one of its component forces as far back as we can. We must form some concept of when each component came into relationship with the individual; the amount of energy behind it; and the direction towards which it will deflect the resultant. To know these things involves a process of tracing back the life of the individual, everything that has come into relationship with him, and their effects on him; and it involves a study of his (individual) origin.

Thus, we have established that, in order to

understand the psychoses of young adults, the question must be approached individually; also that the individual case must be studied developmentally.

To complete the proof of the whole of our proposition, it is necessary to show that the case must be studied in all its aspects. To do this, we must define more closely what these aspects are. That is, we must enquire what components can possibly enter into our scheme of forces. These would appear to be:-

(1) The Raw Material. - The individual as he was at birth.

Can we resolve this further? Undoubtedly, we can.

At birth, the individual begins a separate existence, endowed with certain potentialities. We want to know whether this endowment is average, whether, ab initio, there is some defect in his physical nature, or if we may infer, from a study of his ancestry, the

probability of some of his potentialities being abnormal in some way. In a word, we want to know what he is made of.

(2) Developmental Forces. - We know from centuries of experience in the field of education that the growing individual is an exceedingly plastic creation.

At first, the infant's behaviour seems to be a mass of instinctive and reflex actions, which occur in response to appropriate situations. The emotions are near the surface - simple, easily aroused, and without controlling influence. The intellectual functions of memory and orientation are not apparent for many months, and the higher function of inhibition does not appear until later still; whilst last of all does the highest function of integration, control and moulding of all these functions come into play.

It has been abundantly shown that the development of these functions corresponds with that of the brain. It has also been shown that

failure of development, disease of, or injury to, the brain may, and usually does, interfere with the development of these functions. But - and this is the crux of the situation - it is not valid to argue from that fact that where we find disturbance of these functions, or interference with their development, we must, of necessity, have some physical disturbance of the brain. The fallacy of this argument is amply demonstrated in the clinical and pathological studies which have revealed the fact that such disturbance of function may occur in the absence of demonstrable brain lesion.

All that we are justified in saying, from our knowledge of the contemporaneous development of structure and function, is that the structural development renders the functional development possible. No reasonable person will deny that - apart altogether from brain lesion - physical ill-health, accident or deformity can, by restricting the field of activity, and in other

ways, modify such development; and it is also apparent that such things as example, scholastic education and the inculcation of religious beliefs can profoundly modify the functional development of the individual.

It may be that these modifications have their neurological correlate, according to the "Law of Neural Habit", in the "channelling" of some particular cerebral pathways; it may be that by the minute study of the synapse the neurologists will be able to tell us precisely what is happening in the brain; but does that help us much? The all-important fact is that forces in the environment may completely modify the functional development of the individual; and, therefore, they must receive consideration in our scheme, not only, be it noted, as a means of explaining a psychosis, but also as a means of modifying its course.

Now the study of the forces in the environment in which the individual has developed only

helps us if we consider how they have modified the raw material. It may be that by their gradual cumulative effect they have brought about some psychosis of insidious development; that is, they may have warped the functional development of the individual so that his behaviour has gradually become psychotic.

At all events, it is clear that in development of such a psychosis a number of conflicting forces have been brought to bear upon each other. The patient's instinctive energies have had to submit to the obstructions of convention, religious beliefs, superstitions; and, as long as the balance between these things (i.e., the integrative function) is maintained, there is no psychosis. If, however, some greater obstruction occurs, or if the physical basis of the integrative functions breaks down, the resultant of these forces may be a psychosis.

From the nature of these latter forces - namely, the fact that they are different in their intensity from the ordinary give and take of existence - we may, for convenience, group such forces as sudden physical illness, financial disaster, bereavement, or any other sudden mental stress, under a separate heading:-

(3) Precipitating Forces: and we see that these are of three kinds:-

- (a) Environmental (financial disaster, bereavement, etc.).
- (b) Personal, Psychological Forces ("conflict" - i.e., incompatibility of desires and beliefs, or of ambitions and capabilities, etc.).
- (c) Personal, Physical Forces (injury, disease or poisoning of the body as a whole, and of the brain in particular).

To capitulate, then: the components which go to make up our resultant are to be found in:-

- (1) Endowed potentialities (raw material).
- (2) Events in the environment which modify

the development of these potentialities; the result of this modification being the "personality".

(3) The forces which the personality is called upon to meet (i.e., precipitating forces); and those may be in:-

- (a) the environment;
- (b) the psychological aspect of the individual;
- (c) his physical nature.

Up till this point in the argument, we have been speaking of the psychoses as a whole.

When a psychosis is viewed in the way we have advocated, it becomes intelligible - if we know enough of the component forces - why a breakdown should occur at all. To vindicate itself, this argument must pass successfully the test of meeting and explaining actual clinical cases. We propose to illustrate this by reference to actual cases in ~~the~~ a later part of this thesis.

No doubt, long before this stage of the argument, the recollection of cases of apparently spontaneous psychoses will have presented itself to the reader. It is desirable, therefore, to indicate briefly how our scheme may meet even these.

