A CONTRIBUTION TO THE PSYCHOPATHOLOGY OF MANIA.

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I AM not amongst those who believe that a complete understanding of the manic-depressive states can be reached within the field of psychopathology. On the other hand, it is quite impossible to render intelligible the behaviour, thoughts and feelings of these patients without reviewing the changes which occur at the psychological level. Instead of baffling myself by thinking in those speciously convenient terms "functional" and "organic", I find it more satisfying to look at the patient from the Meyerian point of view; that is to say, as an integrated series of functional levels—an extension, if you like, of Hughlings Jackson's and Sherrington's well-known conceptions of central nervous function, downwards to the more archaic autonomic level (and all that is implied by that), and upwards into the more recently evolved realm of function, of which we can at present speak only in psychological terms, because we do not know enough to speak of it in any others. The disturbance is of the functioning organism as a whole; and I believe that the clinical picture depends to a large extent upon the levels where the disturbance is greatest. Unless all human values go by the board, however, we shall always require the aid of psychopathology to enable us to reach a complete understanding. Frustration will always produce sorrow, or a state of which sorrow is an important component; and achievement will always produce elation or one of its allied states. The converse of these propositions is not necessarily true; and although there may be strong presumptive evidence for doing so in individual cases, it is not necessarily correct to assume that because a state of joy or sorrow exists, it must have been preceded by some achievement or frustration as the case may be. To me, there are two essential parts of the problem in any given case. The first—and more difficult—is, Why does the emotional swing arise? And the second is, To what extent is the psychosis intelligible by considering the emotional change in relation to the sum total of the events that go to make up the patient's life? This involves a process of empathy—what the Germans call *Einfühling*—and it is relatively easy for those of cyclothymic disposition to do it. The crux of the situation is therefore the emotional change; and although its origin may not always lie at the psychological level—in fact in the extreme sense I suppose it never does—

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I am much impressed by the psychological principle implied by MacCurdy's explanation of certain manic states. He says, in effect, that they do arise from achievement, from fulfilment—if we *must* use analytical terms—of an unconscious wish, in respect of which there has been and still is considerable conflict; and that the manifest thought content may be in part a secondary phenomenon, and in part a fragmentary disguise of the wish. It does not matter whether the wish is conscious or not; nor, so far as emotional value goes, does it matter whether it is achieved in fact or in phantasy. A biological urge of some kind has been fulfilled, or what is psychologically very similar, is on the verge of practical fulfilment; and the natural concomitant of that fulfilment is joy or elation. It needs but little introspection and observation to be assured of the naturalness of this reaction; and the benign qualities, which we expect, are present in proportion to its purity. It may be argued that the schizophrenic also secures achievement in phantasy; why then is he not elated? Does not the answer lie in this: The manic patient's thinking and behaviour are gross; they are open for all to see; he is frankly and openly erotic or obscene or aggressive, and the more acute the attack the more gross are his thoughts and behaviour. There is no disguise—or perhaps it would be more correct to say the more acute the attack, the less the disguise. Symbols are practically unnecessary for the manic patient; so is projection; he may transfer his affect, but he does not disguise it. He is in fact uninhibited to a degree. As MacCurdy says, where there is no repression, there is no need for disguise. If one likes to put it so, the material with which the manic patient has to deal is not so deeply suppressed, is more ordinary, less archaic, less perverted, less worthy of guilt, or less infantile, according to the shibboleths of one's own psychological beliefs. Needless to say these views are quite incompatible with those of Freud and Abraham, who, although they differ as to the erogenous zone concerned, are agreed that the manic is narcissistically fixated. Anything less narcissistic than a full-blooded acute mania I have never seen. The whole keynote of the manic is that he is ordinary. He is concerned with real things, the most clamant of which is his own real emotion, with which he cannot deal if, at the same time, he is to keep his thought and behaviour directed towards ordinary everyday external goals.

