COMBINED PSYCHOSES

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A review of the literature of combined psychoses for the past thirty years reveals a surprising paucity of material. I have only been able to find a scant twenty-seven articles bearing on the subject, and some of these only deal with it indirectly. Here and there in the standard works on psychiatry are found allusions to the possibility of the existence of combinations, but only incidentally as it were. I shall not attempt to review or abstract this literature at any length for the number of case histories which I wish to touch upon will fill all the available space. Suffice it to say that it seems to be the opinion of psychiatrists in general that combined psychoses are fairly frequent, far more so than would appear by the published reports of such instances. Nosological fashions have been so mutable in the past few decades that it is often hard to tell whether a writer is referring to a different psychosis from the one which the reader had in mind or is merely using a different name. Something of the difficulty which attends the investigation of this subject even in the records of a single hospital will be mentioned below.

Appended to this article will be found a bibliography as nearly complete as I have been able to make it; I shall only mention briefly a few of the contributions most accessible to American readers. C. M. Campbell,[3] writing in 1882, describes twenty-two cases of typhoid fever occurring in insane patients, all women. Unfortunately he does not give a full enough clinical history in any case to warrant a diagnosis of infection-exhaustion psychosis engrafted on the preexisting condition. Such a state of affairs may be suspected, however, from the statement, "The mental symptoms were intensified during the first few days of the fever." H. R. Stedman,[22] writing in 1883, presents four cases which he calls instances of "change in the form of insanity during acute attacks." The first two cases in the light of our present day viewpoint appear to be manic-depressive psychoses in which the depressed

phase occurred first and was followed shortly by a manic episode. The third case was probably catatonic præcox and the fourth seems to have been a manic with excitements of varying degrees. R. P. Smith,[19] in 1887, reports six cases of typhoid fever in insane patients. Two of these cases were apparently manic and the onset of the illness was marked by a subsidence of the manic symptoms and the appearance of delirium.

J. W. Stevens,[23] in 1907, has shown most indubitably a case of Korsakoff's syndrome coexisting with the depressed phase of manic-depressive psychosis and a constitutional psychopathy underlying both these. Krafft-Ebing speaks of general paresis developing in paranoiacs. Of course here we stumble on the vexed question of what constitutes paranoia, and if we hold to the old "true paranoia" of Kraepelin, and insist on both the clinical and serological proofs of paresis, it is extremely doubtful whether any such case has been observed or not; certainly I have found none reported in the literature, I recall none in my own experience and inquiry among psychiatrists of much larger experience than my own gives the same results. In 1911 Drs. Karpas and Poule[11] presented a case of dementia præcox with tabes to the New York Neurological Society for differential diagnosis from general paresis of tabetic type. In the discussion it was stated by Dr. Kirby that no such combination had ever been observed at the Manhattan State Hospital.

Oberndorf,[14] in 1912, describes psychoses occurring in constitutional inferiors and states that they all present anomalous features. He describes excitements and depressions, alcoholic episodes and præcox syndromes. Of course, strictly speaking, these cannot be called combined psychoses, unless we use the term psychosis in its broadest application, *i. e.,* the expression of an individual's abnormal reaction to a group of circumstances. Constitutional inferiority, psychopathy and other defective states are accompanied by excitements and depressions, especially the former and alcoholic episodes are to be expected, alcohol being the natural defense reaction in these conditions.

W. F. Lorenz,[12] in 1911, published a very good case of manic-depressive psychosis, infection with syphilis, and later on general paresis. Karl Graeter[8] in 1909 published a monograph dealing with the inter-relations of alcohol and dementia præcox in which are cases of alcoholic psychoses on a præcox foundation, and L.

L. Smith[19] found a number of such cases in investigating the cases of dementia præcox admitted to the Government Hospital for the Insane from the United States Army.

G. W. Gorrill,[7] in February, 1914, published in the New York State Hospital Bulletin five excellent cases of combined psychoses. His paper is the most noteworthy clinical contribution to the literature I have been able to find. His first case was a dementia præcox of thirty-three years' duration, who became infected with syphilis when fifty-one years old and about six years later developed general paresis, as evidenced by the clinical, neurological and serological findings. His second case was general paresis developing at the age of forty-four in a woman who had had two attacks of manic-depressive type, one at thirty-three and one at forty-one. His third case was a manic-depressive with a history of three attacks, one at nineteen, one at twenty-two and one at thirty-four, followed by general paresis at fifty-seven. Autopsy showed a paretic brain and arteriosclerosis. His fourth case was not so clearly defined: A man of forty-three years contracted syphilis at twenty-nine, developed an attack of acute excitement at thirty-seven from which he recovered in nine months and seemed well for over five years when he suddenly became excited again and showed a manic-depressive reaction with the physical signs and laboratory findings of general paresis. It is possible that his first attack may have been paresis, followed by a five-year remission of symptoms; the only information given about the physical signs in the first attack is that the reflexes were exaggerated, his pupils reacted sluggishly to both light and accommodation and there was some tremor of tongue and fingers. The fifth case was a woman who had manic-depressive psychosis, one attack at twenty-six, another at forty-four, then at fifty-three an infection-exhaustion psychosis. There appears to be no doubt about this diagnosis.