The essential thing is that we should know enough of the component forces. It is such common experience as to need no actual example here that some psychoses in young adults develop apparently "out of the blue". In our study of the family history, we may not alight on any fact which would justify us in inferring some abnormal endowment of potentialities (that, of course, does not necessarily mean that such abnormalities do not exist). Our study of the forces of the environment during the period of the patient's development may show nothing unusual; there may not have been any apparent "precipitating forces"; that is, the patient may not appear to have been called upon to meet any unusual

or special obstruction to his progress; and, further, may be in apparently good health. Yet, his development diverts from the normal, and he becomes psychotic. How is our argument to meet such a case? It meets it by saying that we have not taken into account the personal psychological and physical forces. We must, therefore, consider these forces further.

Personal Psychological Forces.

Our study of a case may not show that anything unusual has happened in the environment; but, for all that, it is possible that even the usual run of events may have had an unusual effect on the patient. This, only the patient can tell us; we must know the subjective aspect of the case. There is nothing inherently unusual in an adolescent youth being bereft of his parents; yet, such an event may very well precede the psychosis in the kind of case of which we are speaking. Of itself, it does not explain the psychosis; but, if we know something of the youth's attitude to his parents, we may ~~with~~ without evoking

any truly Freudian principles - render the psychosis intelligible. It may be that he accepted his parents' word without question in everything; that he subordinated his own strivings to their wishes; that, in fact, he never trained himself to be independent. He is suddenly called upon to declare his independence - a process which normally takes many years. Is it not intelligible how he may slip into a helpless, hopeless, apathetic, inactive condition, shunning the society of others? Perhaps, too, because of religious education he may believe that this bereavement is a punishment to him because of some real or fancied childish error which to him is a great sin (e.g., masturbation). Thus, although he may have been, objectively, a model child, obedient, unobtrusive, and so forth, and although his religious beliefs may be perfectly orthodox, the knowledge of his attitude to his parents, brought into relationship with his

bereavement and religious beliefs, may go far towards helping us to understand his psychosis.

Such a situation is, however, very simple. The patient, moreover, is fully conscious of the principal conflicting forces.

Can it be that there are other forces in the psychological constitution of the individual, of which he is not conscious?

In Part I we referred to the work of the psychological school. How much of that work may we accept as valid and directly applicable to our problem? Setting aside the differences in actual phraseology used by the different exponents of this school, we would say:-

(1) The concept of the unconscious seems to us a useful and valid one, in its broad sense, that we are unaware of certain of our own psychological activities.

We cannot agree with Freud, however, that the content of the unconscious is solely ^{crude} under sexual striving; nor can we agree with his

elaboration of this theme - that such strivings properly belong to the periods of infancy and childhood.

(2) We can also usefully accept the concept of 'repression'. There is no doubt that a person can 'put thoughts out of his mind'; and there is no doubt that he does tend to 'put out of his mind' thoughts which have reference to crude instinctive desires (not necessarily sexual) which are unacceptable to his 'better self', or, as McDougall has it, to which his self-regarding sentiment is opposed.

(3) This involves the acceptance of the concept of 'conflict' of instinctive desires with one another and with inhibitions of all kinds.

(4) These conflicts may be conscious or unconscious, not in a sharply-divided way, but in the sense the subject may view them clearly in the sharp focus of full awareness, or dimly in the mists of wandering fancy.

We must admit that the content of the unconscious can be a component in our scheme of forces.

Like the individual as a whole, the content of the unconscious is not to be conceived as being a fixed, stated thing. It is a living, dynamic series of processes or forces, each, we may say, the mental counterpart of some biological mode of reaction, which is repressed or debarred from expression, perhaps, because it is unacceptable to the individual as a whole; perhaps from fear of the consequences; perhaps from lack of the necessary vigour or energy to overcome the obstructions in its path.

Is it likely, if great biological forces - such as the reproductive or protective instincts - have once been aroused to such an extent as to require repression, that their psychological counterparts will lie dormant in the subconscious and exert no influence on the individual as a whole? Hardly so. There must be a perpetual

warring between these forces in relation to each other, and in relation to the individual as a whole. Is it not intelligible how some such thwarted force may modify the whole life of the individual?

Is it not intelligible that the 'repressing' forces may be weakened by physical ill-health, or by some environmental disaster; or how the 'repressed' forces may be stimulated anew by some extraneous event, and burst the bonds of their repression?

Is it not intelligible how such a force, denied for ever the possibility of achieving its purpose in reality may be so strong and insistent as to achieve it in phantasy, through its psychological counterparts?

Such phantasies undoubtedly have their neurological basis. That does not invalidate the terms in which we speak of them. We admit that the phantasies of psychotic patients are the psychological counterparts of repressed,

instinctive forces; and we admit that such phantasies may be such as to disguise the real nature of the forces behind them. Then only do certain symptoms, particularly certain hallucinatory experiences, become intelligible. We do not accept to the letter the Freudian scheme of 'symbolisation', but we do admit disguise of crude thoughts, and we seek the reasons for this disguise in the self-regarding sentiment.

Personal Physical Forces.

The symptoms of confusion is such a constant accompaniment of disease, injury or poisoning of the brain, that its presence should always indicate a search for some major etiological force in the somatic field.

This search must be of the most detailed nature, and should, if necessary, employ all the armamentarium of the modern clinical chemist. It would be out of place at this point to go

into technical details. Some comment, however, seems necessary on the efforts of the 'physiogenic' school to demonstrate the presence of organic disease processes in psychoses of which confusion is not a symptom - such conditions as simple states of depression or excitement or delusional states without impairment of orientation, memory and retention. The exponents of this physiogenic school seem to be convinced that some 'toxaemia' is responsible for these conditions.

