

ness and perpetual movement. He would not sit quiet for an instant, talked much, and wandered from one subject to another. He was boastful and insolent.

He continued in this excited state till October, 1907, when he rapidly improved, and has remained well since.

As regards the duration of the different attacks this patient suffered from, his first period of depression lasted for one year and eight months. His first period of excitement lasted five months, which was followed by two years and nine months of sanity. In the second cycle of the disease the depression lasted for ten months and the excitement four months. He has now remained sane for one year and one month.

On the Maniacal-Depressive Insanity of Kraepelin.⁽¹⁾

By THOMAS DRAPES, M.B., Enniscorthy.

THE lectures of Prof. Kraepelin, as presented to us in Dr. Johnstone's excellent translation, form a fascinating study. Yet it is probable that with respect to some of them a reader is apt to rise from their perusal with a certain amount of mental confusion. His descriptions, from a clinical standpoint, are delightful reading, and lucid in the highest degree; but when, with the help of new terms, which really only express old familiar facts up to this otherwise expressed, he casts into new groupings cases which have two or three features in common, although differing considerably in their course and in the varying phases of mental disturbance which they present, there is a difficulty in following him. And any scheme of classification founded on a more or less casual and fortuitous similarity as far as a few symptoms are concerned, while ignoring important points of difference, cannot do anything else than create confusion. No doubt Kraepelin's object, so far as we can judge of it, is to group cases of insanity in such a way as to constitute a real help to diagnosis, and, what is of more importance, to prognosis, in the multitudinous phases of mental derangement which come under our notice, and this object is, so far, a meritorious one. But is the object attained by this method? Is it attainable? The fallacy—for it is nothing else but a fallacy—of regarding any

mere grouping of symptoms of insanity as a distinct disease entity is apparent throughout. Insanity is protean in its manifestations, and the symptoms in any particular case may at one point of its course resemble those of one of the so-called varieties, and at another they may correspond with those of quite a different grouping. This fact alone would seem to indicate the futility and uselessness of founding any system of classification of insanity on symptomatology. The endeavour to do so can only be regarded as an impossible feat, a feat which is nevertheless being constantly attempted with a persistent fondness which is quite pathetic by most classifiers, who seem anxious to rival the punitive labours of Sisyphus or the daughters of Danaus, with similar fruitless results.

The term "maniacal-depressive" is too circumscribed for what it is meant to indicate. It is, no doubt, an advance in our ideas of insanity to have the fact, up till now absolutely ignored in all schemes of classification, now at last admitted—although it would be hardly possible to cite a more perfectly obvious fact—that there is such a thing as mixed insanity, a class into which may be thrown quite a large number, if not a positive majority, of the cases of chronic insanity which people our asylums, who, during some particular day, week, or month, exhibit one phase of mental derangement, and at other times a totally different one. And by introducing this term of "maniacal-depressive" Kraepelin has, no doubt, rendered a service in this direction. But it is too narrow and limited in its scope, and should not be used as indicating a distinct entity, having a definite course and character. The very fact that Kraepelin brackets with the descriptive title "maniacal-depressive insanity" another descriptive term, "circular stupor," shows that the first designation is inadequate; shows that in certain cases there is not merely a condition of mania alternating with depression, but that the same case may also be the subject of stupor. In fact, what Kraepelin emphasises as "by far the most obvious clinical feature of the disease," in other words, its diagnostic symptom, is what he calls "an impediment of volition," and this would seem to be a more roundabout expression for a stuporous or semi-stuporous state. Again, hallucinations and delusions may be present, or they may not. But one striking feature in Kraepelin's writings is that he is not consistent with himself. We need not go