The views of present-day writers in regard to combined psychoses are only found here and there, expressed in the course of articles dealing primarily with other subjects. In an article in the Journal of Nervous and Mental Disease, in 1906, Dr. W. A. White, referring to clinical types, says, "They are not clean-cut entities, but are only groups of symptoms which either seem to occur more frequently in combinations or else have been more definitely and clearly seen because of the nature of their combinations. . . .

The great mass of cases seen are in combinations more or less intermediate in character. . . . There are combinations . . . which are quite frequent and which have only received inadequate notice and even for the most part go unrecognized."[26] In another place in the same article: "Because a person has manic-depressive insanity is no reason he should be immune from the ordinary diseases that affect the brain and impair the mind. . . . Thus we find the paranoia syndrome in manic-depressive insanity, dementia præcox and paresis; flight of ideas in dementia præcox; the Korsakoff syndrome in senescence and paresis; the presbyophrenic syndrome in paresis; katatonic rigidity and negativism in the toxic-exhaustive psychoses, and so on indefinitely."

Dr. E. E. Southard* says in regard to the question of combined psychoses, "I would say on theoretical grounds what I suppose most any of us would say, namely, that the postulate of combined psychoses may often be found to depend upon the priori selection of certain phenomena as constituting an entity, and then finding that entity alongside others in a different case. This, of course, would not constitute a logically rigorous proof of combination of psychoses. On the whole, however, having abundant faith in the future of our science and the confidence that there are multiple causes which may bring about psychopathic phenomena, I must say that I believe that the future will produce good and convincing proofs of the combination of psychoses."

Looking at the subject in the abstract light of speculation we may make the generalization that any two psychoses may occur in the lifetime of an individual. For instance, a man may have an episode of katatonia and recover, a few years later he may have delirium tremens following prolonged alcoholism, he may recover from this and be placed in an environment new to him and at the same time meet with sexual difficulties from which he develops a paranoid state with recovery. He may have typhoid fever and an infection-exhaustion psychosis and lastly he may round out his psychotic history by arteriosclerotic dementia and general paresis. All this is of course merely an imaginative exercise, but as a matter of fact there seems no reason why a toxic psychosis, for example, should not develop in an imbecile, a præcox, a manic or a paranoiac. Or, supposing any one of these four types becomes infected with syphilis, is there any reason why he should not de-

* Extract from a letter to the writer

velop general paresis or cerebral lues? Arteriosclerotic or senile changes are without doubt present in a great many cases of imbecility and præcox which spend their lives in institutions and these terminal psychoses are not recognized clinically. The notes on such cases toward the end are to the effect that they "show much dilapidation" or are "deteriorating rapidly" and it is only post mortem that the superimposed conditions are recognized. There is too great a tendency, also, in taking anamneses of new admissions to take it for granted that if the patient relates a previous attack it is similar to the then existing one. Closer examination of the patient or application to his family, his physician or the hospital in which he was formerly treated may bring to light a totally different psychosis.

The generalization made above, like most generalizations, requires modifying. It is dependent on the assumption that a psychosis appears as the result of a certain group of psychic and physical factors acting upon an individual and if we suppose that these groups vary in properties and potentialities at different times we can suppose them producing different psychoses. On the other hand we must take into consideration the fact that the individual begins life with a certain biological legacy, he is a phylogenetic endproduct. Starting then with this distinctively individual endowment, he is acted upon by a constantly changing environment, the change being always in the direction of complexity. The first change is from the all pervading warmth and support of intra-uterine life, unconditioned omnipotence, to the bright light and (comparative) cold of the outside world, from the complete fulfillment of all nutritive needs without conscious effort to the necessity for systematic and repeated exertions to secure the same result. From this first change the individual runs the gamut of complex situations until we find him an adult, coming into contact at a thousand points with his social heritage, a complex and exacting civilization.

We shall suppose that he adapts himself to the various requirements of life, moulding his environment here and there to suit certain individual psychic needs and occupies his niche in the social and business world with the minimum of friction. We have then an individual at least so far normal that he harmonizes with the general social scheme. Suppose, however, he fails to adapt himself when an exacting period of his life, such as the onset of

puberty, the first sexual experience, the first conflict with the business world or any other trying epoch calls for a readjustment of his scheme of things. The expression of his failure to react adequately we will call a psychosis and the symptomatology of this will depend upon his individual psychology, his make-up. Then, suppose him to have recovered from this psychosis, he again meets with a group of circumstances which call for extra psychic effort and he is again unequal to the situation. His expression of his failure would naturally take the same form, assuming of course the premise that the fundamental features of individual psychology are unalterable.