This naive conception is opposed to the law which states that the latest structure (and function) to be evolved is the first to be impaired when the organism is attacked by some toxaemia.

Now, from our studies of evolution, we know that the mental functions and their neurological counterparts developed in this order:- instinct and emotion; orientation and memory; inhibition of instinctive action; integration. We should expect, therefore,

that if the neurological basis of these functions is attacked by a toxaemia, we should see derangement of them occurring, first as loss of integration, then as loss of control (inhibition) of instinctive functions; then disorientation and loss of memory; finally, a failure of the emotional and instinctive functions. This order is followed precisely in the effects of such drugs as alcohol and chloroform on the brain and of such disease processes as that of dementia paralytica or poisoning by puerperal toxins. But in many psychoses we observe profound changes in the emotional nature, particularly in the way of the development of false beliefs (it has been demonstrated by McDougall and others that belief, particularly belief regarding the person and belief by suggestion are essentially emotional functions) without

any disorientation or loss of memory, while the integrative functions do not seem to be in any way impaired. Such patients are neat, tidy, orderly; in a word, their 'personality' is well preserved. Clearly, then, unless this toxin of the physiogenic school is absurdly selective in its actions, their hypothesis of toxæmia in this type of psychosis is not tenable.

With the endocrinologists the position is rather different. If they can prove that the endocrine glands are the physical basis of instinctive energy, they will have gone far towards the completion of our understanding of the psychoses, if their work is incorporated in a general scheme of 'forces' such as we have outlined.

One final word to the exponents of the physiogenic school: in order to prove their case, they must show not only that toxæmia exists, but that it has etiological

value. We have heard much of intestinal toxæmia. We do not dispute that it exists; but have those who seek to ascribe etiological value to it paused to consider that it may be the result of the altered diet, lack of exercise and mode of life generally of one whose behaviour is becoming abnormal because of other things? Have they paused to consider that such a toxæmia is readily amenable to treatment by ordinary medical methods as indeed are toxæmias from teeth, tonsils and appendices. We may clear up the toxæmia. We may get our patient into such a physical condition that the application of all our standard clinical methods reveals only that he is in robust health. He may live in an asylum that long healthy life which is such a constant accompaniment of the deluded state in which he is, whilst the autopsy which eventually follows reveals only the disease

of which he died and the normal changes of old age.

The argument in support of our proposition is concluded. We have formulated terms in which psychoses may be rendered intelligible; namely, the concepts of a scheme of forces of which the psychosis is the resultant; and the etiological factors are the components. We intend, as indicated, to confine ourselves to the psychoses of young adults for purposes of this thesis.

PART III
CLINICAL APPLICATIONS.

We have endeavoured to show in Part II that a dynamic view of the individual case is essential for the better understanding of the psychoses of young adults. It is proposed in this section to formulate a concrete scheme of approach to the individual case, to select a suitable nomenclature, and to illustrate by clinical records how our scheme of forces works in practice.

It was said, in Part II, that, in order to understand the scheme of forces, we must study (a) the resultant and (b) the components. Translated into clinical terms, this means a study of (a) the clinical picture and (b) the personal and family history. We should expect to find in (a) and (b) some indications of the major forces at work, and it then remains to unravel them.

(a) The Clinical Picture.

(i) Method of making a record. The clinical picture should be a record of fact, not inference. Such an ideal may be achieved in only one way; namely, by writing down what the patient says and does, and the setting in which he says or does it. In other words, the case-record should consist of question and answer, and careful description of behaviour of the patient. Anything else is a matter of opinion, and only when we adhere to what the patient says and does are we remaining true recorders of actual fact.

Now fixed, scheduled forms of examination do not lend themselves readily to the description of such diverse things as the forms of individual human behaviour. The method of applying what is really the old 'faculty psychology' to clinical psychiatry and making notes under such headings as 'the will', 'the moral sense' is neither necessary nor helpful.

It is, however, useful to recognize three facts and to group our clinical data under these headings. They are as follows:-

(1) Any individual thinks along more or less personal trends; i.e., he has a content of thought which is peculiar to himself.

(2) He has, at a given time, a certain emotional state which bears some relationship to his content of thought.

(3) He is capable of performing simple acts of reasoning.

In addition, therefore, to our description of the objective behaviour of the patient, we should endeavour to arrange our questions to the patient in such a way as to determine:

(1) The content of thought and mental trend. — What is the patient thinking about? Does it concern itself with real or hallucinatory experiences? Are his beliefs generally accepted as correct or erroneous?

Apart from such definite components as hallucinations and delusions in the content

of thought, we require to know what the trend of the thinking process is. Thus, without amounting to delusions, do the patient's thoughts tend to be self-condemnatory, or ambitious or grudging?

(2) The emotional state and its relationship to the content of thought and mental trend. -

In spite of numerous attempts to draw up some purely objective, physical criterion of emotion, such as the 'psycho-galvanic reflex', for clinical purposes we must at present be content with:

(a) The motor expressions of emotion (attitude, facial expression, gesticulation);

(b) The patient's own description of his emotional state - his 'feelings' or 'spirits'.

