THE PRESENT STATUS OF PARANOIA.

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It has been with an irregular gait, though perhaps in an onward direction, that we have searched for the well-spring of the psychosis called paranoia. The history of the study of the subject has been so often rehearsed that it is not needful to take up space with it here. Time will, however, perhaps not be lost in tracing lightly such part of the chase as the elusive form has led some of us younger psychiatrists.

We appeared upon the field in time to hear some of the wise talk concerning monomania, but too late to be greatly confused by that significant term. Fortunately, the impossibility of an involvement of any one circumscribed area of mental action has been quite generally conceded and the term "monomania" has been reserved for the most part as a characterization of the impulsive insanities rather than as another cognomen for paranoia. We did begin our studies, however, just in time to absorb some of the confidence which had newly pervaded the minds of psychiatrists as to their conception of the term "paranoia." It was with no uncertain words that we were taught how to make a diagnosis of paranoia. However indefinite might be our knowledge of other psychoses, here was one which we could understand. We were told that when we found a psychosis characterized by fixed, systematized delusions of a persecutory and grandiose nature, we might become suspicious that we had to deal with a case of paranoia. The chronicity and incurability of the disease were made plain to us and then its stages of development were described. There was the stage of subjective analysis, that of persecutory delusions, and finally that of pronounced delusions of grandeur which might be accompanied by a process of more or less rapid mental failure. In our student clinics, patients said to belong to this class were exhibited and we admired, as was expected, the brilliancy of their exploits in certain

directions. We were told that there was not necessarily diminution of the intellectual power of the individual, but that he merely looked at life from a standpoint not common to the remainder of humanity. He was said to be often a man of great capability in certain direction. Here was an individual said to be a scientific genius but one who could not be allowed to pursue in freedom his investigations because he held dangerous conceptions of the relations of other individuals to himself. We were told that many of the great men of history, the men who had accomplished great things, had been really paranoiacs; they were of large ability but with peculiar and deluded ideas; they believed themselves destined for great things, they were incited to deeds because they were dissatisfied with their position in life and thought themselves wronged and persecuted. In the hospital were found numerous patients who were pointed out as examples of paranoia; the fixity of their ideas was tested, the outlines of a system traced in their delusions, the tirades against imagined tormentors heard, the air of superiority and the constant evidence of a heightened self-consciousness observed, and we were satisfied of their right to the title "paranoiac." We have often heard a patient referred to as an old paranoiac in terminal or secondary dementia, while his neighbor, perhaps an older man and one in whom the disease had been longer evident, was spoken of as having undergone very little mental deterioration.

Recently our confidence in the conception of paranoia has received a jar; the Germans have been at work altering classifications; the dust of battle clouds the horizon; we are for a time in a sad state of confusion. Gradually the atmosphere clears and there is seen to have arisen a new form, or rather an old form presenting a new bearing and labelled with a new name, "dementia præcox." Under the term "paranoia" we find that we have been including not only patients, perhaps deserving the same name under the newer classification, but also a large number which now rightfully belong to the dementia præcox group.

It is the *Kraepelin* nomenclature which strikes forcibly on us of America. We not only accept the German's ideas; we bolt them whole. We become absorbed in the task of re-sorting

our patients and placing them each in his own pigeon-hole, placarded with his proper label.

Dementia præcox perhaps received the largest share of our attention. We found it comparatively easy to recognize the catatonic and hebephrenic varieties, and the more weak-minded of the paranoid form were readily assigned to their correct place in the new terminology. When we came to study the least weak-minded of the patients whom we had but recently called paranoiacs we found it difficult to decide who could be properly named a paranoiac and who a paranoid dement. With closer and closer observation of these erstwhile paranoiacs they began one by one to take their place in our minds as subjects of dementia præcox till we awoke one day to find that we had placed all of our paranoiacs in the dementia præcox class. Hurriedly, lest we should be found without a paranoiac in our company, we searched for one near and far. Using the *Kraepelin* definition as our model, we measured the patients directly under our care, but none were found to match it. Scrutinizing our past records none came to light, and finally after examining the recorded cases of literature, we wonderingly asked ourselves the question, "Is there no more paranoia?" Such an inquiry directed against a name which for nineteen years has stood as one of the most significant and stable in psychiatry, brings before the interlocutor a vision of frigid glances and heightened eyebrows. But let us consider the question with as little bias of preconceived opinion as possible.

