Society Proceedings

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The President, DR. SMITH ELY JELLIFFE, in the Chair

A CASE OF EPILEPSY, COMPLICATED BY A TRAUMATIC NEUROSIS

By William Steinach, M.D.

The patient had presented himself at the neurological clinic of the University, with a letter from his family physician, asking that a skiagram be taken and suggesting the possibility of operative intervention. He was an assistant shipping clerk, twenty-two years of age, single; born in the United States of Irish parents, the eldest of seven children, one of whom died in infancy. All the living children, except the patient, were healthy.

Family History.—Practically negative. A maternal grandmother died of apoplexy; a sister, of spinal meningitis at the age of six months. The father died of pulmonary tuberculosis; a paternal aunt, of dropsy.

Previous History.—The patient was born after a difficult labor of fifteen hours' duration, with instrumental intervention. He was brought up on prepared foods. A slight backwardness in learning to talk and walk, and a tendency to stammer while learning to speak, were the only unusual features of his infancy. A severe attack of cholera infantum, which lasted two months, during his first year, and mild attacks of the usual diseases of childhood were his only illnesses before the beginning of the present trouble.

History of Present Trouble.—When ten years old the patient was hit on the head with a baseball bat over the left temple. The wound bled profusely, but the patient did not lose consciousness.

Two years after the injury the patient had the first convulsion. He was found in bed by his mother, jerking violently. During the convulsion, which was general in character, he passed his water and lost consciousness completely. Fifteen minutes later he had regained consciousness and was able to go to school. For four months he received treatment at the Presbyterian Hospital, and in that time had no attacks. When the treatment was discontinued, however, the same trouble returned.

The attacks, of grand mal type, were described as occurring chiefly at night. In the course of them the patient would bite his tongue and void urine. At times he would vomit immediately afterward. The attacks recurred at intervals of from three to six months. There had been, however, as many as three in one day. There were no attacks of petit mal.

Two years ago the patient was struck on the top of the head while coming out of an elevator in a bank. The accident was rather trivial.

and did not affect the patient until there was some talk of a suit against the bank, which was subsequently settled. Since that time, the patient began to have peculiar attacks, in addition to the previously described type, in which his left leg was drawn up and adducted, and his left hand flexed. These attacks were not accompanied by loss of consciousness. They became very frequent,—sometimes as many as five or six in one day, each lasting about two minutes. Dr. Steinach stated that he witnessed one of them, and that the convulsion was clonic in character, involving the left leg and hand, with the back arched in a typically opisthotonos fashion.

Physical examination showed the left pupil a trifle larger than the right; both responded to light and accommodation. There was no abnormality of the motility or fields of the eyes. The left knee jerk was a trifle more active than the right. No clonus; no Romberg; no ataxia. No sensory disturbance; no astereognosis; no asynergism.

The question in connection with this case, Dr. Steinach stated, was whether this was a case of Jacksonian epilepsy in which the convulsions were attributable to a *right sided lesion from contre-coup*, or a case of epilepsy upon which were engrafted hysteroid attacks as an expression of a traumatic neurosis.

In a recent number of the Journal of the American Medical Association Dr. Burr reported a case of multiple neuritis complicated with hysteria, and Dr. Steinach had thought the case presented of sufficient interest to be reported, in that it might be considered a case of epilepsy, complicated by a traumatic neurosis.

Furthermore, the psychogenesis of the traumatic neurosis superadded to the epilepsy was very *distinctly* illustrated. The underlying unstable neurotic disposition accompanying the epilepsy was a ready soil for the neurosis. During the ten years his major attacks had lasted, he was repeatedly questioned by the various physicians whom he consulted, about blows to the head, as being a possible cause for his epilepsy. When he did receive the blow on the head, the repeated questioning having suggested the causal relationship to convulsive attacks, they promptly appeared in the left arm and leg, showing their purely hysterical character.

A CASE OF PERIODIC PARALYSIS

By C. E. Atwood, M.D.

The case, Dr. Atwood explained, was presented on account of its extreme rarity. Fewer than a hundred cases had thus far been recorded. A careful study of the disease were first made by Westphal in 1885, and later Goldflam gave a full description of it. The text-books scarcely mention the disease.