In addition to determining the emotional state itself, we should have some statement from the patient regarding his reason for being in such a state; e.g., "Why are you miserable?". "Because I've done something awful". Here we have an emotional state and a mental trend

of self-condemnation. This emotion and this trend are in consonance or 'harmony' with each other, and disintegration of the psychic functions is, therefore, not present. We should push the enquiry further, with a view to discovering if his belief that he has done something awful is his way of explaining to himself his feeling of misery, or whether he came to believe in the first place that he had done something awful and was miserable because of that. In other words, we want to know which came first, the mood of depression or the false belief.

It is of great importance to determine whether the mood and the mental trend are in harmony with each other or not. As an example of disharmony between mood and thought, we have a patient who states that he is perfectly happy, and, with a smile on his face, demands that one should 'do away' with him.

Not only must we determine the congruity

or otherwise of the mood and thought content, but if, in our conversation with the patient, or in our study of the history, we learn that there has been some definite precipitating situation, such as a sudden bereavement or financial loss, or unfortunate love affair, we must consider whether the mood is compatible with this or not. For example, one has seen states of elation and excitement follow upon the loss of a dearly beloved parent, and we must endeavour to unravel our component forces to explain how this can come about.

(3) The state of the intellectual functions.-

This involves a study of the patient's orientation, memory for recent and remote events, scholastic knowledge, and general knowledge of current events, ability to do simple tests of mental retention, calculations, and ability to detect absurdities in specially made up stories.

The methods of determining these things are so well known already that they require no

elaboration here. Their importance lies in the fact that they tell us the clearness or otherwise of consciousness - whether the patient is fully alive to his surroundings, or whether he is really clouded and in a sort of day-dream, or even delirious state.

It now remains:

- (1) to apply some name to the psychosis;
- (2) to seek some indication of the major etiological forces at work.

(1) The name of the psychosis. - As long as this is standardized, it matters but little what name we apply. There is nothing inherently wrong with Clouston's term 'adolescent insanity', except that the word insanity is unfortunate, because of the stigma attached to it.

'Adolescent psychosis' would be a perfectly justifiable term, but is too limiting as regards age. We can usefully go a little further than that in most cases. We recognize that there are some cases characterized clinically by

disintegration of the mental functions, and others by excessive display of emotion; while there are yet others presenting a mixture of these features, Further, in any or all of these cases, clouding of consciousness, confusion or delirium may be a prominent symptom. For descriptive purposes, then, we may usefully recognize the following clinical types of psychoses of young adults:

Clinical Criteria.

Names of Psychoses.

- | | |
|---|---|
| 1. Disintegration of psychic functions, particularly disharmony between mood and thought content. | 1. The Schizophrenic Psychoses. |
| 2. Excessive display of any emotion which is in harmony with the content of thought and most appropriate to the situation of the moment. | 2. The Affective Psychoses. |
| 3. Persistent Hallucinations or delusions of a personal nature, occurring without disintegration of the psychic functions and in a setting of clear, unclouded consciousness. | 3. The Paranoid Psychoses. |
| 4. Clouding of consciousness, delirium, amnesia, disorientation and other impairments of intellectual functions. | 4. The Organic Psychoses:
(a) Psychoses with organic brain disease.
(b) Psychoses with other somatic disease. |

This is not a rigid subdivision of clinical types.

We really have a graduated scale of cases with pure schizophrenia at one end and pure affective disorder at the other. We must make allowance for the 'in-between' cases, which, at one period of their course may resemble one type, and at another time another type, or which may present at the same time mixed features of schizophrenia and affective disorders. We could call such a case 'schizophrenia with affective features' or 'affective disorder with schizophrenic features', according to its proximity to one or other end of the scale. Further, it is correct to speak of an organic psychosis with schizophrenic or affective features, as the case may be.

The most important thing of all is that we should recognize that by attaching a name to the psychosis we have not rendered it intelligible, nor have we implicitly forecasted its course. We should be quite clear that there is no hard and fast distinction between the

types indicated above. They are merely names devised to enable us to communicate to others what sort of mental symptoms we are thinking of.

(2) The indications of the major etiological forces at work. - It is desirable to make clear at the beginning of this passage that whatever forces are indicated clinically to be of major importance, we must investigate all the ^{forces} ~~forces~~, major and minor, before our explanations of the case is complete. For clinical purposes, however, there is often strong indication of one force being, as it were, the dominating one; hence, we may be able to formulate, according to the particular force at work, a prognosis early in our investigation of the case, and to order our management of the case accordingly.

The first and most important thing is to determine whether the psychosis presents itself in a setting of intellectual clearness or cloudiness.

If consciousness is clouded - i.e., if the patient is in a confused or delirious state - we are justified in concluding that the physical associative apparatus (i.e., certain parts of the cerebrum) is the seat of morbid physical changes, either of the nature of organic brain disease or of the nature of some poisoning process.

We may take it, therefore, that some gross physical disorder is a major component force in the production of a psychosis of this clinical type.

If the ordinary routine physical examination reveals nothing abnormal, we should not be content; we must employ special methods directed to detect obscure neurological conditions and obscure infective or toxæmic processes. So far as the technical elaborations of these methods are concerned, we do not need to discuss them here. If need be, the whole

battery of modern clinical research must be brought to bear on the individual case. The need for this is indicated, as already mentioned, by two things; First, the presence of intellectual impairment as a symptom, and, second, the failure of ordinary clinical methods to detect organic disease. In such cases, lumbar puncture should always be done. The examination of the cerebro-spinal fluid should include Wassermann, cell-count and colloidal gold reaction. The fundus oculi should be examined, and the visual fields too. If these examinations reveal no evidence of neurological disease, then attention must be turned to the rest of the somatic field. Assuming that ordinary clinical examination has detected nothing abnormal in this field, it is desirable to make a complete blood count. Particular attention should be paid to the differential count of the white blood corpuscles as a possible indication of a focus of infection.