So overwhelming is his sense of impending achievement that if he gives himself up to his emotion he passes into a state of manic stupor; if he does not give himself up to it he has not sufficient urge towards external things to attend to them properly, for they cannot serve his purpose. Now it is a clinical truism that in the less severe and less pure form of mania, the course is longer and the result less satisfactory. It is in these forms, too, that one sees the elements of irritability, quarrelsomeness, and that awkward paranoid tendency characterized by complaints and half-truths. I believe that these states have a quite different origin. I cannot accept White's formulation of a " defusion " of affective drives to account for, say, anger in mania; and I believe that there

are elements in the ætiology of these mixed states which are not present in the pure culture of the condition. The attempt to render these impure forms intelligible by the application of a psychopathology that was never evolved from the study of them has done much harm to a valuable formulation. Superficially they resemble true mania, because there is the restlessness, the overactivity, over-talkativeness, the apparent contact with reality without gross oddity of thought content, without gross confusion of intellect. I have not observed, however, that the quality of emotion is one of real joy or elation. It is, no doubt, due to a sort of implied acceptance of McDougall's delightfully simple explanation of mania as an overactivity of the instinct of self-aggrandizement that the admixture of anger and elation has come to be regarded as being of no clinical importance. It is much easier to believe McDougall than to argue with Freud.

Now, although these atypical, but very common, manic patients are not confused in the sense of disorientation, I have found that the application of the finer intellectual function tests often reveals a sufficient evidence of primary disturbance at the physiological association level. Obviously such a disturbance may occur in a person who is so constituted that he possesses a " pattern " of manic reaction within him ; and this pattern may well be released to take command of the final common path by virtue of changes which are initially a matter of toxæmia and lower level release in the neurological sense ; but which, later on, involve additionally the same psychic and biological processes of which I spoke earlier. Thus clinically we get, what we often see, a smouldering hypomania bursting forth into a not quite pure acute manic attack, sometimes passing, if—as my biochemical friends would say—the changes become irreversible, into a state of chronic mania. To this there is no end save by the operation of the law of habit, a gradual withdrawal from true contact with reality, resulting in a sort of disuse atrophy of the adaptative mechanism, which, in their wisdom, our nosological experts of thirty years ago very properly scheduled as secondary dementia.

Discussion.

Dr. HELEN BOYLE said she wished, at the outset, to congratulate the President and Dr. McCowan on the very interesting sessions the Association had had this year. They had been of outstanding value to those who came to the meetings mainly to learn, and most of the papers had been so put together that those present had been able to grasp a great deal of what the papers were intended to help the hearers to understand.

In accepting the honour of contributing to this discussion, she wished briefly to refer to observations on the clinical side, about which she had previously spoken at a meeting of the Royal Society of Medicine in 1930.

What had struck her most in listening to the discussion had been the difficulty in understanding exactly what was meant by manic-depressive insanity. In the discussion involutional cases had been included, also psycho-neurotic cases, while some included arterio-sclerotics and others excluded them. In the discussion it had been difficult to know what cases could justly be referred to this category. Some time ago Dr. Mapother had said that the difficulty about all the psychoses at present was that data were not yet available to name them efficiently, and all that could be done was to talk about certain syndromes of symptoms, and adhere as carefully as possible to those. She suggested—speaking as a clinician—that there were certain cases showing manic-depressive symptoms which could be divided into separate groups. Some of the cases she would speak of had been observed for over twenty years. It seemed worth while to consider clinically, and more fully than was usually done, the links between a large group of manic-depressive or cyclothymic states, and cases of endocrine, particularly thyroid gland disturbances, which latter were so closely associated with the whole vegetative nervous system.

Secondly, there was another—and she thought a smaller—group of cases about which also she would like to hear opinions of members, a group which appeared to be closely associated with hyperpiesis and faulty elimination. These cases gave a history of recurring attacks of insanity, in some of such a severe type as to necessitate certification. In one such case the patient had been several times under care following certification, and in the mental hospital the trouble was diagnosed as manic-depressive insanity, therefore the diagnosis did not rest on her opinion alone. The patient had been acutely suicidal and at times excitable. This patient came to the speaker when an attack was felt to be coming on, and she told her it was better to go back to the mental hospital and be cared for there. However, she refused. Her blood-pressure was over 200 mm., she had an enlarged heart and also renal deficiency. The speaker tried to reduce the blood-pressure, and the patient told her next morning that that was what everybody tried to do, and it made her worse. Accordingly she ceased giving the woman depressants, and substituted tonics. It was found, however, that the blood-pressure could be reduced without mental disturbance by giving steam baths, disinfectants, and very free supplies of liquid to drink. It seemed true that that patient had needed the high blood-pressure, until elimination was promoted in other ways. On a later occasion she nearly had a recurrent attack; she went down to a hydro-therapeutic centre, and though the patient's doctor there was written to, he evidently thought little of it, for he reduced her blood-pressure, and with dire results, worse only being avoided by reversal of the treatment. It needed to be remembered that even a person aged thirty-five might require, in order to live comfortably, to have a high blood-pressure; that should be borne in mind when treating some cases, particularly those who showed any other signs of intoxication. It was explained to this patient that she might die younger if she did not have her blood-pressure reduced, but she replied that her terror was lest she should become insane. There was an optimum

blood-pressure for these cases, and usually it was between 187 and 200 mm., and when treatment was given for hyperpiesis this might not be recognized. Steam baths were preferable to dry heat for elimination. Some observers expressly excluded arterio-sclerotic cases from the manic-depressive group, but she did not know on what grounds.