The writer is free to confess it has been no easy matter to shed these preformed notions, and he is sure that he has more than once read into a patient's mental state a mass of those ideas, more especially in regard to paranoia. Given thoroughly instilled ideas as to what should constitute a paranoiac and finding a large part of the essential constituents present in a given case, it becomes a most facile process to complete the paranoiac picture by subjectively supplying a few deficient features.

In endeavoring to come to a decision it becomes necessary to study each case in question as if it had but newly come under observation. We must go back to the early records (and most of these patients have been in our hospitals for years), we must re-

hearse the statements of friends as to the patient's history previous to hospital commitment, and we must read carefully the notes of physicians and attendants as to behavior and condition in the hospital, before making direct examination of the patient.

Lest there should be any misunderstanding of our position, let us retrace the steps which we have taken in the endeavor to properly classify our patients. Let us begin by supposing ourselves placed before all the patients who are to be classified either as paranoiacs, paranoid forms of dementia præcox, or as subjects of closely allied psychoses. To what conditions should we apply the term "paranoid dement," and are there patients answering to the definition of paranoia as given by *Kraepelin*?

There is a group of these patients which has caused little confusion since the general adoption of the German classification, a form which in hospital experience is the most common of all the paranoid types and one in which the diagnosis is easily made since the patients all have stamped plainly upon them the stigmata of dementia præcox. These produce on the whole such a characteristic clinical picture, a picture which has been so generally recognized, that there is no need of a prolonged description. They are the cases which have rapidly developed under our eyes, or in which we can usually find the history of an acute onset. There have been observed in them at some time, and in a number are present at all times—the symptoms common to all forms of dementia præcox. They have shown, or do show, varying degrees of catatonia, negativism, stereotypy, mannerism, command, automatism, echopraxia, verbigeration in speech or in writing, or are found from time to time in a more or less stuporous condition. Hallucinations play a large part in the complex presented by such patients. Their delusions are usually more or less fantastic in nature. They rapidly pass into the stage in which they exhibit delusions of grandeur. Their degree of weak-mindedness varies from the gross, with almost no intellectual capacity, the patient merely manifesting his grandiose ideas by an occasional incoherent sentence, up to the forms in which there remains the capability of taking an intelligent and coherent part in a conversation. Such patients may present evidence of considerable ability in one or more directions. They may have musical talent of a high degree, possess great manual

dexterity in the arts, or even produce literary specimens of remarkable beauty of form and not altogether despicable as to intellectual content. The fixity and systematization of the delusions are not usually pronounced but vary within wide limits. Even the most intelligent will show, on close inspection of their system, incongruities, lack of logical form, and changes in both form and content from day to day or from week to week. In all of these, no matter what the degree of intelligence, the diagnosis is rendered easy and certain by the prominence of the stigmata of dementia præcox, and the clinical complex is so characteristic that we need not permit our problem to be further complicated with their peculiarities.

In a second group of cases, however, the diagnosis is not so readily made, although the patients are separated from those just described, not by a sharp class line, but merely by minute and scarcely perceptible degrees consisting in differences in the intensity of symptoms. Considering the group as a whole, we find that the patients have very much less mental impairment than those last described, and the feature in particular which renders the diagnosis less easy is that they have never, while under our observation, exhibited to any prominent degree the common symptoms of the catatonic complex. These are the patients with whom the greatest care must be taken lest an unwarranted diagnosis of paranoia be attached to their symptoms. We must see first if there be anything in the mode of onset which is contradictory to a diagnosis of paranoia.