This, in time, would lead to examination of the patient's throat, nose, ears, teeth, and genito-urinary tract, amongst other possible foci of infection. If the question of ordinary common septic infection can be ruled out, then evidence of recent febrile states, such as typhoid, malaria, and so-forth, should be sought.

If nothing bacteriological can be found, then metabolic diseases, such as certain forms of nephritis, diabetes, gout, and all toxæmias associated with pregnancy should be looked for. These involve the use of the latest blood-chemistry and urine-chemistry methods. The next possible source of organic factors is in the exogenous poisons, such as alcohol, certain drugs, lead, phosphorus, and so on.

Such, then, is a brief outline of the methods of investigation to be adopted in the organic group of psychoses. That, is, those psychoses where intellectual impairment is a

symptom and a pointer to the major etiological forces being found in the somatic field.

Supposing that intellectual impairment is not found; where, then, should the major etiological forces be sought, and what are the pointers that lead us to them?

The examination of the patient's mental trend and content of thought should be considered next. Is there any topic which tends to be dominant? Does the patient harp on some environmental disaster which has immediately preceded his illness, or on some great personal changes in his circumstances, such as marriage or religious conversion? Is his content of thought mainly concerned with what may be called his 'inner life' - ideas of sin, religious exaltation, marital infidelity, or the sex-topic in general? In some patients, of course, the content of thought is very wide, as manifested by a diffuse stream of talk, jumping from subject to subject; but

even here, if a careful verbatim record of the patient's spontaneous talk has been made, it is usually found that some topic is dominant.

Having found which is the dominant mental trend, the next thing is to investigate this as fully as possible. This brings us to the consideration of the history of the case. A history taken from one person does not usually cover all the ground. We must get to know the patient from several angles. We should, if possible, have a statement not only from near relatives, but from employers, workmates, personal friends, private physician, and so forth. It is in this extended history-taking that a social service, as managed by most modern psychiatric clinics, is so essential.

The family history gives us some idea of the raw material, as it were. The history of the development of the individual leads up

to a description of the personality of the patient before he became ill; and the story of his life tells us of the situations which he was called upon to meet. Thus, we know the equipment of the patient and the factors with which he had to deal; and so we get a dynamic conception of the case.

If there was some environmental happening which upset the patient, the next step is to discuss this as fully as possible with him and endeavour to find out why he should be so upset by it. The reason for this generally hangs on the patient's mental attitude to himself and to the world about him. This is so essentially an individual and personal matter that it is idle to attempt to enumerate or classify the possible factors which may play a part. It is this type of case which illustrates the dynamic conception of mental illness so well. The illness is essentially a reaction to a situation; and the management

of the case should be an attempt to alter the patient's mental attitude and to re-educate his affective dispositions so that he may meet matters in a more philosophical way.

If the history has not indicated any environmental happening which could be regarded as an etiological factor, we must return once more to the examination of the mental trend and content of thought. We have, thus far, eliminated gross physical disease and environmental disaster from the possible major etiological forces. According to our scheme, there remains only some 'inner difficulty', some essential maladjustment, as a major cause of the psychosis. To find this involves long, intimate talks with the patient, taking into consideration the general nature of the mental trend, the hallucinations or the delusions. Are these in the main sexual, self-accusatory, grandiose, or what? According to the topic indicated, we should guide the patient so as to disclose his inner conflicts and difficulties.

What is he trying to grapple with? Is he so sensitive that he cannot bring himself to seek aid on some intimate matter, but must needs attempt to deal with it himself, possibly ill-equipped to do so? The elucidation of such a problem may take months; success depends upon our ability to make the patient talk, and for this reason slow and gentle inspiring of confidence is to be aimed at rather than any attempt at bullying or forcing a statement from the patient. We want the patient's own version of his life, his hopes, fears and ambitions; the way in which things, apparently trivial to some other person, affected him personally.

Again, our aim should be re-education of the patient's mental attitude. For its success, such a plan demands that these investigations shall take place early in the course of the psychosis. We know how very easily habits are formed. Psychotic modes of thought and behaviour soon become habits with a patient;

and once such habits are firmly formed, it is unlikely that any amount of re-educative efforts will break them. For this reason, it is essential that the psychiatrist should be brought into contact with the early case. Hence the need for legislative reforms and the development of psychiatric clinics, particularly in this country, which seems to be so far behind her psychiatric competitors abroad.

It would appear from the above remarks that early diagnosis is the thing to aim at; and this can only be achieved by a better psychiatric education of the medical profession and the removal from the lay mind of the stigma, with all its policy of concealment, which they attach to mental illness.

Illustrative Cases.

Case 1. Illustrating a complicated reaction to a situation, and the danger of empirical prognostication.

Miss W.T., aged 32, a salesgirl, was admitted to the Glasgow Royal Mental Hospital on 13/10/26.