It is small wonder then that two such opposed methods of handling a situation as we find in the manic and in the præcox do not seem to occur in the same individual. In one case the libido, meeting with a bar to its progress, flows back upon itself and we have the reversion to earlier forms, the reanimation of old channels and the fixation at some point normally abandoned for good. This regression of the libido gives to the psychology of dementia præcox a peculiar aspect, the præcox lives within his self-created world which is admirably adapted to his psychic needs. He lies behind his self-erected fortifications and we can only surmise what activities take place there. The manic, however, pours his libido freely upon the outside world to divert attention from his psychic conflict, just as the garrison of a beleaguered fortress, threatened within by famine and mutiny, make sallies upon the besieging army. These antithetical modes of handling the difficulty are mutually exclusive and appear to be dependent on biological traits which are not altered to any extent during an individual's lifetime.

It will be interesting to observe whether or not the psychoanalytic method will make a change in this state of affairs. It does not seem impossible that some such state of affairs as this may obtain in the future. An individual may develop a præcox episode early in life and become aware of the source of his difficulty through psychoanalysis. His conflict being thus elevated to the surface of consciousness he may handle it successfully and take his place in the outside world. Meeting with a new difficulty years later he may develop a manic reaction, and so on.

The differential diagnosis between the dementia præcox and the manic-depressive psychoses has received its tons of printed trib-

ute to which I shall not add here. Enough to say that we have in the manic a quantitative deviation from normal and in the præcox a qualitative one. Hence it is that the præcox gives us a sense of strangeness while we find it easier to understand the manic's reaction. We can, so to speak, put ourselves in his place. On cross section there are cases which resemble both, but the longer they are observed the more readily they separate out. I have not been able to find dementia præcox and manic-depressive occurring in the lifetime of one individual.

The most common combination of psychoses appears to be an alcoholic psychosis engrafted on a præcox make-up. In fact this combination is so frequently seen that a natural doubt arises as to whether these are in reality alcoholic psychoses or whether they are not rather præcox episodes precipitated by alcohol. It is quite a common thing for instance in the Government Hospital for the Insane to receive a recently enlisted soldier diagnosed as an alcoholic psychosis or as a præcox caused by alcohol and find that the man is a præcox, probably of years' duration. The requirements of military discipline being too irksome for him, he took refuge in alcohol which accentuated the residuals of his old psychosis. I expect shortly to publish a paper dealing with this subject more fully. The relations between the two conditions are undoubtedly very intimate and it is questionable whether an alcoholic psychosis ever develops on a normal basis.

In investigating the subject of combined psychoses the records of the Government Hospital for the Insane from its establishment up to August 1, 1914, were reviewed, a total of 21,350 cases. From this number all those which had been readmitted to the hospital were extracted and only these were considered. This method is of course open to the objection that it does not cover cases which may have been treated in other hospitals for other psychoses or which may have passed through attacks not necessitating commitment. Such cases, however, would have to depend for diagnosis on descriptions given by the patient himself, often absolutely unreliable, the diagnosis made by a family physician, often unskilled in psychiatry or the routine method of examination and diagnosis in another hospital, often differing widely from the one used later on and dependent upon personal equations unknown to the writer. In going over the files 2,031 readmissions were found. Of this number a great many did not have sufficient clinical his-

tory during their earlier admissions to warrant a diagnosis. The staff in those days was not ample enough to permit of periodical notes on patients and such terms as "acute mania," "chronic mania," "acute dementia," "chronic dementia" and "acute melancholia" were in common use, terms which, needless to say, must be regarded as ambiguous now. When those cases from which no justifiable conclusions could be drawn as to their previous mental status had been weeded out there remained 808 cases with adequate histories of two or more admissions. These were all examined carefully. Many cases were thrown out which might perhaps without stretching the verities too far have been called combined psychoses, notably instances of præcox developing on a defective basis or alcoholic psychosis on a præcox basis. A large number of the cases consisted, of course, of attacks of manic-depressive psychoses. When the negative and doubtful cases were sifted out there remained 36 cases of combined psychoses and 5 cases of manic-like episodes in præcoxes. These 41 cases may be divided as follows:

Associated with Dementia Præcox	
Alcoholic psychosis	6
Imbecility	3
Arteriosclerotic dementia	2
Infection-exhaustion psychosis	2
Hysteria	1
Total	14

Associated with Manic-Depressive	
Senile dementia	4
Alcoholic psychosis	2
Arteriosclerotic dementia	2
Infection-exhaustion psychosis	1
Total	9

Other Combinations	
Psychopathic character and prison psychosis	2
Arteriosclerotic dementia and infection-exhaustion psychosis	2
Senile dementia and alcoholic psychosis	1
Senile dementia and infection-exhaustion psychosis	1
Psychopathic character and alcoholic psychosis	1
Arteriosclerotic dementia and alcoholic psychosis	1
Prison psychosis and cerebral lues	1
Paranoid state and general paresis	1
Imbecility and arteriosclerotic dementia	1
Infection-exhaustion psychosis and paranoid state	1
Paranoia and senile dementia	1
Total	13
Cases resembling præcox and manic-depressive	5
Grand Total	41

Abstracts of all these 41 histories would occupy too much space so where there exists more than one similar combination I shall only abstract one case, the most clearly defined one, and mention the others only by number. The number used refers to the records of the Government Hospital for the Insane, cases being numbered in the order of their admission. The first group of cases to be considered is the one comprising combinations of alcoholic psychosis with dementia præcox.

