that a so-called "reactive" melancholia may succeed an excitement. Mixed phases may occur in cases which have before presented only pure depressions and excitements; or, again, all the attacks may be mixed phases. Most cases have repeated attacks, though the intervals may extend over many years (see Case III., *e.g.*). It is also important to note that a number of mild attacks may suddenly be followed by a very grave one, while a case with a series of grave attacks may in the interval show mild short attacks. The duration of the individual attacks varies from a few weeks to a number of years: half a year is perhaps a fair average. The first attacks occur usually in early life but may occur later; and sometimes even a classical circular insanity may commence at or after the menopause. The attacks may show a striking periodicity; much more often this is not the case. I have twice seen regular daily alternations persisting for a number of months. It may here be added that cases of manic-depressive insanity are very common.

As was stated, the cases of manic-depressive insanity show no essential tendency to dementia. But after many attacks, and in rare instances after a few attacks, a certain more or less pronounced mental deterioration may nevertheless develop. Such patients become irritable, morose, show poor judgment and lack of application, and therefore are unable to earn their living, and may have difficulty in living outside of an institution. Kraepelin states that in cases with very short intervals the deterioration may be much more profound.

DIAGNOSIS.—Only the main points in diagnosis can here be taken up, but it is hoped that together with the descriptions above given they may form a guide to a correct diagnosis in the bulk of the cases. It seems best to discuss separately the diagnosis of the depressions, the excitements, and the mixed phases. But a few remarks should first be made about former attacks.

One or more previous attacks followed by recovery, especially when both excitement and depression have occurred, may be a considerable aid in diagnosis. The greater the number of attacks the greater the probability of manic-depressive insanity. But cases of dementia præcox may present one or more attacks with recovery, as may general paralysis even, although in both these conditions, especially the latter, some signs of deterioration are more common. Hysteria and epilepsy also show a tendency to recurrence. In a depression at the involution period it may be of considerable assistance to know that the patient has had one or more depressions or exhilarations in youth, as this speaks very strongly for a manic-depressive nature of the depression.

The most important means for a diagnosis, however, is a careful study of the symptoms.

We may, as in the clinical description, divide the depressions into: 1. The cases with slight retardation showing itself mainly in a certain incapacity and feeling of inadequacy. These cases chiefly resemble neurasthenia, and are especially important to the general practitioner because of the differential diagnosis. For manic-depressive insanity speak the absence of a cause, an abrupt onset, an actual incapacity and feeling of inadequacy instead of the great proneness to fatigue, the existence of former similar attacks, or similar attacks alternating with phases of "nervousness" or slight exhilaration, not to speak of graver attacks. The early "neurasthenic" states of general paralysis rarely present any difficulty in differential diagnosis, but for this the reader may be referred to the section which treats of general paralysis.

2. The cases in which the emotional depression is added to the above slight retardation, which may then be hidden. Here the various melancholias which are mentioned in the section devoted to that topic must be excluded. A well-marked feeling of inadequacy may here show us the way, but it should be stated that it may be difficult to recognize the manic-depressive nature of such cases unless we have former attacks to guide us, particularly with excitement or well-marked retardation. There are especially two kinds of melancholias which have to be differentiated from the cases under consideration: the involution melancholias and certain conditions of dementia præcox. Besides the age, and the absence of former attacks, it is pre-eminently active fear on the one hand, and on the other a certain shallowness of emotional reaction and the existence of absurd delusions which speak for involution melancholia. From the cases with retardation of motion, the involution melancholias are differentiated without difficulty. In dementia præcox depressions occur without retardation. In these the depressive ideas are apt to be absurd, the thinking is somewhat scattered, and the emotional reaction may be singularly shallow,—a certain emotional indifference. On the other hand, in the cases of manic-depressive insanity this indifference is never present.

3. The hypokinetic states. By this term we mean the states in which the retardation shows itself in a slowness in thinking and (as the name indicates) in motion. For these cases we may lay down the general rule that unless manic traits or fear modify the picture the retardation of motion and the difficulty in thinking show a certain correspondence in degree. Moreover, the slowness in motion is consistent and shows itself in all voluntary acts. Therefore a pronounced inability to think, not associated with a corresponding slowness in motion, speaks, in the absence of manic traits (exhilaration), against manic-depressive insanity. Such conditions presenting other features in addition are seen in general paralysis.

Again, states of well-marked mental weakness without corresponding psychomotor retardation (though there is disinclination to move) occur after acute diseases such as typhoid fever, measles, diphtheria, etc. It should also be recalled that there are various grades of stupor which occur in grave brain diseases (meningitis, etc.); in these, again, the "tied-up" state (as a patient called it) is absent.

