yet it inevitably leads, by stressing points of resemblance, to the neglect of other points of difference, the importance of which is not at present realised, and so tends to check the widening of the field of research. It is frequently found that what has been regarded as a disease entity is really only a syndrome which may occur in a variety of conditions of different ætiology, and there is often a risk that new discoveries may be forcibly fitted into a system, when a revision of the system is required to fit the facts.

The second part deals with the application of this view to the present classification of nervous diseases.

The organic nervous diseases can be most satisfactorily classified on a sound basis, but even here there is much divergence of opinion as to the limitations which should be placed between different entities —as in the present tendency to regard tabes and general paralysis as a part of a whole, including many transitional and divergent forms of neurosyphilis. When we consider the neuroses, we find that the sharp differentiation of these not only from one another, but also from organic disorders, leads to a neglect of many points common to both, and that there is often a complete series of transitional forms between the two, the bridge between them being constituted by vaso-motor and endocrine disturbances. The recognition of this is hindered by the retention of points of view belonging to an out-of-date pathology. The author suggests that the distinction should be drawn, not between organic and functional generally, but between those diseases that are due to a definite and known organic cause, and those which he would describe as psychogenic on the one hand, and functional on the other, the former being those in which psychological causes and effects predominate, the latter being those in which actual disturbances of function, either of the vasomotor mechanism or of the nervous system, are present, but are attributable to psychological causes. Finally he emphasises the frequency with which actual organic lesions are accompanied by disturbances of either a functional or a psychogenic nature, which are too often overlooked by those whose attention is directed to the organic factors in the disease. M. R. BARKAS.

On "Depersonalisation": A Clinical Study [*Über "Depersonalisation": Eine klinische Studie*]. (*Zeitschr. für die ges. Neur. und Psychiat., February*, 1923.) *Giese, Hermann.*

As the title implies, this article deals with the subject primarily from the clinical standpoint, touching only secondarily upon the psychological aspect, which has been so much emphasised in recent literature, to the neglect of the study of inheritance and constitutional factors.

Four cases which show this syndrome of depersonalisation are described in considerable detail from the point of view of the clinical psychiatrist, without any very searching investigation of their individual psychology. From the history as given by the patients and their relatives conclusions are reached as to the character types and constitutional tendencies previous to the illness, and the form taken

by the neurosis or psychosis is correlated with these types. The author considers with Heymans that there is a special type of person, characterised by emotional instability, variability of mood, transient fits of disinclination for regular work, in whom the syndrome of depersonalisation is particularly likely to occur. In the four cases described it is an accompaniment of (1) a typical neurasthenia, (2) mild depression coloured by the depersonalisation, (3) severe manic-depressive psychosis, in which the depersonalisation appeared only in the depressive phase, (4) severe manic-depressive psychosis with delusions of " possession " by the devil, in which the feeling of possession was connected with the sense of automatism characterising the depersonalisation syndrome.

The syndrome of depersonalisation is described under the headings given by Schilder in his monograph on *Consciousness of Self and Consciousness of Personality* as follows:

(1) Alterations of perception (of the external world and of the patient's own body): The feeling that people and objects of the environment are strange, not real; that the body is changed; its various parts are larger, double, do not belong to the body; that the patient is no longer the same person.

(2) Alterations in emotions: sudden attacks of anxiety, self-reproach, seclusiveness, fear of illness or insanity, and the feeling that real emotion is absent and any show of emotion is only pretence and unreal. There is no loss of insight, and the condition is subjectively painful and distressing to the patient. Unlike the depression of the melancholic it is readily influenced by discussion, and its lack of real foundation is appreciated by the patient.

(3) Alterations of ideas and memories: There is a subjective retardation of thought, so that the patient complains of inability to concentrate, while there is none of the objective retardation of the melancholic. Memory is objectively intact.

(4) Intellectual defect is never found, self-criticism is unimpaired.

(5) Disturbance of will and of the personality as a whole: there is a subjective inability to execute the commands of the will, which is felt as a painful failure of effort. Obsessive ideas and impulses to do something wrong, compulsive self-observation and the feeling of automatism are prominent, and these changes of the will and personality continue in dreams, and lead to the sensation that the sleep is unreal and brings no rest.

(6) Physical disturbances: various neurotic pains, especially migraine, and increased vasomotor sensitivity; subjective disturbances of vision are especially frequent.

The disturbances of vision are considered in some detail, quantitatively and qualitatively; in all the cases objects appear misty, dull, vague, unreal, or they may be at times doubled, or larger or smaller than normal; or there is a feeling that the eyes are forcibly drawn to the left, or that the visual field is extended to include objects directly behind the patient. All these abnormalities are wholly subjective, no corresponding objective findings appearing in any case; and when this is pointed out the patient accepts the fact, but still maintains that the subjective sensation persists. It is not the raw

material of the sense perception that is affected, but the perception is felt to be unreal by the central ego; it is not united to the whole personality, and is accompanied by a sense of inner disharmony. The patient with depersonalisation shows a typical sense of the incompleteness of the experience and the constant compulsive directing of consciousness to this imperfection. Though there is in some of the cases a possibility that the ocular symptoms may have developed on a site of lowered resistance where there has previously been some slight organic defect, it seems more probable that the symptoms—migraine, squint, etc.—were primarily the result of defect of attention, lowering of psychical energy, and the distraction of attention from the perception itself to the incompleteness of the act of perception.