CASE No. 15983.—A colored male, aged 40 years when admitted to the hospital May 26, 1906. He was first admitted to the hospital on October 12, 1901, and discharged May 30 of the following year as recovered from a psychosis due to alcoholism. The medical certificate which accompanied him on his second admission stated that the present attack began in May, 1906, by erratic conduct, noisy at night, carried stones in his pockets, manifested destructive tendencies and delusions of a mixed nature. Thought that by throwing money about the floor he could remove sins. Physical examination on admission was negative. Mentally clouding of consciousness was present, he was elated and restless, spoke of having talked with the Lord who told him to clean up this place from top to bottom, he saw the Lord at night and the Lord appeared to him in a vision. Ward notes for several days following his admission, described him as highly nervous, excited and restless. After two months he became quiet and worked out about the grounds. He remained in this condition six years and when examined in October, 1912, he was found emotionally indifferent, not caring whether he stayed in the hospital or went home to live with his family who were anxious to receive him. His memory was uncertain and apperception and retention decidedly impaired.

The above seems to have been a case of two alcoholic psychoses occurring in a simple præcox. Other cases of the combination of dementia præcox and alcoholic psychosis were Nos. 20453, 19783, 16187, 19633 and 20562.

CASE No. 16878.—A white female aged 33 on admission, November 7, 1907. Patient was always considered weak-minded and did not progress normally at school. When about 28 years of age she complained of men coming in a balloon to her room at night and molesting her. She would scream and cry and run out on the street. She was admitted here for the first time September 24, 1902, and discharged 16 days later as recovered. Soon after leaving she developed delusions that certain persons were casting spells over her and hypnotizing her and was readmitted October 1, 1904. Mental examination at that time showed auditory and visual hallucinations, delusions of persecution and feelings of influence. She improved somewhat and was discharged July 1, 1905. When readmitted in 1907 she showed no hallucinations or delusions, but a general mental reduction and periodic attacks of

excitement. She remained in this condition and was finally discharged to the care of her family February 23, 1911.

The above appears to be a case of two præcox episodes occurring in a defective, probably an imbecile. On her third and last admission, the diagnosis seems to be imbecility alone. Other cases of præcox episodes occurring in imbeciles are Nos. 19128 and 18879.

CASE No. 4926 shows arteriosclerotic changes in a præcox. This patient, a white female, was admitted to the hospital June 3, 1880, being then 27 years of age. No systematic examination of the case was made until December, 1903, when the physical examination was negative. Mental examination at that time showed partial clouding of consciousness, auditory and tactile hallucinations and delusions of persecution. A diagnosis of dementia præcox was made. During the last year of her life she deteriorated rapidly and sclerotic changes were noticed. In July, 1911, a cerebral hemorrhage occurred and she died the same day.

Another case of arteriosclerotic dementia in a præcox is Case No. 21028.

CASE No. 15250 shows an infection-exhaustion psychosis followed in four years by a præcox which may or may not have existed at the time of the first admission. The patient was a colored female, admitted first September 3, 1904, suffering from a psychosis following ill health and childbirth. The diagnosis recorded then was acute confusional insanity and she was discharged as recovered on October 28 of the same year. She was readmitted on April 4, 1905; the mental examination then showed that she was confused, disoriented, talked incoherently to herself, had hallucinations of hearing and feared some one was going to harm her. She was indifferent to her surroundings, cross and irritable at times, memory defect, no insight, and reasoning and judgment were impaired. A diagnosis of dementia præcox was made; the autopsy four years later showed considerable shrinkage of the brain with no gross lesions. Another instance of this same combination is Case No. 19521.

CASE No. 18531 shows a hysteriform attack in a dementia præcox. The patient, a white female, showed her first signs of mental trouble in March, 1908, being at that time 27 years old. She obtained a revolver and attempted to shoot herself, broke a window and tried to cut her throat, also attempted to strangle herself with a handkerchief. She was admitted to the hospital on March 8, 1908. Mental examination showed apprehension, negativism, restlessness, clouding of consciousness, depression and visual and auditory hallucinations. She gradually improved and was discharged as recovered from dementia præcox on January 29, 1909. May 8, 1910, she suffered from a fainting attack and fell out of her chair. Following this she had several fainting attacks and appeared to be excited. She then became depressed and despon-

dent, complained of her tongue being thick and of inability to swallow, cried frequently without reason and took no interest in her household or her child. She was readmitted to the hospital on May 21, 1910, and showed no mental symptoms whatever, being discharged three weeks later as not insane.