A retardation may also be simulated by an apathy (cases of dementia præcox may develop this state without active symptoms). Here the general disinclination to move is not associated with slowness of motion, and calculation tests give almost normal results, yet the grasp on the surroundings may be rather poor. In cases of mutism, with or without other akinetic phenomena, we can exclude manic-depressive insanity, if the motions in general are not correspondingly slow, or if we can ascertain (by facial expression) that there is no corresponding slowness of thinking. Such cases of mutism occur in dementia præcox. The various hypokinetic states belonging in the group of dementia præcox are the most important as well as the most difficult to differentiate from those of manic-depressive insanity. Hence it is in order to mention here certain features which are especially characteristic of the former. These are (1) cataleptic phenomena, by which is meant the tendency of a limb, when passively placed in any position, to remain in that position for an unusually long time. This is also shown in the spontaneous assumption of odd positions which may be retained for varying periods of time. (2) The negativistic phenomena. The clearest negativism exists when every passive motion, no matter in which direction it is exerted, is at once met by marked resistance. Thus, for example, if we press the head of the patient backward it is at once strongly pushed against our hand, so that it springs forward the moment the pressure is relieved; or, if in the next manipulation the pressure is exerted in the very opposite direction, the same phenomenon is again seen. This symptom may be general, that is, may show itself at any place where we touch the patient, or may be confined to special muscle groups, such as the neck and lower jaw for instance. It is not necessarily consistent. Negativism may also show itself in other ways. These symptoms are foreign to manic-depressive insanity. Hence, if we have to diagnosticate a hypokinetic state, catalepsy, the assumption and retention of odd positions, together with signs of negativism speak, besides the traits above mentioned, against manic-depressive insanity and for dementia præcox (katatonia in the stricter sense). Negativism must

not be confounded with warding off movements and resistance due to fear. There are, of course, other features which might be cited as differential points—we will add only the sudden disappearance of the hypokinetic symptoms for short periods, during which the patient may be very clear. Such intermissions are less apt to occur in manic-depressive insanity, except in mixed phases, in which cases the patient shows manic traits in the interval.

The manic states may present more difficulty for diagnosis than the depressive states. Motor excitement is a more common symptom than psychomotor retardation, and is seen in the most heterogeneous states; it is probably produced in various ways. Again, flight of ideas may be difficult to recognize at its height, and occurs not only in manic-depressive insanity, but in other states as well—notably general paralysis, certain states of exhaustion, and in some forms of dementia præcox. Nevertheless a great many cases present no difficulty for diagnosis. The following general rules, while not claimed to be absolute, may be valuable as guides. The pure manic excitements present a motor excitement in which many of the motions are movements of expression; they are multiform and we can see a meaning in them. The talk, also, though it may be quite incoherent, is not totally incomprehensible and we can see a loose connection. Distractibility is very common. The confusion is proportionate to the intensity of the flight and shows itself in mistaking of persons and places. The patient presents a certain alertness. In the various excitements of "somatic" diseases these relations do not exist, and flight of ideas cannot be recognized. In the deliria the dulling of consciousness is much greater and hallucinations are more prominent than in manic excitement. The same may be said about the excitement of acute exhaustion.

In the excitements of epilepsy neither flight nor distractibility is present and the disorientation is very pronounced. Hysterical excitements are of short duration and also present no flight of ideas. It may be very difficult to differentiate the excitements of general paralysis from those of manic-depressive insanity. The prodromal state, the age, the history of syphilis, and the physical signs are the best guides. We have above spoken of the similarity which certain mild manic states may bear to general paralysis, and have shown that it is, besides the points just mentioned, especially the greater absurdity of the delusions which speaks for general paralysis.

The most important differentiation must be made from the excitements of dementia præcox. This differentiation is usually readily made, but may also present considerable difficulty. We may here, for practical purposes, divide the excitements of dementia præcox into the more typical katatonic excitements and into those which resemble more the so-called hebephrenic excitements. The latter are more difficult. The motor excitement and the talk may both resemble manic-depressive insanity, but they are apt to be less multiform; the talk, in spite of striking clearness in the patient's understanding of things about him, may be more confused, scattered and reiterative. These are points which can best be appreciated in a stenographic report of the talk. At the same time very absurd ideas may be associated with a comparatively mild excitement; such a condition may be especially striking in a remission. Instead of the frank exhilaration, we find a certain silliness; or, in other instances, an ecstatic mood with mystical, religious delusions; this latter mood, according to my experience, seems not to occur in manic-depressive insanity. Sudden non-periodic remissions with striking clearness, or episodes with akinetic katatonic traits, may also be valuable in the differential diagnosis.

The katatonic excitements may show a motor excitement, which differs clearly from the manic. While in the latter the movements are multiform, seem to have a meaning, and are often gestures, they are in the former more aimless, more impulsive, one might say coarser, and they make more the impression of something forced; often they are quite stereotyped. With such an excitement there may be no talk whatever, or it may be strikingly stereotyped, consisting in the repetition of words or sentences, or again remarkably confused in comparison to the clearness of understanding. The emotional state is here not one of exhilaration, but rather of indifference; at times silly, or again at intervals ecstatic, in which case a peculiar, forced, rather nonsensical talk with much pathos may be noted. Here the alternation with akinetic traits is more common than in the other states above mentioned. Flight of ideas and distractibility are absent in these cases.