The other group of cases appeared to have too close a relationship to thyroid disturbances for this to be a mere coincidence. Kraepelin had pointed out that in manic-depressives one met with conditions which were almost myxœdematous, e.g., in the depressed phase the hair might become thin and lustreless and the nails suffer, and that at a subsequent stage the hair and nails were restored. In comparing the phases of cyclothymia with brain disease and hyperthyroidism complicated by, as Dr. Golla said, " the exhaustion asthenia following on the excessive metabolism ", it was impossible not to be struck by the common pattern. Dr. Golla had further said of the mental symptoms of brain disease that " they resemble in many ways those of manic-depressive insanity " ; the same authority said " symptoms of hyperthyroidism are not infrequent in manic-depressive insanity ".

Some common factors between hyperthyroidism and the manic-depressive syndromes were the following : (1) Both were more common in women than in men. (2) The usual age of onset was almost the same. (3) The functional activity of the normal thyroid showed annual fluctuations, and many manic-depressive patients did the same. There were cases which had attacks in springtime, so that one reflected on the association in the other group with defective elimination. In this group the cases might start young. There was a tendency to regard the enlargement of the thyroid gland in girls as a physiological enlargement, and to feel that there was no need to pay attention to it. She would suggest that some were associated with early cyclothymic states. Her observation had been that these girls were extraordinarily keen, and, as a rule, very intelligent, and she—Dr. Boyle—dissociated herself from the statements sometimes made that there was a large amount of mental defect in subjects of manic-depressive insanity. She would have said, rather, that the manic-depressive syndrome was somewhat conspicuously associated with brilliance and capacity in the mental sphere, though her acquaintance had been largely with cases of the milder type. The cases she had seen of enlarged thyroids at puberty were, in many instances, daughters of professional people, who were keen upon the examinations being passed, and on their daughters doing well in academic life. She wondered whether it was possible that in those cases there was a great lashing-up of the whole organism to pass the examinations and do what was required with increase of thyroid activity. Might they not feel that they were faced with a very serious situation ? The patients were usually good at games, as well as at academic tasks, and they exhausted themselves, so that they fulfilled Dr. Golla's description of the asthenia which succeeded excessive metabolism. A theory she had, from observation, was that the activity of the thyroid and endocrines generally fluctuated, and, following a period of tiredness and asthenia, the girl lashed herself forward again, and once again she suffered from the same asthenia until it might pass from that to cyclothymia and manic-depressive psychosis. She had seen that happen several times, and she thought the appropriate treatment of rest and relief from all anxiety should be given to these girls, as contrasted with the neglect which was so often their lot. (4) There was a tendency to glycosuria in both. (5) A large thyroid might appear in both, or might be absent in either. (6) Palpitation, or a rapid heart-rate, might be common to both, as also was (7) tremor.

The so-called " physiological enlargement " of the thyroid in adolescents was not an uncommon occurrence. It seemed to her to synchronize with a physiological alteration in mood—a fact which might be significant. These girls were usually conscientious and hard workers ; some of them developed a cyclothymic temperament later. She asked what was the connection here, if any. She submitted the possibility of an intense desire to excel, coupled with anxiety as to possible failure to attain to the desired degree of excellence. Dr. Crichton Miller had

suggested as a matter of speculation concerning this disease that periodicity appeared to be a physiological rather than a psychological quality, and that it was therefore reasonable to look for a somatic rather than for a mental explanation. Other observers were making observations on similar lines.