The *Kraepelin* paranoia is a slowly developed illness, the ONSET often extending over years, during which the conduct and behaviour of the patient may show no great disturbance. There exists a secret, gradually increasing opposition between himself and his environment. If, therefore, we are to diagnose our patient as a paranoiac, we must be able to throw doubt upon any history of an acute onset. Howsoever gradual the evolution of a mental disease may have been, there seems to be always a proneness on the part of the friends to remain blind to it. One would expect that such unusual mistrust, depression and discontent would have attracted attention long before any gross breach of orderly conduct or grotesque behavior had produced a crisis calling for immediate surveillance of the patient. When,

therefore, in reading the records we find, as we did with a patient, that one of the first occurrences to attract attention was an unseemly walk upon the top of a piano, we are likely to think of a psychosis which is characterized by a more sudden onset than paranoia. It is rarely that anything like an exact previous history can be obtained from friends or relatives, as is well known, and our opinion as to the mode of onset must in the majority of cases be influenced by the character of the employment and the position in society which the patient has held for the years preceding the mental catastrophe which brings him to the hospital. If we have an opportunity to talk directly with the friends we must not be satisfied with an indefinite history of erratic conduct, irritability of temper, depression, etc., but must demand a description in minute detail of the behaviour and conduct from childhood. In this interrogation we may often find evidence of mannerism, stereotypy, negativism or an account of grotesque and nonsensical acts which will be highly suggestive of dementia præcox. *Schneider*¹ has beautifully demonstrated how the close inspection of a patient's early history may throw bright light upon the problem of diagnosis. The mental condition of the patient he describes had been diagnosed in Mannheim as *periodischer Verfolgungswahn*, in Weinheim as *chronische Verrücktheit mit Verfolgungs- und Grossenwahn*, and in Heidelberg as paranoia. *Schneider* traced the patient's course from earliest years to the present date, a period of about sixty-six years. He found that the history was one of advancement during the first thirty-three years of that period, that the patient had been industrious, saving, had made the most of his opportunities, had struggled manfully and successfully against adverse circumstances, and that nothing plainly pathological could be indicated in all that period. About the thirty-third year he exhibited for the first time symptoms of a grave mental disturbance, which remained practically unchanged in its type for the following thirty-three years. *Schneider* reasonably concludes that the evidence is of a sort to favor the assumption that a psychosis became active in the neighborhood of patient's thirty-third year. With the patients under discussion careful inquiry reveals a preponder-

¹ *Allgemeine Zeitschrift für Psychiatrie*, March, 1903.

ance of histories as, or even more, acute than that above quoted, but there are undoubtedly cases in which the onset is so gradual that there is nothing therein to contra-indicate a diagnosis of paranoia, and in these latter if such diagnosis is to be discarded it must be done because of other particulars in which the symptoms disagree with the definition of that psychosis.

With *Kraepelin* in paranoia the CLEARNESS OF CONSCIOUSNESS is not abnormally diminished, and a number of patients, whom we might on other ground designate paranoiacs, must be otherwise classed, inasmuch as we find evidence of pathological disturbance of consciousness. While, as has been stated above, these patients have never, under our personal observation, exhibited to any prominent degree the symptoms of the catatonic complex, we find in reading the ward notes and previous records that many of them have shown at times periods of confusion in which the incoherence of expression and conduct were not based upon delusional excitement. The descriptions of such attacks remind one of the epileptic confusional states, in that the excitement is of an aimless sort, of which the patient can neither at the time nor afterward give any explanation. "Transient periods of abstraction accompanied with fixity of gaze" is a frequent note in the early history of such cases, and it may be noted that the patient could be aroused from such condition only by a considerable effort on the part of a second person. It is often noted that these abstraction periods were not noticeably connected with any affective disturbance and, reading the records at this date, it must be confessed that the descriptions are highly suggestive of catatonic stuporous conditions. In a certain number there has occurred at one time or another a transposition of dates which in a few may have taken place consciously and because of delusional reasoning, but which in several instances suggests strongly gross disturbance of consciousness.

In paranoia of the *Kraepelin* conception HALLUCINATIONS form no essential part of the psychosis; they are as a rule absent or appear only in the auditory field, limited in most cases to the form of single words or short sentences. In *Schneider's* case, the Heidelberg diagnosis of paranoia could not be conceded as correct, not only because the evidence pointed to an acute onset,

but it could be shown that the patient had been at various times the subject of very intense hallucinations which played a large part in the up-building and preservation of his delusions. Our experience may have been exceptional, but with the patients who otherwise bore the greatest resemblance to the classical description of paranoia, the hallucinations were often intense, were of frequent occurrence, and formed, as a rule, a considerable portion of the ground-work of the delusional structure. The patients without hallucinations who bear the greatest resemblance to paranoia are those of the "high grade imbecile" class, a form which will be spoken of more in detail in another place.