In the diagnosis of mixed phases we must keep in mind the chief possibilities of combination—since it is the very combination of symptoms which is characteristic. Thus, in pictures which present melancholic traits, the existence of flight of ideas may be said to be diagnostic. The same symptom is also important in cases in which the delusional element is the most prominent. In states of mental insufficiency with a poor grasp on the surroundings, clear indication of an exhilaration (represented by frequent laughing and smiling, or certain mischievous actions) is characteristic and we shall usually find certain evidences of a modified motor retardation associated with it. These cases may be mistaken for certain hypokinetic states of dementia præcox; and we must guard against mistaking the peculiar set smile which is sometimes seen in akinetic states of dementia præcox, and which seems to express no emotional state, for the frank smile of the manic-depressive which denotes a happy mood. We must also clearly differentiate between impulsive acts which may occur in dementia præcox and certain mischievous acts of the cases under consideration.

Those states which are pre-eminently excitements may by their sterility in talk, and silliness in talk and actions, suggest excitements of dementia præcox; in such cases the evident disorder in thinking, manifesting itself in a difficulty in answering simple calculation tests and memory questions, as well as in the poor grasp on the surroundings, will help us to make a correct diagnosis. We see, therefore, as was stated, that it is here, as in all mixed phases, the peculiar combination of symptoms which points the way to a correct diagnosis.

It is practically of great importance that when once we feel sure about the diagnosis of manic-depressive insanity, we are justified in giving a good *prognosis* so far as recovery from the attack is concerned. This knowledge is especially important in the protracted attacks and certain mixed phases which give the impression of dementia; and while recurrences are always to be feared, recovery from each attack may with few exceptions be confidently expected. In regard to recurrences it has been my experience that if all the cases are taken into consideration, we find that the classical circular insanity as well as the frequently recurring manias and depressions are in the minority, and that cases with few attacks are more common. It is impossible, however, to say in a given case whether many or few attacks will follow, unless a tendency in the one or the other direction is already established by the previous course; even this consideration is not absolutely binding. On the whole the cases with good heredity, occurring subsequently to well-marked exhausting influences or the like, and after the age of thirty, are in this respect prognostically more favorable than early cases with bad heredity and without appreciable cause, especially if the first attack is short. In the climacterium recurrences are not uncommon.

The *treatment* of manic-depressive insanity is, of course, only a symptomatic one. States of excitement, with the exception of the mild ones, should always be sent to a hospital, unless a sufficient number of nurses can be procured. In the short time which elapses before this transfer can be effected, it will scarcely be possible to avoid the use of sedatives, which should otherwise be as much as possible dispensed with. Bromides in large doses, and hyoscine gr. $\frac{1}{200}$ to $\frac{1}{100}$, administered hypodermatically, have a quieting effect. The general treatment consists in the exclusion of all exciting influences. For this purpose bed treatment should as much as possible be employed;

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with this should be combined prolonged baths (temperature 98° F.). The patients soon get used to this treatment, though sedatives may at first be necessary to make it feasible. The effect is often remarkable and the sleep is generally improved. For the attainment of the latter object trional, paraldehyde, chloralamid, or alcohol may also cautiously be administered. Sufficient feeding is very important, and tube-feeding may have to be resorted to. Stimulants or strychnine may be necessary. Cases of manic-depressive excitement should not end fatally from exhaustion if treated properly.

For the treatment of depressive states I refer the reader to what has been said in regard to treatment in the section devoted to *Melancholia*, and I will here only add that in the mild cases of depression the patients should not be prodded to exert themselves, nor should diversion be forced upon them, since the condition is only aggravated by these measures. On the contrary all responsibility, all exertion, should be taken away from them and a large part of their day should be spent in bed. The idea of the benefit of forcing exertion upon these people arises from a misconception of the disorder. Suicide is to be feared and guarded against in even the mildest cases.

August Hoch.

XX. INSANITY: MANIA.—Under the head of mania various states of excitement have been included; but as is the case in melancholia, which the writer has treated in another section, there is little doubt that heterogeneous clinical pictures have here been united. The most important form of excitement and that which seems to have been the basis for most descriptions of mania is the symptom complex which represents a part of manic-depressive insanity. Some may question whether all forms of mania presenting the features there described belong actually in this group, and whether there does exist a mania as such. Whatever position we may take in this matter we can affirm that it is not possible to separate symptomatically such a mania from the excitements of manic-depressive insanity. There is consequently no occasion here to describe these states, and the reader may be referred to the section devoted to manic-depressive insanity. Excitements also occur in various other diseases, some of which manifest themselves pre-eminently by mental symptoms, while there are others in which mental symptoms are only occasionally seen. Among the latter we may mention myxœdema and Graves' disease, and the delirious excitements of various acute infectious diseases. Mental diseases in which excitements occur are chiefly general paralysis, senile dementia, epilepsy, hysteria, dementia præcox, and the excitements following upon acute exhaustion. The symptomatic characteristics of these various forms will be found in the sections which specially deal with them. Under the diagnosis of manic-depressive insanity, the writer has attempted to indicate some of the features that characterize the excitements of dementia præcox.