Dr. TÓMASSON said he would like to make a few remarks on Prof. Mayer-Gross's paper on irritability. It was a well-known physiological law that there was an inverse relationship between the psychic activity and the peripheral innervation. That was demonstrated by the fact that one could not, at the same time, carry heavy weights, run very fast, and be absorbed in intense psychic work, such as the solution of philosophical or mathematical problems; similarly, while absorbed in a scientific problem one might not pay attention to coldness or stiffness of feet until about to stand up. That law applied to manic-depressive patients as well as to other people, and he thought it might help to explain a number of the phenomena of the psychoses. The substratum of the peripheral innervation, which was biochemically the sodium-calcium ratio, was, as he thought he had been able to demonstrate, altered in such a way that the peripheral innervation of these patients must be diminished. The consequence was that (1) fewer peripheral impulses were conducted centrally to the brain; (2) fewer central impulses were conducted peripherally. If fewer peripheral impulses reached the brain, the processes of the brain were less interfered with from without, the stream of thought was more free, and the faculty of co-ordination was increased, as in mania, and so there occurred an excitability of the patient. Variations in the innervation explained variations in the irritability. *Mutatis mutandis* the same applied to the depressions. The concentrated attention of these patients might be regarded as an increase of cerebral activity, and a greater capacity to concentrate on a subject. It might also explain the irritability of the depressed, which, if closely studied, seemed to have a different psycho-pathogenesis to the irritability of manic patients. In both phases irritability could be considered as the sequence of humoral deviations found in these patients, and therefore they showed the importance of investigating these deviations.

Dr. AUBREY LEWIS said: My remarks will be of a general kind. The first point is that I think there is an advantage, for research, in making a distinction which, for clinical purposes, we should not make, between the psychology of the previous personality, that of the attack as such, and of the psychogenesis; they are often dealt with as though they were inevitably part and parcel of the same thing. Clinically this is a justifiable and useful assumption, but I think it can lead one astray in investigation.

1. It is perfectly true that the previous personality often shades into the attack, which seems only an exaggeration of it. Valuable as it is to study and emphasize this relationship, we must reckon with the many cases in which there is no apparent consonance between the tendencies and traits evident prior to the outbreak, and those manifest during it; this is true of the type of personality as a whole, and of such special traits as sensitiveness in relation to paranoid ideas and so forth. My own opinion is that there is nothing by which we may differentiate the normal, i.e., pre-morbid psychology of the person who will have a manic or depressive attack, from the psychology or the structure of the similar normal personality in those who will never have an attack. It is true that there may be dispute about what is normal and what is healthy, but so long as personality remains within the commonly accepted bounds of the normal and healthy, i.e., so long as there is not incipient or established illness, there is nothing psychologically recognizable that we may take as characteristic of the manic-depressive illness. The medical value of personality, psychology and psychopathology is in the field of retrospective construction, and it is dangerous to use it as though there were always psychological instead of biological continuity. Sometimes there is, but often there is not.

2. Psychogenesis should not be taken to be psychopathology set forth as an explanation of causes. Psychopathology, in one or other of its aspects, cannot be more than a partial view of the phenomena, i.e., the phenomena interpreted or described in the light of psychological concepts; obviously such an interpretation can be made consecutive and even explanatory, but however artificial or however useful such an explanation, it does not enable one to distinguish the indispensable from the trivial causes, or the common causes from the infrequent ones, using the word "causes" as synonymous with preceding happenings in a connected sequence.

It has often now been pointed out that psychological connections may be comprehensible but not necessarily causal; constancy and specificity should be the characteristic of the "causal" connections, otherwise every case is inevitably psychogenic; the word loses all precision of meaning, and psychopathology becomes the slave of forced ætiology.

3. The phenomena of the illness itself are commonly taken to be contrasted in mania and depression. I think that to limit the illness to pure forms of these conditions is to exclude much that is relevant, but in so far as one does this, i.e., limiting, it is still, I think, useful to see in what respects they are alike. Their differences leap to the eye; they are dramatic; but their points of similarity are numerous, if unobtrusive. Some of the French writers, like Neuberger, have dwelt on this, but they do not include all the points of identity. Deron gives a most valuable analysis of the psychological phenomena of mania in which, without referring to the likeness, he often seems to be describing melancholia. The chief point lies in the restlessness and activity of thought, turned, in depression, more inwards, but just as striking, reported subjectively, and as far removed from emptiness of thought or apathy as in mania. The frequent recurrence of emotionally stressed ideas is common to both; in mania, of course, it can easily be overlooked, but is usually found when looked for. In both there is distractibility and difficulty in remaining at a purposeful task which brings one into relation with the environment; the distractibility of the depressive must often be inferred from his wandering glance, his attention to trivial perceptions, the increase in his slowness when some ordinarily negligible external occurrence breaks in upon the fragile sequence of his more ordered and purposive behaviour. In both there is much aggression and a tendency to paranoid distortion of experience, ideas of reference and influence, and much demanding of attention. These phenomena are not invariable in either condition, but occur with such frequency, when looked for, as to justify the parallel, or rather the assertion that they represent the same psychological happenings. This may be said, too, of the hypochondriacal preoccupations, the anxiety and the sometimes trenchant self-criticism. I would repeat that I am not asserting an identity of mania and melancholia at all points, which would be absurd, but an identity in respect of certain psychological happenings, which are, superficially, different. Benon, on the other hand, denies that they are polar contrasts, much less similars, and would oppose hyperthymia to depression.