The elaboration of a SYSTEM in the delusions was as much a part of the older conception of paranoia as it is of the *Kraepelin* delineation. It is to be feared that we may have been rather careless in the use of this term, so that it is perhaps not altogether superfluous to indicate what is meant by "system."

According to *Church and Peterson* "SYSTEMATIZATION consists of combining with the fixed idea complementary delusions in a more or less logical order, or the fantastic elaboration of the original delusion." A no more lucid definition, though one through which the subject is viewed at a slightly different angle, might describe a system as a multiplicity of delusions of which each individual false belief had had for one of its premises an antecedent error of belief, the whole delusional structure tracing its origin backwards over an ever-decreasing and more closely related number of fallacies. A system may thus consist of a small number of delusions, it may be confined to some particular group of concepts, or it may be so extended that it underlies every variety of association of ideas, alters entirely the relation of the individual to his environment and brings about complete transformation of personality. It is this last mentioned, broad and far-reaching elaboration of delusions which forms the system corresponding to the conception which obtains in the psychosis called paranoia.

Even when a system in the delusions has been determined there is need of much careful thought and consideration of the details of its structure if its exact nature is to be appreciated. To refer again to the helpful study of *Schneider*, the patient there reported, in speaking of his misfortunes or any of the ills

of life, charged all to the account of one whom he nick-named the "bulldog," who made mystical nocturnal visits to his room where she wrought all sorts of havoc among her victim's papers and possessions; he considered the influence of this persecuting individual to be all pervading and all powerful. *Schneider* shows that in the patient's attitude toward this mysterious person there was an absence of that intense and absorbing interest which one would be expected to exhibit toward such a powerful influence in the affairs of life, and that the "bulldog" merely offered a convenient explanation for every unfortunate occurrence for which the weak mind of the patient was unable to find the correct interpretation; thus in place of the "bulldog" playing the principal role in a far-reaching and intricate system, she was merely used as a personified and convenient cause to explain an effect, the real mode of production of which was beyond a weakened comprehension. When we find that a patient has delusions of persecution, that this or that body of organized individuals, government officials, relatives or other parties, are scheming for his downfall; when we find that he ascribes bad fortune and all of the ills of life to these instrumentalities; when we find that the patient not only attributes his ills to a delusional bad agency, but also claims to have an opposing good agency which he uses in support of a grandiose belief in his superior and exalted position in life; even with such extensive superficial evidence of a far-reaching system, let us be positive that the good and bad agencies do not afford an ever-ready explanation of what might be perplexing problems to a weakened mind. Such expressions on the part of the patient may be mere elaboration of, and have little more significance, than the terms "bad angel" and "good angel," "my guiding star" or "my fate," as used by many normal individuals.

Not only may we misinterpret a system or exaggerate it to a dignity of which it is undeserving, we may create one where none existed. It may seem childish to warn the trained man of science against rearing for himself in imagination that which never existed, but unscientific and crude as it may have been, the writer believes that he has been often guilty of reading a system into delusions where none, or one of a very minor degree, was present. It is easy and often entirely correct for

us to consider the patient as being on the defensive in the examination, but ought we not to be a little slow in suspecting him of concealing a whole system of delusions simply because he wears an air of mistrust or answers our interrogations in monosyllables? If we find that a patient believes that every picture-frame in the room is charged with electricity, that the trees outside are made of paper, that she has four thousand children, that one leg belongs to a far distant friend, and that her neck is turning to stone, we may say rightly that she has a multiplicity of delusions, but not necessarily a system. Such delusions may have, of course, no more intimate relation with each other than their common pathological basis. To exemplify the ease with which a system may be unwarrantably predicated we may briefly outline the course in a given case. Before coming to the Hospital, A. had attracted attention by going to the house of a friend and refusing to go to his own, asserting that he had been badly used by his father. For a period erratic conduct continued, finding expression largely in abusive remarks directed toward his father and culminating in a scene at his father's funeral. On admission he was morose and silent; direct questions were fruitless in procuring information as to the content of delusions. A few days later, in the course of a conversation, he made hateful reference to the Jews and spoke of a certain individual as "the king of the Jews." Was it not natural for us to keep these remarks in mind as possible indications of delusions in which the Jews figured as persecuting agents? On the following visits the patient meets us with sullenness or casts a glance of suspicion, and we perhaps come to the conclusion that recent questioning has aroused his suspicion and that he has included us in his system of delusions. Later we deliberately engage him in conversation concerning the Jews; he asks us if his nose is of the Hebrew type and says that his father's nose was perhaps a trifle more prominent and hooked than his own. We are not altogether without warrant now in associating such expressions with an early antipathy toward a parent and previously stated opinions concerning the Jews. It takes but little subtlety of imagination on our part to insert that which we consider to be the missing links in the delusional chain. We think that patient's early enmity toward