A word may be said about chronic mania. There are cases which more or less persistently present states of excitement for years. Some of these are prolonged attacks of manic-depressive insanity, with ultimate recovery; a few are undoubtedly cases of manic-depressive insanity in which the intervals between attacks have become shorter and shorter until finally the attacks run together; some are cases of dementia præcox remaining permanently excited; but finally I must acknowledge that there are cases in which the condition is by no means clear.

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XXI. INSANITY, DEGENERATIVE.—The insanity of degeneracy comprises those forms of mental disease which seem to bear a close relation to defective hereditary endowment.

The term was first used by Morel (1860) in his etiological classification, where he applied the name to three types of cases in which faulty heredity was the most prominent factor. These groups were: the insanity resulting from congenital nervous temperament, moral insanity, characterized more by the disorder of the actions than of the intelligence, and the feeble-minded, the subjects of morbid impulses and those prone to commit criminal acts. From this time the insanity of degeneracy has been recognized as forming one of the larger groups of the insane. Following Morel, Schüle and more recently Krafft-Ebing, Dagonet, Regis, Magnan, Spitzka, and Berkley have maintained the same view. The different forms of mental diseases grouped here have, however, varied somewhat with the different writers. In general it may be said that the term has been used in a broader sense by German and American psychiatrists than by the French.

Krafft-Ebing laid stress upon acquired degeneracy, that arising from head injury, disease of the brain, and anomalies of development, and also characterized the insanity of degeneracy by certain general features which distinguished it from another large group of cases which seemed to arise quite independently of any faulty endowment, the functional psychoses or psycho-neuroses. In a general way these characteristics were: the insanity of degeneracy is constitutional, *i.e.*, it appears in individuals who from early childhood give evidence of a faulty constitution, and whose mental equilibrium is always easily disturbed; the exciting causes may be nothing more than the physiological phases of life (puberty, puerperium, climacterium, and menses); there is little tendency to recovery, but remissions and periodicity are notable features, and there is also a tendency to transmission of insanity to the progeny in an even more severe form. He groups here reasoning insanity (folie raisonnante), paranoia, periodical insanity, including dipsomania; neurasthenic insanity, including compulsive insanity; epileptic and hysterical insanities and hypochondriacal insanity.

Spitzka includes practically the same forms of mental disease in this large group. Macpherson places here premature dementia (hebephrenia), moral insanity, paranoia, folie-à-deux, aboulia, obsessions, impulses, perversions of instinct and conditions of arrested mental development.

Berkley places in this group paranoia, periodical insanity, epileptic, hysterical and neurasthenic insanities, and remarks that it probably includes more cases than any of the others, that the onset and prognosis are essentially different, and that the "one-sided or warped evolution of mental faculties is usually to be traced to anatomical abnormalities such as defective development or malformation of the cranial bones with imperfections in the brain structure, especially in convolutions, and abnormalities in the vascular construction."

Kraepelin fails to recognize any features characteristic of this large group except that of heredity. He says, introductory to the last half of his text-book, that following the involution psychoses, those forms of insanity are described in whose origin a defective basis becomes a more prominent factor. These psychoses are manic-depressive insanity, paranoia, the constitutional neuroses (epileptic and hysterical insanity and traumatic neuroses), the constitutional psychopathic states (compulsive and impulsive insanity and contrary sexual instincts), and the conditions of arrested mental development.

The French psychiatrists, including Magnan, Dagonet, and Regis, limit the insanity of degeneracy to a small class of cases, which includes only the imperative ideas, the impulses, contrary sexual instincts, moral insanity, and the conditions of arrested mental development.