The patient was the tenth case in a family whose history was studied for four generations. The cases were all on the maternal side, and all were born in Russian Poland.

The patient was twenty-one years of age, and the second of three children, all males. One brother and the mother were affected by the same disease, and had also been examined by Dr. Atwood. The next nearest relative was a maternal uncle. Most of the other cases were cousins, once or twice removed. One second cousin choked to death dur-

ing an attack. He had been left alone and was unable to turn his head in order to throw off some food which had regurgitated. Another second cousin, who was subject to the disease, while serving in the Russian army had a severe attack, and died from burns inflicted on him during it because he was thought to be malingering.

The medical history of the case presented, aside from the attacks of periodic paralysis, was negative. The patient was well-built, muscular, with massive quadriceps. There was no dystrophy although an associated dystrophy had been found to occur in a few of the cases on record. There were no evidences of local wasting, or local paralysis. Examination between attacks showed that sensations to touch, temperature, pain and pressure were present. The reflexes were present and normal; the cranial nerves were normal; the fundus oculi was normal; the heart and lungs, normal. There was no spasticity or flaccidity of muscle. The electric reactions were present. There were no hysterical stigmata. In all respects, physically and mentally, the patient seemed normal. His history, however, showed that he was subject to attacks of motor paralysis at intervals of a few days to a few weeks, lasting for a few hours to two or three days..

Dr. Atwood stated that he had seen the patient and examined him during three of these attacks. The first one which the patient ever had occurred when he was four years of age. It lasted twenty-four hours and was general. The second attack was at the age of twelve, and lasted twenty-four hours; also general. The third attack occurred at fourteen, and was typical and severe, and was followed by milder attacks as often, as once a week, or even daily. Since the age of fourteen his severe attacks have occurred, at first, one in two or three weeks; later on, once in two months; and, under treatment since 1911, have recurred at longer intervals, until lately they have increased in frequency. They are more frequent in cold weather. They are sometimes preceded by a heavy feeling in the legs, which then enables the patient to foretell an attack. Attacks usually came on at night.

The first one witnessed by Dr. Atwood was on November 14, 1911, twelve hours after its inception. It was not a very severe one, and may have been lessened in severity by magnesia citrate and an enema. The patient was entirely conscious, and no abnormal mental symptoms were noticed. The left side was more affected than the right. There was great flaccidity. The patient felt weak in the ankles, knees and wrists. He was able to get out of bed with assistance at the time of the visit, but felt weak, dizzy and faint while in the erect posture, and could not stand unsupported. Sensation to touch, temperature, pain and pressure was everywhere preserved. Muscle irritability was diminished on the less affected and absent on the more affected side. The cranial nerves were free. The left knee jerks could not be elicited; the right was barely present. The left plantar reflex was absent; the right normal. A bruit could be distinctly heard over the apex of the heart. This bruit was not present when the patient was examined between attacks. The apex beat was at the sixth intercostal space. The attack lasted twenty hours. The next day on examination both knee jerks were present and there was complete restoration in muscle function and reactions. The mitral bruit had disappeared, but the apex beat remained in the sixth intercostal space.

On December 7, 1911, an examination of the patient was made during an attack, fourteen and one half hours after it began. The patient could talk, but was otherwise almost completely paralyzed. He had eaten heart-

ily just before retiring, and had smoked more than usual. Also, the evening before, his legs had seemed weak in walking, and he could not extend the fingers of the left hand. It is possible that these symptoms may have indicated a slight attack at that time. He went to sleep as usual, however, but awoke at two a. m., unable to move the arms and hands and right leg, but could move the left leg and foot slightly. He was able to sleep again, but awoke at three a. m. and found that he could move only his head. On examination at 4:30 p. m. recovery had begun. He could move the great toes, and flex the fingers; could slightly roll the head from side to side, and slightly move the left leg and the right forearm. His paralysis was flaccid. The knee jerks were absent; ankle jerks barely present; abdominal and cremasteric reflexes present, slight. The heart showed a mitral bruit. The breathing was shallower than normal and carried on mostly by the diaphragm. The voice was fairly strong; the cranial nerves were free; there was an absence of muscle tone; no responses to direct tapping. All sensibility was unimpaired; the mind was unaffected; the mucous membranes appeared normal; the hands and feet were warm; the patient was able to swallow a glass of milk and retain it. Improvement continued from the periphery upward,—the wrists, elbows, shoulders and ankles improved during a period of about two hours. The condition returned, however, at midnight after the examination, and the patient became again paralyzed, except in the fingers and neck. He vomited at eleven p. m. the milk taken, and voided urine. He was unable to expel two enemata of soapsuds administered during the attack. The following morning he awoke at six a. m., entirely free from symptoms.