his father may have been intimately related to an imagined connection between the parent and the Jewish race, and deem it not only possible but probable that patient conceived this relation to be a blood-tie. Is it not easy to go beyond this point and elaborate a system along lines which we know such delusions commonly follow? We may think it probable that patient does not consider himself the son by blood but merely the adopted son of his so-called father. If the patient speaks of frequent headaches and wonders if there may not be something harmful in the food we are quick to suspect him of delusional belief in a poison, and we conjecture as to whether the delusions find their origin in hallucinations of taste or if they are independent of these. As time passes by it may be that the patient comes gradually to be surrounded by a halo of imputed sagacity. His failure to give direct evidence of delusion is spoken of as cunning evasion. His every move is watched, his every word recorded and peradventure these may be woven into a system existing in the mind of the examiner more than in the thought of the patient. The possibility of thus imputing a system where none existed is not exaggerated, since the very details here used as an example are taken from the case of a man who, long considered as a paranoiac and supposed to have many delusions concerning the Jews, in a frank talk with writer denied ever having had such beliefs. His attitude was such that an examiner became convinced of his innocence of any attempt to conceal the truth. He gave ample evidence that he had ground in his personal experience for prejudice, since he had once paid a single fee of \$10,000 to a Jew who charged that amount for obtaining his freedom from an institution. The last statement could probably be substantiated, since it is notorious that his comfortable fortune had been dissipated in legal proceedings revolving about commitments and attempts to regain freedom.

There is no attempt to argue here that there is no broad and extensively elaborated system in the mind of some insane patients, but merely that it is not altogether impossible to attribute to the diseased mind a system of delusions which exists wholly or in part in the fertile imagination of the examiner. The preceding expressions are also intended to demonstrate that a careful and conscientious search for a system in false

beliefs may exclude a patient from the class of paranoiacs in our nomenclature.

To correspond with the *Kraepelin* definition of paranoia the system of delusions must be found to be ENDURING and UNSHAKABLE (*unerschütterlich*). These qualifications are practically those implied in the old term "FIXITY." The delusions must remain throughout life; they are unshaken by argument, and the individual is unteachable as to the incorrectness of his views. Although experience is directly contradictory to the false beliefs it has no influence in bringing about their dissolution. The delusions may become slightly altered in form or in the mode of expression, they may become a trifle broader in scope, but never can the character of the content change. Here again, if we would make a diagnosis of paranoia, great care must be exercised that preconceived notions do not take the place of a careful observation. Because we find that the subject complains of the same persecutors to-day, next week and next month, we may jump to the conclusion that there is a marked fixity to his delusions. Unless we are particularly on our guard, we are not unlikely to attach our attention to some word which the patient has used in connection with his delusions and become accustomed to using it as a sort of trademark, a label, so to speak, of the mental content. Whenever this word reappears we take it for granted that the content which was thus labeled at an earlier examination still corresponds to the name. Thus one of the type which we are now considering used the self-manufactured term "tencilling" to describe the secret process through which enemies sought to harm him; this word appears again and again during the man's history; we find it after seven years have passed as we did at the initial examination. How easy it would be to conclude that the man's delusions had become fixed and to disregard the possibility of an alteration of the whole essential character of the content. It may be that those whom he considered enemies are now friends; where he once considered himself to be a high and mighty individual, the most careful examination would now fail to reveal that he believed himself of any more importance than plain John Smith. The continued use of the term "tencilling" might remain as a convenient term for, and a brief method of explain-

ing certain peculiar, unpleasant feelings. Among these patients we find a certain number whose delusions have retained all the characteristics embraced in the term "fixed," but careful study eliminates from the paranoia class others who might approach nearer to the requirements of such a diagnosis.

