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CONFUSIONAL INSANITY AND DEMENTIA PRÆCOX.¹

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The history of the differentiation of acute confusional insanity from other forms of mental disease follows the ordinary course. First established as an independent affection by Delasiauve and Westphal, it might fairly have been supposed to have won definite recognition with the appearance of Meynert's masterly essay in 1889 and Chaslin's monograph a few years later, even though English and American writers, always slow at that time in assimilating the psychiatric work done upon the continent, made little mention of it.

The subsequent history of confusional insanity, however, has been peculiar. With a number of writers amentia, the term suggested by Meynert, was substituted for confusional insanity, but the development of Kraepelin's doctrine has forced amentia decidedly into the background and established dementia præcox as the chief mental disease. Amentia, according to Kraepelin, occurs in only one half of one per cent. of admissions to his clinique, while dementia præcox occurs in about fifteen per cent. and forms the great bulk of the permanent chronic inmates of the asylums. Stransky reports cases of amentia as a rarity and Jahrmarker believes that many cases of this rare disease are really dementia

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præcox or maniacal-depressive insanity. There has been a tendency, however, to include amentia with the toxic and infectious psychoses and to admit some connection if not an actual identity of the affections.

In the differentiation between the two affections Kraepelin, as is well known, stated that in dementia præcox the onset is gradual and there is not a previous history of exhausting influences. Among the characteristic symptoms are negativism, verbigeration, mutism, stereotyped attitudes and katatonic states. The patient is not influenced by emotions, and his attention is defective, but he has good perception and orientation. He has a fair memory for recent events, understands his environment, has correct ideas of time and recognizes persons. Hallucinations and delusions are less frequent. In amentia, on the other hand, consciousness and memory are more impaired, perception and orientation are much affected, the patient has no knowledge of persons or of recent events, and he is often emotional and has hallucinations and delusions. Negativism, verbigeration and stereotyped attitudes are rare. Amentia is of sudden onset, and often follows some exhaustion. Recovery is not uncommon, while in dementia præcox the tendency is to mental deterioration and recovery is rare and apt to be incomplete or followed by a recurrence of the disease with increasing dementia.

Many of the symptoms which Kraepelin attributes to dementia præcox, however, were described by Meynert as characteristic of amentia. The confusion of amentia, for example, is regarded as due to a disturbance of association, the projection system being unaffected. Perception is, therefore, not disturbed, but when the process advances further the projection system also becomes involved, and a state of stupor develops in which perception is also affected. Confusion and stupor, with Meynert, are thus different stages of the disease, the disturbance of perception marking a greater involvement of the brain. Kraepelin, however, assumes that the disturbance of perception is one of several symptoms which serve to differentiate amentia from dementia præcox. There can be no doubt that the cases reported by Meynert and his description of amentia correspond very closely to the cases and descriptions given by Kraepelin and his followers of dementia præcox. The distinction between the two is admittedly difficult at times (Paton). It is therefore not surprising that Bianchi

frankly admits that amentia, acute dementia, dementia præcox, katatonia, stupor and mental confusion are merely syndromes representing certain phases of a complex psychosis, to which he gives the name of sensory phrenosis, or that Régis and many other French writers regard dementia præcox simply as a more advanced stage of acute confusion.

Pathological anatomy, unfortunately, can offer us no aid in deciding whether we have to do with amentia or dementia præcox. The data are still too uncertain, even in the most intense form of the acute psychosis, delirium grave, for us to be able accurately to correlate symptoms and lesions, and in the less severe psychoses the pathological lesions are still more indefinite and inconstant. It is probable that in amentia and dementia præcox there are various alterations in the cortical neurones of the nature of central chromatolysis, dislocation of the nuclei, etc., but they are not constant and show no special differences, when they do exist, in the two affections.

The study of the pathogenesis of the two affections, furthermore, has not as yet reached the point where it can afford any definite help. While exhaustion or intoxication often plays an important part in the genesis of amentia, other cases arise where such a factor can not be discovered. Hereditary taint may exist in either affection, and its actual etiological significance is seldom carefully weighed; in amentia and dementia præcox, as in most nervous or mental affections, the existence of one or more cases of nervous or mental disease in the antecedents, no matter what their nature, is sufficient to prove the importance of heredity as a cause. Jung and Freud have of late sought to demonstrate the influence of various chains of associations or thought complexes in the genesis of dementia præcox, yet Jung is forced to introduce toxines as a further factor, and Weygandt and others of the Heidelberg school, opposing Jung's hypotheses, emphasize the significance of toxic factors in the genesis of the disease.