Urinalysis during attack showed increased acidity; increased indican; little albumin; increased sulphate partition. Bacteriological study of the feces showed a marked intestinal infection and a state of fermento-putrefaction, due to a clean-cut infection of the *Bacillus aerogenes capsulatus*. The same condition was found in the mother and brother in a lesser degree, and was present very slightly in the father, who was not affected.

Dr. L. Pierce Clark said that he would like to ask Dr. Atwood if he had found out whether there were times when after indulging in these various irregularities of diet the patients did not have attacks in consequence, and also if experiments had been made at different times with a view to suggesting a suitable diet and finding out just how susceptible the patients were to these changes.

Dr. Atwood, in reply to Dr. Clark's question, stated that he had not been able to handle the case closely enough to do work along such lines; the conditions surrounding the patient could not be controlled to this extent. John Mitchell, Edsall and Flexner carried out a series of such experiments some years ago, and found diminished kreatinin excretion.

There have been but few autopsies and no histological studies after death. Findings based on the urine, feces and blood are conflicting. There has been no examination of the spinal fluid, as yet, during an attack. Determining causes of individual attacks have been ascribed to muscular exertion, indiscretions in diet, exposure to cold, constipation, nervous and mental fatigue, worry and emotional excitement, etc. There is a general consensus of opinion, however, that as regards the pathogenesis of attacks a condition of auto-intoxication is present. Nearly all the various other theories are found untenable. There seems to be a

deficiency of elimination of nitrogenous metabolic products, and the absorption of some toxic substance, perhaps from the gastro-intestinal tract, which is capable of acting as a paralyzant to both the endings of the peripheral motor nerves and to the muscle-fibers themselves.

A MULTIPLE SCLEROSIS IN MOTHER AND SON

By I. Abrahamson, M.D.

Before presenting the patients, Dr. Abrahamson read a short account which the son had written of his own case, and which gave evidence of the unimpaired intelligence of the patient.

The son, a student, twenty years of age, was born in England. His earliest recollection of the trouble, he stated, dated back to four years ago, when there began to be a numbness in the limbs; weakness in the legs; tremor of the hands, together with an inability to hold objects. There were no urinary symptoms with this first attack. The trouble continued for two weeks before the patient recovered.

The recent exacerbation came on three and a half months ago, when the patient began to have difficulty in starting the stream of urine, though no urgency. Also, he was troubled with obstinate constipation. About six weeks before, on his return from the country, where he had been able to do hard work, and had had a record of walking ten miles daily, he began to notice a weakness in the right leg, which increased until he was compelled to drag it after him as he walked, and for a week's time he was unable to bend it at all. Shortly afterward his right hand became so weak that he was unable to write. There was no tremor no paresthesia, nor headaches.

It was after the second attack that the patient was examined at Mt. Sinai Hospital. The following are the findings:

Pupils normal, nystagmus to the left; bitemporal pallor of the discs; jaw jerk lively; lower abdominal and right cremasteric reflexes absent; upper abdominal reflexes diminished; all tendon reflexes lively; ankle clonus present; bilateral Babinski; fine tremor of the hands; head tremor; Romberg; spastic ataxic gait, with a tendency to go to the right. Wassermann negative; cerebro-spinal fluid negative. Increased blood pressure.

The patient left Mt. Sinai Hospital improved, but recently had another slight attack. The viscera were normal, there were no abnormalities of emotional control, no real intention tremor, no pigmentation.

