PSYCHOPATHOLOGY.

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PSYCHOPATHOLOGY is a speculative subject, whose limits remain undefined. It is concerned with the isolation of clinical entities on a psychological basis, and with the investigation of the aetiological factors and psychological mechanisms that may be responsible for these conditions. There is much division of opinion among psychopathologists on basic principles. Particularly is this so regarding the relative importance attached to innate factors, infantile experiences, early training and psychical trauma in adult life in the causation of mental disorder.

The chapter is divided into two sections. The first is concerned with additions to, modifications of and criticisms of the more important schools of thought on psychopathological theory. The second section deals with such psychopathological phenomena as are not specifically studied in other chapters. Where so much is subjective and all controversial, criticism has been reduced to a minimum.

I. THEORY.

Constitutional types.—Since Kraepelin, Kretschmer's work on constitutional types is possibly the most important single contribution to orthodox psychiatry. Of recent investigations in this direction Bowlby's monograph (1940) is one of the most significant.

Bowlby studied the pre-psychotic personality of 59 patients (13 schizophrenes, 23 affective-psychotics and 29 psychoneurotics). The questionnaire method was used, 105 character-traits and symptoms being listed. These were sub-grouped under the headings work and interests, social relations, attitude to authority, mood, temper, attitude to family, habits and obsessions, health. In most cases the patient's own answers were checked by information obtained from one or more relatives.

His findings confirm the view that most individuals can be recognized as belonging to one of two genetic types—cyclothymics and schizothymics. Since, as will be seen later, the cyclothymics are only isolated as a result of the absence of schizoid traits, it remains an open question as to whether there may not be other types—for instance, the epileptic. Bowlby disagrees with Bleuler's view that, except in extreme cases, all personalities are mixtures.

His second point is that, as has been contended by Mapother, Meyer, Lewis and others, the only difference between the normal, the psychoneurotic and the psychotic is a quantitative one. For instance, an obsessional may be schizoid or syntonic. The former may progress to schizophrenia, the latter have a

melancholic episode. He finds it unscientific to isolate groups of cases into watertight compartments on the strength of a few outstanding symptoms; the personality should be taken as a whole.

Thirty-three traits are listed as being more or less specific for the schizoid personality, i.e. five traits or more indicate a schizoid, two or less a syntonic. The schizoid traits differ little from those of Kretschmer and need not be described here. The other 72 traits are non-specific and merely suggest an unstable personality; any of them may be present in the schizoid. Here Bowlby's findings are in opposition to those of Kretschmer, Bowlby's diagnosis of a syntonic being made on the absence of schizoid features, not on positive syntonic traits as postulated by Kretschmer. Bowlby also finds that Kretschmer draws rather too flattering a picture of his cycloids when he describes them as sociable and good natured, and attributes nervous characteristics to the intervention of schizoid components. He finds that an investigation into the previous personality of patients suffering from affective psychoses shows them to have been commonly referred to as quiet, keeping themselves to themselves, shy and so on.

There is one obvious criticism of Bowlby's otherwise important piece of research. It is difficult to see how in the absence of psychosis or specific physical features and merely on the absence of certain personality traits, one is to form a type out of what is only a residue, for this is all Bowlby's cycloids can claim to be. It is as if one insisted that modern painters, who did not use Seurat's pointillist technique, were all of one school, instead of being cubists, surrealists, primitives or followers of Cézanne.

Lastly one should note Bowlby's conception of the relation between the innate factor and environmental stress. Bowlby holds that "whilst heredity is responsible for the main type to which a given individual belongs, whether he is syntonic or schizoid, infantile and childhood experiences are fully as important as heredity in determining whether that individual develops a stable personality, or becomes unstable and so liable to develop one of those particular forms of mental illness which his inheritance has made available for him."

Bowlby has little if anything to say about the physical make-up of his patients. This interesting matter is the subject of a group of papers by Cohen (1938–41). An analysis of the measurements of male patients (25 manic-depressives and 22 schizophrenics) showed that, regardless of general magnitude of body-build, male manic-depressives tend to exceed male schizophrenics in waist and pelvic circumference, whereas the latter exceed the former in leg and arm length. Again, in a group of Jewish female patients (31 schizophrenes, 22 manic-depressives), it was found that there is a very marked tendency for the syntonic females to have deeper chests and broader pelves than the schizophrenes, this difference being independent of differences in general magnitude of body build. In a third paper Cohen applies the same measurements to 50 normal subjects of about the same age (male students at University College, London); unfortunately no attempt is made to correlate these results with the personality type.

Elliot (1941) compares 100 schizophrenic young women with 100 controls regarding body build. Only 10 per cent. of the schizophrenes were of the

pyknic build, as against 40 per cent. in the non-psychotic group. Of the 50 per cent. asthenic and athletic types among the non-psychotics, 7 showed evidence of "instability." The author concludes that her findings support Kretschmer's theory. This is so to some extent, but here again it would have been of greater value if an attempt had been made to classify the non-psychotics according to personality type as well as body build.

The study of psychopathology in general, and the hypothesis of constitutional types in particular, stands or falls according to whether it is able to provide an aid to prognosis. It is therefore not out of place here to review those recent publications devoted to this subject.

Barham Carter (1942) studied prognostic factors in 78 cases of adolescent psychosis admitted to Shenley Hospital from 1935 to 1937. Relevant points from his conclusions are that, as regards physique, pyknosomatics had the best prognosis, dysplastics the worst. As concerns personality, he found that those showing an ability to come into contact with the world—some amiability, initiative and adaptability—were associated with recoverable psychosis. Those personalities lacking the above and showing a shut-in and sensitive reaction, unable to make social contacts and unable to stand up to reality, seemed unduly vulnerable to psychosis, and were likely to accept and retain psychotic reactions. Further he finds that intellectual and emotional poverty rarely recovered, and psychoses superimposed on mental deficiency were invariably malignant.

Kant (1941) made a study of 39 completely recovered and 39 deteriorated schizophrenic patients. In the recovered group he noted besides acute onset, psychogenic precipitation and the presence of clouding, extraversion (by which I think the author means the absence of a schizoid personality) and pyknic physique. Blair (1940) investigated a series of 120 male schizophrenics for prognostic factors. His findings as regards body-build and personality are in agreement with Kant.

Other workers have studied the constitutional make-up in the organic psychoses. In the case of dementia paralytica, Pollack (1939) has confirmed the findings of previous investigators, who show that the success of malarial treatment depends, among other factors, upon the previous make-up of the individual treated. Pollack found that the majority of the chronic paretics, who remained in hospital at least two years after adequate treatment, showed preponderance of schizophrenic reaction types.

Hoch and Davidoff (1939) made a similar study in relation to the traumatic psychoses. While admitting the importance of the severity of the trauma, the significance of the localization of the lesion and the role of other constellatory factors, they conclude that the previous personality is of considerable prognostic significance. They found that cases with a schizoid or introvert make-up regained their mnestic functions and the lucidity of their pre-psychotic intellectual state, but unharmoniously retained their hallucinations and delusions. The ratio of unimprovement in the introvert type as compared to the extravert type was approximately 2 to 1. It should be noted that Hoch regards the terms extravert-introvert and cycloid-schizoid as practically synonymous.

In another publication (1940) Hoch made a study of 200 cases of alcoholic psychoses. He found that 72·5 per cent. were predominantly extravert—a

ratio of 3 to 1. Of the extraverts 78·3 per cent. recovered, while of the introverts only 26·3 per cent. recovered. As regards clinical types, he found that there was a very marked preponderance of extraverts in those whose psychosis took the form of delirium tremens or confusional states. Introverts were in excess among those with acute hallucinosis and paranoid states.

Psychoanalysis.—The roots of psychoanalysis, that is the hypothesis of the unconscious and the mechanisms underlying unconscious motivation, had been firmly established in the early years of this century.

When looking to recent developments I find no offshoot of major importance during the period covered by this survey. On the other hand, there are three main branches, which have had their origin within the last ten to fifteen years. Recent work has largely been confined to an extension, refutation or limitation of these concepts. There has been also much research into technique, a subject outside the province of this chapter.

Of the three main branches, the first is the increasing interest that has been taken in ego-psychology. Freud first broached this subject in *The Ego and the Id* (1927); ego defence-mechanisms were first studied in some detail in his *Inhibitions, Symptoms and Anxiety* (1936).

In a paper by Bibring (1941), recently translated, there is an excellent summary of the development of Freud's theory of instincts. Bibring isolates four stages in this development, and stresses that though the theory has undergone many changes, it has remained consistently a dualistic conception. In the first stage the sex instincts were isolated from the ego instincts. The former were closely studied, while the latter remained an unknown quantity. In the next stage the concept of narcissism was introduced. This led to the postulation of a libidinal component of the ego instincts. Freud, however, insisted that there must also exist a primary non-libidinal component; this he called "interest" in a non-commital way. The third stage was that the aggressive trends were ascribed to the ego instincts as being among their essential constituents. The last and most recent stage was due to a growing knowledge of the structure of the mental apparatus as a whole, and its division into a "vital" stratum (the id) and an organized part (the ego), and to a study of the unconscious region of the ego, the super-ego. The gist of this view was that the aggressive trends were no longer regarded as primary attributes of the ego instincts, but as independently existent instincts of aggression and destruction existing side by side with the sexual instincts in the vital stratum of the mind. The ego instincts ceased to be independent entities, and were derived partly from the libidinal and partly from the aggressive instincts. This latest development also postulated the existence of primal instincts—the instincts of life and death.