The attempt to differentiate diseases by the presence or absence of certain clinical symptoms is often necessary, especially in the early stages of investigation, but it is not always successful. Few symptoms are pathognomonic and most of them occur in a variety of affections. True as this is in regard to disease in general it is still more true with regard to diseases of the brain and especially to the more complex affections without such simple

symptoms of excitation or deficit as convulsions, paralysis or anesthesia. Such simple symptoms may point definitely to the seat of the trouble, but even these may give little help as to the nature of the affection. It is an axiom which can not be too often insisted upon, that the symptom in brain disease is dependent not upon the nature of the lesion but upon its location.

Now, whether we consider merely the various symptoms already cited, upon which Kraepelin has based his symptomatology of the two affections, or whether we study the more elaborate psychical phenomena with Sommer, Neisser, Stransky, Gross, Freud and Jung,—the blocking of thought, the narrowing of the field of consciousness, the capricious inability to recall facts, the enfeeblement of apperception, the negative suggestibility, the automatic compliance, the poverty of the emotional attitude, the incongruity between the emotional reaction and the content of thought, the dissociation of mental activity into several simultaneous trends of thought, and the like—certain things must be borne in mind.

In the first place these complex psychical phenomena just referred to, and even the simpler psychical symptoms, such as orientation, negativism, attention and the like, have not as yet been studied with sufficient accuracy and in a sufficiently large number of individuals in health and in diseases of varying kinds. The methods of investigation of these phenomena are not yet generally familiar and the technique is not yet definitely established. We do not yet know how often such phenomena may occur in normal subjects, or, if they do so occur, what are the conditions which may determine them, although some attempts have been made to investigate these points, notably by Stransky. There can be no doubt, however, that some of the psychical phenomena which have been noted in cases of mental disease are not the direct products of the disease itself but the normal reactions of an undeveloped mind reacting perhaps to diseased conditions. Mental depression, explanatory delusions, certain actions of the insane are but normal manifestations brought about by diseased mental states. Other conditions, slowness of thought, resistance to commands, attempts at would-be wit, even Ganzer's syndrome itself, may be merely the mental characteristics of a stupid, pert young person who ordinarily has no restraint or good manners. Much of the affectation, posing, mannerisms and romantic dreaminess of the pre-

cocious dement, if an adolescent, is but an exaggeration of the normal characteristics of adolescence so well described by Marro.

As an example of the results sometimes obtained in making psychical tests in supposedly normal persons let me refer for a moment to the very simple test proposed by Marie for the examination of aphasic patients,—the test of the three pieces of paper of different sizes, with specific instructions as to what should be done with each piece. Whether it be from inattention or inability to grasp more than one simple idea at a time, a certain percentage of out-patients without any brain disease will fail to comprehend so simple a command, even when twice repeated. Even people supposed to be better educated, when a command involving two or more simple ideas is given to them, will half comprehend the first portion of the command and pay no attention to the subsequent modifications. The simple command "Lie on your back" is misunderstood by a considerable number of hospital patients; they catch the word "back," pay little attention to the rest of the sentence, especially if the word back be made emphatic, get the idea that the back is the important thing to be examined, and promptly roll over on the belly.

We lack, furthermore, sufficient information as to the modifications in these various psychical phenomena brought about by disease in different forms, or by physiological changes in the economy. We have certain studies, it is true, of the psychical symptoms of a few diseases which affect the mind predominantly, but we still lack psychical studies in cases of ordinary disease, or psychical studies made under varying physiological conditions. Jung, for example, has shown certain resemblances between hysteria and dementia præcox, but much remains still to be investigated.

Admitting, however, that we can determine these complex psychical symptoms as accurately and interpret them as definitely as we can the simpler symptoms of brain disease, the fact remains that neither the symptoms as given by Kraepelin as characteristic of dementia præcox, nor the more complex psychical states since investigated are pathognomonic of that disease. Verbigeration, negativism, katatonia, stereotyped positions, etc., may occur in amentia and the exhaustion and toxic psychoses, perception and orientation may become impaired in dementia præcox. Furthermore certain symptoms may be present at one

period in the history of the individual patient and not in another.

