Chronic Hallucinatory Psychosis.(1) ROBERT HUNTER STEEN, M.D.Lond., M.R.C.P.Lond., Medical Superintendent, City of London Mental Hospital, Professor of Psychological Medicine and Out-Patients' Physician, King's College Hospital, London.

FOR several years past my attention has been directed to a series of cases in which the *principal* symptom has been the presence of hallucinations.

Employing the recognised classifications in use in this country, it has often been a matter of the greatest difficulty to decide under which heading individual members of this group should be placed.

As the hallucinations give rise to slight depression some might possibly be included under melancholia. In others delusions of persecution develop and paranoia might be the provisional diagnosis. Others, again, might be swept into the wide-spread net of dementia præcox.

This state of affairs cannot be regarded as satisfactory, for, as will be shown later, they are not truly cases of melancholia, paranoia, dementia præcox or any other described affection.

It is the purpose of this paper, therefore, to attempt to prove that there are certain hallucinatory cases which can be grouped together to form a well-defined clinical entity. This I have called "chronic hallucinatory psychosis." The choice of a suitable name is of no small importance, and the reasons for the selection of this one will be given as the discussion proceeds.

The main feature of the illness is the presence of hallucinations. These may be of all the senses, but auditory hallucinations are the most prominent.

At the beginning the patient may realise that the hallucination is a morbid phenomenon and unaccountable. He may admit that though he hears a "voice" speaking, there is no one in the flesh actually doing so. Such a state of affairs may last for years, and possibly, though rarely, for life, and the subject would not be deemed insane in the ordinary sense of the word. It is probable, however, that this condition forms the first stage of the illness, which eventually develops on definite lines. The patient demands an explanation of the hallucinations. As none is forthcoming he tries to account for their presence, and the result is a delusion, and, most frequently, a delusion of persecution. The point to be noted is that the delusion is a comparatively late arrival and is the logical result of the hallucinations.

Other abnormal mental symptoms in the early stages are, as a rule, absent. The patient is quiet and orderly. The memory is good, and,

(1) A paper read at the Quarterly Meeting of the Medico-Psychological Association on February 24th, 1920.

outside the sphere of influence of the hallucinations, conversation is rational and little amiss is noticed by the friends.

Before embarking upon a more detailed account it will probably assist the comprehension of the subject if a few clinical illustrations are given.

CASE I.—M. T—, female, æt. 20, single, no occupation. An aunt was insane. I was asked to see the patient in the autumn of 1916, as she had been subject to uncontrollable fits of crying since about Easter, 1916. Though no mention of hallucinations had been made to me, to the question "What is the matter?" she immediately replied that she could hear two voices talking to her "as clearly as you are talking to me." In reply to the question as to the nature of the messages, she said "Hell" and "other words too awful to mention." On one occasion she had seen "pictures of Gethsemane and other religious pictures." These were the only visual hallucinations, and they did not recur. There were no hallucinations of taste or smell, but she had once the strange sensation "as if someone were touching the skin of my body." On subsequent occasions more information was obtained as to the content of the auditory hallucinations. She told me she heard the voices say: "Don't take no notice." "Mary, it is Satan talking to you." "Do you hear me?" "You had better kill yourself." "You'll be a lunatic before you are many days older." When she tried to sing hymns the voice said, "Oh, shut up." On one occasion when I was called away from our interview for a few minutes I asked her to write down exactly what she heard in my absence, with the following result: "What do you mean by telling Doctor all I have told you? Mary, why don't you take any notice of me? Go and see your Dad. Mary, don't you hear me. What are you looking at? Whatever are you writing down all this just to amuse? You are a wicked cat. You won't go to Heaven," etc. Except for the fits of weeping, there were no other abnormal symptoms, mental or physical. She was a happy-looking girl, and no one, not even her own parents, had any suspicion of the presence of hallucinations.

The case was intensively studied and may be recorded more fully on another occasion, but for the present purpose it will suffice to state that after several interviews the fits of weeping ceased. Each time she came to see me I explained the hallucinatory nature of the voices, which she accepted, and as time went on she felt herself more and more able to disregard them. I found, also, that there was a very severe secret conflict in the life of the girl which was unknown to her family, and with the confession of this she improved so much that the treatment was discontinued.