Case No. 16411 shows a manic-depressive case, complicated by senile changes. The patient was a colored female, aged 70 on her last admission, February 19, 1907. She had been a patient five times between 1895 and 1903, each time suffering from an excited phase of manic-depressive psychosis, with recovery. On her last admission she showed arteriosclerotic changes, was excited and remained so for several months. When she quieted down, she was found to have marked mental deterioration. From then on until her death in 1909 periods of excitement alternated with quiet intervals and during the latter she showed senile defects. Other cases showing senile dementia in manic-depressive types are Nos. 15399, 16168 and 15981.

Case No. 19843 shows three attacks of manic-depressive psychosis, followed four years after the last one by an alcoholic psychosis. Patient is a white female, born in 1870. In 1900 she was treated in this hospital for one month, the diagnosis then being acute mania, discharged recovered. April 4, 1908, she was readmitted; mental examination showed her to be depressed and apprehensive. Consciousness was clear and she showed no delusions or hallucinations. She was discharged by the court nineteen days later and a diagnosis of manic-depressive insanity was made. May 5, 1908, she was readmitted with the same diagnosis and discharged four months later. In January, 1912, she began to drink heavily, was frequently intoxicated and on April 4 of that year she became voluble, resistive, removed her clothing and later became violent and entertained delusions of persecution directed against her relatives. She was readmitted to the hospital April 11 and was noisy, restless and confused. She continued in this state of confusion two days. At that time she had hallucinations of sight and hearing, imagined she saw animals and vermin on the wall of her room and would strike at imaginary objects on the wall. She remained in this condition about one week, when she became quieter, the hallucinations disappeared and mental examination revealed no psychotic symptoms. This is undoubtedly a case of delirium tremens occurring in a manic-depressive individual. Another example is Case No. 19641.

Case No. 6729 shows a manic-depressive individual who later on developed dementia of an arteriosclerotic type, this diagnosis being confirmed by the autopsy findings. Patient was a white male, first admitted to the hospital in 1881 and again in 1886. Before this he had been treated in the Utica State Hospital. His age at his first admission was 41. The chief mental symptoms are given as depression with delusions of persecution, alternating

with periods of restlessness and exaltation. From 1902 on he demented and died in July, 1908, at the age of 68. Autopsy showed atrophy of the brain, opacity of pia and arteriosclerotic softenings. Case No. 20884 shows a similar combination.

Case No. 20253 shows three attacks of what was probably manic-depressive psychosis, complicated in each instance by the excessive use of drugs and in the last one by an infection-exhaustion psychosis. The patient is a white female, born in 1868. In 1905 she was placed in a private sanitarium where she remained for nine months. Her mental condition while there is not known. After leaving she became addicted to the patent medicine habit and took vast quantities of these. In the summer of 1908 she attempted suicide on three occasions by taking laudanum. October 21, 1908, she was admitted to this hospital. Mental examination showed emotional depression, agitation and feeling of unreality; she thought her food was poisoned and that she had no bowels. This was succeeded by an excitement during which she broke dishes, threatened to kill herself, refused food and had to be tube-fed. She gradually improved and obtained good insight. On March 31, 1909, her case was considered at a conference of the medical staff and she was discharged recovered, April 3, 1909. She got along well, until July, 1910, when she began taking laudanum for pain in her side. She also took whiskey in large doses. She was readmitted to the hospital July 12, 1911, very much depressed, and discharged as recovered September 19, 1911. She got along well until the first part of September, 1912, when she began scolding her husband and nailing the doors so he could not enter the house. She would not allow anyone in the house and was active and talkative, working continually, canning and preserving until late in the night. She threatened to kill her husband with an ax, and would do nothing he requested of her. About this time, she developed a malarial attack and took a considerable amount of quinine. Following this, she had auditory hallucinations which excited her so it was necessary to commit her to this hospital. On admission she was quite disturbed, ran constantly about the dormitory, overturned the other patients' beds, talked to imaginary voices, approached the windows and called to the people passing by to come in and protect her. She continued this excited condition for about three weeks and then began gradually to improve. Mental examination at this time showed a flight of ideas, vague persecutory delusions concerning her husband, emotional depression but no clouding of consciousness or hallucinations. She was discharged as recovered on February 12, 1913.

A number of cases of the combination of prison psychosis with psychopathic constitution might be cited, in fact, it would seem to be the case that usually only those constitutionally predisposed,

develop such episodes. I have selected only two cases, and will quote briefly from one of them.