In 1937 Anna Freud made an important contribution to ego-psychology. In this work the technique of psychoanalysis is used in order to investigate the ego itself. Previously the method had been used to explore the unconscious mind, any information discovered about the ego being in the nature of a by-product. Anna Freud finds that the ego is fundamentally hostile to the instincts, and her investigations are mainly concerned with the mechanisms used by the ego to ward off anxiety aroused by the intrusion of the

instincts. These mechanisms include regression, repression, reaction-formation, isolation, undoing, projection, introjection, turning against the self, reversal and sublimation. Again she finds that there are three main motives for this defence against the instincts. The most familiar is super-ego anxiety, as it occurs in adult neurosis when an instinct is gratified or even merely aroused. This has led to the belief that the super-ego is the root of all neurotic illness. According to certain theorists, if the super-ego were weakened by bringing up children leniently, that is by allowing a maximum instinctive gratification, there would be no neurosis. Anna Freud, with the majority of psychoanalysts, is sceptical both of the theory and its implication.

The second motive is objective anxiety as it occurs in infantile neurosis before the super-ego has come into being. The examples of the ego defence mechanisms here studied are: Denial in phantasy, denial in word and act, and identification with the aggressor.

The third motive is instinctual anxiety, that is, dread of the strength of the instincts. Especially at puberty and at the climacteric owing to physiological changes, there is a sudden accession of instinctual energy, which threatens to upset the balance of the psychic institutions. The last section of the book gives a masterly study of this form of anxiety and the ego defence mechanisms as they occur at puberty. Her analysis shows that two striking characteristics of the adolescent, asceticism and intellectuality, are actually defence mechanisms by means of which he attempts to come to terms with the instincts.

Fenichel (1938) notes that in recent years the ego has taken the place originally occupied by the instincts as the chief object of psychoanalytical investigation, and sounds a note of caution. While condemning those psychoanalysts who believe that only the deepest, genetically earliest layers are of importance, and who are not interested in comprehending the surface as the differentiated product of the instincts, he also condemns the supporters of the other extreme who forget the id while concentrating on the differentiation of the ego, and take from psychoanalysis its biological basis—that of instinctual needs.

In support of the above he reminds us that it is important that the words "ego" and "id" should not be taken too rigidly. Whatever the mental mechanism may be that is under investigation, id and ego elements will form component parts. Even an instinctual fixation is not only due to a particular satisfaction or frustration of the instinct in question, but at the same time serves as a defence or reassurance.

Fenichel's main contention is that the id can only be attacked *via* the ego, it being the object of the analyst to divide the ego against itself by separating the reasonable observing ego from the automatic, defensive, experiencing element. In his view there was to begin with a conflict urgent and alive. The subject withdrew from this conflict by means of permanent ego-alterations. A latent state had been reached, for the forces which at one time opposed each other are now wasted in the useless and hardened attitudes of the ego. It is the object of analysis to reactivate the old conflict and to set free the bound energy.

Helene Deutsch (1939) carries on the study of ego defence mechanisms in an

investigation of "intellectual resistances." She finds that certain patients attempt to retain the *statu quo* between the id and ego by means of certain intellectual forms of defence. She isolates three types:

(*a*) Highly intellectual individuals with genuine sublimation.

(*b*) Obsessional neurotics, whose intellectual resistances usually take the form of direct "reaction-formations" or "isolations."

(*c*) Patients with blocked or disturbed affects, who, having repressed the affective side of their life, have retained the intellectual side as the sole means of expressing their mental personality.

She does not agree with Anna Freud's view that the tendency to intellectualization in puberty is an effort of the ego to master the instincts with the aid of thought processes. In her view, this form of defence appears only in those young people in whom specific instinctual tendencies in early childhood have already prepared a defensive process of this kind, and in such a manner that that process can cover a gratification of instinct. For instance, in the case studied, it was sexual curiosity and everything connected with it which was indirectly gratified by the "intellectualization."

Reik (1941) agrees with Anna Freud that identification with an aggressor is a special instance of identification for the purpose of mastering anxiety. He adds, however, that between the stages of anxiety and aggression there is hatred of the aggressor. He does not think that Anna Freud is right in thinking this is an intermediate stage in the development of the super-ego. Reik thinks, on the contrary, that it is because the super-ego is exceptionally severe that the ego must project the aggression if it is to remain intact. The development of the super-ego is not too feeble, but too powerful in relation to the ego and to the subject's self-feeling. Finally he maintains that aggression based on identification with an aggressor is originally a response evoked, not by an anxiety-situation, but by a danger situation. Only later does it come to be employed secondarily as a defence against anxiety. As Reik explains, anxiety may be regarded as a buffer or safeguard adopted by the ego to ward off fright —the reaction to an objective danger-situation.

The second important contribution is associated with the name of Melanie Klein. In 1933 she published her *Psychoanalysis of Children*, where an important discovery in technique—play analysis—is introduced for the first time. As a result of her research she concluded that identification and consequent super-ego formation take place at a much earlier age than formerly had been realized. In a later work (1935) she follows Freud and Abraham in stressing the importance of introjection in the psychogenesis of melancholia, but goes much further. For Klein and her followers introjection has become the all-important mechanism in the child's development; other processes have faded into insignificance. This theory has been severely criticised by many, and has produced something of a cleavage within psychoanalytic circles.

Fairbairn (1941), strongly influenced by the Klein school, attempts an ambitious revision of psychoanalytic theory. He finds Abraham's conception of fundamental erotogenic zones an unsatisfactory basis for any theory of libidinal development, because it is based upon a failure to recognize that libidinal pleasure is fundamentally just a signpost to the object. Fairbairn

does not dispute that schizoids are fixated at the early oral and depressives at the late oral stage. His main criticism is levelled at the two anal and the phallic phases, which he considers to be artefacts. In his opinion, paranoid, obsessional, phobic and hysterical states essentially represent, not the products of fixation at specific libidinal phases, but simply a variety of techniques employed to defend the ego against the effects of conflict of an oral origin.

Fairbairn's own theory is based directly on the relationship of the ego to the object, and it must be remembered that, for this school, the breast is the original object for which every subsequent object is an indifferent substitute. He traces the development of object-relationship from the infantile dependent stage, characterized by an attitude of taking and based upon identification, through a transition stage of quasi-independence to a stage of mature dependence, characterized by an attitude of giving and based on differentiation of the object.

The schizoid and depressive fail to establish a satisfactory object relationship during the infantile period. In the schizoid the emotional conflict arises in the early oral phase, taking the form of the alternative " to incorporate or not to incorporate," i.e. " to love or not to love." The schizoid is pre-ambivalent; hate does not enter into his relationship with the object. But every relationship with a loved object is seen as one of oral incorporation and, therefore, to love is to eat and destroy the object. In consequence he is afraid to love and erects barriers between himself and objects. As libido is withdrawn from objects it is directed towards internalized objects; hence the introversion and narcissism of the schizoid. In the depressive the conflict arises in the late oral phase, and the problem is how to love the object without destroying it by hate; he is capable of ambivalence and aggression. It is when his hate is directed towards the internalized object that a depressive reaction supervenes.

Paranoid, obsessional, phobic and hysterical reactions are fixated at the transition phase. Here there is no longer ambivalence but dichotomy of the object—the original loved and hated object is replaced by two, one of which is accepted and the other rejected. Paranoid and obsessional states employ special defensive techniques which derive their pattern from rejective excretory processes. The paranoid externalizes the rejected object and treats it as a persecutor. For the obsessional the excretory act represents not only rejection of the object, but parting with contents. The conflict of the transition period also represents itself as a conflict between an urge to expel and an urge to retain contents. Both attitudes are attended by obsessional anxiety —the attitude of expulsion being attended by a fear of being emptied or drained, and the attitude of retention by a fear of bursting. The phobic and obsessional techniques represent two different methods of dealing with the same basic conflict. From the phobic point of view the conflict presents itself as one between flight from and return to the object. From the obsessional point of view the conflict presents itself as one between expulsion and retention of the object. Concerning hysteria, Fairbairn thinks it is superfluous to bring in an Oedipus situation to explain the rejection of the sexual organs, since it is clear to him that " the hysteric identifies the genital organs as a part-object with the original object of the libidinal impulse at the stage of infantile depen-

dence, viz. the breast." This rejection, therefore, is an unsuccessful attempt to abandon the attitude of infantile dependence. The distinctive feature of the hysteric is that the rejected object remains incorporated.

I. M. Blanco (1941) strongly criticizes the Klein school for their universal application of the mechanism of introjection. He finds developments here "reminiscent of the casuistry of the Middle Ages. The introjected object has become something so concrete, so well delimited or sharply defined, that when one hears of people introjecting either the whole or part object, and then projecting it on to the outside world, introjecting it again, cutting it to pieces, blowing it up, putting the pieces together again—when one hears all this one cannot help recalling the animistic conceptions of children and primitive people." He believes that the term is of real value in explaining the processes at work in melancholia, but that it is a mistake in procedure to apply the conclusions drawn from those suffering from severe depression to all human beings. He admits that the phantasy may be there, either in the mind of the analysand or of the analyst, but this does not mean that the interpretation is correct. He speaks of a juggling with words and a distortion of clinical material to fit preconceived theory. For instance, the absorption of milk has many symbolic meanings for the normal mind, but for Klein and her followers these symbols would invariably be explained as an introjection of a part object—the maternal breast.