farther than the first two cases of maniacal-depressive insanity which he describes, for a glaring example of this. After describing the first case he says: "This condition differs from that of our melancholic patient in a very definite way, through *the strong impediment of volition and the absence of the apprehensive restlessness* so clearly marked in them. Experience shows that the condition is very characteristic of an entirely different disease, to which we will give the name of 'maniacal-depressive insanity.'" (The italics are mine.) This statement lays down—if it lays down anything—that the *diagnostic symptoms* of "maniacal-depressive insanity" are an impediment of volition and an absence of apprehensive restlessness. Yet, in the description of the very next case, also a presumably typical one, it is stated that she became "apprehensive and restless," saw flames, blackbirds, and dogs, heard whistling and singing, began to pray, screamed out of the window, lamented her sins, and could not sleep. Comment here is unnecessary. But that is not all. In the further account of this second case we read: "The patient has absolutely no clear idea of her position, does not understand what goes on around her, and cannot solve any mental problems. A similar difficulty in thought is associated with the difficulty in the action of the will. . . . This *impediment of cognition*, as we will call it, is in fact a symptom regularly accompanying the state of depression in maniacal-depressive insanity." Now, look back to the first case: "He has the most perfect comprehension of his surroundings, and is able to follow difficult trains of thought." Could anything be more absolutely different than the mental conditions of these two patients respectively? In the one case the patient is apprehensive and restless; in the other there is an absence of apprehensive restlessness, and we are there and then told that this is one of the diagnostic and special characteristics of the "disease" so-called. The one patient has the most perfect comprehension of his surroundings and can follow difficult trains of thought; the other has absolutely no clear idea of her position, does not understand what goes on around her, and cannot solve any mental problem. Is it exaggeration to say that there is an unquestionable inconsistency in the inferences drawn from these cases, or that such inferences can do anything else but land us in confusion?

This confusion becomes worse confounded as we read a further comment on the same (second) case to this effect : "The condition of severe impediment of volition is generally included with some other and outwardly similar states under the name of *stupor*. We may call the form now before us 'circular stupor,' as maniacal-depressive insanity is often called circular insanity (*folie circulaire*) on account of the cycle of recurrent conditions." Now, does Kraepelin, or does he not, mean to convey that maniacal-depressive insanity is only another name for *folie circulaire*? If he does, I must confess I don't know where we are. Can it be possible that he regards as the same clinical entity cases following such an irregular course as any of those described by him, and a case of *folie circulaire* in the ordinary and accepted meaning of the term? *Folie circulaire* is the one type of insanity which is characterised by a remarkable regularity in its periodicity, so that we can at once recognise a case of the kind without difficulty, and, having recognised it, we are as a rule able to predicate an unfavourable prognosis. But this regularity is just the feature which Kraepelin's cases do not exhibit, and no one who reads them, apart from his comments, and with an unbiassed mind, would dream of including them under the heading of "*folie circulaire*."

In the single example which Kraepelin gives of "circular stupor" there seems to have been an absence of stupor in the ordinary sense of the word. Beyond the fact that the patient was somewhat reticent, and slow and hesitating in her speech and movements, nothing of stupor properly so-called can be said to have been present. The case would seem from the description to have been one of continuous, or almost continuous, melancholia, with "ideas of sin" and suicidal impulse, and how could it be even proposed to regard it as an example of *folie circulaire*?

No one will deny that Kraepelin is an acute observer, and a most accurate delineator of morbid mental conditions; but he does seem to suffer from a kind of psychopathic colour-blindness which has the effect of making him rivet his attention on one or two special features in a case, and draw deductions from these alone, while it seems to escape his observation altogether that certain other features, to the bearing and significance of which he is apparently blind, entirely negative the conclusions at which he has arrived. This kind of mental

obliquity is difficult to account for in a mind of such striking ability and such wide experience in the study of mental disease.

But surely these symptoms of impediment of thought and will are not peculiar to any one of the so-called "varieties" of insanity. They are present in any form which is accompanied by any degree of stupor; in melancholia, in adolescent insanity (or, as Kraepelin would prefer to call it, dementia præcox), in ordinary dementia, in post-epileptic insanity, etc. In his lecture on "Insanity after Acute Diseases" he describes a case in which the patient, after an attack of erysipelas, became deranged: "The patient understands with difficulty, has to think a long time over simple questions about her age and birthday, answers hesitatingly, and in monosyllables." Is not this "impediment of cognition"? "She does not obey orders until they have been given repeatedly and emphatically." Does not this correspond with what Kraepelin describes as an "impediment of volition"? And he seems to be quite alive to this himself, as he says later on: "Forms such as this are generally included, together with certain pictures of dementia præcox [there's a delightful vagueness about this phrase] and maniacal-depressive insanity, under the name of an *infectious state of weakness*." Another coinage, as an addition to our already overloaded terminology! Does it make any addition to our knowledge of such cases?