I am very sorry to have to report that since this paper was almost completed, namely, in last December, the patient has found it necessary to return for treatment. She states, however, that for three years she was entirely free from hallucinations. The "voices" have now returned with renewed intensity, and I have been able to discover that the conflict to which reference has been made was not entirely resolved, and its re-appearance upon the scene has caused the return of the distressing symptoms.

Discussion.—It is not easy to put a name to this condition. Hysteria might be thought of and the fits of weeping might easily be termed "hysterical," but their origin was due, as the patient definitely informed me, to the annoyance caused by the "voices." To call the case one of hysteria or neurasthenia is really only an abuse of these terms and merely a cloak for ignorance. My own feeling is that it is a case of chronic hallucinatory psychosis. She was not insane. She did not develop any delusions with regard to the voices or herself. She quite realised that these were abnormal. It is for this reason that I have adopted the word "psychosis" instead of "insanity." I would not like

to hazard an opinion as to what is in store in the future for this patient. The French call the condition "*hallucinose*," and the majority seem to hold the view that these cases eventually develop delusions. An illustration of this is given as Case 3.(2)

CASE 2 is similar in many respects to case 1, but is of a more severe type.

S.S.—, female, æt. 38, married, no children. Father suffered from senile insanity. A half-brother committed suicide. In June, 1914, she fell down the stairs of a motor-bus and was much shaken. After this she suffered from sleeplessness. About August, 1914, she and her husband went to live at some flats. The rooms were close together and she thought she could hear the people talking to each other. For example, one night she thought she heard one man say to another," What the devil did he mean by frightening me about motors." Owing to her nervous condition they left the flat and went to Maidenhead, and then to another address. Here she was "delirious" she said. No one knew, however, that she was "delirious." By this expression she meant that she could hear "music in her head and gramophones talking three or four together. It was like Hell." The hallucinations had existed in much the same condition, some days slightly better and other days slightly worse, till she came to see me in July, 1918. She then gave a full account of the numerous "voices" she heard. I asked were the voices imaginary and she replied," I know they are not real, but they are so persistent I cannot think of anything else." She was unable to offer any explanation of them. What led to our interview was the fear that she might lose control of herself. For example, a voice told her to warn the police that there was a foreigner in the village she was then living in and she was afraid she might do so. She was anxious for institutional treatment and at her own request she was certified. She came to the City of London Mental Hospital, where she was given full parole and worked on the farm and for a time the hallucinations almost ceased. She had a slight injury to her foot, and during the enforced rest the hallucinations returned with increased intensity, and now the chicken and ducks began to speak to her. She left on trial on November 30th, 1918, not really any better. At the present time (November, 1919) she complains of severe pain on the left side of the head, "just like an abscess." When the sounds come up to the left ear it seems to cause an awful throbbing. The voices are almost continuous. When asked to repeat some of the actual words she hears she says, "A boy's voice has just said 'Some of the dirty little donkeys couldn't find it out,' and 'Who would think I should come down here to make such an enemy as this.'" The second sentence was said by a boy's voice a long way off. Birds and animals appear to talk to her. For example she says, "Yesterday the birds said they were sorry they could not get me into the best society." She was at a public procession a few days ago, and a horse appeared to speak quite distinctly to her. A fresh phenomenon is that every movement made by people seems to result in a voice speaking to her. In order to find out if any delusions were being formed I asked her again what was her explanation of all this. She said, "It's a nervous thing, a most mysterious thing." She admitted that though other people were with her, she alone hears these different noises. The nearest approach to a delusional interpretation was her question, "Do you think Mr. Maskelyne could cause all this by putting me under his influence?" The hallucinations started in the left ear, then affected both ears, and now again are chiefly in the left ear. There have been no hallucinations of the other senses. She lives at home and engages in

(2) As at the time I first saw this patient I was unacquainted with this variety of illness, I had considerable anxiety as to whether I should recommend that she should be sent to a mental hospital or not, more especially as the voice once said, "Kill yourself." She had, however, either to remain at home or be certified—there was no other alternative—and I am now glad I stuck to my guns and kept her at home. What a case, however, for a psychiatric clinic! May these institutions soon come!

her housework, but is easily tired on account of the continual struggle with the "voices." Her friends notice little the matter with her except her preoccupied expression. She says, "I have two heads. I have a very sensible head, and yet you would be surprised at what is going on in the other head." The "sensible head" enables her to keep up appearances. This spontaneous expression is very interesting as indicating that the patient herself has a feeling of dissociation.