The third main sphere of development has been the application of psychoanalytical theories to psychosomatic medicine, a subject discussed in the second section.

During recent years there have been at least two attempts to subject the basic hypothesis of the psychoanalytic theory to a critical examination. Of these Dalbiez's work (1941) is the most ambitious, and deserves a very careful examination.

Dalbiez is a trained and practising psychoanalyst. He is also a philosopher, and it is as philosopher that he approaches the fundamental tenets of psychoanalysis. One of Dalbiez's main criticisms is that Freud makes no clear distinction between methodology and doctrine. It is with certain features of the latter that Dalbiez is in total disagreement. The first volume is devoted to an exposition of the Freudian theory and need not detain us here. The second volume provides the critical discussion. The subjects discussed are the unconscious, psychodynamics, methodology, sexuality and sublimation.

Regarding the unconscious, Dalbiez has little use for either the idealistic or the materialistic approach. He approaches the problem as a realist, taking as an axiom that "external sensation is an organic-psychic operation, unconscious *per se*, which directly apprehends an actual material reality." From here he has little difficulty in building up the argument that consciousness does not coincide with psychic activity. This view is reinforced by an examination of such phenomena as habit, artistic and scientific inspiration, hallucinations, obsessions and various disorders of personality. He then turns to Freud's theory of psychic dynamisms, which he believes can be verified by the application of Pavlov's physiological experiments on conditioned reflexes and artificial neuroses.

Turning to methodology, Dalbiez makes out a very strong case for the scientific validity of the associative and symbolic method of exploring the unconscious, if properly applied. Regarding free associations Dalbiez cites five criteria by means of which the accuracy of an interpretation can be judged. These are spontaneous evocation of memories, similarity between the associative fact and the conscious element, frequency of the same association, convergence of the first criterion, and the objective verification of the accuracy of the memory. Discussing symbolism, Dalbiez thinks that much of the opposition is due to the confusion created by the use of the word " symbol " in the sense of index or effect-sign. He suggests that if Freud had represented the dream as a psychic symptom of deep psychic states, he would have been better understood and much less criticized. He further demonstrates that Freudian symbolism or effect sign can be indirectly confirmed by the study of language, myth and folk-lore.

Dalbiez is much less sympathetic towards the Freudian sexual docrine. He agrees that infantile sexuality is normal, and that there is a genetic link between infantile sexuality and the sexopathies. On the other hand, he criticizes the view that the normal infant is a polymorphous pervert. In his opinion the infant's sexuality is merely undifferentiated and unintegrated, and he would substitute the term " polymorphously pervertible." He is also very sceptical of the universal applicability of the " sexual " Oedipus complex, the theory of erotogenic zones and the developmental stages of sexuality, and finally the theory of the death instinct.

Dalbiez next turns to morbid psychic causality. Following Hughlings Jackson he contrasts negative symptoms proceeding directly from the lesion with positive symptoms, the reaction of the healthy organs. A long philosophical argument leads him to the conclusion that the most that can be said in favour of psychic causality is that in certain disorders there is the predominance—not the exclusiveness—of the psychic factor in the aetiology.

Dalbiez is quite unable to support the Freudian doctrine of the pan-sexual aetiology of the neuroses. He finds that its role is very limited and often unnecessary as far as the negative symptoms are concerned, and no one has as yet succeeded in demonstrating that all positive symptoms are related to the sexual instinct. Dalbiez is particularly severe on the psychoanalytical doctrine as it is applied to the higher spiritual values. His argument against determinism is, in the main, that it cannot be proved. Nevertheless for scientific work it is a useful hypothesis, which is more than can be said for free will, as Bertrand Russell has made abundantly clear. To disprove Freud's theory that morality is derived from the Oedipus complex, he quotes Malinowski's scathing criticism of the cyclopean hypothesis. Against Malinowski's unsubstantiated statement that Freud's primal horde never did and never could have existed, there are the very careful observations on the social behaviour of sub-human primates by Zuckerman. Dalbiez makes no reference to Zuckerman's work. Lastly, on the Freudian interpretation of religion and art, Dalbiez would appear to have misunderstood Freud. It is constantly reiterated that psychoanalysis can tell us nothing as to the essence of religion or art. If by essence is meant the platonic forms, there is little doubt that Freud would have been the first

to agree. All psychoanalysis attempts to show is that in a given individual the particular religious or artistic content is determined by the way he reacted to infantile sexual problems.

The second critical examination is a contribution by Herold (1941). While agreeing with the super-structure, Herold subjects some of the basic psychoanalytic concepts to severe criticisms. His views evolve from Descartes, Kant and Schopenhauer and show an extreme dualism. Regarding the undifferentiated self he discards Descartes' knowing self and Schopenhauer's willing self in favour of Freud's pleasure-pain self. In some way and for some reason not explained he finds that only in the pleasure-unpleasure experience is there no objective interference. The ego stands midway between this subjective world of pain and pleasure and the objective world of things, partaking of each.

Herold thinks that Freud's sexual theory would have been more acceptable if he had used the term "sensuality." He shows very clearly that the process of "loving" an object is essentially a process of knowing it, and that in the infant this loving and knowing objects is not so much a symbol of the sexual act as a forerunner of it.

On the libido theory of energy or drive Herold believes that the motive power is supplied by the body substance, or that part of the ego-concept which is non-self. The self, however, though unenergized, is credited with the power of directing this energy or drive towards a given end. He goes on to explain that there can be changes of direction and of intensity of drive, but not changes of quality. Therefore there is no place for such concepts as sexual, destructive, or other specific instincts. The term "instinct" is, in fact, unnecessary except to express those few inherited mechanisms through which our drives find an outlet. It is essential for healthy behaviour that energy should be free to flow out on to objects. Fixation of energy on the body substance is correlated with Freud's destructive instinct. Death, therefore, is the result of accumulated energy centred upon the body substance. A moderate degree of such fixation but a degree beyond normal limits is called narcissism.

Analytical psychology.—Much of Jung's work has been devoted to schizophrenia, and it is, therefore, not surprising that many of the recent contributions from analytical psychologists have been concerned with this psychosis.

In a recent paper (1939) Jung sums up his views on the aetiology of schizophrenia. He agrees with his teacher, Bleuler, that psychological causes produce the secondary symptoms. On the other hand, he considers that an organic cause for the primary symptoms has yet to be established. He points out that the biology, anatomy and physiology of this psychosis have been fully studied, while its psychology remains a vast and unexplored field. Until the psychological side has been more fully investigated there are advantages in treating schizophrenics as if they were psychogenetically determined and could be cured by psychological means.

In Jung's opinion there are two aetiological groups of schizophrenics. In one group the primary symptoms coincide with the condition which Pierre Janet has formulated as "*abaissement du niveau mental*," that is, it is due to a peculiar "*faiblesse de la volonté.*" In the other group it may be a question of atavism, or "*developpement arrêté.*" Here a more than normal quantity

of primitive psychology remains intact and does not become adapted to modern conditions.

Both schizophrenia and neurosis are consequences of "*abaissement*" and in both the result is dissociation. The difference, for Jung, is quantitative as far as the dissociation is concerned, but leading to qualitative differences in the personality as a whole. A neurosis is a relative dissociation, a conflict between the ego and a resistant force based upon unconscious contents. The characteristic of the neurotic is that he fights for and maintains the supremacy of his ego-consciousness and subjugates the resistant unconscious forces. On the other hand, in schizophrenia there is dissociation of a different and much more serious nature. "The psychical totality falls asunder and splits up into complexes, and the ego complex ceases to play the important role among these. It is just one among several or many complexes which are equally important, or perhaps even more important, than the ego is." Though Jung sees a clear dividing line between neurosis and psychosis, he also finds that many cases of neurosis may prove to be latent schizophrenics. For many years they may maintain ego-supremacy and then, as a result of some unusual stress, there may be generalized disruption of the personality.

Baynes (1940), in a recent monograph, makes an important contribution to the psychopathology of schizophrenia. The work is devoted to an analysis of the artistic productions of two "border-line" schizoid subjects. The two series of paintings and drawings are of exceptional psychological interest, and the productions of the second subject are not without artistic merit. The analyses show that the genesis of the disease embraces two relatively independent factors—namely, the weakening of the conscious threshold on the one hand, and the activation of the unconscious on the other. It is admitted that other factors, heredity and emotional trauma in childhood, are also of significance, and in both the subjects studied, immediate conflicts were precipitating causes.

As is well known, according to Jung, there is, beyond the personal unconscious, an archaic or collective unconscious common to all. These archaic contents are experienced consciously as universal myths. They, the archaic contents, are not specific to schizophrenia; only the attitude which permits them to rule in place of the authentic personality is truly psychotic. Baynes agrees with Jung that two groups of schizophrenia can be recognized. In the one consciousness is weak and, therefore, unable to keep back the flow of unconscious material. In the other, normal consciousness is suddenly confronted with a strongly activated unconscious which it cannot withstand.