I think there is a risk of making psychopathology too biological while we are still in doubt about the biology. I question whether we can fructify biology at present by our psychological methods; we cannot hasten ahead of biology on its own ground; yet much of the psychopathology of melancholia, for example, is based on what are really biological conceptions of instincts and their development, which the biologists do not accept or would not extend to the human fields in which we use them. We have no more business in psychopathology to hypothesize biological phenomena than to do so with physiological or chemical ones. The dangers of such methods are seen in some of the psychopathological explanations of the tendency to periodical recurrence in manic and depressive attacks.

Also I think that where the quantitative deviation from normality is considerable, qualitative deviations inevitably enter. The derivation of the morbid phenomena from the quantitative heightened affect, which is didactically so useful an approach, is subject to error through assuming that there are no qualitative, but only quantitative variations in the manic-depressive conditions. If we take depersonalization

or hypochondria, the fallacy inherent in this common psychopathological assumption is well illustrated. I cannot now develop in detail the positive side of this view, but it is valuable in studying the particular aspects of the affective syndrome, apart from the restricted disturbance of affect.

Dr. A. A. W. PETRIE said that he would like to ask a question of Prof. Mayer-Gross, and he had hoped that the meeting might have heard the same thing from Dr. Tómasson, in regard to some possibile biochemical explanations of at any rate some of the changes in irritability. To give point to his questions, he would mention some cases which he came across many years ago. A colleague of his, Dr. J. J. M. Shaw, was doing some work on epilepsy. In order to study the calcium metabolism of these cases, he gave them small doses of oxalic acid to lessen the calcium metabolism. The result, while diminishing the fits, was a notable and extraordinary irritability, so that the staff who supervised the cases asked that the unfortunate patients under their care might not be given that mixture. The alteration of the calcium metabolism in those cases induced a tremendous irritability ; and in order to alter the pH of the blood—it was before much of the modern work had been done—he gave sodium carbonate. That came to be known as " the good temper mixture ", owing to its greatly diminishing the irritability. That led the speaker to ask Prof. Mayer-Gross regarding some of the biochemical changes which might be underlying factors in this variation in irritability.

Prof. HENDERSON said the discussion had been concerned with a very big field, and to enter upon it fully now would take the members too far. He felt the truth of Dr. Skottowe's remark, that it was easier to agree with all the speakers than to argue with Freud or other authorities.

He had enjoyed the discussions very much, and had learned a great deal from them. He wished to express his thanks for the arrangements made for the meeting, and to those who were responsible for bringing up this topic for discussion.

Dr. GUIRDHAM, in reply, said he was glad Dr. Skottowe raised the point about the numerical standard of diagnosis being no substitute for clinical diagnosis. He, the speaker, thought people using the Rorschach test had laboured too much the fact that it was essentially a psychometric test ; it was held by Beck and others that it was not a subjective test. What one was studying was the organism reacting as a whole, and that was the attitude he himself took, because, any system of philosophy being a history of the clash of conflicting temperaments, a standpoint was chosen which Nature had ordained. Mathematical factors in the Rorschach test were of secondary importance, and he did not regard them as anything but a convenient method of assessing what was essentially derived subjectively.

Dr. TÓMASSON, in reply, said he thought the irritability coefficient was primarily a calcium-sodium ratio. Some years ago he himself did some experiments with oxalic acid, and he knew it lowered the calcium of the serum, and increased the sodium ; but those changes were of only very short duration. It seemed to be necessary to give the oxalic acid every two hours throughout the day to keep the level low. He did not continue it longer than a few days, as the toxicity of the oxalic acid was so pronounced, and therefore he did not consider it efficient enough to be used in therapeutics. (Dr. PETRIE : I gave half a grain three times a day for a time.) Sodium carbonate Dr. Tómasson had not used, and he had no information about it. Sodium chloride, in large doses, increased irritability, and, to some extent, gave a definite result.