Discussion. Here, then, is a patient with auditory hallucinations which have been in existence for over five years. It is a worse case than No. 1 owing to the almost continuous presence of hallucinations. I am afraid she is beginning to seek for some explanation, which, later on, may found a delusional system. Except for the severe pain in the head and the occasional absent-mindedness there are no other mental or physical symptoms. She converses naturally and rationally on other topics. At times she looks slightly worried and depressed, but mostly she is bright and cheerful. She eats and sleeps well.

As regards diagnosis, the remarks made about Case 1 apply equally here. As regards causation, one must note the accident. A prolonged examination into the history of her life has revealed several severe conflicts, and the investigation is being continued.

The next illustration is taken from French literature. For the purposes of reference I shall call it CASE 3. The following is the translation of a report (3) of a meeting of the Psychiatric Society of Paris held on June 15th, 1911.

M. Séglas said: "I shall take advantage of the present occasion to give a brief summary of a new case, the full history of which I shall publish in detail later on. It is that of a female, æt. 35, who has been tormented for the last five years by 'voices.' These 'voices' are heard in different ways. Sometimes they speak 'mutely' to use the actual word of the patient. This is the well-known symptom of 'inward voices' (*voix intérieures*). Sometimes, on the contrary, they seem to come from the external world, as though someone were speaking loudly, or more often with a whispering sound drawing gradually closer to the patient. This discrimination, quite a spontaneous one on the part of the subject, is very important, for it seems clearly to prove in the second variety the existence of hallucinations properly so-called which are exteriorised. The patient adds that then the voice appears to come from around her, sometimes from the right side, sometimes from the left, sometimes from below, just as if the speaker were lying down at her feet on the floor.

"At the same time she experiences what has been called the sense of a 'presence,' and often also, when the voice approaches to speak in her ear, she feels the grazing of the actual contact of a body leaning on her shoulder. This sensation of contact can be produced as an isolated symptom. It can also be exaggerated as the feeling of a 'pushing.' At other times she feels in her limbs, as it were, a 'trifouillage' (4), which forces her to execute strange movements . . . This condition has lasted for five years without the patient being able to decide as to the nature of these 'voices' of hers. She does not at all realise their subjective character and will not admit that they come from herself, as they annoy her so much at the time as to make her angry. On the other hand she does not know what can produce them, and her ignorance in this respect is well expressed in the neuter designation which she uses: 'It speaks to me.' She has not built up any system of interpretation regarding them, and even appears much astonished at all

(3) *Encéphale*, vol. ii, 1911, p. 157.
(4) Untranslatable.

the questions she is asked in this connection. She only repeats that she has many times asked the 'voice' what it all meant and that she has never obtained any reply but this, in my opinion a very characteristic one—'Mystery! Mystery!'

"As I have already had occasion to remark, and as M. Buvat has just reminded you, patients of this kind are to be kept distinct in our minds from those who are consciously hallucinated—that is to say, those who of themselves realise the subjective character of their hallucinations. They are also to be kept distinct, on account of the poverty or even the absence of any attempt at systematic interpretation, from the systematic hallucinated insane. However, the character, the contents and the evolution of their hallucinations seem rather to bring them in near relation to these latter, to which they are in all probability closely connected by a series of intermediary cases."

To those interested in the subject two similar cases will be found in *Annales Medico-Psychologiques*, vol. ix, 1909, p. 256.

CASE 4.—This is also from the French, and was brought before the Society of Psychiatry of Paris in November, 1911, by MM. Louis Boudon and Pierre Kahn.

"Mme. F—, æt. 44 years, has shown signs of hallucinations for three years. Auditory, olfactory, visual, and those of general sensibility have appeared in her in succession.