It is furthermore admitted that both diseases may pursue a similar course, although cases of amentia are more apt to recover and less frequently become demented. The outcome of dementia præcox, however, varies. Some cases recover completely, even after the disease has lasted fifteen years (Schaefer); some remain in a paranoid state for years, showing some mental deterioration but no marked dementia; others, especially the more youthful patients, rapidly become demented, and a few succumb in the early stages of the disease. Cases of amentia may result in the same way.

Although the distinctions are not absolute between the two affections, whether we consider the pathology, the pathogeny, the symptoms, or the outcome, it may be claimed that, nevertheless, there is enough to warrant differentiating the two diseases, even though we cannot draw a sharp line of division between them. There is certainly a difference between a case of simple hallucinatory confusion which makes a complete recovery in three months and a case of hallucinatory confusion which rapidly goes on to a stuporous dementia with negativism and stereotyped attitudes, or a case which dies in a few days with intense febrile delirium; yet the first and third types are classed together, and the second is classed under a different heading. There is, however, as much resemblance between the average case of amentia and the average case of dementia præcox as there is between Kraepelin's three types of dementia præcox, and as many transitional forms may occur. The variation in the symptoms is not always due to a difference in the disease itself, but to variations in the extent and severity of the morbid process or to differences in the subjects attacked by the disease. We see this most strikingly, of course, in the various types of mental disturbance due to chronic alcoholism. It is not probable that alcohol causes several different forms of mental disease, but the different mental syndromes that are produced by alcohol are due rather to the intensity of the toxic effect or the differences in the brains that are affected. It is hardly possible at present to prove absolutely by the study of individual cases whether they can be demonstrated to be amentia or dementia præcox. I can merely admit that the distinction is often difficult, and incline, like Bianchi and Régis, to the doctrine that the two affections are identical.

It may be said, however, that all this is a mere question of nomenclature, hardly worth spending so much time upon. Amentia is rarely spoken of to-day by American alienists and still more rarely diagnosticated. It is an ill phrase, any way, for amentia in its true sense, absence of mind, was long ago applied to idiocy. The French term of acute confusion or Bianchi's sensory phrenosis is much better; but it is the fashion to-day to call everything dementia præcox that we do not call by that most vile phrase, neither German nor English, "manic-depressive," so why should we not be content?

The objection to the term dementia præcox is obvious and is similar to that used by Børne against the name of the Holy Roman Empire—"weder heilig, noch römisch, noch Reich." It is admitted by Kraepelin himself that the disease sometimes begins after the age of fifty, and some cases do not become demented. The main objection, however, is the emphasis which is laid, by the acceptance of the term, upon the idea of dementia.

As Blumer has recently shown, the definition of the word dementia is still uncertain, but, after being originally applied to any form of madness, it gradually acquired, in the usage of earlier English alienists (Copland, Davis, Reynolds, Maudsley), the significance of "a failure or loss of the mental powers, usually consequent on other forms of insanity"; a terminal state of incurable mental decay.

That many of the victims of "dementia præcox" pass somewhat rapidly into a state of profound mental deterioration, and that many others show sooner or later considerable mental defect is only too true. In other cases, however, there is either complete recovery or healing with defect. In the latter case the patient may show merely a lack of insight into his previous condition, a few explanatory delusions, a deficiency in mental application and the like, perhaps so slight in character as to permit him to resume the ordinary duties of life, or at least to live in the world under a certain surveillance. In other cases there may be fairly complete recovery. I recall a case that seemed fairly typical of dementia præcox, with profound mental failure and most of the characteristic features of the disease, where the patient recovered so as to resume his profession and to lead an active professional life for years, with no mental change or deterioration in twenty years time, unless a lack of memory as to

certain features of his mental illness be regarded as evidence of dementia.

It seems hardly legitimate, however, to cite such slight mental disturbances, such as failure to recollect certain episodes in the past, a diminished capacity for protracted mental effort, a few eccentricities or even some explanatory delusions as a proof that mental deterioration is the inevitable outcome of the disease. Every form of brain disease shows during its progress some mental defect, and after recovery from any serious form of such disease there is usually some permanent defect left behind, although possibly slight in degree. Few persons regain their former state absolutely after severe neurasthenia. It is, however, certainly stretching the definition of dementia beyond its somewhat uncertain limits to pronounce such defects manifestations of dementia.