While one can readily recognize the greater prevalence of defective heredity in the large group assigned to the insanity of degeneracy by Berkley, Krafft-Ebing, and others, it must be admitted that there is an absence of any characteristic phenomena either in symptomatology, or course, or outcome in common to all or most of the forms grouped here, excepting the constitutional psychopathic states and arrested mental development, which would warrant such a classification. In comparing manic-depressive insanity with paranoia, for instance, the mode of onset and the age at which it occurs, the individual symptoms, the course of the disease, and the ultimate outcome are essentially different in each. The advancement in psychiatry during the past two decades, with the growing conception of definite clinical entities, each with its own characteristic symptomatology, course, and outcome, has rendered the gross separation of psychoses depending alone upon heredity, of secondary importance. Furthermore, there has always been a considerable number of cases allotted to different forms of the insanity of degeneracy, in which there were absolutely no evidences of faulty heredity, and in many of these the characteristic symptoms have appeared only after an injury, infectious diseases, or an emotional shock in infancy or youth; and there are still other etiological factors such as faulty training and masturbation, which seem in individual cases to be of equal import to faulty heredity. While it still may be said, with the exception perhaps of dementia præcox, that defective heredity is more prominent in paranoia, manic-depressive insanity, the constitutional neuroses, constitutional psychopathic states and arrested mental development, than in the other psychoses recognized by Krafft-Ebing as the functional or simple psychoses; there is, in fact, very little of similarity in the symptomatology to warrant their being grouped under one heading.

Manic-depressive insanity is characterized by a recurrence at varying intervals throughout life of mental disturbance of a maniacal or depressive character or both, unaccompanied by progressive mental deterioration, the patients, in the vast majority of cases, in the interval being able to return to their usual employments. Paranoia is characterized by the gradual morbid transformation of the entire psychic personality accompanied by the development of fixed delusions, which are maintained throughout life, becoming more and more systematized, but without impairment of the perceptive faculties, the memory, or coherence of thought.

The constitutional psychopathic states and arrested mental development are the only forms of the so-called insanity of degeneracy which present common characteristics beyond the mere prevalence of faulty heredity, which would possibly justify a common grouping and the application of the name of the insanity of degeneracy. These forms are characterized by stigmata of degeneracy in both the physical and mental fields.

In the mental field the stigmata vary from more or less complete arrest of development of the intellect and the moral sense to mere anomalies of these faculties. The arrest of development may be both intellectual and moral, producing imbecility and idiocy (arrested mental development) or may involve only one of these fields, as in the case of moral imbecility (moral insanity). However, whenever the moral defect is very pronounced, more or less intellectual enfeeblement accompanies it.

The mental impairment is usually general and involves all the more complicated mental processes; apprehension, memory, judgment, association of ideas, emotions, and volitions; but there is a class of patients in whom an impairment of some of the faculties is accompanied by an exaggerated activity of others, as of memory or the association of ideas with enfeeblement of the will or judgment. Some are regarded as intellectually bright, but commit the most absurd acts and show the credulity of a child, there are idiots who exhibit remarkable taste for drawing and music, and some imbeciles have an excellent memory for dates or calculate with great ease and accuracy.

The disharmony of the intellectual and the moral faculties is one of the most striking features of degeneracy. As in the defects of the intellectual development, so in the moral sphere, the condition varies from a complete arrest of moral development to all forms of moral perversion and even to an abnormal development of the moral and emotional sensibility. All of these conditions may exist with a perfect development of the intellectual faculties. The conditions of arrested moral development comprise moral imbecility. Among perversions are those of the sexual sense, which include bestiality and what Westphal calls the contrary sexual instincts. This last also includes masochism and sadism. The professional criminals should also, without doubt, be included in this class, as they present all possible varieties of moral perversions and anomalies, all of which may exist with preservation of the intellect and even with intellectual keenness. Finally there may be only an extreme mobility of the emotions, an extraordinary susceptibility to impressions of every sort. The extreme type of this condition constitutes congenital neurasthenia.

It is upon the basis of such mental stigmata that compulsive and impulsive insanity and contrary sexual instincts arise. Magnan terms these the episodal symptoms of the insanity of degeneracy. It is a general characteristic of these disturbances to appear very early in life and especially during puberty.

Physical stigmata, which exist from infancy, include anomalies in the development of the cranium, face, body, and limbs; asymmetries, malformations of the external ear, strabismus, faulty speech, including stuttering, thickness of the lower lip, malposition of the teeth, atypical palate, prominence of the lower jaw, hypospadias, epispadias, anorchism, etc., etc., all of which are more fully treated in the description of *Insanity from Arrest of Development: Imbecility and Idiocy*.

As arranged by the editor of the Handbook, the insanity of degeneracy, as described here, will comprise paranoia, and manic-depressive insanity, the description of which will be found elsewhere under those respective headings, circular insanity, the constitutional psychopathic states, including congenital neurasthenia, compulsive and impulsive insanity, and contrary sexual instincts; also moral insanity, folie-à-deux, and hypochondriacal insanity.

Circular Insanity (*Folie circulaire, Folie à Double Forme*).—The recognition of circular insanity as a distinct form of mental disease dates from Falret (1851) and Baillarger (1854). According to them it could be distinguished from ordinary mania and melancholia, and was characterized by regular periods of depression and elation, which succeeded each other with or without an intermission of lucidity, the duration of the attack varying from one or more days to a year. The transition might be sudden or gradual, the former being the case when the attacks were short. It was also recognized that the disease was markedly hereditary, appeared mostly in women, and had an unfavorable prognosis.