"For more than two years, as MM. Dupré and Gelma have said in this place, she remained simply an hallucinated person without any delusional idea. But at the present time the clinical picture has changed: delusional ideas have been added to the hallucinations.

"*Present condition: Auditory hallucinations.*—These do not allow the patient any peace. Sometimes she hears things of no consequence; most frequently, however, there are insults or menaces. People reproach her with not loving her children, with having had sexual relations with a Protestant or with having had abnormal relations with her husband. They whisper to her villainous things. Certain hallucinations of an imperative character order her not to rise up from bed, not to eat, and not to dress herself.

"Some antagonistic hallucinations advise her not to be uneasy in mind, telling her she is a well-conducted woman. But in spite of all that 'it is unbearable to be incessantly insulted.'

"*Hallucinations of taste and of smell.*—Our patient does not admit any hallucinations of taste, but she has olfactory hallucinations, and these are generally combined with those of hearing.

"*Hallucinations of general insensibility.*—These consist in sensations of formication, of tearing and of '*picotements.*' These the patient herself often calls by the name of '*crépillements.*'

"*Genital hallucinations.*—F— complains that persons make her submit to touchings of the parts.

"*Visual hallucinations.*—In the evening at nightfall, but sometimes also in the daytime, F— again sees people that she has seen on preceding days; occasionally they appear to her 'as in a cinematograph,' and when her husband has gone out she sees him as if he were with her paying visits to the tradesmen of the district.

"*Psychomotor hallucinations.*—F— complains that people make her execute movements in spite of herself, and that they compel her to speak.

"Our patient then is still badly hallucinated. But at the present time the symptomatology she has presented for some months past is enriched by new elements which are—

"*First: Delusional interpretations.*—It is the neighbours who insult F— because, she says, she one day refused an invitation addressed to her by one of them. It is a gentleman whose name she does not know who reproaches her with having had certain relations with a Protestant. It is *églantinards* and freemasons who speak to her.

"People magnetise her. One of the physicians who formerly attended her magnetised her while auscultating her. People have some scientific means by which

they can make her hear voices at a distance. In the same way, if, while alone, she sees people she knows, it is that these persons have been given a certain power (*fluide grâce*) by which they can reappear before her. We have not ascertained any ideas of grandeur.

"*Second: Neologisms.*—Not numerous, but among others you will remember the word '*crépillements*' by which F— names certain of her hallucinations of general sensibility.

"*Third: Reactions in opposition to her persecutors.*—These have diminished to a great extent.

"However, F— answers the insults that she hears and often gets angry. She has told us of her intention to change her residence when she leaves the asylum. She requested her husband to lodge a complaint at the police station against her persecutors.

"Lastly, she has come to us hoping that physicians would be able to instruct her as to the proper scientific means to thwart those of her enemies."

It may be as well to pause here for a moment to review the ground covered so far. The first case is that of a patient who was completely aware of the abnormal character of the hallucinations. The second is of a more severe type. The patient had at first distinct insight as regards her condition, and for many years has been able to live among her neighbours without their noticing anything amiss, but she is now beginning to lose touch with her environment and is afraid of herself. Delusions seem to be on the point of developing. The third patient has not developed delusions, but has no insight of the nature of her illness. Case No. 4 is one in which definite delusions have developed in a person who for many years had hallucinations only.

The following and last case is an example of the same sequence in one of my own patients. I have selected this one as she has been under observation for some time.

Case 5.—C. N. C—, female. Admitted to the City of London Mental Hospital, January 6th, 1915. Single; governess. Father alcoholic. Father's brother died insane. One sister insane, a second sister unstable, a brother died insane, another brother died from alcoholic excess, another brother had a drug habit. Father and mother are dead, and she had been living quietly with a sister at D—, going out as a daily governess.