The findings, together with the history of remissions and exacerbations, fully justified the diagnosis of multiple sclerosis.

The mother was Russian, and had lived for a time in England. She was 48; had eight living children, and had had no miscarriages. With the exception of the one son, all the children were healthy.

Up to her twenty-second year the patient had been very erotic; after her marriage at that age she became frigid. Three months after her marriage, following a mental strain, there came the first indications of the disease, in the form of weakness and paresthesia in the hands. The sensation of touch remained for a long time after discarding an object. When she had dropped a key to the floor, she seemed still to feel it in her fingers; even after voluntarily laying aside a thing she would have in her hand the persistent sense of still touching the object she had put aside. In

walking the soles of her feet felt as though they were treading upon a soft, yielding surface, like a pillow; the gait was unsteady and reeling, and standing was difficult. There were no pains; voice and swallowing were normal. After a gradual increase of symptoms for four weeks, followed by six weeks' treatment by electricity at the London Hospital, she recovered sufficiently to return home.

Immediately upon her return she found that the house had been robbed, and the shock caused a return of the previous symptoms, together with diplopia and flaccidity of the legs. At the National Hospital, where she was treated during this attack, Dr. Bastian was said to have diagnosed the case as weakness in the legs, due to worry. After this attack she made apparently a complete recovery, and was entirely well for years.

Ten years ago, after the death of her father, there was a third attack, with a return of the weakness in the legs and unsteady gait, which lasted two months before the patient recovered.

Her recent exacerbation came on a year ago, and during this time the former symptoms returned with steadily increasing force. The gait again grew difficult and unsteady, the lower extremities weak, with a twitching of muscles of the leg, and a stiff feeling below the knees. There was imperative urination. The singing voice was lost. During this, as well as the other attacks, there was no loss of emotional control.

Her status, on examination at Mt. Sinai Hospital, November 22, 1914, presented unmistakable characteristics of multiple sclerosis.

Eyes: Small; pupils have a sluggish light reaction; nystagmoid movements in extreme positions; bitemporal pallor of the discs. Reflexes: Oppenheim; Romberg; bilateral Babinski present; absent abdominal. Tendon: U. E. diminished, lower present. Motor control: Spastic face; ataxic gait; hypotonia; slight unsteadiness in left hand at times; marked unsteadiness in the legs. Heart: Systolic apical murmur. Viscera: normal. Wassermann and spinal fluid: negative. Also a case of multiple sclerosis.

ETHICAL ASPECTS OF PSYCHOANALYSIS

By John T. MacCurdy, M.D.

(By invitation)

Psychoanalysis is a method of psychological investigation and therapy, which with its theory stands in a peculiar position to-day, inasmuch as both its opponents and its adherents show a spirit in their attacks or defense, so strong as really to be inconsistent with dispassionate scientific argument. There must be something in it, therefore, which stirs an emotional response. What this is may be inferred from the fact that the ranks of psychoanalysts have recently been split on that very rock which is the target for the abuse of the opponents. This is the claim that unconscious sexual motives, particularly of abnormal cravings, are basic dynamic mental factors. The claim that a mental cause may produce disease meets naturally with opposition from those who are convinced that there must be a physical abnormality in the brain corresponding specifically with every mental symptom. But equally bitter attacks come from those who are open to a belief in psychogenesis. The crux of the situation is therefore in the nature of psychoanalytic claims.

It is necessary to examine these claims from two standpoints—that of objective validity, and that of their ethical value or potentiality for good and evil. The evidence in favor of the truth of the teachings of psychoanalysis rested originally on the method of free-association. As this method implies a familiarity on the part of the physician with his technic such as is only gained by experience, and as the patient to coöperate must have established a certain *rapport* with the analyzer, it is difficult to demonstrate *objectively* that no suggestion is at work. It has been found, however, that the history of myths and folk-lore shows a development of ideas identical with those which Freud claimed to find in the unconscious of the neurotic individual. This would seem to offer strong support of his theory. But more recent work with the psychoses has shown that there is no “complex” reported by Freud which does not reach open expression in the psychoses under conditions which preclude suggestion. Moreover, the relation of these normally unconscious ideas is so regular that it is now often possible to predict the delusions or hallucinations to arise in a psychosis, knowing once the make-up of the patient and the precipitating cause of his break-down, although there may seem to be no surface relation between these factors whatever. This is such a flawless objective proof, as it reduced the problem to experimental conditions, that no psychiatrist can now be scientifically honest and deny the substance of these claims.