The mental phenomena characteristic of the disease were further elucidated by Meyer (1874), Mordret (1883), J. Falret (1890), and finally Ritti (1892). According to these writers circular insanity consists of recurrence of periods of mania and melancholia, which, when separated by longer or shorter intervals, constitutes the periodical type, or without the interruption, the circular type. The periods of mania are one of two types: simple mental exaltation, characterized by an over-excitation of all of the faculties, perceptive, intellectual, and volitional, without incoherency of speech, sometimes accompanied by impulsive actions, such as dipsomania, kleptomania, and nymphomania; or, pure mania with incoherency of speech, frequently clouding of consciousness, and sometimes with delusions of exaltation. The periods of melancholia are of three types: simple depression of the mental and physical energy, absence of will power, and an incapacity for action but without delusions; melancholia in which simple depression is complicated by depressive delusions, either of self-condemnation, or of punishment and incapacity, with hypochondriasis; and finally melancholia with stupor and occasional periods of excitement and cataleptoid conditions. Of these types the simple mental exaltation and the simple mental depression are distinct from all other forms of mania and melancholia and can be regarded as pathognomonic of the disease. The other types are not. The disease usually appears between the ages of fifteen and twenty-five with a period of depression, and at the onset is more often of the periodic type, *i.e.*, with prolonged lucid intervals. The lucid intervals as well as the periods of depression and of exaltation may be of varying duration from one or more days to months or years. In a few cases the

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duration of the periods presents a marked regularity, so that there is a daily, weekly, monthly, semiannual, or yearly alternation between excitement and depression. This has given rise to the special term, circular insanity of the alternating type. The transition from one period to another may be gradual or sudden.

The prognosis of the disease is unfavorable in view of the tendency to recurrence of the attacks, yet only two or three attacks may occur in a lifetime and terminate in recovery. On the other hand, dementia does not occur, or at least not until late in life or after very many attacks. In spite of frequent recurrence of periods of excitement and depression the intellect remains unimpaired in the intermissions and the patients are capable of successful employment. Furthermore the longevity of the patients is but very little influenced by the disease, although a few patients succumb during the height of the disease as the result of self-inflicted injuries, exhaustion from excessive excitement, and from suicide. The disease is hereditary. In some cases a tendency for the same form of mental disease to be transmitted to the progeny has been noted. Among the exciting causes the most important are gestation, puerperium, menstrual disturbances, and mental shock.

The above conception of circular insanity as forming a distinct entity has not been acceptable to some psychiatrists including Krafft-Ebing, Spitzka, Berkley, and Kraepelin, who regard it simply as a form of periodical insanity. Kraepelin in his sixth edition goes even further, and abolishes the name of periodical insanity, merging the separate forms, periodical mania, periodical melancholia, and circular insanity into a large group which he calls manic-depressive insanity. In it he discerns certain fundamental symptoms which not only give the disease picture a more definite symptomatology, so that it can be distinguished from all other forms of mental disease presenting symptoms of excitement or depression, but also permit its recognition at the very onset. While the etiology, course, and prognosis of his manic-depressive insanity do not differ materially from that outlined by Meyer, Falret, and Ritti, and described above, the disturbance of the apprehension, memory, judgment, train of thought, emotions and volitions, comprising the symptomatology, as described by Kraepelin in the author's mind justifies this new conception of the disease. Therefore, the reader is referred for a detailed description of manic-depressive insanity to the article on that subject by Dr. August Hoch, who includes in it both periodical insanity and circular insanity.

CONGENITAL NEURASTHENIA.—This form of mental disturbance appears on a defective constitutional basis and is characterized by a continuous state of ill-humor with perverted tone of feeling, an increased sense of fatigue, indecision of conduct, and a tendency to hypochondria. It is to be distinguished from acquired neurasthenia, which is far more prevalent, arises from nervous exhaustion, and has a better prognosis.

The symptoms of the disease usually appear about the twentieth year, although the patients frequently give evidence of neurotic tendencies from childhood, such as neuroses, hystèria, chorea, etc. A delicate and frail constitution may be the only proof of a degenerate heritage. At this time in life, either as the result of an attempt to assume the more serious responsibilities of life, an emotional shock, or some physical disturbance, especially uterine trouble, or quite independently of any external causes, the patient develops a perverted tone of feeling, becomes ill-humored, looks only on the dark side of life, and shows an increased sense of fatigue and a tendency to hypochondria.

He becomes very susceptible to the cares and misfortunes of life, is easily discouraged, and feels that he is of little account in the world. There is often a complaint of nervousness or fear of some chronic disease. Pressure or pain in the head or peculiar sensations in all parts of the body, and many other hypochondriacal ideas, as well as insomnia, are prominent symptoms. The hypochondriacal whims may become even more prominent, giving rise to apprehension of death. Some patients are constantly talking of death and even making preparations for it. They are sorrowful and gloomy, any possible present happiness is clouded by past sorrow or fears for the future.