Still another diagnostic qualification of paranoia, according to *Kraepelin*, is COMPLETE RETENTION OF THE ORDER OF THE THOUGHT PROCESSES, expressed otherwise by some authors as RETENTION OF THE LOGICAL FORM. *Deffendorf's* adaptation of *Kraepelin's* work adds still another shade of strength to the definition by translating the *Kraepelin* phrase as "without clouding of consciousness, or involvement of the COHERENCE OF THOUGHT." Measured by any of these interpretations of the qualification, a large number of the patients who otherwise correspond closer to paranoia, must be differentiated from it. If the definition merely applied to certain periods or stages of the psychosis, a number of patients might answer to the description, for all of those whom we are now considering have long periods in which the order of the thought processes is apparently completely retained, but there is scarcely one in whom, either earlier in the course of the disease or in recurring attacks, there has not occurred for a longer or shorter time loss of the logical form of the thought processes. It is not always the case that such periods of confusion in thought and action are connected with intense affective disturbances. One patient, who has for years been considered a paranoiac, and whose spoken thoughts show ordinarily a fair degree of logical sequence, writes habitually such passages as the following: "The hospital and its employees still imprison my liberty and I wonder at it, a doctor tinted due from a principle latent in ladies clubs based on untrue accusations laid to my tongue, more likely I guess from ferment arising from quarrels of ecclesiasticism responsible for the stupendous beliefs insufficiently illustrated in active goodness by gigantic trusts in behalf of humanity and adversity as a matter of divine right." Another was held for some time to be a most perfect type of the *Kraepelin* paranoia. Her husband stated that in the earlier stages of the disease she spent much time in writing, and on request, specimen letters were brought for inspection. A certain number were illegible scrawls, the substance of

which could only by an effort of imagination be interpreted as forming a coherent part of a delusional system. An example is here given:

"Nothing pleases me more than to receive a direct communication from Mr. Nye the Camp Meeting Advertiser.

"Grover and Camp Meetings are going to have. I most heartily endorse the movement, but the Pleir State that those I attend through the month of August will be a limited number.

"Never you fear 'Mr. Duffy will get there,' and along with him he will carry his little 'Son' just beginning to walk, for having had a blind closed he has been unable to see the light and if the courts don't see the Duff I'll see the courts."

"NIGGERTUN."

Such and other productions hardly bespeak coherence of thought in a woman who had for years been considered of average intellectual capacity and keenness, and yet in this case the symptoms were more strongly indicative of paranoia than were those of any other patient whom we have had under observation. There is always a tendency toward the preservation of those specimens of patient's work which are remarkable for some beauty of form or intelligence of construction and an aptitude to pass by without close analysis the more mediocre and inferior productions. These latter are not so often brought for the physician's inspection as the former, and it is to be feared that such from the hand of many so-called paranoiacs have never received their proper significance as indications of incoherence of thought.

Another important characterization of the *Kraepelin* paranoia is that the delusions must be formed without marked MENTAL DETERIORATION. The psychical weakness develops gradually and only becomes especially noticeable after decades. Naturally then, in endeavoring to group cases, the degree of mental impairment becomes an important factor for determination. As there is no standard of mental measure, it is by no means always easy to estimate the volume, velocity and vigour, so to speak, of the current of a man's mentality. As *Mercier*³ says when we attempt this "our measuring tape becomes an India rubber band." We

³ *Mercier*, Psychology, Normal and Morbid.