CASE No. 19440, white male born in 1885. The account of his school life was obtained from the patient himself, who stated that he was a bright scholar of unusual intellectual attainments. After leaving school he lost several situations on account of outbursts of temper, resulting in fights with other employes. He had several gonorrheal infections, the first one at the age of fifteen; was infected with syphilis at a very early age; used alcoholics to excess, and was intoxicated on numerous occasions. In the summer of 1909, he was arrested for robbery and released on bond which he forfeited by leaving the jurisdiction. When the police went to a nearby city to arrest him, he met them with a loaded pistol and it was necessary to use force to subdue him. At that time he was living on the earnings of a professional prostitute to whom he claimed to have been married for several years. Correspondence between him and this woman showed that he fully sanctioned her mode of life. He received a five years' sentence in the penitentiary, and soon after arrival there was noted as being excitable and irritable. He had several attacks described as maniacal, and during these he frequently attacked the attendant. He was transferred to this hospital April 7, 1911. On admission he was nervous and apprehensive, easily became excited, and there was clouding of consciousness. When an attempt was made to examine him the following day, he became intensely excited, profane and threatening. This excitement somewhat subsided and he was allowed the privilege of walking in the yard. He comported himself well, except when spoken to by the physician, when he would become quite excited. He made a plot to escape which was detected. In consequence of this, his privileges were removed, and this was followed by another excited attack. He was finally discharged as recovered from prison psychosis, August 10, 1911. A similar case is No. 19438.

CASE No. 19243 shows an infection-exhaustion psychosis followed several years later by an arteriosclerotic excitement. Patient is a colored female, and was first admitted to the hospital in 1908, being at that time fifty-four years old. She was diagnosed as an infection-exhaustion psychosis and discharged as recovered three months later. She was readmitted June 19, 1911. Mental examination at that time showed her to be extremely excited, yelling, singing, praying and running about, overturning the furniture. There was complete clouding of consciousness, memory was fair and the special tests were well performed. She believed that she could converse with spirits, and had the gift of prophecy. She thought the world was coming to an end and that she had been sent to warn the people. The physical examination showed sclerosis of the arteries and high blood pressure. She continued excited for several months, then quieted down. The

field of consciousness became clear and no hallucinations or delusions could be elicited. A diagnosis of excitement associated with arteriosclerosis was made, and she was discharged recovered. At the time of her first admission, she was suffering from septicemia due to a large abcess on the leg and lymphangitis. A somewhat similar case is No. 19623.

Case No. 18556 shows a white male who was admitted to the hospital on February, 1907, suffering from alcoholic psychosis from which he recovered and was discharged in November, of the same year. May 30, 1910, he was readmitted and found to be suffering from senile dementia. He remained in the hospital until his death, March 6, 1911. Case No. 16300 shows a white female, seventy-eight years old who was admitted first in January, 1906, suffering from senile dementia, and was discharged to the care of her daughter in August of the same year. Five months later, she was readmitted suffering from an acute confusional state which was found to be due to kidney and heart disease, and cleared up under appropriate treatment, leaving the senile dementia as before. Case No. 21348 shows a psychopathic character, a colored female who has been admitted to the hospital on six occasions, suffering from alcoholic psychoses. Case No. 20872 shows a white male who was admitted to the hospital in 1898 and discharged a few months later. Readmitted in January, 1899, and discharged December, 1905. Readmitted June, 1907, and discharged November, 1907. Readmitted December, 1907, discharged January, 1910. Readmitted April, 1910, and discharged October, 1911. Readmitted February, 1913, discharged May, of the same year. On each of these admissions, he was suffering from alcoholic psychosis. He was readmitted the last time in August, 1913, suffering from excitement associated with arteriosclerosis.

Case No. 14933 is a colored male, aged nineteen on his first admission in March, 1902. He had previously been an inmate of the district jail, being sent there for attempting to kill a man with a knife. While at the jail, he became violent, fighting the guards and beating his head against the wall. About two weeks after admission to this hospital he became quite excited while at dinner one day, jumped on one of the attendants and began to fight. He became involved in several other fights with the attendants during his residence here, but finally became free from excitement and was discharged in December, 1902, as recovered from prison psychosis. On September 22, 1904, he was readmitted and found to be disoriented in all spheres. He could give little account of the events leading up to his second admission. Up to February, 1907, he is described as being stubborn, resistive, excitable and had to be restrained on many occasions. February 2, 1907, he had a general convulsion accompanied by loss of consciousness and vomiting. Since that time, convulsions were frequent. He was unable to get about and was almost constantly noisy, shouting, yelling and

screaming. He was filthy in his habits and totally oblivious to his surroundings. He died June 14, 1911. Autopsy showed the presence of cerebral syphilis.

Case No. 17465 is that of a white male who had a paranoid state when fifty-five years old, lasting about one year, and terminating in recovery followed five years later by general paresis which ended in death fifteen months later. At the time of his paranoid state, he was an inmate of the Soldiers' Home, and suffered from delusions of persecution and auditory hallucinations; at times he was so violent and assaulted the other members of the home on such slight provocation, that it was necessary to seclude him. An autopsy was performed at this hospital which confirmed the diagnosis of general paresis.

Case No. 14618 is that of a colored male who was first admitted to the hospital in 1900. His age at that time was uncertain, being probably somewhere between twenty-five and thirty-five. He was found to be an imbecile and was discharged to the care of his family two months later. Two years later, he was admitted again and remained in the hospital seven months. Two years following this, he was readmitted suffering from excitement with delusions of a grandiose and persecutory tendency. He died in February, 1913. The post-mortem examination showed arteriosclerosis of the brain.