It is important, however, to examine the ethical aspects of psychoanalysis, for if the matter concerned be morally repulsive, anyone may be pardoned for paying no attention to it. That psychoanalytic claims are often regarded as being repulsive is certain. How has this come about? It is probably owing to two misconceptions: that what is unconscious is to be judged by the same standards as what is conscious; and that a symbolic outlet to a forbidden wish is as reprehensible as a direct fulfilment of such a wish. It is, however, obvious that if any idea be unconscious it can have no relation to reality. If not in contact with reality it cannot lead to any overt act. Immorality implied an act or at least the thought of some act; but an unconscious idea cannot be spoken of as immoral or even dangerous, so long as it remains in the unconscious. If the history of these wishes be followed, they are found never to have been in contact with reality, never fully conscious. This may be seen in the growth of the unconscious wish for incestuous outlet with a parent. The child loves his parent and naturally strives for expression of his affection. As soon as sex consciousness begins to develop, it is inevitable that the idea of physical outlet with those he most loves should appear. In so far as this outlet is frankly sexual, however, it is repressed into the unconscious. That the wish exists in the unconscious only is therefore a tribute to the morality of the individual. When these wishes do get into consciousness, it is only by symbolic expression. These symbols are symptoms, or sublimations. In both cases there is a distortion which makes the final concept perfectly acceptable to the moral side of the subject, except in such unusual cases as the kleptomaniacs. Sublimations are more than mere distortions; they are outlets which are socially useful. The individual in this case then uses the energy of his forbidden wish to benefit mankind. In demonstrating this, psychoanalysis pays a tribute to the morality of mankind rather than debases it. Both repression and sublimation demonstrate an ethical power in human beings, previously unguessed.

Dr. August Hoch said that he thought all must have been impressed

with the atmosphere created by this paper of Dr. MacCurdy's, an atmosphere different from that which the opponents of psychoanalysis have been accustomed to associating with the subject, for to them it was a subject in which nothing else but sexuality was dealt with, more particularly sexuality as they conceived it. Such an exposition of psychoanalysis as Dr. MacCurdy had just given should go far toward correcting such an impression. The psychiatrist had of course long been impressed with the frequency with which sexual motives were found in the psychoses, and therefore, it was not surprising that a similar state of affairs should be found in the closely related neuroses. He thought that the most fundamental part of Freud's teachings, namely, that of the importance of the imperfect development of the love instinct, was proved by studies in the field of neuroses and psychoses; but he felt that Dr. MacCurdy had done a distinct service toward a better understanding of psychoanalysis by laying stress, not only on the more individualistic side of our instinctive life, but on the social side as well, *i. e.*, the moral, adaptive forces which represented not only the ethical aspects of psychoanalysis but of the neuroses and psychoses as well.

Dr. Steinach asked Dr. MacCurdy how he could explain the Abderhalden reaction which recent investigators have shown to be fairly constant in dementia præcox, if the disease were of purely psychogenetic origin as he seemed to indicate in his paper.

Dementia præcox seemed to the speaker more like a chronic intoxication due to perverted metabolism and probably resulting from disarrangement of some of the internal glandular secretions.

With equal propriety one might make a psychoanalysis of any intoxication such as alcoholism or the delirium of typhoid fever, but the conclusions arrived at would in no respect help to solve the question of the origin of the condition.

Dr. Clark said apropos of critical remarks made concerning the much vexed question of the pathogenesis of dementia præcox, while it must be recognized that in certain mental diseases there are metabolic changes, yet this fact does not necessarily make observations of its manifestations of no value in the effort to gain some clue to its primary causes. Allowing the position of Dr. Steinach its full force, what had he to say with reference to the undeniable similarity of mental trends in organic nervous diseases and those psychopathic conditions where there is no manifest organic change? Where like physical causes were not operating to produce like effects, certainly it seemed reasonable to explain similar trends as due to some related underlying cause of a different nature, which the Freudian theory does by attributing both types of mental disorders to defective adaptation of primary instinctive trends to adult purposes in life.