The character of the mental defect, moreover, is unlike that noted in either paralytic or senile dementia. Kraepelin lays special stress on the sudden flashes of intelligence and the understanding of his surroundings which the "precocious dement" sometimes shows. Only the other day such a patient, whose only response to me for years had been an unintelligible grunt, called me distinctly by name—a striking contrast to the impossibility of getting any spark of intelligence from an advanced paralytic or senile dement. It gives the impression that there are some cerebral neurones still capable of function, but inhibited by some unknown influence, whereas with the paralytic dement the conviction is only too strong that these same neurones are forever destroyed.

The old stuporous states and the term stupor have fallen into a more or less innocuous desuetude since the hegemony of dementia præcox, but the term stupor should not be abandoned and it is often more suitable for some of these conditions than the term dementia. It is often difficult to differentiate between the two or to decide when acute curable stupor passes into incurable terminal dementia, but the effort to distinguish between them should always be made.

Another noteworthy difference between dementia præcox and the other forms of dementia is shown by the course of the mental deterioration. Kraepelin and his followers have emphasized the "dementing" character of the various psychoses which

Kraepelin has grouped under the one heading of "dementia præcox," the tendency which they almost invariably show to mental deterioration. This is, however, only partially correct. In the majority of cases the mental failure develops more or less rapidly up to a certain stage and then becomes quiescent. This mental failure is usually more rapid and more complete the earlier the disease begins, the "hebephrenic" type occurring several years earlier than the paranoid type. This is to be expected, since the earlier in life that any disease attacks the brain the more likely it is to give rise to impairment of the intellectual faculties. The juvenile and adolescent brains are more unstable and more readily damaged irretrievably by disease. We note this especially in cases of hemiplegia: the adult hemiplegic often shows some slight mental impairment, but the juvenile hemiplegic is often an idiot as well.

After the establishment of his "dementia" the precocious dement may live to an advanced age, showing comparatively little change in his mental condition. I remember a case in an asylum, years ago, when the only record for several years was "Same old Sally"—a proof, of course, of the laziness of the physician in charge of the records, yet not wholly incorrect as depicting the unchanging nature of the trouble in one of the typical asylum dementes who, like St. Simeon Stylites, keeps a fixed attitude for years. In paretic or senile dementia, on the other hand, the mental failure is steadily progressive, and is associated with progressive physical weakness. In the one case we have plainly to do with a progressive degeneration of the cortical neurones, in the other with a more acute morbid process which does its work of destruction, and then ceases to act, leaving behind a defect. It is true that the mental deterioration may seem to progress somewhat as time goes on, but this is often due to other causes. External stimuli have less effect upon the crippled brain and the deadening influence of asylum life produces "asylum dementia" which follows a life without interest, stimulus or occupation. The dullest of these "dementes" are re-educable to some degree, as every asylum attendant demonstrates when his working patients are transferred to another ward, but systematic scientific effort by the physician for such reëducation is unfortunately too often neglected, although Colucci a few years ago showed that it might be attended with good results.

The "dementing" character of these psychoses, therefore, is not progressive, and the "dementia" can often be arrested and sometimes can be decidedly improved. Such a contrast to the true dementia of senility or general paralysis is certainly a reason for criticizing the appropriateness of the term as applied to these conditions.

The fact that a term is inappropriate or etymologically incorrect is not a sufficient reason for discarding it, if, like hysteria, it has the sanction of long usage. Dementia præcox has not that sanction, and, what is still worse, it is a term prejudicial from the start. To the physician, the family and even the patient it emphasizes the feature of dementia as the inevitable outcome of the disease, which to ordinary minds, in spite of the term "acute curable dementia," only too often convokes an incurable terminal state. The teaching of Kraepelin emphasizes the element of mental deterioration if not of actual dementia, which is not an inevitable result even if we accept the extreme doctrines of the Heidelberg school. Bianchi's term of sensory phrenosis is not open to this objection, and, if we accept with him the probable identity of confusional insanity (amentia) and dementia præcox, we can extend a larger hope to the patient and his friends by recognizing that complete recovery is often possible and that the patient is not inevitably doomed to "dementia præcox."