In the summer of 1912 a brother, F. C. C—, to whom she was very attached, was missing for several weeks. She and her sister were daily expecting his arrival, and no news was received from him. As far as can be ascertained he was in trouble with the police, and shortly afterwards fled the country. While in this state of anxiety, in September, 1912, she consulted Dr. D— about a small growth in her gum, and continued going to see him for about two months. Shortly after her first visit to Dr. D— she began to hear "voices." At first she thought it was his voice. About the same time she commenced to have strange sexual feelings which she attributed to Dr. D—. The hallucinations continued during the winter and spring, and in the summer of 1913 she went to some relatives at F— and the voices were not so persistent as at home, but it was here that "nasty words" began to come—"such nasty words." She gave up teaching during this summer, but resumed this in the winter, and finally ceased her work in August, 1914. About this time, also, it seemed as if "thoughts" came to her from other people, and that other people could read her thoughts. In November, 1914, she had the visual hallucination of seeing Dr. D—. To use her own words, "Quite plainly I could see his presence beside me. I was talking to my sister one night and not even thinking about him, when his presence seemed to be standing quite close to me."

Condition on admission.—She was a quiet, lady-like patient, and conversed in a natural manner and rationally. Her memory was excellent. I asked her to write down the actual words she heard, and she gave me two closely-written sheets of notepaper, too long to quote, but containing, amongst others, the following words: "Eternal weary man," "Too rummy," "Too guarded," "Can't beat it," "Booby," "Get thinner," "Unhealthy yet married," "Tea," "Cursed in spite," "Hoodwink." "Beat her, bruise her," etc. She had also the "echo"-sensation of hearing her thoughts spoken aloud. There were no hallucinations of the other special senses. Besides the hallucinations she complained bitterly of the sexual feelings.

During the last five years there has been but little real change, though she is at times worse than others. Mostly she is industrious, but at other times refrains from all work, as it does not seem to further her discharge. At first she could offer no explanation of the hallucinations, but she has now formed the delusion that she is being persecuted by some unknown agency. She is seclusive and rather avoids myself, as she thinks I ought to take active measures to stop this persecution.(5)

It is interesting to note that a sister, who is still engaged in teaching, and whom no one seems to suspect of being mentally affected, as long as three and a-half years ago told me that she heard my voice talking to her all the way in the train as she was travelling up to London.

Discussion.—Here, then, is a patient who, since 1912, has been the subject of auditory hallucinations. Arising from these, delusions of persecution have developed in a logical manner. These delusions are vague, and have appeared only as a late symptom, and there are no signs of dementia.

The illness came on after a period of severe anxiety. About the same time she consulted a doctor whom she fell in love with. Her symptoms and the analysis of her dreams clearly proved this to be the case. Both the disgrace of her brother and her love for the doctor were strongly repressed, and, to my mind, this repression caused the auditory hallucinations. This, however, is another matter which will be considered later when the ætiology of the disease comes under discussion.

The point we are most concerned with at present is—"What is the diagnosis?" The seclusiveness suggests dementia præcox. Against this there are absolutely no other signs or symptoms of this disease. The predominance of the hallucinations rules out paranoia.

A systematic description may now be attempted. This will be made as brief as possible. Some amount of repetition will be unavoidable and, it is hoped, will be excused.

Ætiology.—In most cases a careful research into the family history will reveal a strong hereditary tendency to nervous instability. This is particularly well marked in Case 5. A statistical inquiry at this stage is premature, as the numbers known to any single observer are few. It is not to be inferred, however, that it is a rare disorder, for I can select half-a-dozen or more with the greatest ease from my own practice. Without statistics, then, my general impression is that the affection is

(5) This patient now complains that she hears "silent voices"—her own expression. Compare Case 3.

one of adult life and begins mostly between the ages of thirty and fifty. Most of my patients have been women, and it is more frequently met with in the private than the rate-paid class.

Other observers have suggested that an illness such as pneumonia may act as a predisposing cause. Such, however, has not been my experience. As regards the actual cause, it may be noted that a history of physical injury is often met with. In Case 1, for example, she dated all her troubles from the time when some fire-irons fell on her ankles. In Case 2, it will be remembered, the patient fell down the stairs of a bus. Though a physical trauma may play some part as a precipitating factor, I feel that the main cause is psychical. In all cases which I have studied intensively, I have found evidence of severe mental conflict with more or less repression of the same.

Pathology.—There is no known special morbid anatomy. Not one of my cases has died, and other observers have published no accounts of *post-mortem* examinations so far as I am aware.