The greatly increased sense of fatigue interferes with regular employment. The patients are perfectly capable of taking up a piece of work with intelligence and skill, but they tire easily and demand frequent rests. Continued application causes headache, insomnia, and malaise. Furthermore, they are very easily distracted; very trifling events divert the attention and lead to frequent interruptions in the work. While some patients present a characteristic indecision in conduct and frequent change of purpose, others are painfully deliberate in all their actions and show extreme precision and punctuality in little things. The intellect remains unimpaired. There is no disturbance of apprehension, and thought is coherent. Many patients are conscious of their unfortunate state.

There are a few cases of congenital neurasthenia, which not only present the sad and ill-humored disposition, but also show an increased egotism with a corresponding disregard for the feelings of others. These patients are sensitive, fault-finding, quarrelsome and distrustful, sometimes tractable, but more often stubborn and even aggressive.

The disease when once established continues throughout life. At first there may be remissions, but even during these the patients are apt to show peculiarities.

In the matter of treatment, the patients may be made very comfortable by a well-regulated life with suitable environment. On the other hand, family strife and increased responsibilities tend to diminish the chance for improvement, while undue sympathy with absence of restraint is deleterious. Suitable employment which can be so adjusted as to increase gradually the expenditure of energy and responsibility is most helpful. Massage and gymnastics are of value in inducing new energy for work and in establishing self-dependence. Hypnotic suggestion may help in relieving insomnia and imaginary complaints.

HYPOCHONDRIACAL INSANITY (*Hypochondriasis*).—The term hypochondriasis is, with melancholia, one of the relics of the age of Hippocrates and Galen, but, like melancholia, it has suffered many changes in definition from time to time, and has now become so limited in its application as to fail even of recognition at the hands of some clinicians. The term is still much used by the general practitioner to represent that peculiar condition in which patients present an abnormal tendency to dwell upon trifling symptoms of an indefinite and apparently chronic ailment. Many psychiatrists (Kraepelin, Pitres, Kirchoff, Tuczek), on the other hand, regard it only as a symptom of an abnormal mental state, and place it as one of the manifestations of some psychosis, especially neurasthenia, and also melancholia, paranoia, and paresis. But there still remains a small group of cases characterized according to Boettiger, Romberg, and Hitzig by a continual emotional depression depending upon a morbid alteration of self-perception, leading to concentration of the attention upon self and a domination of thought by ideas of physical disease with a corresponding limitation and poverty of thought in reference to matters external to self, and a resultant interference with mental application, without a tendency to profound mental deterioration.

Some writers (Gowers) maintain that hypochondriasis is not a form of insanity, making the arbitrary distinction that the ideas of physical disease should not pass the boundaries of that which is physically possible and should be reasonable. This contention is hardly tenable, however, in view of the fact that the false ideas of the existence of disease do not have an adequate basis in morbid organic changes in the body and cannot be reasoned away, so must be regarded as delusions.

Undoubtedly the abnormal mental state arises either primarily from a morbid functional change in the brain

or secondarily following some sort of an abnormal sensation in the peripheral sense organs. It is thus seen that the disease approaches closely the constitutional psychoneuroses and, in common with them, finds its most prominent etiological factor in a defective constitutional basis. The disease, however, sometimes appears in individuals without this defective basis, in which cases it has been called acquired hypochondriasis in contradistinction to the temperamental forms (Gowers). The only clinical difference in these two forms is that, in the acquired, the symptoms are episodic and have a good prognosis, while in the temperamental form the disease appears earlier in life and presents a continuous course throughout life with remissions and exacerbations (Krafft-Ebing). The disease may appear at any time from youth to old age. Exciting causes are usually present in the form of some physical disturbance, although this is most often of a very trifling nature, such as a moderate chronic gastric catarrh. The disease often follows persistent ill-health.

The patient conceives the idea that he is suffering from some physical disease. His attention in most cases is attracted to some gastric or intestinal disturbance, which for some time may have been causing him distress after eating; but now, the distress is more or less constant and extends over the whole abdomen, creating great discomfort and unfitting him for work. In connection with this the "nerves of the leg tingle" and a cold perspiration appears over the whole body. The appetite fails and the bowels constantly rumble. There is a peculiar sensation at micturition and the urine is highly colored. The altered and illusionary perception of these numerous sensations increases with the concentration of the attention upon the self, until finally every organ of the body is involved and gives rise to the idea that the patient is suffering from some terrible disease. A patient whose hypochondriacal ideas originated from headache, in describing her symptoms said: "I have such a distressed feeling in my head all of the time. Sometimes it feels as though it would crack open, sometimes as if a tight band were about it, or as if it had all shrunken up. Yesterday it felt numb all day. I can hardly see with either eye because of the pain. I have not read a book or written a letter for a long time because of this pain and have stayed in a darkened room for days. I have no control over my eyes and cannot look at an object long at a time. For some time I could not smell anything. It seems to affect my legs, because at times I lose all strength and sensation," etc., etc. Next to dyspeptic disturbances and heart troubles, cephalic sensations are the most common in hypochondriasis, but in the end not an organ or a part of the body remains unaffected.