During the acute state of conflict the schizoid subject is in an introverted state, his consciousness being dominated to a varying extent by unconscious material. The psychotic is at this stage trying to solve his conflict by means of a myth or fantasy expressed in symbolical language, and in these specific cases by bizarre paintings and drawings. Baynes is of the opinion that the religious question underlies the majority of psychopathological disorders; it is this question that the myth attempts to solve. As analysis proceeds, the evolution of the myth is reflected in the artistic products. At first these are purely concerned with symptoms or unresolved complexes; later and to an

increasing degree there is evidence that libido is being directed outwards, of a creative urge and of a desire to adapt to society.

It is also hinted that, besides providing a solution for personal problems, the content from the archaic unconscious may also have a prophetic value not only for the individual but for humanity at large.

Drawings play an important part in the therapeutic work of the analytical psychologist. G. Adler (1941) studies the dream of a border-line schizophrenic aged 30, of the intuitive intellectual type. There are three parts to the dream symbolizing, according to the author, the persona, the personal unconscious and the collective unconscious. On the author's request the subject continued his associations to the last part of the dream in a series of drawings. Analysis showed that the dream expresses the patient's fear of facing the problems of his emotions and of his instinctual life. The task of the analysis is to integrate within the patient's consciousness the disruptive tendencies which spring from primitive and still unconscious levels of feeling.

Analytical psychologists, like psychoanalysts, insist on the importance of infantile trauma in the aetiology of the neuroses. Baynes (1937) believes that the main difference between the Freudian and Jungian approach is that the former is a study of psychic mechanisms, the latter an understanding of values. For Baynes the Oedipus complex is merely a symbolical expression of the drama of the unconscious, evolution *versus* regression. "The vital energy either flows forward to its evolutionary objective or backwards to its source. In the human family the backward stream of libido is necessarily motherwards, seeking, apparently, the original state of contained security. The father represents the cultural symbol of masculine authority and progression." Baynes finds that severe injury to the child's psyche does not so much result from brutal acts and shocking experiences as from living in an atmosphere of insincerity. Nothing, he believes, is more likely to provoke neurosis than to be brought up by parents who teach one code of morality, while practising another. The child, he maintains, is "the potential indicator of his parents' unconscious problems."

Individual psychology.—Individual psychology has been well defined by Wexberg as "a means of understanding or an attempt to understand an individual through a study and interpretation of the goals he has set himself to achieve." In a recent paper Squires (1938) enlarges on this definition. He regards four concepts or conceptual terms as of primary importance for an understanding of the Adlerian approach. The first of these is purpose. It is postulated that the organism, consciously or unconsciously, has an urge to attain some higher state or end. The second is what Squires calls creative power, "the ability an organism—in this case a human organism—is presumed to possess that enables it to mould within definitely prescribed limits its future destiny and fate." It is, of course, this latter postulate that brings Adlerian theory into line with the other dynamic psychologies. The third concept is a quantitative one, and Adler calls it "activity or degree of activity." According to Adlerians the abnormals can be distinguished by the degree of activity, neurotics being the least active, delinquents the most active, and perverts taking an intermediate position. Squires assures his readers that he

has found this last concept very helpful; the more pertinent question would seem to be: Is it true? The last of these concepts is social or community interest. Adlerians stress that though the individual is a purposive unit, he is not in isolation but a member of a group. The key to successful therapy is to guide and establish personal interests within group interest. Shyne (1941) also thinks that the main value of individual psychology is the stress laid on social factors, so paving the way to a *rapprochement* of sociology and psychiatry. Normality, it is explained, implies an equilibrium between individualism and social feeling, while neurosis implies a lack of sufficient social feeling to maintain this equilibrium.

Adler was certainly one of the pioneers in the field of psychosomatic medicine with his well-known concept of organ inferiority. His theory is, however, the obverse of that of other psychologists (see section on psychosomatics). According to Adler organ inferiority is a cause not only of disease in that organ, but also of psychological maladaptation; while in the opinion of other schools it is psychological difficulties that may set in motion organic dysfunction. There would seem to be little doubt that the Adlerian view is correct for certain specific cases, but the generalization is by no means proved. As Shyne rather naïvely admits, it is sometimes very hard to determine the presence of organ inferiority on account of hyperfunction of the defective organ, through increased action of another organ, or because of compensatory activity of the central nervous system. In his later writings Adler posited a number of other causes for inferiority reactions, such as environmental stresses, parental attitudes, sex and position in the family constellation. As far as the present writer is aware *Individual Psychology Pamphlet* No. 9 (1933) is the most recent study of specific psychosomatic disorders.

Like the psychobiologists, the individual psychologists make the point that the individual is a somatic whole. They differ, however, from other schools in that they find that this whole is united in purpose and aim; for the Adlerian, psychological conflict does not occur. To quote Crookshank (1937): "Here we have a terrific line of demarcation between I.P. and the psychologies which deal with persons as agglomerations of separate qualities and things, which make them the sport of material and efficient causes: the sport of inherited tendencies, of congenital variations, of biological predestination." He then goes on to explain that every idiosyncrasy of behaviour is an expression of the individual personality and of his purpose in life. Even doubt is not an expression of conflict; he chooses "this state of doubt so as to fulfil his own purpose." The fallacy of the above argument is that whatever else it does it brings forward no evidence to refute the theory of conflict; still less does it show that there is unity of purpose. Pavlov's experiments in artificial neurosis in animals would seem the strongest argument favouring the hypothesis of intrapsychic conflict as a useful concept. Concerning doubt and aim it may be true that the mule has chosen to remain between the haystacks, but would he regard this as even a fictive goal?

In a short paper Woodcock (1938) summarizes the Adlerian attitude to sexuality. We learn that for everyone the true goal is monogamy, official or unofficial. Every other exhibition of sexuality represents a failure to achieve

this aim and is explained as a manifestation of the will to power. For example, autism is a refusal to give; impotence is due to fear of a dominant partner; ejaculatio praecox is due to egotism; frigidity and vaginismus are reactions to the female's feeling of inferiority; "homosexuals are cowards who fear to function on normal healthy lines, but many attempt by craftiness to elevate their weaknesses into a 'fictive' superiority." Sadism is a demonstration of superiority, and masochism is sometimes used by the oppressed to turn the tables on the oppressor or sometimes is a manifestation of guilt. It will probably be agreed that while these factors may be present, they only represent a small part of the psychopathology in a portion of the cases.

Psychobiology.—Noyes (1942) provides one of the most recent attempts to formulate the theory of psychobiology. He classifies it as "that branch of biology that deals with the organism as a person—a biology of the personality, a study of its natural history." This psychobiological entity, which is known as the human personality, is defined as "an integration of all functions of the human organism including that of the mind, the function of which is characterized by symbolization." The personality must be examined both from a genetic and dynamic viewpoint. Personality is the product of the total forces of the organism. To understand its mechanism one must have data from the chemist, physicist, biologist, physiologist, anthropologist, sociologist and psychologist. Noyes postulates an evolution of this psychobiological unit—the personality. Its dynamics and force of development depend upon an interaction between the innate biological drives and affective needs of the individual and the social and cultural environment. Not only does the individual meet with frustrations from the culturally-conditioned environment, but there are also internal incompatibilities in its own values. Primary urges common to all are often at variance with drives, needs and tendencies peculiar to the individual. The psychiatrist should approach the personality with the assumption that all its expressions are those of fundamental, underlying psychobiological dynamics, and should regard mental disease as an undesirable, socially impracticable functioning of the personality. Symptoms are regarded as rational but extreme psychobiological reactions—"the exaggeration of processes that have long been operative in the individual processes, however, which because they do not adequately meet the needs for which they were created, became so intensified and striking as to be called symptoms and, if disregardful of reality, psychotic symptoms." The psychiatrist should attempt to analyse and reconstruct in their flow of dynamic relationship the common factors operating both in the prepsychotic personality and in the psychosis. In both there will be revealed the way the patient has reacted to specific personal needs.

Noyes believes that this formulation tends to exclude a point of view permeated, on the one hand, with dualism or, on the other, with quasi-animistic concepts, both of which unduly suggest the antithesis between mind and body. It tends also to prevent an overstressing of the theory that the normal basic personality is largely biochemically determined, and that therefore mental illness with its exaggerations of personality is likewise determined. It is further consistent with the belief that the person with nervous or mental

symptoms is of fundamentally the same organization as the so-called normal.

If the above is compared with the Adlerian conception it becomes clear that the two schools have a very different conception regarding the structure of the psychosomatic unit.

Henderson and Gillespie's *Text-book of Psychiatry* is, of course, very much indebted to the school of psychobiology. In the latest edition (1940) Meyer's most recent classification of mental illness is discussed. This classification epitomizes the Meyerian psychopathological theory. Meyer does not speak of mental diseases but of reaction-types. This term makes it clear that, in Meyer's opinion, the constitutional factor determines how the psychobiological organism will adapt or fail to adapt to environmental influences. Physical or mental stress may be the essential cause of psychotic behaviour in certain instances, but the nature of that behaviour will depend upon the reaction-type. Meyer uses the term " ergasia " to indicate the total behaviour of the individual. From this root word he constructs the following classification:

Merergasia—the usual psychoneurotic reactions.

Thymergasia—the primary affective disorders, divided into hyperergastic or other active manic states and hypoergastic or depressive retarded states.

Parergasia—the fantastic, incongruous schizophrenic states.

Dysergasia—the toxic delirious states.

Anergasia—with defect traits characteristic of the organic group.

