

REMARKS UPON UNDIAGNOSED CASES, CHICAGO  
STATE HOSPITAL, 1919.\*

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The classification of mental disorders, other than those of grossly organic types, can never be an entirely satisfactory procedure, nor is it always a necessary one provided the examiner is alert to the situation and in touch with the great movements in the mental life of his patient, their origin, trend, and development.

Institutional practice, however, for statistical purposes, demands classification of as many cases as possible, though in complying with this demand there is no doubt but that too many cases are fitted into genera and species by a *tour de force*.

At the Chicago State Hospital, 1900 patients were admitted in the year 1919, 146 of whom were left undiagnosed when presented before the medical staff. Of these cases, the author (with the assistance of Drs. Rotman and Ewerhardt, of our medical staff, in a number of summaries) has analyzed 66 and tentatively offers the following comment.

SEX.

Of the 66 cases, 22 were male and 44 female. Our admissions during this period ran in the proportion of 11 men to 8 women; and it may fairly be asked if some of this preponderance of females left undiagnosed is not due to emotional oscillations more varied in coloring and more complex in character than in the male, and for this reason more difficult of interpretation.

AGE.

There are few below 25 and none over 60; accounted for, no doubt, by the fact that the pronounced organic types were very naturally excluded, along with the feeble minded and the simpler types of præcox reactions in the very young. The great bulk of

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the group lies between the ages of 25 and 50, where stressful psychogenic and somatic factors are most active.

#### NATIONALITY.

Contrary to the writer's expectation only 24 were foreign born, of non-English speaking races, and few of these could not speak enough English to be understood. Fifty per cent of our admissions are foreign born.

#### HALLUCINOSIS.

Forty cases showed no hallucinosis or left its presence a matter of grave doubt. Whether this proportion of almost two to one is in accord with that of other admissions, the writer does not know. Possibly it indicates that the absence of this symptom contributes to uncertainty of diagnosis where other symptoms are confusing. Out of 14 cases that sooner or later showed a well marked præcox symptom complex, nine were without hallucinosis when first presented. Though hallucinosis is not at all essential to the picture of this psychosis, its presence very possibly has something of the same reassuring diagnostic effect possessed by a positive Babinski in an obscure organic case.

#### RECOVERY.

Of the 66 cases, 19 were discharged as recovered after a few months of hospital residence and the usual period of parole; very nearly 30 per cent. Our average percentage of recoveries to admissions for the year of 1918 was  $8 \frac{1}{10}$  per cent. Sixteen of the series were discharged improved, four unimproved, eighteen remained in the institution, and nine have died. Among those discharged as recovered were a number of psychogenic depressions, only two or three frankly manic reactions, three or four alcoholic cases, two who were very possibly never insane, and several with mental upset very probably preliminary to a more frankly præcox outbreak.

#### ANXIETY STATES.

There were a large number of cases in which apprehension and anxiety figured more or less conspicuously. Several of these

were probably alcoholic and some without definite etiological factors.

Case No. 7 represents this type fairly well: a colored woman, aged 50, admitted with a history of having been melancholy at times for years, became rather restless, thought people were following her and that they would try to cut her fingers off. When admitted she was resistive but would answer questions, denied hallucinosis, and had to be spoon fed. In a few months she had cleared up, was jolly and cooperative about the ward, and was said to have good insight, though there is no detailed account of this. The case was left undiagnosed because it was said that the pupils were sluggish and the knee jerks exaggerated upon admission.

Another patient, No. 18, a man of 35 years of age, four months after an attack of influenza suffered an acute attack in which he smelled gas, became afraid that he was to be killed, heard people talk about it, wandered about and seemed confused. Later he performed odd actions without explanation; said that he felt "doped" and that at times his mind was blank; that he could not think, etc. Still later on he ate poorly, lay with his eyes closed, was impulsive and violent; seemingly a case of dementia præcox with a fear reaction of considerable intensity, left undiagnosed because of the apparently toxic character of the onset. He was later discharged, improved.

Case No. 34, a woman, single, 26 years of age, suffered an abrupt onset in which she walked up and down calling for her mother, but could not explain why she wanted her; later developed ideas against her father and stopped talking. Physical examination was negative. When admitted she continually twisted her hair and rubbed her hands. No particular mood was evidenced but the picture, upon the whole, suggested a stereotyped agitation. Recovery gradually took place, together with some insight, but with little explanation. The case was probably one of catatonia, but in the presence of signs of agitation it was thought wise by the staff to leave the case open.