The same process is seen in the alteration of the personality; there is a sort of dissociation between groups of mental energies in the field of consciousness, so that one part of the personality can look at another part and feel it to be distinct and strange. The similarities and differences between this condition and that in hysterical dreamy states, hypnosis and schizophrenia are discussed.

Psychological theories of depersonalisation are briefly considered, from that of Janet, who regards it as a kind of inward perception of a disturbance of the "*fonction du reél*," to that of Schilder, whose account seems to the author the most satisfactory. He describes the condition as one in which the individual feels himself to be fundamentally altered from his previous state of existence, the change involving both ego and the environment, and bringing it about that the individual does not recognise himself as a personality. His actions seem to him automatic, and he observes his own actions as an onlooker. The world seems strange and new to him and has lost its reality. It is the self, the personality that is altered, and the unchanged central ego is aware of this change in the self, which is no longer united as before in its experiences. The sense of reality depends on the complete absorption of the ego in its perceptions—thinking, judgment, memory and ideation; and the sense of unreality depends on a failure of this, and the compulsive awareness of that failure, which is felt to be painful.

He then attempts to discover the causation of the state of depersonalisation, and rejects the view that it results from a mental conflict and is a flight into disease, like other neuroses. The attacks occur without definite mental trauma, and when such traumata occur the patients react in other ways, as with a hysterical attack and amnesia, or a state of confusion. The character of the depersonalisation syndrome is regarded as being against the theory that it is a refuge from conflicts. He therefore concludes that while it occurs chiefly during times of emotional disturbance, usually depression, arising from psychological or external conflicts, the determining factor in the choice of this mode of reaction is a constitutional biological tendency (Anlage). In persons with this tendency the syndrome may appear under any disturbance, toxic or emotional, which lowers the unifying forces of consciousness. The appearance of the syndrome in various toxic or endocrine disturbances, and in organic focal lesions, cerebral tumours, encephalitis, epilepsy, and dementia.

præcox, is quoted as bearing out the view of Schilder that organic focal lesions may, under some circumstances, disturb psychogenic cerebral mechanisms.

Finally the differential diagnosis of the syndrome from hysteria, the sensitive "reaction type" of Kretschmer and schizophrenia is discussed, and a case of the latter disease is quoted at some length, in which depersonalisation appeared at an early stage before severe deterioration and dissociation of the personality had developed.

M. R. BARKAS.

True Melancholia and Periodic Asthenia [*Melancholie Vraie et Asthenie Periodique*]. (*L'Encéphale, December*, 1922.) *Benon, R.*

The author controverts the view that true melancholia is either part of a periodic insanity or of dementia præcox. This view of Kraepelin is seductive, but incorrect, and mixes two essentially different syndromes.

The periodic melancholia of authors is asthenia. The fact that true melancholia is liable to relapse, although rarely, has helped this confusion. True melancholia commonly occurs in people between 40 and 50 years of age, but can occur in young subjects. The onset is gradual, and the cases have a feeling of sorrow and anxiety. The grief is sometimes associated with the idea of past evil, and sometimes with the idea of future trouble, in which cases anxiety is more prominent. A sense of anguish is more marked in these cases as compared with the resignation of ordinary melancholics. True melancholia progresses slowly and recovers slowly, and recurrences are rare. A case, exceptional in this respect, with four relapses is described. Periodic asthenia, on the other hand, is not an emotional disturbance, but a trouble of nerve force (dysthenia). Hallucinations and mental confusion are rare, and agitation is seldom marked. Recovery occurs suddenly and relapses are common.

A. A. W. PETRIE.

Studies of the Complications and Mental Sequelæ of Lethargic Encephalitis (Bradyphrenia) [*Études sur les Complications et les Sequelles Mentales de l'Encéphalite Epidemique (La Bradyphrenne)*]. (*L'Encéphale, July*, 1922.) *Naville, F.*

All serious infections can be accompanied by various mental phenomena, and also by muscular tremors, pupillary disturbances and ocular palsies, but encephalitis lethargica, while it may show similar disturbances in the early stages, shows certain mental complications which rarely occur in other diseases. Cases are quoted of the various psychoses which have followed encephalitis lethargica, such as manic-depressive and confusional insanities, Korsakow's syndrome and dementia præcox, but these sequelæ are noted as exceptional, although an initial delirium is frequent and mental prodromata are commoner than in other diseases. Insomnia in adults may be troublesome and may persist for as long as a year, and is often associated with a dreamy state during the day. In children the disturbed sleep is characteristic, and may be associated with