Dr. MAYER-GROSS, in reply, said he wished to express his thanks for the opportunity which had been given him of speaking to members of the Association, and of contributing to this important discussion. He regarded it as especially important

that, as Dr. Lewis had said, one could look at psychopathology as a scientific matter, not only hovering in the air and concerned with philosophical theories, but as being supported by biological findings, such as Dr. Tómasson had shown on the previous day. Out of these points which had been opened up during this meeting, the question arose as to how to separate those two aspects, so that there might not be a confused overlapping, as sometimes happened when psycho-pathologists used biological expressions or took over points of view from the biologist which he himself did not agree with, or which were out of date. Conversely it might be that the biologist took such an expression as, e.g., " rage ", and made it a sort of unit or psychological concept, when it had not in fact been properly worked out by the psychologist. At any rate the discussion which had taken place at this meeting had shown that at last fruitful co-operation was possible in the matter.

Dr. Tom A. Williams (former Consulting Neurologist to Gallinger Hospital, and Professor and Director of the Department of Neurology in the Post-Graduate Medical School, Washington, D.C.), who was unable to be present at the meeting, sent the following contribution to the discussion : Depression or exaltation may be caused by concussion or a poison ; it may also be caused by the kind of stimuli termed "psychological". In both, the depression or inhibition of an activity must be distinguished from a mere feeling of depression. Similarly the augmentation of function is not the same thing as the sentiment of capability. The sense of illumination and accomplishment of the dreamer or ecstatic connotes a superior product. When put to the test, enthusiasm is no measure of value of output.

Elations and depressions are only adjudged abnormal when not directly excited, or when they are so extreme as to endanger life. That the taking of life may be sometimes based on reason, however, no one will deny. Nor will it be disputed that the depressed or excited man may consider valid reasons which appear absurd to the well balanced. These cases, however, reach the mortuary as often as they do the psychiatrist. However, for many persistent deviations of feeling tone, anamnesis reveals no adequate psychological foundation. Some psychopathologists have invoked a hypothetical unconscious to explain what seems irrational. To them rebellion against frustrated animal drives is responsible for those disturbed feelings which lead to irrational belief and conduct. The theoretical possibility of this has attracted many subtle minds ; but the psychological analyses practised by them have been meagre of result in affective psychoses, as contrasted with the supreme value of skilful psychotherapy of psychoneuroses without any recourse to a hypothetical unconscious, interpretation of dreams or the invocation of repressions. It is accomplished by procedure which relies upon the ascertaining of faulty conditioning ; and patients are dealt with by measures similar in principle to those of Pavlov, although carried out in a very different way, by the indirect medium of language.

Although laden with psychological symptoms, the affective psychoses cannot now be adjudged psychogenetic. Perhaps, indeed, they are differentiable by the very failure of psychotherapy. Not the intensity of the symptoms presages the measure of refractoriness to treatment ; for many psychoneurotics seem to suffer more intensely than do many of the insane, and yet are rapidly relieved by a proper psychotherapy and do not relapse. Of course in the outspoken cases, physical symptoms clearly differentiate. Such are retardation or its converse of rapid reaction time, with their accompanying metabolic sluggishness or acceleration, which do not characterize psychoneurotics. But when these are not conspicuous, as in the agitated depressions of involution, psychopathology may be the diagnostic criterion. Thus :

Increasing anxiety and agitation of a barrister of 48 became so intense that he could not bear to be without the presence of a member of his family even in the toilet. There was great loss of weight and obstinate insomnia ; he showed the distressed appearance of agitated melancholia, plus a wild look. He attributed his distress to injuring others through carelessness with poisons he must have sent

them through the post; so that panic seized him whenever a post-box or office was passed; and every letter which left the house had to be inspected again and again to make sure no poison was contained.

Despite treatment in a sanatorium, attention to teeth, and then removal to the seaside, he had become steadily worse since the onset of scruples after an attack of influenza over a year before I saw him; so that he had lost insight and was deluded into believing that he must have done harm to many people, and must be protected from injuring others by the constant presence of a member of his family.

Examination showed no retardation, nor flight of ideas, although he was quite incapable of analysing his own psychological state.