Too often when patients clear up, a katamnesis that might shed much light upon the mechanism of the attack is not obtained and the case is left an open one until readmitted.

#### DEPRESSIONS OF PSYCHOGENIC ORIGIN.

A number of cases of depression with considerable apprehension and of well marked psychogenic origin do not group satisfactorily under manic depressive, involutional melancholia, nor the anxiety neuroses.

Case No. 42, an Italian, aged 32, was an ignorant but hard-working man who never failed to send money to his wife in Italy, from whom he had

been separated six years on account of the war. He was a moderate drinker. After being held up and beaten he developed ideas that people were after him and was committed. Physical examination was negative. He was timid, but evidenced no behavior disorder and delusions, nor hallucinations. Many of the members leaned toward the diagnosis of a preliminary flurry in the development of dementia præcox. The patient left the hospital a month later apparently well. No one can say whether or not he will later develop dementia præcox, but there is basis for an argument on behalf of an anxiety state based upon long separation from his wife, capped by a mental and physical shock.

Case No. 15, a widow of 56, after a frustrated love affair and under the strain of worry over a son in the army, developed apprehension; thought her children were murdered, became agitated and continued in this condition *four years*. Physical examination was negative, save for a blood pressure of 190°. Because of her age and a questionable amount of confusion, she was diagnosed as "presenile" but rapidly improved and was finally discharged recovered. When visited a year after discharge, she was found to be in excellent condition, helping with the housework in her daughter's home.

Case No. 58, a young man of 31, German, intelligent, formerly a sergeant in our regular army, was married six months before commitment and shortly after his discharge into the reserves. He did not do very well in civil life and began to fear that he had infected his wife with syphilis acquired prior to marriage. In spite of his wife's knowledge of this actual infection their relationship apparently remained a congenial one. He was finally committed because of a determined attempt at suicide by gas. At the psychopathic hospital he was said to have been rather indifferent, to have heard voices and to have felt electricity in his bed. When examined here he declared that he had attempted suicide because he had infected his wife. He denied hearing voices. Physical examination was negative, save for a positive blood Wassermann; spinal fluid, negative. Patient improved very rapidly and was discharged recovered.

No. 50 is a somewhat similar case in a woman of 36, hereditarily burdened, who had reached only the third grade at ten. She had had several induced abortions, Neisserian infections and a laparotomy with consequent premature menopause. In 1917 she blamed herself for the infection of her husband (with apparent reason), confessed to him her various indiscretions, became very jealous and developed the idea that there were worms in her blood; that they would eat her up; that God would punish her, etc. For a year and a half prior to admission she clung to these ideas with varying tenacity. When admitted she was restless and agitated, but talked readily and later adapted herself well to the institutional life and was discharged, very much improved in a few months.

In this last case the examiner suggested manic depressive, while others contended that the patient's statements were too fantastic

and that the case was probably one of dementia præcox. It was pointed out, however, that she was merely voicing her own ideas of infection and that the case might be one of psychogenic depression. A naïve metaphoric expression of her ideas of infection, together with an invaliding sense of sterility, go to make up in an inferior individual a picture for which there seems to be no very appropriate place in our present system of classification.

#### Feeble-Mindedness vs. Dementia Præcox.

Now and then it is difficult, in the absence of a satisfactory anamnesis, to differentiate defectiveness from a simple type of dementia præcox, though considerable stress is laid upon the Binet-Simon when failure scatters over several years, say from eight to twelve. We are usually loath to make a diagnosis of dementia præcox upon a defective basis. Though, no doubt, this occurs at times, the average præcox has not been intellectually defective whatever his other faults may have been, and the disturbed periods of the feeble-minded are more apt to be of a manic type than otherwise. Several cases of this type occur in this series.

For example, No. 66, a woman mentally aged about ten years, after treating her children badly following desertion of her husband, was deprived of them by court action and developed the idea that one of them had been kidnapped by two negroes. This idea was reacted to quite adequately and because of the trouble she made about the court she was finally committed. In the hospital she works well in the occupational therapy department, though it is said that she talks to herself at times. Here the question is that of deterioration in dementia præcox versus the development of a simple paranoic trend in a feeble-minded individual. Continued observation has rather strengthened the probability of the latter diagnosis.

The question as to whether or not there are individual types of reaction, very poor in quality but not necessarily dementia præcox-like in gravity, cannot well be answered unless the cases in argument have already died mentally intact or have developed a rather typical deterioration. The preliminary flurry in dementia præcox is easily recognized in retrospect but not so readily at the time. For example, Bleuler quotes the case of a young soldier who, when asked to present his gun for inspection, quite unexpectedly assumed a threatening attitude with the remark, "While I live I will

not disgrace my weapon." Not until six years later did the patient begin to manifest other symptoms of dementia præcox.