Oligergasia—the group of constitutionally defective states.

The eclectics.—Dicks (1939), while accepting much of the Freudian doctrine, is at variance with the theory on fundamental issues. Instead of regarding the aberrations of the sexual instinct as the essential cause of mental abnormality, he finds that infantile fear is at the root of all repressions and psychopathological conditions. He points out that the importance of infantile fear is implicit in the nomenclature of other schools. For the psychoanalyst it is castration fear; for the individual psychologist it is the fear of insecurity or insignificance, for which abnormal compensations are sought. For the analytical psychologist it is the fear of advancing towards the next stage of development—imperiously demanded by the banished, because feared, unconscious.

In conformity with this view he postulates three main instinctive tendencies—the self-preservative, the sexual and the aggressive. Of these the first is the most fundamental and the earliest in its domination of the field. Fear and a feeling of insecurity, besides causing a deflection in the normal development of the self-preservative instinct, will also have repercussions on the other tendencies. Summing up, he states that " every patient with mental illness was more afraid than he could tolerate when he was a baby, and the faults in his psychic structure represent the gallant attempts to allay this intolerable feeling by the inadequate means at his disposal."

Concerning the body-mind problem and the part played by constitutional factors, heredity, physical type and endocrine disturbance, Dicks believes that the most useful conception is a monistic one. By this he means that the physical and psychical are different aspects of a unity—reality. The point of convergence towards this psychosomatic unity should be through a more

thorough investigation of the mid-brain, automatic nervous system and the endocrine glands.

William Brown (1938, 1940), who borrows from a number of sources, postulates a large number of instincts, including sex, self-assertion and self-preservation, each with its own distinctive form of energy. Following McDougall he superimposes an organization of sentiments under the ultimate control of the sentiment of self-regard, which Brown prefers to call the love of goodness or eternal values. Any failure to obtain or maintain this hierarchy will result in dissociation of varying degree and in the formation of complexes. The dynamic side of the sentiment of self-regard is the will, and Brown agrees with Janet that many forms of psychoneurosis are due to feeble will-power. Re-education and constructive suggestion can improve will-power and so obtain psychosynthesis.

Murdo Mackenzie (1941) bases his psychopathology on a study of psychological types. He finds that people vary in what he terms their temperamental pace and value. Regarding pace, a man may be an Immediate or a Deliberate. The former will react quickly to a situation and, according to success or failure, will be described as brilliant or superficial; he is an opportunist. The latter reacts slowly to a situation, has a narrow range of interests and, according to success or failure, he would be labelled sound or dull. The second temperamental factor is value and here again there are two contrasting types, the Simplifier and the Amplifier. The former contracts the facts into a unifying principle; he is subjective. The latter orders the facts into a chain of evidence; he is objective. This provides four possible combinations which have much in common with Jung's extravert and introvert and their subtypes. Another feature, reminiscent of Jung's theory, is that, in a deliberate simplifier, the other two factors, immediacy and amplification, are not absent but are blocked. It is this blocking that causes persistent conflict and "primary nervousness." Mackenzie finds that there are four forms of primary nervousness corresponding to his four types. The depressive is a deliberate simplifier; the obsessive a deliberate amplifier; the hysteric is an immediate amplifier, and the assertive is an immediate simplifier. Regarding the assertive, Mackenzie explains that where there is marked mental arrhythmia, the anxiety phase of his assertives has been called mania by others, and the apathy phase, depression. Since assertives and depressives according to this theory are different psychological types, it is hardly surprising to find that Mackenzie denies the existence of the manic-depressive psychosis. On the other hand, he blames British medical psychologists for being so busy expounding the views emanating from the Continent that they have failed to notice the reaction of assertion, here described for the first time. He goes on to say that, with depression, this is the most common psychological illness met with in this country. Besides the above conditions, called "primary nervousness," the theory is further complicated by the fact that the same symptoms may be present as "secondary nervousness." For instance anxiety thinking may occur in any psychological type as a temporary event conditioned by the environment, and in primary anxiety the picture may be complicated by secondary depression or assertion. It would appear that it is these secondary features which, confusing the minds

of other clinicians, have led to the isolation of the clinical entity, manic-depressive psychosis. Finally as a principal cause in the aetiology of primary nervousness, Mackenzie frequently finds a tendency to over-value the opposite types of thinking, and very often there has been a persistent attempt to think and react in the way that is opposed to the innate nature of the individual.

II. Phenomenology.

Amnesic syndromes.—In view of the fact that little has been published on the psychopathology of fugues, Stengel's theories on compulsive wandering (1939) and fugue states (1941) are of particular interest. His studies are based on a detailed investigation of 25 cases, of which 10 were related in some way to epilepsy, one was a schizophrenic, and the remainder were typical manic-depressives, hysterics and psychopaths. A feature common to the great majority of the cases was the tendency to periodical changes of mood, and in most of the female cases the onset of the fugue state was related to menstruation. The individual case-histories revealed one characteristic feature. The patients were persons during whose development there had occurred a serious disturbance in the child-parent relationship, usually of such a nature that relationship to one or both parents was either completely lacking or only partially developed. In some cases the patient had lost one or both parents during childhood, in others a parent had been absent for several crucial years, and in others again, though both parents had been present during childhood, the relationship had for one reason or another been particularly unfavourable. In the majority of patients the relationship to the parent of the opposite sex was disturbed. Another important factor was a constitutional or acquired tendency to react to various kinds of disturbance with an alteration of consciousness; besides the epileptics there were five typical day-dreamers, and fantastic pseudologia was present in eight patients.

The author concludes that there are three essential conditions without which fugue states do not develop: the tendency to indulge in periodic changes of mood, a disturbance of home conditions in childhood, and a tendency towards the production of twilight states.

It is to be noted that the author stresses the importance of lasting or transitory separation from one or both parents in childhood. Seventeen patients had lost one or both parents during childhood. In view of the fact that Palmer (1941) and Reitman (1942) stress the aetiological importance of this same factor in suicide, it is significant that 12 of Stengel's patients had made one or more suicidal attempts. Further, he thinks that the compulsion to leave home and wander aimlessly may mean dying in the deeper layers of the mind.

Sargant and Slater (1941) in a series of military neurotic casualties found a large number who presented an amnesic syndrome. Though epileptics, schizophrenics and cases of head injury were seen, the great majority were psychoneurotics. In about 25 per cent. the condition was precipitated by trivial concussion or dazing. Many had been subjected to severe stress—for instance, the Flanders retreat. Those without such a history were for the most part

severe psychopathics, and in 83 per cent. of all the psychoneurotic cases there were indications of constitutional instability, some showing a specific constitutional tendency to disorders of consciousness. Two types of amnesic syndrome were isolated—fugue and retrospective memory gaps; the former were found to have more psychopathic traits. Those breaking down under stress were men of a simple, superficially calm, well-adapted, extraverted type of personality.

Anorexia nervosa.—Masserman (1941) studied a case of anorexia nervosa associated with neurotic vomiting, diarrhoea and character difficulties. The organic dysfunctions are shown to be somatic manifestations of a highly complex personality disorder arising from severe early emotional conflicts, especially in the oral sphere.

Anxiety.— Kubie (1941) approaches the ontogeny of anxiety from the Pavlovian viewpoint. He finds that anxiety is a reaction to a stimulus which has become conditioned to the "startle state." There is no evidence of the "startle state" or anxiety prior to birth, and it is therefore probable that the type of reaction to the "startle state" is determined at birth. There is not however at present sufficient evidence to show whether individual differences of reaction are determined physiologically, psychologically or in combination.

Rogerson (1940) provides an interesting paper on the relationship of anxiety to depression. This embraces the larger subject of the differentiation between psychoneuroses and psychoses, a problem that has already been considered in the first section and about which there is much controversy. Rogerson gives a very fair presentation of current opinion. His own view more or less coincides with that of Ross, who maintains that there is a qualitative difference between psychoneuroses and psychoses, and more particularly between anxiety and depressive states. Ross, however, is inclined to ignore the fact that depression is often a conspicuous feature in anxiety states, while anxiety is not uncommon in the symptomatology of depressive conditions—a fact that is stressed by Rogerson. Here, therefore, he falls into line with Gillespie, who postulates two types of depression, psychoneurotic with anxiety and psychotic without. Rogerson does not agree that the criteria for a diagnosis of psychoneurotic depression are to depend in the main on reactivity; in his opinion the differentiation should be based on the patient's relationship to reality. He finds that in the neurotic this relationship remains fundamentally intact, while the psychotic lives in a world of phantasy, and the mood change, once produced, pursues a course at least partly independent of the environmental problems. Rogerson would include many "agitated depressions" among his anxiety neuroses.

Rogerson's theory would seem to imply that the psychotic state must have an abrupt and fulminating onset with an immediate and total maladjustment to reality. If, on the other hand, the onset were insiduous, a slowly changing process in which contact with reality was gradually lost, then it is difficult to see how it would be possible for the subject not to pass through a phase comparable to that classed by Rogerson as a separate clinical entity.