Once more, in his lecture on "Mixed Conditions of Maniacal-Depressive Insanity," Kraepelin states that "a cheerful frame of mind, *with facility of expression of the will*, usually accompanies maniacal-depressive insanity." Now facility of expression of the will is the direct antithesis of strong impediment of volition, which in his first lecture on the subject he describes as, "by far the most obvious clinical feature of the disease," in fact, its chief diagnostic symptom. Are not these two statements absolutely inconsistent? How can they possibly be reconciled? The other diagnostic symptom given in the first lecture is the "absence of apprehensive restlessness." Yet, in the second lecture, in each of the cases described the condition of morbid apprehension and restlessness was a prominent feature. The first patient in his first attack was "sad, thoughtful, and over-anxious on account of a tape-worm from which he suffered"; in the second attack he was "very confused and apprehensive

expressed ideas of persecution, and had to be fed artificially." In the second case the patient had a whole repertoire of morbid apprehensions, believed he was to be kept for ever and ever in the penitentiary, that he was thought to be incurable, that he was certainly to be put to death; "had groundless anxieties, showed great apprehension," etc., and "great motor unrest showed during the whole illness." In this patient also there was "full freedom of the expression of the will." Here, again, there is absolute incompatibility with Kraepelin's original description of maniacal-depressive insanity. In *that* the diagnostic symptoms are impediment of volition with absence of apprehensive restlessness; in *this* great apprehension with great motor unrest, while there was full freedom of expression of the will. Could anything be more contradictory?

In the third case, the patient was full of delusions of the morbid, apprehensive, and persecutory class, "overheard people in the street who threatened to shoot him, and to set fire to his house. In the streets, voices pointed out the way he ought to go to avoid being shot; behind doors, windows, hedges, pursuers seemed everywhere to lurk," and so on.

In the face of such discordant statements, how can we for a moment accept the contention that there is a distinct psychopathic entity corresponding to what Kraepelin terms maniacal-depressive insanity, which in the first instance he affirms is characterised by certain definite diagnostic symptoms, while in several of his illustrative cases, not only were these special symptoms absent, but the very opposite symptoms were present? Surely we can come to no other conclusion than that there has been an error of judgment on the part of the writer, and that there is no such "disease" as he postulates; or, rather, that the very different cases which he describes may be all included under the simple general term of "mixed insanity," a term which I am not without hopes that our authorities on classification will, one day or other, see fit to adopt. It involves no theory, it avoids confusion, it expresses a fact obvious to all.

DISCUSSION

At the Meeting of the Irish Division in Dublin, November 7th, 1908.

Dr. RAINSFORD said that the Association was under a debt of gratitude to Kraepelin for providing so fruitful a topic of discussion, but he himself was still far from clear on the subject. He related the case of a lady who, at the age of

29, had been attacked with mania followed by melancholia, and then by apparent recovery. Later, another attack occurred with the sequence mania-melancholia-stupor. He wished to know if this was a case of maniacal-depressive insanity.

The HON. SECRETARY alluded to the prominence of pseudo-logical reasoning in cases of folie circulaire. He expressed dissent from the theory of maniacal-depressive insanity as defined by Kraepelin.

Dr. MILLS had never recognised this entity amongst the patients at Ballinasloe Asylum, the majority of whom were persons of weak mind in a stuporose state.

Dr. DONELAN said that a number of cases only had one attack, and wished to know if they were supposed to go through all the phases in such a single attack.

Dr. COTTER stated that in his paper the word "attack" meant "admission." Melancholia was the first stage and then mania. Eight of his patients should, in his opinion, be classed, not as maniacal-depressive cases, but as cases of recurrent melancholia.

Dr. DRAPE thought that the irregularity of these cases was an argument against maniacal-depressive insanity as an entity, and advocated the use of the term "mixed insanity" to cover all cases of that type.

The Case for Dementia Præcox.—By THOMAS JOHNSTONE,
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BEFORE submitting to you my ideas on the much-disputed question of dementia præcox, there are one or two points in the papers of Drs. Jones and Urquhart to which I should wish to draw attention. I will take them in the order in which they occur.

We need not ask Dr. Jones to seek for the origin of hebephrenia in any such romantic source as the goddess of youth. In common with many medical terms this word might be derived from a mixture of Latin and Greek, *viz.*, "hebes," dull or stupid (old English "hebet"), our English word "hebetude" being from the same source; and the Greek "phren" with its ordinary signification.

As far as I can see, the derivation of paranoia comes from the Greek verb "paranoio," meaning "to understand wrongly" (a similar word, to which I will refer later, was in use in English medical books half a century ago). "Paranoia" is thus a more accurate term by which to describe that particular condition than is "monomania," for though its victims may understand, they understand in a wrong way, and this peculiarity is not confined to one subject only as the term "monomania" would imply.

Later on I will deal with other words which would appear to be as stumbling blocks to Dr. Jones.