She was said to have been ill for 4 months, and had already been for 3 months in a Mental Hospital at R----. Beyond the fact that she was thin, and had a coated tongue, there was no abnormality to be made out in her physical condition.

She was in a state of considerable excitement, smiling, grimacing, rolling her eyes, and muttering unintelligibly to herself. She constantly changed her position, and made bowing movements. She fell voluntarily to the floor in a silly sort of way. Conversation with her was very difficult. The following is an example of it:-

Q. "Do you know what place this is?"

A. "I didn't expect so much for a title; ... it seems so humble to do that" (shifting to and fro on her seat); "I've got to do this."

Q. "Who tells you to do it?"

A. "I didn't think you'd like that at all."

She named the day of the week correctly, but her answers to other questions, put with a view to estimating her intellectual state, were

irrelevant, as shown above.

For some days she was unresponsive, giggling, grimacing and inco-operative. While still in this excited state, she was persuaded to attend the Hospital dances. She danced well, but was answering "the voices" all the time. Oddities of behaviour were marked; she would slide on to the floor, and wave her legs about; she stated that she was Lady G----.

About one month after admission, the excitement began to abate, and, although still foolish, hallucinated and impulsive, she was more accessible, and it was possible to learn something of her content of thought. The most prominent feature of this was that she heard the voices of her mother, father and brother calling her; and she believed that her brother was in the next ward.

A month later, there was a further access of excitement, and little more could be got from her in conversation. Six months after admission, she began to improve. She put on weight; became

careful of her appearance, neat and orderly in dress. Eight months after admission, she was very much improved, and was able to discuss her illness in a detached way. She said she knew that she had been very ill, but remembered practically nothing of her illness. She believed that the shock of her mother's death had made her ill. She stated that she used to lean heavily on her mother; she went to her with every little trouble, and never really broke the childish bonds.

She was discharged recovered 8½ months after admission. I had an opportunity of seeing her at the Western Infirmary Psychiatric Clinic three months later. She was bright, steady, and sure of herself, and apparently quite well.

The history of this case is as follows:-
the patient came of good stock, and developed normally through the infantile and school periods. She displayed no neurotic traits. She was a

child with initiative and a great capacity for make-believe, being perfectly content to play with her toys and to "build castles". She got on well with other boys and girls, and was a prizewinner at school. At the age of 14 she entered a thread mill, did well, and rose to be an 'examiner'. After this, she entered a drapery store, where she had been employed for 8 years prior to her illness.

Her medical history was uneventful. She had had pneumonia at the age of 7. As an adult she was a good, steady worker, affectionate, and a home-lover. She had 'turned down a good man' because she 'had a good home and a good situation'. She was not, however, prudish or priggish, and was fond of children. She was beloved of all. People used to go to her with their troubles. She was fond of music and dancing, and was considered the life and soul of the party. The one unusual thing which stood out in her personality was her attitude

to her mother. This was genuinely childish. Even as an adult she slept with her mother. They used to lie with their arms round each other. She was absolutely trusting and confiding to her mother, and showed strong sentiment in regard to her.

The patient's illness began when her mother was killed in an accident, in January, 1926. Immediately after this, the patient was so upset that a doctor was called in. Looking up at the ceiling she would say, "I'll not be long here. I'll soon be smiling." Her condition was not helped by some well-meaning but misguided friends, who chaffed her about this behaviour. The patient said, "I wonder you take this so lightly". She said she saw God on the roof. This episode passed off after fourteen days, and nothing further was noticed about the patient until June, 1926, when she began to read the Bible to excess. She bought a biblical dictionary,

and was a keen follower of explanations of Biblical events. She talked of what Christ had suffered. While at work she went into another department and stated that two of the employees were conspiring against her. She evidently made a scene, and was taken home by her father. For three days she was hallucinated, tried to take off all her clothes. and stood in the crucifixion attitude. She stated that she 'had to make a sacrifice'. She kept on repeating, "God, God, God, God". She did not take food, and did not sleep. Sometimes she spoke only in whispers. She would stop in the middle of a sentence, and go on to speak of something else. She took off her stockings, saying, "I hate black". She cried for "Jimmy" - the man whom she had 'turned down'. She squatted down in the drawing room in mixed company and passed water. She was taken to the Hospital at R---- in June, 1926, and a report from there shows

that her condition was much as described above.

Comment.- This is a case where a psychosis follows a precipitating situation - the death of the patient's mother. This bald statement in itself does not, of course, explain the psychosis.

When we consider, however, that by her own admission, and from the observations of other relatives, she had a ~~very~~ ^{very} curious attitude to her mother, the explanation becomes clearer.

A woman of 32 habitually sleeps with her mother in a close embrace. She runs to her mother with everything; she 'turns down' a good man because she prefers her home and her mother. In other words, The patient's mother occupies the same position in her affection as she did when the patient was an infant. This woman has never learned really to 'fend for herself', so far as the more intimate side of her life is concerned. The mother is the main

support of the patient's emotional life. This support is suddenly taken away, and immediately we see all the childish capacity for make-believe (known to be a trait ~~in~~ the patient's character) coming into play. "I'll not be long here. I'll soon be smiling". She 'has to make a sacrifice'. Obviously, the mainspring behind such expressions is the wish to be with her mother; i.e., dead. Then we get a partial readjustment, an attempt to 'make the best of a bad job', and we find the patient crying for "Jimmy" - the next person in her affections. Coincidentally with this is a wish to forget the mother's death, and she tears off her stockings, saying, "I hate black" (the symbol of death). Then comes a great excitement, and behaviour of a truly childish kind (giggling, wetting ~~the~~ ^{the} floor, and so on).