Kozol (1940) studied the acute anxiety attack in a series of 48 cases from the psychobiological viewpoint. He noted that manifestations of autonomic nervous disorders usually involved both sympathetic and parasympathetic

divisions, with some predominance of the former. The attacks appeared in a background of tension or chronic vague apprehension, but were not described by the patient as a mere exacerbation of these, but as something new. Regarding psychopathology, it was found that in the majority of cases the attacks were the end-result of a multiplicity of factors. Of these the most common single feature was insecurity, relating to affection, sex, marriage, health or economic status. Sexual difficulties played a role in four-fifths of the cases, and in nearly half were of primary importance. In early life the over-concern about the patient's bodily health on the part of an over-solicitous mother was frequently noted. Over one-third of the patients were "body conscious." The following personality traits seemed to be characteristic of the potential anxiety patient: egotism, hypersensitivity to the opinion of others, ambitiousness, aggressiveness, intensity and apprehensiveness. In only 5 out of the 48 was there no evidence of personal unbalance. In three-quarters of the patients there was a psychotic heredity; in about one-third there was a family history of anxiety attacks.

Palmer (1941) presents a paper on "attacks" which he points out are the meeting-place of the psychiatrist, neurologist and cardiologist. The psychiatrist refers to these as anxiety attacks; for the neurologist and cardiologist they are the vaso-vagal attacks of Gowers. Palmer prefers the term "vaso-automatic seizure." He describes a series of cases and concludes that these states form a continuum. At one end diathesis predominates, at the other psychic morbidity. Where there is a family or personal history of epilepsy, migraine, asthma or hay fever, where the attacks are occurring with a fairly regular periodicity, where the attacks are fulminating and punched-out in expression, and finally where the occurrence is more frequent than twice a week, it is assumed that the patient is diathetically predisposed, and that an intensive psychological approach is likely to be disappointing. In the predominantly psychogenic group the attacks may occur in anxiety states, phobic-obsessional states, hysteria and psychotic conditions. The point insisted upon in this paper is that it is essential to maintain the psychobiological approach in these cases, and to estimate carefully the relative degree of importance of diathesis and psychogenesis in the aetiology, for the former will not respond to psychotherapy.

Schilder (1941), in agreement with other psychoanalysts, is impressed by the importance of aggression in the psychological structure of the anxiety states. He points out that during the whole course of ego development the love object is not only a protection against deprivation, but is also feared as a possible aggressor. It is from this fear that the anxiety state may arise. Schilder thinks that the different types of anxiety neurosis can be classified according to the quality and structure of the aggressiveness:

"In the first group of cases the aggressiveness is directed against the love object as a whole. There is a tendency to wish the loved and hated person dead. . . . Cases of this type may be agoraphobic or may suffer from a fear of sudden death. Space is measured as the distance from the love object or from the place which symbolizes the love object. Pregenital sexuality does not play an outstanding part. . . .

" In the second group of cases the hostility does not tend merely towards the removal of the love object, but seeks a more far-reaching destruction. The anxiety attack leads to a fear of being dismembered. The love object appears as someone who threatens to push the subject into an inferior position. Pregenital sexuality becomes more important. Obsessional trends are more pronounced. Claustrophobic elements may also be present. There are more severe distortions of space. The fear of going insane may become more important.

" The third and last group puts the theme of dismemberment in the foreground. There are severe distortions of space. Violent impulses are more outspoken ; pregenital sexuality plays a still more important part. . . ."

Schilder also finds that anxiety may have its origin at various levels of ego-development. In early childhood it will react with anxiety when its supply of food is not assured. It will react in the same way if threatened by loss of equilibrium and by the physical forces of gravitation, for at this stage of development the love object represents among other things a safeguard against falling. The relationship between anxiety, clinging and equilibrium is the subject of an important paper (1939) by the same author. The main points of Schilder's theory are inserted here.

It is noted that clinging may take place by means of the mouth to the nipple or by means of the hands to the breast, hair or other parts of the body. Its aim is to secure equilibrium and support by union or reunion with the mother's body. The child will respond with anxiety or panic if he feels uncertain of being able to maintain his position. As he develops and in the favourable case he will acquire the necessary confidence to maintain his posture alone. If however he fails to acquire this self-confidence and continues to cling to the love object, his dependence will sooner or later be felt as a compulsion, with consequent aggressive feelings towards his supporter.

At a slightly later stage in development anxiety will be aroused in response to the idea that the inside of the body is threatened with destruction. This is related to the child's own aggressive impulses directed against the bodies of other people. At this level fear of dismemberment in general will become important and later, with the awakening of genitality, this will culminate in the theme of castration. Schilder also finds that different types of anxiety are associated with different attitudes towards death. Where there is only moderate aggression death will only mean separation from the love object ; where there is deep regression the idea of death may be associated with fears of dismemberment and annihilation.

Caner (1940) shows how fear and anxiety may stimulate superstitious self-protection, and that these symptoms may have the unconscious purpose of obtaining protection through propitiation. The superstition that misfortunes occur in groups and that good fortune will be followed by bad fortune are grounded in the belief of primitive man that misfortunes are caused by hostile gods and spirits. The idea that the powers that control fate may be moved to pity and mercy by suffering is present in the unconscious of most people. It has led to an unconscious mechanism of self-protection through suffering, and may express itself in pessimism, worry, puritanism, excessive mourning and other

neurotic and psychotic symptoms. In the author's opinion this mechanism is especially to the fore in biogenic depressions. Here the physiologically determined depression itself acts as an intangible and sinister threat against which the patient is unable to protect himself except by the mechanism of propitiation.

Body-scheme.—There is much evidence in favour of the view that each of us has, at the fringe of consciousness, a plastic and tridimensional bodily schema. This body image is built out of various perceptive elements, including superficial and deep sensibility, the sense of vision, and the vestibular sense. In a recent monograph (1939), Lhermitte, besides reviewing previous contributions by Head, Schilder and others, provides an authoritative study of the origin and nature of the body image, its deviations from the normal under certain morbid conditions, and finally its possible neuro- and psychopathology.

In the first chapter he traces the development of the body image in the child. By the age of nine months the child has learnt to distinguish self from non-self, but it is not until the age of two that he has learnt to appreciate the self as a unit. Play is found to be a most important factor in helping to form the body image. Lhermitte considers it unlikely that the image is fully developed until the age of eight.

Much of the author's evidence is derived from a study of the phenomenon of the phantom limb, a subject upon which he has previously made important contributions and which are incorporated in this monograph. Besides the well-recognized phantom limb of the amputated, a number of case-histories are presented in which the same phenomenon is met with in those suffering from various lesions of the central nervous system. Lhermitte favours the central rather than the peripheral theory of origin, maintaining that the body image is intimately associated with the cerebral cortex, more particularly the inferior parietal, marginal and angular gyri.

Besides the mutilations and distortions which portions of the body image undergo in cases of phantom limb, under certain morbid conditions the whole image may be projected into space as the illusion of a double. The more usual type is the external illusion, but a few are cases of internal illusion. Here as a result of a disorder of the coenaesthesic and visual senses, the patient believes he sees in front of him his viscera as if on a dissecting table. The illusion of a double may occur in normal people by a process of introspection, and under abnormal conditions such as the hypnotic state and in intoxication. More evidence is obtained by a study of psychopathological personalities. Here besides personal investigation of psychotic cases, the experiences of Goethe, Maupassant, Musset, E. A. Poe and others are reviewed.

Lhermitte believes that the fundamental psychopathological condition is a state of dissociation between the conscious, volitional and observing ego on the one hand and the physical ego, represented as the bodily schema on the other. In many cases closely allied to the illusion of doubles there is a failure to locate the conscious ego in space. To the subject it seems as if the observing ego is located outside the body, which it is able to watch as an automaton.

Teitelbaum (1941) presented two cases of hysterical body image disturbance associated with symptoms of agnosia and aphasia. He also described four

experimental cases, in which similar disturbance in the body image mechanism had been produced by means of the post-hypnotic suggestion that the patient would forget all about his, or the human body; or that he would forget the names of the parts of his or the human body. Teitelbaum finds striking similarities between the symptoms due to psychogenic causes and those due to irreversible organic brain disease. Despite this resemblance he thinks that these two types of disturbance occur on different levels of cortical function, and disrupt the psychogenic mechanisms involved by different means. Besides the hypnotically produced disturbances in the body image there occurred associated disturbances in aphasia, agnosia, and in the central perception of primary sensation. The degree and range of associated disturbance was found to be subject to wide individual variation. All cases, clinical and experimental, showed distinct disturbances in spatial construction. In the clinical cases the body image disturbances were found to be due to emotional problems.

Spillane (1942) also supports the view that disturbances of the body schema are sometimes associated with an organic lesion of the brain. The degree of disturbance depends not only upon the localization of the lesion, but also upon which side of the brain is affected, lesions affecting the left side being associated with more severe disturbances. In a case with lesion of the right thalamo-parietal region there was unawareness of left hemiplegia, periodic forgetting of the left arm or leg, and a disappearance of the left side of the body from consciousness. Hallucinations of sensation with transference to the normal side also appeared.

In a case of a lesion of the left parietal-occipital area there were disturbances of both sides of the body. There were confusion of right and left and finger agnosia. Often there were agraphia and acalculia. Spillane believes that the coincidence of finger-agnosia, acalculia and agraphia may result from proximity of cerebral localization and/or because there is some deep similarity between them.

Few among recent investigators have made a more exhausting study of the body image than Schilder; in his last paper (1942) on the subject he studied the manifestation as it appears in dreams. He finds that as a rule in dreams the body image appears in infantile form and symbolically disguised, even when it appears also in the manifest content of the dream.