However, persevering anamnesis brought to light a history of scruples against injuring others, from early boyhood, derived from his father and reinforced by some striking incidents which had originated a feeling of guilt which created a habit of social reticence, despite which he made a great success at the Bar and had a devoted wife and three happy children, the eldest of whom was a partner and constant companion in his illness.

On the above grounds compulsion neurosis was diagnosed tentatively, and treatment was directed towards reconditioning the besetting phobia. At first he seemed incapable of grasping the psychological connection, in spite of an intelligence dialectically trained in his profession. His reports of our interviews were well enough expressed, but were only a series of clichés. In a fortnight, however, he began to see light, and then rapidly gained an insight into his own psychology. After this he began to sleep a little better, but did not begin to gain weight for two months, although his fears no longer dominated him. In three months more he was back at his law practice and has remained well over four years.

In the case of a young man, also a lawyer, the psychopathological criterion also seemed conclusive, until sixteen years later doubts arose on account of a psychotic disturbance which proved unamenable in other hands.

Twice holding a pistol to his head, a science lawyer, æt. 28, twice refrained from firing. For six months he had secluded himself, going out only to snatch meals at deserted night lunch rooms, and beset by a terror which had increased since childhood. Because of this and a bad family history, he believed himself fated to insanity. He had lost forty pounds, and wore an anxious look, immediately stating, "You can do nothing for me". His agitation kept him perambulating his room nearly all night.

Anamnesis showed, however, a quite logical development. His father, a brilliant but eccentric professor, had deliberately inculcated in his children fear as the beginning of wisdom, throwing them into the sea to sink or swim, chasing them out of bed with a whip until they took refuge by climbing a tree, running through the snow to do so. He succeeded only too well. The patient, as a boy, struggled bravely against the fear he had of every situation. Later he had fought it to the extent of playing American football at college, which he dreaded and loathed; later still he tried to acquire bravery as a lumber-jack. It was his failure to overcome his fear that made him believe he was a degenerate fated to insanity.

By means of facts concerning Mendelian heredity and about the role of psychogenesis and the nature of belief he was enlightened. This was done only after sleep had been induced through hypnosis. The result was the dissipation of his fears within a fortnight. He celebrated this by sitting up all night to write spontaneously a long account of his situation. It showed the enthusiasm of the convert, and I almost suspected that my own intervention might be a mere coincidence in a periodic psychosis of which his enthusiasm was the expansive phase, until the extravagant behaviour gradually subsided.

"I've won, I've licked him; I've driven away the beast that was driving me mad. As soon as I knew just what he was, and why he came, I poked him with my finger and he busted. He's not gone entirely, he's crouching growling nearby, waiting to jump on me again. Occasionally he gives me a twinge, such as some men get when passing a looking-glass. I laugh at it. I'm on my back no longer. I'm fighting! I'm fighting now. My battle is all but won. I wrote

my last letter on Friday. Yesterday I had fun. I got up singing in the morning, dressed carefully, and went down town. I ate my breakfast slowly, but made the waiter scurry. I roamed the streets. A week ago I slunk into a restaurant, because I was fearfully hungry, unshaven, unshorn and unkempt, and the waiters all laughed at me, and I hurriedly gobbled my food, and crept trembling out again. I went back there yesterday and bullied the whole crowd. One of them came up grinning, and I looked him in the eye, and the grin changed to a smirk. I kept him standing waiting, while I read the menu through. And I said, ' Bring me this and this and that, and Waitah, hurry, and don't you dare to not do so always '. Ten days ago I sneaked up to the Sherman statue, by moonlight, and looked at the statue of a soldier, longingly, and wondered how he could be. Yesterday I walked up to him laughing, and wished I could shake his hand."

Thus both in the young and the middle-aged man a picture of intense anxiety with complete incapacity for affairs, with extremely faulty interpretations was presented. In both cases, however, psychogenesis was clearly traceable, and in both cases reintegration was effected in short order by a rational psychotherapy, without recourse to any far-fetched hypothysis of an unconscious, without the use of artificial association experiments, without analysing dreams, and without invoking any theory of repression.

The attitude towards diagnosis was the possibility that the patient's emotional distress might have been conditioned psychologically, as physical signs were not apparent. Therefore exploration might reveal a psychological conditioning sequence. It did so. Hence the psychotherapeusis consisted of the reconditioning of the faulty intellectual attitudes. When this was accomplished the emotional consequences ceased.