Case No. 2 illustrates this latter point rather well. A Russian Jewess gave a vague history of a brief attack of nervousness and fear at the age of twelve. When admitted at nineteen she was much elated following an extended period of physical complaint and depression. She was without hallucinosis and quite talkative though not showing a flight. The staff wavered between manic depressive and dementia præcox. One man held that she showed too much emotion to be a præcox—a not uncommon viewpoint, even among experienced men who seem to forget that loss of affect, though an important aid when present, is not at all a requisite for a diagnosis in the early stages. The patient was paroled, much improved, worked four months, suffered influenza and returned mentally excited, talking irrelevantly, hallucinating, filthy in habits and with little interest in her surroundings.

#### CONCURRENT MANIC AND SCHIZOPHRENIC REACTIONS.

Now and then paranoic or schizophrenic reactions occur in an individual who also manifests decided manic depressive tendencies.

Case No. 25 is a man of 30, a German Jew, heredity unknown, attained the fifth grade at thirteen, changed jobs frequently, never earned much money; four previous attacks, 1907-1913. He tried army life with poor success; was invalided home from France, and finally transferred from an army hospital with the diagnosis of dementia præcox. When received he showed a marked manic reaction, mood elevated, active, in good contact with his surroundings; but had many odd ideas; had heard God's voice; was the Christ; his mother was Mary, etc. When told there were others in the hospital who claimed to be Christ he responded manic-like that they were imposters who went insane when he was born because they knew him to be the real Christ. He had many peculiar sexual ideas and was very probably somewhat homosexual. He described in detail the visions wherein he discovered his true parentage and his mission as the Savior to the Israelites. Gradually he quieted down and was taken out by his mother, who states he has never been well, even between attacks. At present he is said to be in some government institution. The writer has had a touch-and-go acquaintance with the patient for many years in another hospital and had always thought of him as quite a typical manic until a wealth of schizophrenic delusional formation was revealed in this last examination.

#### CLOUDING AND CONFUSION.

In the description of some half-dozen cases, the patient is said to have appeared to be *confused* at one time or another and in a number of cases this account, together with some apparent degree

of amnesia, has led to a disagreement in diagnosis; that is, the condition has been assumed to be one of actual clouding of consciousness. Confusion is perhaps best reserved in case records for the description of states of uncertainty, such for instance, as may normally be found in the presence of emotional turmoil, and which may very well exist in acute *præcox* reactions as well as in states of depression with extreme agitation, etc.; thus reserving the term "clouding of consciousness" for such cases of a delirious or semi-delirious character as seem to be toxic or infective in character. In four cases of the series the term "confusion" was applied to describe the condition of a patient in whom other symptoms pointed very strongly to dementia *præcox*. One was probably an acute catatonic excitement, another became later an obvious *præcox* who betrayed in various ways an evident *præcox* mechanism although later he seemed to recover. Another patient appeared actually clouded and was probably of an infective exhaustive type; still another evidently suffered from alcoholic delirium, while one or two were senile. In a young individual betraying symptoms of confusion without toxic or infective history the chances would seem to be in favor of a schizophrenic mechanism, though the tendency upon the part of many staff men is to give the patient "the benefit of the doubt."

#### INADEQUATE TYPES OF REACTION.

A few cases represent types of reaction which, though poor in character and suggestive of dementia *præcox*, are not quite definite enough to bear this label, though too severe to be classified as psychoneuroses.

No. 10 was a colored woman of 47 with history of previous attack. At the time of the last attack her husband was in jail as a conscientious objector, when she began to look for the end of the world; at the Lord's direction refused to eat; heard other commanding voices, etc. Finally she accepted the suggestion that she offer herself as a sacrifice and cut her throat, following which she was committed. Upon admission she was quiet, heard no voices, seemed to have some insight into her abnormal experiences but was still very religious and fond of biblical quotations; in fact, said she had been overly religious for a number of years. She worked well and was discharged apparently recovered, three months after admission. An account of her case later received from New York state described a somewhat similar attack in 1907, involving a ten months hospital

residence and a diagnosis of hebephrenia, from which, however, it is interesting to note that she was discharged *recovered*. Here the staff agreed upon a descriptive diagnosis of compensatory religious ecstasy in a colored woman of poor makeup and subject to stress on account of her husband's imprisonment.