in America are constrained, in the greater poverty of our language, to speak of DEGREES OF DEMENTIA, while in Germany *Verblödung* and *Schwachsinnigkeit* are terms that may be used alone or so qualified as to express the varying shades of deterioration to be differentiated. But whether the term used be dementia, weak-mindedness, mental defect, impairment or deterioration, the writer has never been able to shake off a feeling of absurdity in speaking of a patient as having little or no mental weakness when he is at the time misinterpreting every one of the smallest incidents of life, when he argues wonders of significance from the chance flight of a bird, when he utterly misconceives the careless and accidental glance of a stranger on the street. It is perhaps correct enough in such cases to say that the process of mental deterioration is not progressing rapidly, or that it has been stationary for years, but surely it must be admitted that a high degree of mental impairment has at some time originated and persisted, inasmuch as the individual forms fallacious judgments in every hour and minute of life and clings obstinately to same in the face of diametrically opposite experience, testimony and authority. It is immaterial whether the delusion is formed because of defect of memory, because of abnormally intensified affection, or because of gross congenital or acquired mental disease; it remains nevertheless a sign of impaired mental action even in the face of preservation of the logical order of the thought processes. It may be argued that the entire personality has been altered and that what is taken for mental impairment is simply the result of a standpoint so altered that all the relations of the individual to the outer world have been transformed; that in his own little world his mind is acting correctly and without defect. If this is so we may still be allowed to ask what it is that has changed the individual's standpoint and relations with the outer world if it was not his own, either inherited or acquired, impaired and weakened mind? During that time in his life history, before he had formed definite delusions, when he was merely morose and depressed, jealous and suspicious, either because of continued states of hyperintensified emotion or because of some other congenital or acquired weakness, he began to find not only conceivable but even credible those things which by the mind of

normal strength are taken as inconceivable, or, at most, conceivable but not credible. There has taken place what *Mercier*¹ terms a transference from one category of belief to another without appeal to authority, experience or testimony, and the mind has performed merely, in a less significant degree, the same process which manufactures delusions out of similar concepts. Call this abnormal mental action a lack of the power of judgment or a lack of the ability to suspend judgment, or by any other name, the fact remains that premature and incorrect conclusions are day by day altering the personality and carrying the sufferer forward to a shifting of his standpoint (*zu einer Verrückung des Standespunktes*). Be it a weakness of judgment only, it is nevertheless a mental weakness, an impairment, an intellectual defect. After the standpoint has been shifted it may be pointed out that the order of the thought processes remains the same, that memory shows no defect, and that the patient is still capable of very intelligent and even brilliant exploits in the arts or sciences. In other words, the mental deterioration or defect is not progressing in extent, and that it has never gone beyond the point of shifting the standpoint and destroying the patient's chance of acting the part of the normal man. That the mental defect differs in paranoia from that of dementia præcox, in that the former is a defect in the course of development, while in the latter it is a retrograde process, can scarcely be argued, since in paranoia also the patient has for years been able to make correct judgments and so to order his life that no abnormality of conduct and behaviour could be pointed out; and that here too there is a decidedly retrograde process from the beginning is evident in that the individual departs more and more from his ability to make correct judgments. Whether this accident is in any important particular different from the injury which has occurred to those lighter forms of dementia præcox in which the disease process has come to a standstill, the writer does not pretend to say, but it is of importance to us to know that the paranoiac has at some time suffered either gradually or suddenly from mental deterioration and that the mental weakness thus produced can scarcely be differentiated from that which char-

¹ *Mercier, Psychology, Normal and Morbid.*

acterizes certain forms which bear lightly the finger-marks of dementia præcox. In these latter cases it may be that the disease process has extended a trifle further and has produced the conditions which give rise to hallucinations and occasional periods of incoherence of thought, and it really seems that the lighter the attack of dementia præcox, in these paranoid cases, the more does the individual resemble the paranoia of *Kraepelin*.

Determination of the weak-mindedness of some of these higher forms of dementia præcox is often difficult and rests chiefly on finding by close observation and study slight incongruities and contradictions in the thought-processes, a tendency toward emotional indifference, abstraction or apathy, especially in the often remarkable indifference to, and absence of, chafing under hospital restraint. Though they are usually bright and may at times show even brilliancy, there is nevertheless a degree of psychical torpor as is seen in their absence of ambition and lack of eagerness to seek new pursuits and more congenial occupation. A few, even of the higher types, will occasionally exhibit brief periods of automatic agitation or traces of stereotypy, as in the case of one who at intervals utters loud and stereotyped declamations composed of his grievances and desires.

It is certainly suggestive that the cases with which we have dealt approach the paranoia of *Kraepelin* by gradations of less and less mental defect but that there is not one which conforms to his definition in all essentials. Either in the mode of onset, in the course and symptoms, or in the outcome were found a number of particulars so materially different from paranoia that such a diagnosis could not consistently be made.