The conception of the real nature of the illness will depend on the theory of hallucinations in general. Such a theme would suffice for many papers. Though the following statement sounds dogmatic I hope it will be forgiven, as in the interests of brevity I have tried to make it as concise as possible.

There are many theories with regard to hallucinations founded on a material conception, and so far no centrifugal, centripetal or special centre theory has met with general acceptance or advanced our knowledge in the least degree.

The nature of the phenomenon can be best understood if approached from the purely psychical side. An hallucination is the result of dissociation of the mind. As to what is meant by this, the following examples may be given: When a man reads aloud and his thoughts wander to other matters there is a small amount of dissociation. A greater degree is met with in automatic writing. Other examples could be given showing increasing severity till the extreme limit of the multiple personality is reached. In chronic hallucinatory psychosis dissociation of the mind has taken place. This dissociation has been caused by mental conflict more or less repressed in a person congenitally mentally unstable. It is noteworthy that the patient may possibly have a feeling of dissociation. An example of this has been given in Case 2.

Symptoms and course.—After a period of some mental uneasiness, and possibly sleeplessness, an auditory hallucination appears with startling suddenness. The patient is naturally astounded. Other auditory hallucinations follow rapidly and cause a certain amount of distress. At first it is admitted that these hallucinations are "imaginary" or "not real." These are the expressions used by the sufferers

themselves, and though, strictly speaking, not very accurate ones, they convey to our minds the fact that the patient realises he is dealing with something abnormal in his personality. At a later stage he abandons the position that the voices are subjective and states that they are produced externally by some unknown agency. In a word, insight is now at an end. The final stage is, that the unknown agency is now known, and consists of "freemasonry," "wireless telephony," "a gang of persecutors," etc., and the patient is now the subject of hallucinations plus delusions. The delusions, moreover, are the logical product of the hallucinations. The hallucinations do not differ in any marked manner from those met with in order forms of insanity. They may be of all the senses, and auditory are most frequent, visual least so. One very painful feature is that the voices convey messages of an obscene or blasphemous nature. With regard to the sensation of touch, a symptom which causes intense distress is the hallucination that the genital area is being touched or interfered with. A strange hallucination is that of someone being present in the room—not seen, or heard, or felt, but just a feeling as if there were a "presence" near. In some cases the hallucinations may be continuous while the patient is awake. They cease during sleep, but immediately reappear on awakening either in the middle of the night or in the morning. Sleeplessness is not a prominent symptom except in the later stages of the disorder.

During the first part of the illness, for many months, or even years, other mental symptoms are absent. The general behaviour in no way attracts attention. The expression is normal, conversation is quiet, rational, and without loquacity or retardation. The memory is excellent, emotional excitement rare and depression only slight. In short, outside the sphere of influence of the hallucinations there is nothing that can be taken exception to. Later on, as the hallucinations with their delusions assume the control of the personality, many symptoms arise. The expression becomes anxious. A listening attitude may be adopted and the "voices" may be conversed with. Memory for recent events may be poor, because the attention is distracted. Conversation is to a considerable extent confined to the hallucinations and delusions. Letters may be written to the Home Secretary or other important personages. The police are asked why they do not interfere to stop the persecution. Violence may be threatened and suicide suggested. The extent and severity of these symptoms will depend on the hold the delusional system has obtained. This may be put in other words, using the illustration of Case 2, who said that her mind was divided into two parts—a "sensible" and a "bad" one. At the beginning the "sensible" part is by far the larger and can easily control the aberrations of its fellow, but as time goes on the former shrinks *pari passu* with the increase of the latter and the symptoms mentioned appear.

The whole process is very gradual, hence the name "chronic." It is not strictly continuous, as there are periods of remission and exacerbation, with again subsidence, but viewing the illness as a whole it steadily increases in intensity. Having reached its maximum, the severity of which varies in different subjects, the condition remains stationary for years. Possibly I have not observed the cases for a sufficiently long time, but I have not seen the development of delusions of grandeur followed by dementia as described by some authors.