Dr. Smith Ely Jelliffe said that he had nothing to add to Dr. MacCurdy's paper, except that it seemed to him to set forth what might be called the trend of modern opinion regarding psychopathic cases and that it was of value to have had a presentation of the subject which, as Dr. Clark and Dr. Hoch had just said, should go far toward creating in the minds of those hearing it a clearer conception of certain commonly misunderstood phases of the subject.

Freud explains very distinctly that neuropathic disorders have their rise in the reluctance of the subject to recognize certain vital situations which offend the moral side of his nature; rather than consider the possi-

bility of taking any step downward in his ethical attitude toward certain social reactions, the patient is ready to suffer martyrdom.

To brush aside an explanation of such conditions by such a sweeping objection as, "But these are abnormalities," reminded the speaker that in a celebrated dialogue of Protagoras a similar attitude was most strikingly disposed of. It might bear repetition at this late date since one hears it repeated so frequently in discussions of a so-called logical type. Here Protagoras called the attention of Morosophus, his adversary, to "Xenias the son of Glaucus," asking Morosophus if he knew him.

Morosophus: Yes, but he seemed to me a very *ordinary* man and quite unfit to aid in such inquiries.

Protagoras: To me he seemed quite wonderful and a great proof of the truth I have maintained. For the wretch was actually unable to distinguish red from green, the color of the grass from that of blood! You may imagine how he dressed, and how his taste was derided. But it was his eye, and not his taste, that was at fault. I questioned him closely and am sure he could not help it. He simply saw colors differently. How and why I was not able to make out. But it was from his case and others like it, but less startling, that I learned that truth and reality are to each man what appears to him. For the differences, I am sure, exist, even though they are not noticed unless they are very great and inconvenient.

Morosophus: But surely Xanthias was diseased, and his judgments about colors are of no more importance than those of a madman.

Protagoras: You do not get rid of the difficulty by calling it madness and disease. And how would you define the essential nature of madness and disease?

Morosophus: I am sure I do not know. You should ask Asklepios.

To which Protagoras remarks: "Ah! he is one of those gods I have never been able to meet."

Dr. MacCurdy, after expressing his appreciation of the cordial reception which his paper had met, said the fact that it had not given rise to more discussion by those holding contrary beliefs was to him a disappointment, since he felt sure that a talk extending over some fifteen minutes' time could scarcely have done a great deal toward changing views; he regretted that there had not been more adverse discussion of his paper, particularly since he had grouped the points made therein in such a fashion as to make it possible to take them up one at the time, with the idea of making them the starting point rather than the close of discussion.

Referring to Dr. Steinach's question, Dr. MacCurdy said that he presumed Dr. Steinach used the Abderhalden reaction as a specific example of a toxic influence which might be the causative factor in dementia præcox. That organic factors were important in dementia præcox is not only admitted by psychoanalysts, he claimed, but psychoanalysis furnishes a most definite proof of the existence of such factors. If normal, neurotic and psychotic individuals all had identical unconscious "complexes," then the difference these different types of individuals show in meeting certain situations common to them all could only be explained by the dementia præcox individuals' having from the outset an inelasticity and a defective adaptation, which must be founded on a physical basis. Any more specific statement of the relation between insane ideas and diseased cortex was impossible. The origin of definite ideas could only be traced by psychological means; a physical correlation implied a knowledge of what the

mechanical or chemical properties of the ideas were. That, of course, was ridiculous in the light of our present ignorance of such things.

SOME OBSERVATIONS ON DEMENTIA PRÆCOX

By Walter L. Treadway, M.D.