There is a form of insanity decidedly of the paranoid type which, however, cannot be classed with the paranoia of the late classifications nor yet can it be included with dementia præcox. We refer to the delusional psychosis of the high grade imbecile. It is probably not possible in all cases to differentiate such cases from the paranoid forms of dementia præcox, but that there are cases of the variety indicated we are in a position to affirm since we have under observation a mother and a daughter whose symptoms did not have an acute onset, are identical in character in the two cases, and with whom the whole clinical com-

plex differs quite materially from that of dementia præcox, on the one hand, and from paranoia on the other. *Sander* proposed the term "ORIGINAL PARANOIA" to embrace cases probably the same in character with these here mentioned. The same term is used by *Brower and Bannister* in their lately published text-book in which it is stated that these patients "differ from paranoiacs * * * in the genesis of their insanity and delusions: in the former (paranoiacs) the mental disorder originates from an apparently normal condition; * * * the condition is a pathologic one though imposed upon a predisposed and more or less defective organization. In original paranoia, on the other hand, the mental disorder is in the natural order of the patient's development, the inevitable result of a defective organization." There is not space to describe in detail the characteristics of this class; we may merely indicate a type which will be readily recognized in that the onset is never sudden, the patient having shown peculiarities and deficiencies from childhood, there are no hallucinations (or if present they are of secondary importance in the complex), there are none of the catatonic stigmata of dementia præcox, and the subject occupies himself from morning to night in elaborating romantic fantasies of a delusional nature just as an author would elaborate the plan of a book. They are day-dreamers, and just as the air-castle builder changes his fancies, just so does the fixity of the delusions of these patients depend upon the passing mood. There is somewhat of a system in these delusions, although as indicated, it is of a dreamy and superficial variety.

Another paranoid type is the so-called ALCOHOLIC PARANOIAC. These cases can be recognized by their alcoholic history, as well as from the character of the delusions which are described in every text-book on insanity.

In *summing up* our study of the psychoses which have been heretofore called paranoia, together with those which have been designated as paranoid forms of other psychoses, we may thus briefly word our deductions:

1. There are patients with paranoid characteristics who, because of gross weak-mindedness and well-marked catatonic symptoms, are easily recognized as subjects of *dementia præcox*.
2. There are others not nearly so weak-minded as those of

the first class who have never exhibited prominently the signs of the catatonic complex, who have shown the so-called paranoid symptoms to such an extent that in our earlier experience we were wont to call them paranoiacs, and who may be classed in *dementia præcox* in that one or more of the following qualifications find direct application to their symptoms.

(a) *The onset* was more or less acute and was not of the type which has been characterized as "shifting of the standpoint."

(b) *Consciousness* has, at one time or another, suffered *clouding* or *disturbance* not due to delusional or other excitement but of decided pathological nature and as an essential expression of the psychosis.

(c) *Hallucinations* are, or have been, of exceeding prominence.

(d) Careful observation and analysis show that the *delusions* are not really *systematized* or that the *system is incomplete* and constricted to a field less than that covered by patient's whole mentality and conduct. Moreover, certain of the dominating delusional concepts are used as ready explanations of phenomena which a weakened intelligence is unable to interpret in a more logical manner.

(e) The delusions are not *fixed*.

(f) *Gross incoherence of thought* of a pathological nature has been evident either in spoken or written expression.

(g) Analysis of the significance of conduct and behaviour discovers a degree of *mental impairment* not consistent with a diagnosis of paranoia.

3. There is a class of patients in which the paranoid delusions occur in the natural course of development and because of defective organization. The peculiarities and deficiencies are apparent from youth. These are often spoken of as *paranoid high-grade imbeciles*, or as *original paranoiacs*.

4. There is a *paranoid form of alcoholic insanity*.

5. Though paranoid symptoms occur often in *senile dementia*, in *paresis*, in *manic-depressive insanity* and in *melancholia*, the characteristic stigmata of the particular psychosis in which they occur will lead to correct diagnosis.

6. The study of our own patients, of old records and of the classical cases of literature has thus far failed to present to us a case which could not be classed with greater appropriateness

with some one of the above mentioned psychoses than nominated paranoia.

In conclusion it may be said that the writer is aware of the sad irony of a situation in which, only nineteen years after the introduction of paranoia into psychiatry, he makes room for a "paranoid dement," for a "paranoid alcoholic," for a "paranoid high-grade imbecile" and for paranoid forms of other psychoses, but none for a simple, plain, unqualified "paranoiac."