In the clinical picture we see obvious pointers to the major etiological factor when we study the content of thought - hallucinatory

voices of the dead mother, and the belief that the mother is with her. Because the original endowment of the patient is good - she comes of good stock, and had made a good external adjustment to life - the patient is able to survive and readjust to a crisis which she should have gone through nearly twenty years before - and then over a period of years instead of days - namely, the breaking of the childish emotional bonds between mother and daughter.

One other comment on this case: it illustrates excellently the danger of the empirical method of diagnosis and prognosis. On the face of it, with the hallucinations, foolishness and wetting, the case falls into the dementia praecox group, and as such is implicitly given a hopeless prognosis. This case illustrates the great importance of taking all the factors into consideration, and regarding the case from a dynamic viewpoint.

We must give it a name. Clinically, there was a true splitting or dissociation of the psychic functions - a temporary disintegration, in fact. It would, therefore, be valid to call this case one of schizophrenia.

Case 2. Illustrating a more complex series of etiological factors, and showing how a careful study of the clinical picture points the way to their elucidation.

A young girl, a domestic servant, aged 19, was admitted to the Cardiff City Mental Hospital in December, 1927. She was elated, overtalkative, laughing and keeping up a running commentary of everything that was going on around her. "Clang" associations were prominent, the patient calling out, for instance, "Fire 'ere, diarrhoea", and laughing loudly.

She stated that she was 'as happy as she could be'. She was quite inco-operative in ordinary examination.

Physically, there was an exudate from the tonsillar crypts; foul breath; a pultaceous abdomen, and general exaggeration of the tendon reflexes. Otherwise, no gross abnormality was made out.

When seen again a few days after admission, she stated that she 'saw horrible things at night', and that she "heard mummie's voice calling" her "name". Her memory for remote events was good, but she was quite unable to recall more recent ones, such as her admission to Hospital. She was disorientated, and unable to give a satisfactory account of the past few days. She recognized and admitted that she was unusually 'keyed up' and emotional, and that she was talking a great deal. Real insight, however, was lacking, for, on seeing me again, she cried out, "Oh, what you did to me last night! You gave me a 'Lucky Dream' cigarette and operated on me. Oh, God, this is awful. The things I see when I shut my eyes."

This state of excitement continued until March, 1928, when it abated somewhat, and it was possible to enter into more satisfactory conversation with the patient. Speaking of herself, she said that she had not been happy at school, because she felt that everyone hated her.

Q. "Did you feel that you were not as good as others?"

A. "Always."

Q. "Why was that?"

A. "I thought I was ugly, to give you a plain fact, and others were jealous because I was deemed better than them. I had long curly hair and the boys used to pull it. Instead of crying I used to hit them. The men teachers made a favourite of me, and this made the women jealous because they were their sweethearts."

Q. "Why did you think you were ugly?"

A. "I was always called 'ugly duckling' by my cousin."

Patient went on to tell how her father had been head gardener to Lord I----, and had taken ill - chronically - so that he had to give up his position. Her mother then tried to run a little shop, but became bankrupt, and the whole family had to move to relations in Cardiff. They were greeted at the station by patient's aunt and cousin, and the latter when he saw patient (then about 12) said:

"Ugly duckling, ugly duckling, quack, quack,
quack,
" Go to the Devil and don't come back."

When she got to this stage of the narrative, patient burst out with great emotion, "I hate Cardiff and everything in it". Calming down, she said that she 'always found reasons for hating Cardiff', but in the 'background of her mind' she 'vaguely pictured that scene at the railway station every time'.

For a long time she had been made to feel that she was a 'charity child'. Gradually her mother re-established their position, and

her father was able to find employment once more. Patient was then sent to a Protestant school, but happened to be living in a district where most of the children were Roman Catholics. The Catholic children used to throw stones at her. She said that this 'made her feel that people hated her' and that she was 'no good'.

When asked how long that feeling lasted, she said, "I've still got it", and then (with great emotion), "Since mummie's gone I feel I could lie down and not get up again". (Her mother had died in July, 1927 - see history below).

She said that all her boisterousness and jollity were forced, and were just to make up for all the unhappiness that she really felt. By May, 1928, patient was again as excited as she had been on admission. This excitement continued for 6 weeks, and in July, 1928, she

developed signs of acute appendicitis. She was operated on, and a distended, acutely inflamed, retrocaecal appendix was removed, there being abundant evidence of long-standing inflammation in the adjacent parts.

After the operation, patient was very acutely excited - more so than before. This abated, and fluctuations in her mental state continued for some months. She was not making satisfactory progress. She continued thus until February, 1929, when, on account of persistent exudate on the tonsillar crypts, her tonsils were removed. After this, there was a brief, final 'flare up' of excitement, lasting only a few days, and the patient made an uninterrupted recovery, leaving Hospital on May, 1929.

The previous history of this case was as follows:- The family history was negative for nervous and mental diseases. Patient was,

apparently, a healthy, aggressive child, mixing freely with others, and being in a class ahead of her years at school. She was boisterous and excitable, full of fun, but at times very quiet.