#### COLORED PATIENTS.

Six of our cases were colored and represent the uncertainty often felt in the presence of mental disorders in this race. Many are superstitious and have naïve religious beliefs, which together with thought processes of peculiar vividness, a childlike adaptation to hospital routine and close contact with environment, often lead to confusion in diagnosis, with a tendency to an overemphasis of supposedly manic depressive traits.

#### PRESENILE TYPES.

The diagnosis of *presenile* is offered by one staff member or another in the case of almost all patients over 40 and not obviously organic in type. Kraepelin reminds us that this field is perhaps the most obscure in all psychiatry. The writer is not well satisfied with its treatment in the classification recently adopted. By reason of its inclusion under the senile psychoses, too much in the way of organic dementia must be found or at least assumed to be present. Several cases in this series suggest the presenile type.

No. 41 was a woman of 58, with a bad heredity and a paranoid onset dating back a year and a half before admission, with an increasing amount of conduct disorder. Another state hospital where she stayed a few weeks reported that she laughed to herself, said she was Christ, denuded herself, seemed confused and was restless. After being cared for in some private institutions, she was finally admitted to the Chicago State Hospital, where she was described as being impulsive, lay in bed with the covers over her head, was inaccessible, etc. Blood pressure was 160-80. When paroled a few months later she was delusional and incoherent. Three weeks later she reported in person and one of our most experienced and conservative staff physicians noted her as being in "very good condition." Later she was discharged recovered. Unfortunately at this time when she would have talked freely there was no inquiry into possible dementia. Dementia *præcox*, arteriosclerosis and presenility were discussed at staff meeting. A report secured a few days ago states that she did the housework and marketing, was quiet and well behaved for six months and then committed suicide by hanging.



Case No. 61 is interesting in that it concerns a woman of 52 who suffered an attack in 1912 and was confined in a western hospital from which she was discharged as recovered after a year and three months, diagnosis manic depressive, no details. In April, 1919, she came to Chicago without friends or funds to find a missing daughter, was apprehended and committed on account of strange stories concerning vast estates in Europe, her work for foreign governments, etc. Blood pressure was 160.80; blood Wassermann negative. She was usually quiet and well behaved but had spells of irritability and talkativeness. Her ideas were rambling, of a grandiose trend and developed no further. General knowledge and memory seemed intact. Dementia præcox and presenility were considered. She continued delusional and was irritable at times but became a good worker, manifested some insight and was finally paroled after an institutional life of one year. In this case, was the patient's first attack really manic depressive in character, and did she actually recover in the interim? Is she now a manic depressive in the involutional period; or is she senile-presenile, and if so where, after eight years, is the dementia?

#### ORGANIC CASES.

Eight or ten cases were undiagnosed because of what were thought to be organic findings though of an indefinite or confusing character: matters of blood pressure, cerebral spinal fluid findings, sluggish pupils, hardened radials, etc. Only three were actually organic, two of these were already hemiplegic and the third is an interesting case of psychopathic constitutional inferiority—a man of 28 who presents a four-plus cerebral spinal fluid Wassermann with 172 cells, positive blood and negative Lange, no physical symptoms. He is at present out upon escape but is said to show no evidence of mental enfeeblement.

There are, of course, many other interesting cases that might be discussed from the standpoint of diagnosis but they are of no especial interest save to those who have personally observed them.

#### CONCLUSIONS.

1. The undiagnosed cases in institution psychiatry present interesting problems as to diagnosis and prognosis.
2. Many case histories are lacking in clear description of historical facts, conduct disorders, stream of speech, etc.
3. Undiagnosed cases should be followed up most carefully. The average hurried and perfunctory note is only a little better than no note at all.

4. Conclusions without a statement of facts are misleading. Terms such as *rambling*, *confused* and *violent* should be used very cautiously in the primary case record.

5. Undiagnosed cases should be represented as often as new facts discovered will warrant.

6. In a considerable percentage of undiagnosed cases, disagreement and hesitation upon the part of the staff indicate, though oftentimes unwittingly, a good prognosis.

7. Confusion and apprehension in an acute psychosis would seem to indicate dementia præcox more often than any other disorder.

8. The absence of definite hallucinosis in a case otherwise doubtful contributes to failure in classification.

9. There are depressions of psychogenic origin that are not manic-depressive in nature and these types often occur between the ages of 40 and 60 with recovery.

10. The senile-presenile state is uncertain ground. A return should be made to the Kraepelinian presenile grouping.

11. Psychiatry is so far from being an exact science that many cases must be left undiagnosed if the psychiatrist is to retain his self-respect. He can not honestly diagnose them all.