Case No. 20661 shows a white male aged twenty-six on his first admission, January, 1909, when he was suffering from an infection-exhaustion psychosis following malaria. He was discharged as recovered in December of the same year. He was readmitted two years later with the same diagnosis, and was discharged as recovered at the end of seven months. He entered the Soldiers' Home in March, 1913, and was admitted here in May of the same year, with a history that he had various delusions, was noisy, required to be restrained and was destructive. Physical examination made here was negative. Mental examination showed him to be accurately oriented. No hallucinations could be obtained. He suffered from paranoid ideas directed toward the officers of the Soldiers' Home, who he thought discriminated against him. He soon recovered from these ideas, was given parole of the grounds and finally discharged November 3, 1913, as recovered from paranoid state. This is indubitably an individual of unstable organization who had two attacks of infection-exhaustion psychosis, and later on paranoid state.

The only case of paranoia complicated by any other psychosis which I have been able to find does not lend itself very readily to abstraction. The patient was first admitted to this hospital on April 6, 1910, Case No. 18451. He was then sixty-seven years old. At that time, his case attracted considerable newspaper attention. He was well known throughout Virginia, District of Columbia and Maryland by the legal profession. It seems

he began many years ago, to file suit against residents of these states, some of the defendants being his most intimate friends and neighbors. The courts all over these states were appealed to by this patient for redress for his fancied grievances. He succeeded in obtaining a number of judgments, and frequently attempted to execute these, the exact number of suits which he has filed is not known, but they are estimated as several thousand. His claim against one express company alone amounted to more than one million dollars. He was referred by the newspapers as the "King of Litigants," and the "Eternal Litigant." Lawyers refer to his case as "The Romance of the Law," and some of his cases are quoted in legal text-books in the states in which he operated. His case is undoubtedly litigious paranoia. Since being an inmate of this hospital, he has shown considerable deterioration, so that his case might be taken for one of senile dementia by any one not familiar with his history. He is quite childish in his appearance in conversation and his productions now are quite puerile. It is evident that in his present state, he would not be able to carry on his former activities. His defective judgment is shown by his transparent ruses to gain his release; for instance, when one of the physicians is away for a few days, he will hand his substitute a document which he says was written by the other physician. This is something to the effect that he is sane. He always states that the other doctor gave it to him before he left, in spite of the fact that is in the patient's own handwriting. He writes sometimes to his relatives requesting that they bring him a revolver and some ammunition so that he might shoot the physician and gain his release. He writes a letter one week alluding to a certain lawyer in town as a "shyster" and a "crook," and a week later writes him to come out and handle his case.

A careful search of the records failed to reveal any cases of manic-depressive psychosis and dementia præcox occurring in the same individual, but there were five well marked cases of the manic-depressive reaction in a præcox case. One of these will suffice for illustration. Case No. 16984, male, white, age twenty-six on admission, single, letter-carrier, resident of the district. Father and brother were at one time insane. Early history unknown. Patient had been erratic in conduct for some time before his first admission here. July 1, 1905, he packed his trunk, left the city without notice, visited his relatives at Port Deposit, Md., acted strangely, and had to be brought back. He showed psychomotor activity, marked flight of ideas and emotional excitement. On his first admission on July 19, 1905, he was quiet and orderly. Improvement led to his being given parole on August 9, 1905, but three days later, he eloped and on his return after three days, he was erratic, talkative, noisy, fault-finding, disorderly. He was discharged by court, August 18, 1905. The patient then worked as a letter-carrier, and baggage agent. On several occasions when

seen by physician, there was mild flight of ideas, lack of insight, and evidence of excessive alcoholic indulgence. He sent irrational postcards to hospital employees. Medical certificate from Washington Asylum Hospital shows that since discharge by court, patient had been addicted to alcoholic excesses, and for three months prior to the last (second) admission, he showed pressure of activity, flight of ideas and emotional exaltation, with a tendency to probable impulsive attacks, and fits of violent temper, in which he was destructive, noisy, and profane. There were mild transient delusions of persecution, he imagined his food was being poisoned, and the police were after him. On readmission, January 17, 1908, there was psychomotor activity and flight of ideas, with some apparent looseness in the train of thought, and neologism. Stenogram four days after readmission shows a lessening of both psychomotor activity and emotional exaltation, with flight of ideas and distractibility. August 30, 1908, patient presented a dull expression, slowness of comprehension and ideation; disorientation for time and person, and partially for place; well marked indifference, disagreeable auditory hallucinations, lack of insight. On November 16, 1908, there was apparent mutism and negativism, even to refusal of food, so that tube-feeding had to be resorted to. Two days later, patient became a little more communicative and complained that the milk and eggs made him sick. On examination by the physician he was put to bed, a double lobar pneumonia developed, and on November 28, 1908, he died from cardiac failure. There was no autopsy.

The other cases which show this same combination were Nos. 17484, 18325, 19630 and 16776.