(By invitation)

The paper dealt with dementia præcox in men, and called attention to the fact that it is no longer to be questioned that in the genesis of dementia præcox the so-called shut-in type of personality is essentially the type that breaks down with this disorder. The original description of the shut-in type of personality left out, to quite a considerable extent, the abnormalities in the sexual life of these individuals. Dr. Treadway pointed out that in the development of sexuality certain types of shut-in personality show an inability to fuse the tender feelings and the sensual feelings, and to bestow the two together on an adult object. The Oedipus situation plays the important part in preventing the biological demands of adult life properly to adapt itself,—i. e., an inability to replace the infantile tendencies with an adult object,—hence a defective adaptation in love affairs, mating, and propagation; in other words, a defect in the instincts.

The first case considered was that of a normal man with externally an excellent adjustment to life, but with evident difficulties in the sexual sphere. He was quite capable of having sexual relations with women, but for them he had no tender feelings. He was also quite unable to have any erotic desire for a woman for whom he had a real feeling of love or reverence. Two women for whom he held this tender feeling were older than he, and of them he drew a plain parallel with his mother, so that both represented mother substitutes. This case was presented with a view to bringing about a better understanding of the cases which followed.

The article was not confined to the make-up of dementia præcox cases, but to some points about the precipitating causes, and about the content of the psychosis.

The first case of dementia præcox presented a shut-in personality with the following abnormal traits in his sexual life.

Although the purely sensual side of his sexuality seemed not to be repressed, he was decidedly defective in his capacity to make love and to contemplate marriage seriously. Such abnormalities were considered an evidence of an infantile attitude, so far as love and marriage were concerned, and represented an inability to develop beyond the mother attachment. This case showed that the man's ideas which referred to his getting an independent position in life, and the finishing of his apprenticeship, were closely related with the idea of marriage, and owing to his make-up it was precisely that from which he shrank so much. It was then regarded that the taking up of a definite life work, and the final coming into sight of the termination of his apprenticeship, represented the precipitating cause, or the precipitating cause acted in the same direction in which the defect of his make-up tended. The content of his psychosis was marked by homosexual features, but there was also another part which represented the wish not to go through the apprenticeship, not to have sexual power, all of which was connected with his ideas of marriage.

The trend was an expression of a regressive sexuality; that is, of non-adapted love; namely, in this case homosexuality. So that make-up, precipitating cause, and content were the expression of the same innate tendency or defective adaptation.

Two other cases were briefly reviewed.

The second case of dementia præcox was that of a typical dementia præcox make-up. But in this case the subject broke down, not under the demand for adult love, but when his father died. A manic-depressive personality would have developed a retarded depression, but in this case the subject developed a crude infantile sexual trend. At first glance it looked as if the principle of the two cases were very different, but much similarity was in evidence. In the first case of dementia præcox the patient broke down because he was unable to meet the demands of adult love; he was unable to do that on account of his infantile tendencies. In the second case of dementia præcox no demand was made, but the infantile tendencies became suddenly inflated through the death of the father, *i. e.*, his rival. The patient presented a very infantile trend, a cosmic formulation, of having relations with his mother, of being his father, and of recreating himself with his mother. The principle, however, that the make-up, the precipitating cause, and the content of the psychosis were closely connected and worked all in the same direction, was again evidenced in this case as well.

The third case of dementia præcox showed a very marked incapacity for adult love which stood distinctly in the foreground, and was rather more marked than his general shut-in tendencies. No definite precipitating cause was demonstrated. But the case showed an interesting feature which formed a parallel to the precipitating causes, especially that of the second case of dementia præcox reported. He changed his habits after the father's death, began to wish to appear more manlike, drank, and became an agitator. The inflation which the unconscious tendencies received after the death of the rival was in this case not transformed into psychotic symptoms so much as into fairly well adapted habits,—in other words, sublimated. He got an outlet in more association with men, in drinking with them, and in becoming a revolutionary spirit. His trend was essentially a homosexual one. Aside from the usual homosexual accusations, his ideas chiefly were that he was changing into a woman. Here, as in the first præcox case, one of the typical escapes from real love destiny was chosen, the path of unreal adult love, that of homosexuality. In this case the trend and the make-up were the result of the same tendencies.

The following points were brought out:

First: That the adaptation defect in the sexual sphere, although it may express itself in a complete shunning of all sexual relationship with the opposite sex, may often not lead to any marked repression of mere sensual sexuality, but may gravely interfere with the capacity to meet the demands of adult love,—*i. e.*, marriage.