Such ideas come to occupy the mind exclusively, and then any sort of a trifling sign is interpreted as an additional positive symptom of the dread disease; mere flushing of the face means syphilis, a slight cough is positive evidence of consumption, or a leucorrhœal discharge of cancer of the womb. In search of further evidence of physical dissolution these patients scrutinize their excretions: the fæces for intestinal parasites, the urine for calculi, and the sputa for tubercle bacilli. They begin in the morning by examining the face, eyes, and tongue. After breakfast, they watch for the formation of gas in the intestines and stomach, for irregularities in the stools and urine, and thus the entire day may be passed in self-examination.

As the ideas and the interpretations of these sensations become more and more absurd, the emotional attitude of the patient becomes one of permanent sadness and gloom. In connection with these changes, the ideas of the patient become exclusively egocentric and there develops a corresponding disinterest in the affairs of the outer world.

The hypochondriacal patient has but one purpose and that is to nurse and seek relief for his disordered body, so he goes from one physician to another and runs the whole gamut of the medical profession from the regular school to the osteopath. Mental application and successful employment are impossible except for short intervals, and the patient sooner or later becomes relegated to a life of invalidism.

As already indicated, the course of the disease tends to chronicity, with remissions and periods of exacerbation, except in the few acquired cases. There is no tendency to mental deterioration except the moderate degree resulting from the extreme concentration of the attention upon the self, and the progressive narrowing of ideas relative to matters outside of self.

The recognition of hypochondriasis is difficult only in cases of acquired and congenital neurasthenia and when hypochondriacal ideas appear as prodromal symptoms in certain forms of insanity. The boundary between acquired neurasthenia and hypochondriasis is sometimes very indistinct, especially in those cases of neurasthenia in which hypochondriacal ideas are very prominent. In the latter, we have more prominent exciting causes in the form of exhausting influences, greater irritability, with difficulty of thought and of mental application. In congenital neurasthenia there is also greater irritability, increased susceptibility to fatigue and emotiona despondency independent of hypochondriacal ideas. In the prodromal stages of melancholia, dementia præcox, and paranoia, in which hypochondriacal ideas may be a prominent symptom, differentiation is difficult and depends upon the presence of delusional ideas which extend beyond the patient's own body and involve the outer world. In melancholia these ideas may dominate the clinical picture, giving rise to a special form called "hypochondriacal melancholia," but here the delusional ideas soon become very absurd and pass beyond the limits of possibility. The patients complain that organs have been removed, the intestines or throat occluded so that food no longer passes, and the brain transformed into sawdust, etc. The author believes that that class of cases, characterized by hypochondriacal ideas of a sexual nature, which eventually end in mental deterioration should be included in dementia præcox. Some have regarded these cases as a special form of hypochondriasis with an unfavorable prognosis. Other forms of insanity, in which hypochondriacal ideas may appear as one of the symptoms, are paresis, epileptic and hysterical insanities, and manic-depressive insanity. In the early stages of hypochondriasis, it is necessary to eliminate the possibility of the existence of some organic disease.

In treatment, naturally an effort should first be made to correct diseased conditions of the viscera, should any exist, but one should not be over-zealous in making exploratory incisions or in removing innocent organs unless definite objective symptoms can be demonstrated. In this way temporary relief may be afforded, but sooner or later the sensations return in some other field with equal intensity. In a recent case which came to the author's attention, a patient during fourteen years had had her eyes examined and refitted to glasses many times, had undergone a uterine operation, and was contemplating an exploratory trephining of the skull for brain tumor.

Constitutional treatment should be directed toward the improvement of general nutrition. An attempt should be made to break down the morbid self-concentration by distracting influences, such as occupation, exercise, and amusement. The symptoms are only aggravated by the ennui of an idle life. Furthermore, the physician must obtain the confidence of his patient at the outset; which he cannot do if he belittles his sufferings or discredits the supposed symptoms. One may later, by the aid of suggestive therapeutics, depreciate these symptoms. Indeed, this method of treatment offers the greatest hope for permanent improvement.

COMPULSIVE INSANITY (*Imperative Concepts**).—In the constitutional psychopathic states described here, compulsive ideas overwhelm the patient, inhibit thought, dominate emotions, and often lead to compulsive acts. Compulsive ideas may appear as episodal symptoms in some nervous diseases and especially melancholia of in-

* Imperative ideas, obsessions, impulsions intellectuels, Zwangs-irresein.

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