The above cases are not sufficient material upon which to base any generalization. A few points only appear somewhat remarkable and may perhaps be noted as affording basis for future investigation. It seems rather strange, for instance, that there were more psychoses associated with dementia præcox than with manic-depressive psychosis. Also it might have been expected that more than two cases would have been found of syphilitic psychosis engrafted upon another variety. The total number of combined psychoses found—forty-one—is rather small, when we consider the large number of readmissions to the hospital, but this is largely due to the inadequate notes made on cases up until comparatively recent years. Probably the future will uncover a larger proportion of combined psychoses owing to the fact that it is the present custom and has been for the past eight or ten years to obtain elaborate anamneses and to make copious notes at regular intervals.

BIBLIOGRAPHY

1. Blum. Beitrag zur Frage der sukzessiven Kombination von Psychosen. Neurol. Centralbl. Leipz., 1907, XXVI, 662-664.
2. Bornstein, M. Zur Frage der kombinierten Psychosen und der patho-

logischen Anatomie der Landryschen Paralyse. Ztsch. f. d. ges. Neurol. u. Psychiat., Berl. u. Leipzig, 1912, XIII, Orig. 1–16.
3. Campbell, C. M. On the effects of enteric fever in the insane. J. Ment. Sc., London, 1882, 212–220.
4. Gaupp, R. Zur Frage der kombinierten Psychosen. Centralbl. f. Nervenk. u. Psychol., Berlin und Leipzig, 1903, 766–775, Also Allg. Zeitschr. f. Psychiat., Berlin, 1904, 404–406.
5. Geist. Ueber Kombinierte Psychosen nebst einem casuistischer Beitrag. Allg. Zeitschr. f. Psychiat. (etc.), Berlin, 1906, LXIII, 434–447.
6. Gilyarovski, V. A., and Zinovyeff, P. M. (Presenility with katatonic phenomena.) Sovrem. Psikhiat. Mosk., 1913, VII, 1–14.
7. Gorrill, George W. Combined Psychoses. N. Y. State Hospital Bulletin, February, 1914.
8. Graeter, Karl. Dementia præcox mit Alcoholismus chronicus. Leipzig, 1909, 200 p.
9. Hammond, W. A. A case of intellectual monomania with mental depression. Amer. Jour. Neur. & Psychiat., N. Y., 1883, II, 110–128.
10. Janssens, G. Senile Rindenverödung bei manisch-depressiver Psychose. Psychiat. en neurol. Bl., Amst., 1913, XVII, 207–217.
11. Karpas, M. J., and Poule, E. M. Dementia precox with tabes. J. Nerv. and Mental Dis., 1911, XXXIII, 485.
12. Lorenz, W. F. Manic-depressive insanity, then syphilis, later general paralysis. Med. Rec., N. Y., 1911, LXXX, 974.
13. Norman, C. Variations in form of mental affections in relation to the classification of insanity. Tr. Acad. M., Ireland, Dublin, 1887, V, 41–49.
14. Oberndorf, C. P. Constitutional inferiority and its psychoses. Jour. A. M. A., Chicago, 1912, LVIII, 249–252.
15. Pick, A. Beitrag zur Lehre von den combinirten Psychosen. Prag. med. Wchnschr., 1882, VII, 227.
16. Pick, A. Notiz zur Lehre von den combinirten Psychosen. Prag. med. Wschnschr., 1883, VIII, 103.
17. Pick, A. Ueber die Combination angeborener psychischer Scwächezustände mit anderen psychisen Krankheitzforman. Ztschr. f. Heilk. Prag., 1885, VI, 183–191.
18. Siemens, F. Einiges über combinirte Psychosen. Neurol. Centralbl., Leipzig, 1884, III, 223–227.
19. Smith, L. L. Dementia præcox and chronic alcoholism. Mil. Surg. Washington, 1912, XXXI, 265–278.
20. Smith, R. P. Cases of typhoid fever in the insane. Jour. Ment. Sc., London, 1887–88, XXXIII, 90–95.
21. Soukhanoff, S. Demence precox et alcoolisme. Ann. méd., psychol., Paris, 1913, 227–284.
22. Stedman, H. R. Change in the form of insanity during acute attacks. Boston. Med. & Surg. Jour., 1883, CVIII, 505.
23. Stevens, J. W. Korsakoff's psychosis superimposed upon melancholia. J. Nerv. & Ment. Dis., N. Y., 1907, XXXLV, 447–458.
24. Urstein, M. (Manic-depressive and periodic psychoses as a phenomenon of katatonia.) Medycyna i. Kron. lch., Warsawa, 1913, XLVIII, 20, 43.
25. Virsuboff, N. A. (Cyclothymia and its combinations.) Psikhotes apiya, Mosk., 1912, III, 120–134.
26. White, W. A. Types in Mental Disease. J. Nerv. & Ment. Dis., N. Y. 1906, XXXIII, 254–264.
27. Zilocchi, A. Epilessia arteriosclerotica nella frenosi maniaco-depressiva. Morgagni, Milano, 1911, LIII, pt. 1, 161–174.