Capgras' syndrome.—In 1923 the illusion of doubles was first described by Capgras. Subsequently a number of cases were reported in the French periodicals and the condition became established as Capgras' syndrome. Various theories have been put forward to explain the psychological mechanism at work, and these are shortly summarized by Davidson (1941).

This writer presents two male cases, and concludes that the illusion of doubles signifies a denial, negation or rejection of a person or persons, because they are the centre of psychological conflict. As a mental phenomenon the illusion belongs to the projecting and identification mechanisms. The degree of its expression depends upon the resources of the total personality and the degree of disturbance of affectivity. He further finds that there is always some regression to a magic form of thinking.

Catatonia.—Melici (1942) points to the similarity between catatonia and

the instinctive immobility reaction exhibited by certain animals confronted with a life-threatening situation. He suggests that this reflex is seen in catatonic patients who hide in corners, and where negativistic behaviour is clearly a rejection of the outside world. A more complete rejection, catatonic stupor, is described as a feigning of death to escape a disagreeable reality. He believes that the constitutional make-up, the catatonic reaction type, is the most important aetiological factor, and that under stress, physical or chemical but usually psychical or social, this form of evasion of the life situation will take place.

The author believes that there may be in some cases a conscious rational motive—that is, that the catatonic deliberately regresses to a phylogenetically older mechanism. It is further noted that there are striking similarities between stupor, sleep and death. All three can be considered flights from burdensome life. Normal sleep is a regression, and at the onset of psychosis there is often an increased desire for sleep. Melici regards catatonic stupor as a form of psychological suicide. The author makes no mention of anergic and hysterical stupor, to which his psychological theory would appear to apply more aptly. A study of his case-histories rather suggests that some of his "catatonics" may have been melancholics. There is a good deal of evidence in favour of the view that the catatonic is a physiological more than psychological reaction type, though the latter may play its part in some cases.

"Dejà vu."—According to Oberndorf (1941), the "*déjà vu*" phenomenon arises when the present situation has an associative link with some past experience or occurrence for which the individual is amnesic. This forgotten incident had been the centre of psychological conflict and consequent repression. "*Déjà vu*" is in fact a defence mechanism and is, in Oberndorf's experience, always associated with an unpleasant feeling tone. Analysis shows that the forgotten experience is invariably one of uncertainty and failure. The "*déjà vu*" reaction serves to reassure the individual against this insecurity; it is no new danger; it has happened before and he has survived. The phenomenon is common in young persons, and not uncommon in the normal adult. In the psychoneurotic it is frequently associated with other more distressing symptoms—depersonalization and feelings of unreality. These last have the same psychopathology as "*déjà vu.*"

According to Freud and Ferenczi, "*déjà vu*" is a response to an Id wish which, provoked by a real situation, emerges and causes the unconscious ego to defend itself against it. In place of the repetition of an unconscious fantasy appears the sensation of "*déjà vu.*" For both Freud and Ferenczi the Id impulse is primary. In contrast to the Id type of "*déjà vu,*" Bergler (1942) describes two examples of what he calls the super-ego type. In this type the unconscious ego defends itself against a reproach of conscious by means of "*déjà vu.*" In both the Id and super-ego type the identity of this repressed fantastical experience is replaced in consciousness by the identity of the apparently real situation.

Da Costa's syndrome.—Da Costa's syndrome is usually described as being characterized by a "certain group of symptoms which unduly limit the subject's capacity for effort, and by a number of signs depending upon disturbance of

the automatic nervous system, when such symptoms and signs are not due to any known organic disease." Having enumerated the cardinal symptoms, Wood (1941) points out that this definition pays no attention to the psychological aspects. In his opinion the clinical features of the syndrome more closely resemble those of emotion, especially fear, than those of effort. In this connection it is noted that "effort syndrome in the male soldier becomes cardiac, respiratory or other neurosis in the female civilian." Wood believes that emotion, usually fear, acts as a central stimulus, provoking the somatic symptoms. The syndrome does not depend upon hypersensitivity of the peripheral autonomic system. Various factors relate the syndrome to effort. These include misinterpretation of emotional symptoms, certain vicious circle patterns, the growth of a conviction that the heart is to blame, consequent fear of sudden death on exertion, conditioning and hysteria. Incapacity tends to be exaggerated consciously or subconsciously in order to protect the individual from further painful emotional experience. Since a proper psychiatric diagnosis is nearly always available, it is urged that the diagnosis "effort syndrome" should be dropped.

Wood provides a large series of cases to demonstrate his hypothesis, and the evidence of emotional factors as the cause of the condition is overwhelming. A careful study of cases described as constitutional, induced, post-infective and physically fatigued types proved that such subdivisions were meaningless. In all cases the essential common factor was the emotional reaction.

If, however, it is clear that physical factors are not a cause of the effort syndrome, it has still to be shown that such a psychological mechanism cannot or does not produce irreversible tissue changes, as is believed to be the case in many other psychosomatic syndromes. If such were the case it would be likely to occur in just those patients who did not come for treatment until organic changes had occurred. Lastly, Wood offers no satisfactory explanation as to choice of organ, and unless a psychoanalytic explanation is accepted, it would appear necessary to postulate a constitutional organic predisposition.

Depersonalization.—According to Wittels (1940) the normal young person makes use of the mechanism of identification in the formation of his personality. He forms within himself a varying number of phantom figures; an ideal or ideals are set up which he more or less successfully imitates.

In cases of depersonalization an unusually great number of phantom figures are set up, leaving the ego in such a position that it cannot decide which one of the figures has to be acknowledged as its representative; in other words insufficient ego libido is invested in any one of these phantoms.

Wittels finds that in all cases of depersonalization the genesis of the condition can be traced back to an unsatisfactory father-child relationship. It is therefore the super ego, the representative or phantom of the father which cannot be satisfied, which, by condemning all the phantoms as unreal, is responsible for the disintegration of the personality.

Brock (1942) concludes that depersonalization and derealization are symptomatic of disturbance at the highest levels of consciousness. They may occur in a number of conditions, some cases being ascribable to psychogenic, others to organic causes. Regarding the latter it is noted that depersonalization is

closely related to "*déjà vu*"—a condition which, he states, is known to be due to organic disease of the temporal lobe.

Dys-symbole.—As a result of his work with shock therapy Skottowe (1939) finds that there exists within the schizophrenic group at least three subgroups, which call for differently arranged and proportioned forms of therapy. The first of these types is characterized by dys-symbole, defined as a "state of mind which manifests itself by the inability of the patient to formulate his conceptual thoughts upon personal topics, or to discriminate the gradations of his emotions in language which is intelligible to others, notwithstanding that he may be in a state of clear consciousness, while he still retains word-utilizing ability at the level of perceptual thinking and so is not aphasic in terms of sensorimotor neurology."

The second group, dyskinesic, is taken to mean a disorder of motility of such a nature that the movements are fragmentary or incomplete and appear to be purposeless, although not without conscious concomitant, when considered in their environmental setting and in relation to the content of thought.

The third group, simple paranoid thinking, is applied to cases without difficulty of formulation, and in a clear intellectual setting. They are therefore to be distinguished from the more complex paranoid states, which are really florid manifestations of dys-symbole.

Skottowe maintains that shock therapy may at best clear up the florid symptoms in the first group, but it leaves the essential psychopathological change, dys-symbole, untouched. The dyskinetic group do well with shock therapy; improvement is certain and recovery is probable. The simple paranoids become more accessible with shock therapy, and if it is adjuvated by psychotherapy a good result may be expected.

Thomas (1940) goes further still. He confirms dys-symbole as a valid clinical sign and suggests that it is pathognomonic of true schizophrenia. He thinks there is much to be said in favour of a reversion to the older term "primary dementia" for this psychosis, in order to differentiate it from anomalous schizoid states of different quality which are often labelled "schizophrenia." He also finds that dys-symbolic cases do not recover with insulin or convulsant therapy, although the more prominent symptoms may be temporarily relieved.

The present writer is by no means convinced that the concept dys-symbole adds anything to our knowledge of schizophrenic thinking, or that it represents an advance on the work of Stransky, Bleuler and Storch.

Exhibitionism.—Rickles (1942) is of the opinion that exhibitionism may be a separate entity as well as a symptom of another disease. The same is true of any anti-social act—for instance fire-setting or stealing. He suggests the following classification: (1) Depraved—including all cases where the exhibitionist has carnal knowledge as his intent; (2) psychotic—where the act is only a minor manifestation in the pathological behaviour of a paralytic, epileptic, senile, or alcoholic; (3) expomania—where the act is the paramount symptom in an otherwise healthy personality. In these last the exhibitionism is due to a compulsion neurosis. He finds marked Oedipus fixation, and poor heterosexual and economic adjustment, the last despite a high educational

and intellectual standard. Most of his cases had a pathological degree of repression and responded well to psychotherapy.

Fetishism.—Payne (1939) finds that the fetish is over-determined, being dependent upon a number of factors. In her opinion the fetishist is dominated by castration fear and she traces this fear to pre-genital causes, the chief of which are repressed sadism, and fixation at the oral and anal stages. Freud's view that the fetish is a defence mechanism against homosexuality is hardly touched on. Instead, there is, in the Klein tradition, much discussion of orally incorporated part-objects and of projection-introjection mechanism.