Diagnosis.—Hallucinations occur in all forms of mental disease and are probably the commonest symptoms met with. It is therefore evident that the mere presence of hallucinations will not suffice for diagnosis. In chronic hallucinatory psychosis, however, the disorder begins with hallucinations, and the patient outside the sphere of these appears to be normal, so that in the early stages the diagnosis will be simple. In the later stages, this will have to depend to some extent upon the history of the illness and may not be so easy a matter. But if the delusions appear to be the logical outcome of hallucinations which have preceded them, and that if outside the diseased area composed of hallucinations and delusions the patient appears but little abnormal, the diagnosis will be made.

Differential diagnosis.—If these main points are remembered there will be little difficulty in excluding general paralysis, the manic-depressive group, true melancholia and the secondary and organic dementias. Neither need acute confusional insanity, also called acute hallucinatory insanity, detain us as it is altogether different. Chronic hallucinatory insanity of alcoholic origin has many points of resemblance to the disorder under discussion, but in the former there is a history of alcoholic excess for a long period, in the latter this is wanting. Moreover, in the alcoholic, the delusions of persecution are more pronounced and appear at the same time as the hallucinations.

In practice, however, the temptation will be to include the cases we have been considering under the heading of dementia præcox, or paranoia.

To take dementia præcox first. No doubt many cases similar to those I have described have been squeezed into this category because there was no other place for them. It has ever been the bane of our specialty that it has suffered from nosological fashions. When a certain clinical entity looms largely before the eyes of the practitioner it becomes the universal disease. To-day it is dementia præcox, and I think it will be admitted by all that we have to be constantly on our guard so that we do not diagnose dementia præcox in cases which our present ignorance should urge us to deem as unclassifiable. There are really very few points of resemblance between chronic hallucinatory psychosis, as I understand it, and dementia præcox. It is true that in the paranoidal form there may be delusions of persecution with hallucinations.

But these delusions are not systematised nor are they the logical outcome of the hallucinations. They are constantly changing and have that "freaky" character common to dementia præcox. Furthermore, a typical case of this latter disease with its emotional apathy, lack of judgment, scattered ideation, and all the peculiar behaviour such as impulsiveness, negativism, stereotypy, mannerisms, monkey tricks and the rest, bears no resemblance to one of chronic hallucinatory psychosis.

Lastly there is the question of paranoia, and this cannot be dismissed so summarily. In both paranoia and chronic hallucinatory psychosis the beginnings of the illness may be unnoticed for years by the friends of the patient, the evolution is slow and gradual, and outside the sphere of the disorder the patient is well conducted, collected and rational in conversation. In neither, even after long periods of time, does dementia supervene. There is, however, this great distinguishing feature—that paranoia is characterised by the absence of hallucinations, and in chronic hallucinatory psychosis the presence of hallucinations is the main symptom. I could give numbers of references from various writers to show that they regard almost as pathognomonic of paranoia the fact that hallucinations are absent. Perhaps one will suffice: Kraepelin, in discussing the differential diagnosis of genuine paranoia and dementia præcox, states that the former do not suffer from hallucinations.(6)

Someone may say, "Why not call this new disease 'hallucinatory paranoia'?" and in some ways such a course would be plausible, but it seems to me contradictory to set out to describe an hallucinatory form of a disease which is characterised by the lack of hallucinations.

Before concluding the differential diagnosis reference must be made to descriptions given by various authors of disorders which more or less resemble chronic hallucinatory psychosis.

From a large list I have selected the following three:

First of all must be mentioned the Laségue-Falret syndrome, which dates from the middle of last century. This consists, to put it very briefly, of four stages. In the first, delusional interpretation of the environment occurs; in the second stage hallucinations develop; in the third stage disturbances of general sensibility arise; and the fourth stage is characterised by the formation of delusions of grandeur.

Later on came Magnan with his description of *délire chronique* This, like the last, has four stages also: *First stage*—suspicion of the environment with delusions; *second stage*—hallucinations with systematisation of the delusions; *third stage*—delusions of grandeur; *fourth stage*—terminal dementia. Most writers agree that a typical example of Magnan's disease is rarely seen, and regard it more as a schema to which various cases approximate more or less accurately.

(6) *Dementia Præcox*, Kraepelin, translated by R. Mary Barclay, p. 276.

Finally mention must be made of Kraepelin's paraphrenia, a full account of which is given as the terminal chapter of Dr. Mary Barclay's translation of Kraepelin's dementia præcox. This conception seems to be founded largely on Magnan's *délire chronique*, which it resembles in many respects.