The acute phase in her illness began in December, 1927, a few days prior to admission. She had been nursing her mother for about six months, until the mother died in July, 1927. After that, the patient was frequently seen studying books, and she expressed a desire to be a nurse. Apart from this rather quiet and seclusive behaviour, nothing was noticed until the acute phase began. She became 'keyed up' and overtalkative. She said that she had dreamed that she saw her mother, who, in the dream had said she (patient) would win a prize-drawing in a newspaper competition. After this, she became expansive, and "wanted all the Church people to come and hear the glad news". She expressed a desire to send

presents to all the poor children in the district. She was elated and apparently happy. When arrangements were made to take her to the workhouse observation ward, she appeared attired in a dance frock, and announced that she was going to be married that afternoon; and that she had come into a great deal of money, and was going to send her brother to college.

Comment. - Three major etiological forces stand out in this case. They are:-

(1) An environmental disaster (death of mother);

(2) Personal psychological forces (ideas of ugliness and inferiority);

(3) Physical ill-health (appendix and tonsils);

and these are being brought to bear on a personality which is excitable and easily upset; which reacts with

a vivid affect to the situation of the moment -
in a word, the syntonic personality.

It is of the greatest importance to note that, as seen at the time of her admission to Hospital, and shortly afterwards, one of the most striking clinical features in this patient was the impairment of the intellectual functions. She was disorientated; ~~her~~ memory for recent events was so impaired that she could not remember being admitted to Hospital; she confabulated. As was pointed out in the Historical Survey, intellectual impairment has been shown to be an almost infallible criterion of actual disease, injury or poisoning of the brain. Following out ~~one~~^{our} plan of clinical approach, what could we find in the physical state of this patient which might be of etiological importance? Admittedly, not a great deal. Her tonsils were infected, her breath was foul - that was about all there was on the surface.

Bearing in mind our warning to the ultra-physiogenic school of thought, had we any right to ascribe causal significance to this apparently mild septic state?

We would formulate our answer to such a question as follows:- the mental symptoms pointed unequivocally to there being some important physical factor at work. Routine examination showed that the tonsils were unhealthy. Therefore, they must, in this case, be suspect. Had there not been intellectual impairment, then there would have been no justification for ascribing major importance to the physical condition.

At first, the patient was considered much too excited to risk operating on her. Then, as a surprise, came the acute appendix, demanding urgent operation, which revealed old-standing trouble - further justification of our belief in some important physical forces in this case. But not until the tonsils were removed

did the patient recover. Whether 'post hoc ' or 'prop~~ter~~-hoc' we do not know, but in this case there is some justification for believing it to be 'prop^{pter}ER~~ter~~ hoc'. Admitting then, the major importance of physical forces in this case, how does a study of other factors help us to understand it?

Take the girl's own conversation. She always felt 'ugly' and 'no good'. She felt other children at school were against her (apparently with some justification). She longed for joyful companionship, yet she had to be content with being a 'charity child'. What strange conflicts must such conditions have set up in this adolescent girl. After months of strenuous nursing by patient, her mother dies. The girl has lost one of the few supports she had in what was to her an antagonistic world ("I hate Cardiff and all that's in it"). It hardly demands any abstruse psychological delvings to appreciate why this simple, sensitive, imaginative child

should dream, after a period of simple reactive depression, that her mother tells her that she is going to win fortune in some newspaper competition. Would not that go a long way towards solving her difficulties and realizing her ambitions? A simple matter of a conscious wish being fulfilled in a dream. Then the true dynamic viewpoint must be taken. We must not consider this dream as a static thing, complete in itself and detached from the patient's life. We must consider its effect on the patient and her reactions to this experience. Bearing in mind her emotional state, engendered by the death of her mother and her environmental oppression, what is more natural than that she should take this dream as a good omen and talk expansively of what she would do? Add to this some toxic episode, and it seems that our explanation of the psychosis is as nearly complete as we can make it.

For descriptive purposes, one would call this an organic psychosis with affective features.

We are aware that McCurdy (according to his 'Psychology of Emotion') would probably explain this psychosis on a different basis. He would say that the state of elation was the conscious concomitant of a subconscious wish-fulfillment; viz., the death of the mother, who, it would be suggested, was obstructing in some way the instinctive strivings of the patient, these being represented in the expansive talk and so forth which characterized the onset of the psychosis. This, however, seems to be an unnecessarily recondite explanation; and, moreover, there is no evidence that the mother was obstructing the patient's instinctive strivings. In this case, at any rate, the superficial explanation is the one which not only fits the facts, but is actually supported by them on every hand.

There is one other lesson to be learned from this case. It concerns the personality of the patient before she broke down. Her

father stated that she was bright and cheerful - a good 'mixer', and apparently perfectly happy save for transient periods of quietness, to which he did not attach any importance. But we have it from the patient that she was, in fact, far from being happy; that she felt her position keenly; and that an incident which her father laughed off had had a far-reaching effect upon her (the 'ugly duckling' incident); so that her outward appearance was a conscious effort to make up for her inner discomfort.

Again, therefore, we would emphasise the importance of the subjective aspect of things. It is not the events in a patient's career that matter; it is what they mean to the patient that is all important. The attempt to make psychology and psychiatry the study solely of objective behaviour can never lead to an understanding of the conditions with which we seek to deal.

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