This is of course a trait not confined to dementia præcox, but is one of the ways in which, as Freud has shown, the defect of sexual adaptation may manifest itself in any neurotic individual. The first case reported was a good example of this.

Second: That when we fully appreciate the internal unconscious meaning of the defect of sexual adaptation,—namely, the fixation in an infantile state of attachment to the parent of the opposite sex—it is clear that the

peculiarities of make-up, the nature of the precipitating causes, and finally the content of the psychosis are very closely related, in that they all are dominated by the incapacity to fulfil the demands of adult love, and the desire to get away from this.

The trends described in the cases here reported are either a direct expression of the desire to avoid marriage, or they represent an escape in the sense of homosexuality, or they are directly of the nature of plain infantile sexuality.

Dr. Hoch stated that it seemed to him very valuable to bring out the points which Dr. Treadway had just developed, by demonstrating the possibility of viewing the make-up, the precipitating cause, and the ideas expressed by the patient (the so-called content of the psychosis) from a common point of view, namely, from that of an underlying defective development of instincts. He stated that after the earlier studies on make-up in dementia præcox, which had led more to a surface description of the essential traits of the constitutional abnormality, it had more recently become possible to demonstrate that the stunted development of the adult love instinct represented an important component of the make-up of dementia præcox cases, and that this inadequate development also showed itself in the ideas expressed by the patient, which betrayed motives belonging to an earlier stage of development.

Seeing a significant point in connection with one of the cases presented by Dr. Treadway, that of the workman who as soon as he had finished his apprenticeship found it impossible to go on doing his work, Dr. MacCurdy said that a striking thing in this instance was that no difficulty whatever had been experienced with the work until a time was reached when the training was finished and the man had reached an independent position; everything went smoothly until that particular period was reached which, according to the confession of the patient, was identified with the assuming of a certain responsibility,—that is he was now a worker for a higher wage and could afford to marry. Confronted by the removal of all obstacles that heretofore had deterred him from this step, which he seemed to consider a duty, he suddenly found it impossible to do the same sort of work which he had been doing before to the satisfaction of those who employed him. Evidently, at the time of the breakdown, the work was no longer viewed as a thing in itself, but rather was unconsciously considered in the light of its associations. A knife which a man carried around with him, using it to cut his bread, or sharpen a pencil, is of course to be regarded as simply a knife. But when a man feels that the knife *must* be carried, through the force of some compulsion he would be at a loss to explain, which fills him with a feeling of gone-ness if he does not have it with him, then, to him, the knife has ceased to be a mere knife, and has assumed an importance that can be explained only as being symbolic. So, in the case under discussion, it seems reasonable to conclude that the illness came not from any strain directly attributable to the work itself, but rather from conditions which in the patient's mind had become identified with the finish of his apprenticeship and the obtaining of an independent position in life—conditions which, since he felt it impossible to meet them, put in motion the associated feeling of an inability to go on working, as he heretofore had done.

Dr. Clark commented upon one of the cases presented in Dr. Treadway's paper, that if it be true that the primary fault in dementia præcox is an inherent inability in the individual to adapt himself to the socialistic tendencies of adult life, and particularly to the main purposes of a proper

marriage, then is it not possible for us to see some therapeutic advantage in this conception? If one may be fairly certain of this position, why not arrange the lives of the præcox to the simpler adolescent tasks whose trends do not lead essentially into situations that call for these impossible demands? Industrial occupations, shop, farm and garden work and life led apart from the temptations for heterosexual life, may conserve the præcox from the deterioration consequent from being measured up to a standard he cannot meet. This position would possibly render stationary the cases which are first made quiescent by hospital treatment; but to be fully effective the præcox would have to be diagnosed and placed under treatment early, whereas at present only too frequently he is not even seen by physicians. The early detection of the sinister import of the shut-in type of personality in adolescence is very imperative as we gain a truer insight into the essential pathogenesis of the disorder. All agencies dealing with children should be keenly aware of some of these newer studies in order that the above conservation principle of treatment may be applied.