Time does not permit of a detailed differential diagnosis of these from chronic hallucinatory psychosis.(7) It will, however, have been noticed that in them delusions of persecution form the main feature of the illness and that these delusions appear prior to the appearance of the hallucinations, whereas in chronic hallucinatory psychosis the reverse is the case. Furthermore, in the latter delusions of grandeur and terminal dementia do not occur.

Prognosis.—The earlier the case is seen the more hopeful is the outlook. After the development of delusions little can be done to avert chronicity. The general health is not affected and there appears to be no danger of terminal dementia.

Treatment.—In the early stages benefit is sometimes obtained by change of environment. Rest from work, freedom from anxiety and change of air and scene should be advised; these measures, with plenty of nourishing food, relief of constipation if present, tonics and an occasional hypnotic to ensure sleep may do good in some cases. I have not much faith in the efficacy of any particular drug to remove hallucinations. Small doses of the bromides or hydrobromic acid have been recommended. If the patient does not improve under this treatment a thorough mental examination must be undertaken. This will, almost certainly, reveal a conflict, which, with repression of the same, is causing the dissociation. Even then the work may not be at an end and a psycho-analysis will be necessary. The difficulty at the present time is to get in touch with the patient in the primary stage. Even now, however, some do come to the mental out-patient departments of the large hospitals and in the future many more will be met with in the clinics. When the patient reaches the stage when he has to be certified the whole morbid state has become so fixed as to be little affected by analysis in the majority of cases. Even then, however, this should be undertaken with a view to the study of the mechanism of the process. If it be generally confirmed that dissociation is the pathology of the condition then we might expect that hypnosis would be beneficial, seeing that Morton Prince produced recovery in the classical case of Miss Beauchamp (a dissociated personality) by this means. On this matter I cannot speak from personal experience.

(7) This matter is discussed in considerable detail in a paper by Roxo on "Délire Systematisée Hallucinatoire Chronique," read at the International Congress of Medicine in London, 1913, and published in the *Transactions*, section "Psychiatry," Part II, p. 104.

When the condition has become chronic little can be done save to treat the patient on general lines, and by means of suitable occupation to prevent him from becoming worse.

In conclusion, I would venture to suggest that the subject of the hallucinatory insanities should receive more attention in England in the future than has been the case in the past. If the medical journals of other countries, notably those of France, are studied numerous papers and discussions on these matters will be found in them, and yet in this country they are rarely mentioned. The subject is undoubtedly a difficult one, but it appears to me that out of the mass of somewhat confusing material the disorder I have tried to describe can be separated as a definite clinical entity. It may seem to some a matter of indifference what nomenclature is adopted. This, however, to my mind is most important, for with recognition and naming come investigation on definite lines.

I am therefore expressing the hope that others will follow suit on the same lines, and that by additional intensive study many gaps in my description will be filled in, and that eventually with timely recognition early treatment may lead many patients to recovery.

Head Injuries in Relation to the Psychoses and Psycho-neuroses.(1)

By RICHARD EAGER, O.B.E., M.D.Aberd., Senior Assistant Medical Officer and Deputy Medical Superintendent, The Devon Mental Hospital, Exminster; late Officer in Charge of The Mental Division, The Lord Derby War Hospital, Warrington.

UNTIL the outbreak of hostilities in August, 1914, the number of cases of mental disorder associated with head injury investigated by any one individual must of necessity have been very small. Hence the sparcity of literature on this subject. Never before the outbreak of the late war have so many men been engaged in armed conflict against one another, and never before have arms of such a destructive kind been employed.

Comparatively suddenly, therefore, we are brought face to face with a large number of men receiving terrible injuries to the skull and its contents, the like of which has never before been known. Thanks to the high standard of efficiency of modern surgical methods a large number of these cases have been restored to a condition fitting them to become useful citizens, but on the other hand the ultimate condition of some has not been such a favourable one, and it is with regard to these cases that I am confining my remarks in this article.

For a period of two years, during which I was in charge of the Mental Division, comprising 1,000 beds, at The Lord Derby War