W. H. Gillespie (1940) provides a much more balanced psychopathological theory. He agrees with Payne on the over-determination of the fetish, the importance of castration anxiety, sadism and introjection-projection mechanisms. On the other hand, he criticizes the tendency to regard all symptoms from the oral and anal levels. He finds that superficially obvious oral and anal features are often used to mask more important underlying phallic anxieties. He also reminds us that it is castration anxiety we are dealing with, not the trauma of weaning. He confirms Freud's view that the essential mechanism is one of defence from sexual inversion, and that the castration anxiety means to the fetishist a talion punishment for incestuous wishes directed towards the mother.

Folie à deux.—Deutsch (1938) studied four cases psychoanalytically. For this school the mechanism of identification plays a most important role. The delusional idea of one person, it is contended, will only be taken over by the induced when there already exists in the latter a repressed phantasy life of similar content. Such a phantasy will concern the Oedipus situation, and the inducer will be identified, in the mind of the induced, with the parents, whose place in the original phantasy he takes over.

Last and Coleman (1939), in citing three instances, consider that a number of contingencies must be present at one and the same time. An inducer holding a delusional scheme which he is anxious to induce. It is essential that he should still be at the resilient stage: that is he must not have come in for so much hostile criticism as to have resulted in total withdrawal into himself. Again, his delusional system must not be of so personal a nature and so inelastic as to present no pragmatic solution for the personal problems of another individual There must be in close proximity for many years a suggestible individual of the hysterical type, capable of taking over the delusion. Here again the ideas which the inducer wishes to propagate should be acceptable to the lifeline and wish-fulfilments of the induced. As has been generally agreed, the inducer, in some way or other, must represent authority. It is noted that extreme poverty is the ground upon which folie à deux flourishes. Page (1942) supports these contentions.

Gralnick (1942) provides the most exhaustive study of the condition. The literature is reviewed and a table appended which represents all the cases (102) reported in English, the author himself describing seven examples. As a comprehensive term " the psychosis of association " is preferred to folie à deux, which is considered to limit the clinical entity in a number of undesirable ways. The usual four subtypes are recognized: Folie imposée, simultanée, com-

muniquée and induite. Of these the imposed type is the most common (61 out of 102 cases), followed by the communicated type (24 cases). The frequency of combination is: Sister-sister (40 cases), husband-wife (26 cases), mother-child (24 cases), and brother-brother (11 cases). The following reasons are put forward to account for the fact that folie à deux is more frequently found in women: they tend to be more isolated within the domestic circle; they are, on the whole, more passive, submissive and suggestible; their outside interests and ambitions are more likely to be restricted or frustrated. The evidence, according to the author, does not go to prove that a constitutional predisposition is a significant factor. The importance of identification is stressed in the mechanism of folie à deux. Paranoid delusions are found to be preponderant, and the aetiological significance of homosexuality is discussed.

Oatman (1942) presents a case in identical twin-brothers. His example illustrates some of the points stressed by other writers, viz.: the illnesses in the two brothers showed resemblance to a remarkable degree; they had led an isolated life for a number of years; one brother was clearly the aggressor, while the recipient was of a neurotic make-up and fertile ground for a psychosis. Though the author admits that communicated insanity may occur in three, four or even five persons, he insists that the term cannot be applied to larger groups who "adopt the religious or pseudo-philosophic delusion of their self-appointed leader." Unfortunately Oatman does not back up his statement with an explanation. It would be interesting to know what new motives or mechanisms are introduced when the specific number of five has been passed.

Hallucination.—Maclay and Guttmann (1941), in a further attempt to throw light on the physio- or psychopathology of hallucinations, have made a study of visual hallucinations during mescaline intoxication. Some of the pictures, representing the visions, were characteristically formal and repetitive and could be accounted for entirely in physiological terms; in others there were many features representing the free play of phantasy. The authors conclude that hallucinations during mescaline intoxication cannot be explained in either physiological or psychological terms alone. It is further pointed out that these conclusions cannot be applied to other hallucinatory conditions without further study.

Impulsions.—Bender and Schilder (1940) describe a condition peculiar to children and closely allied to compulsions and obsessions, which they call impulsions. In these cases specific interests, ideas and actions dominate the clinical picture and make social adaptation impossible. The symptomatology comprises continuous looking at and handling of a specific object; drawing of the object; preoccupation with the object in fantasies or in thoughts; excessive walking; counting and preoccupation with numbers and space. The subjects insist upon immediate fulfilment of their wishes and cannot stand any frustration. The patients are stubborn, show hypochondriacal preoccupations, and may use asocial means to satisfy their strong desires. The authors found these symptoms in boys between the ages of four and twelve.

Impulsions differ from compulsions and obsessions in that in the two last the subject protests against his thoughts and impulses. This is not so in the

case of impulsions, which are characteristic of childhood, where the ego-super-ego system is comparatively inefficient. The condition may pass on to obsessions or compulsions in later life. Impulsions take their origin from early infantile situations and desires, and can be compared with the preoccupations of infants under two. They are never direct expressions of sexual and aggressive drives, but are always related to the family situation, and are, therefore in many respects, the result of transformations and symbolizations.

Insight.—Insight is a very valuable concept, especially as far as prognosis is concerned. It is however, as is clearly demonstrated by Campbell (1940), most difficult to evaluate. Insight and judgment, it is shown, are an exact index of each other and involve similar mental function. According to Campbell, insight is concerned primarily with the awareness of psychological change; secondarily, with the judging of this change, as to whether it is recognised as morbid; or in a sick mind the change may be judged to be the result of demoniacal possession, religious influence or other preternatural intervention. In any mental disorder it is with the whole disordered personality that the patient contemplates his state or special symptom. Insight is therefore bound to be distorted in one contributing function or another. In certain cases, it is shown, statements superficially indicating insight are the most outstanding features of the psychosis, and far from indicating insight are a result of severe disturbances of affect, such as severe anxiety, self-reproach or hysteria. Typical examples are such remarks as "I must be mad" or "I ought to be in an asylum." It is therefore concluded that insight is only relative, and should never be stated categorically but only with appropriate explanatory terms.

Osgood (1940) studied the insight of 100 patients discharged from hospital. He found that of those diagnosed depression on admission there were a greater proportion of patients who showed good insight on admission than among those with other psychoses. Psychoneurotics all showed fair to good insight. He found that absence of insight on admission did not impair the prognosis for recovery, but patients with partial insight showed a poorer recovery-rate than either those with no insight or those with good insight.

Psychosomatics.—During recent years considerable evidence has accumulated to suggest that certain physical disorders are determined to a varying extent by psychological factors. The experimental work of Pavlov has had undoubtedly an important influence on this line of research, even though the Pavlovian theory itself pays little attention to psychological phenomena. Both psychobiologists and psychoanalysts have studied this subject, and their contributions will be reviewed in turn. The two schools differ in the main in their explanation regarding choice of organ. According to psychoanalysts, psychological factors are all important, while psychobiologists include other determining factors. The approach of the individual psychologist has been discussed in the first section.

Noyes (1939), for instance, stresses that while the constitution is the most important single factor in deciding the choice of organ, psychological factors may also play their part. These include the nursing of a near relative with a specific organic disease and overvaluation of an organ on account of occupation.

Noyes makes some attempt to differentiate between the types of psychosomatic disorder. His first group includes those organic disorders which are secondary to psychological stress. The psychological stress produces anxiety, which in its turn causes dysfunction of the endocrine-automatic system. The next group includes organic diseases and accidents, in which there is an overlay of psychotic symptoms on account of the disability, financial loss or compensation factors. Finally there is the pseudo-organic symptom of the hysterical type, which has an underlying emotional conflict and in which the symptom has a symbolical meaning for the subject.

Fox (1942) thinks that the greatest danger in studying psychosomatic states is the fundamental habit of viewing body-mind problems as dualistic, instead of as a psychobiological entity. It is equally unfortunate for the patient whether the over-emphasis be laid upon the physical or the psychical sphere. In a series of cases Fox attempts to demonstrate that the bodily parts and functions should be included in the biographical stream according to their symbolic participation in the life of the person. Choice of organ in psychosomatic disease may be determined in two ways. First the organ may act as a symbol referring to a special experience—for instance, vomiting because of disgust—and secondly the organ may act as " symbolee "—that is, the object symbolized, for instance, where a patient states, " He makes me sick."

Jelliffe's monograph (1939) presents the psychoanalytical point of view. His general theory is that as a result of mental conflict and repression in certain neurotic types libido becomes fixated upon a particular organ or system. At first this process is reversible and is called an organ neurosis. Later, as a result of prolonged faulty adaptation, structural changes will occur. The condition is now irreversible—organic disease. Jelliffe illustrates his theory with numerous case studies, which include skin lesions, arthritis, hyperthyroidism, cardiovascular disorders, gastro-intestinal conditions, asthma, pulmonary tubercle and disease of bone.

Notkin (1941) provides a useful review of the principal contributions during the years 1933 to 1939. He believes that a conscious or unconscious unpleasant emotional stimulus reaches the thalamus. This induces prolonged overactivity of the autonomic system. This overactivity, in its turn, causes over-stimulation of the end-organs and consequent dysfunction—organ neurosis—and passing on finally to structural changes—organic disease. It is not made clear if the choice of organ is constitutionally determined, or depends on psychological factors.

It may now be in place to examine contributions on specific psychosomatic syndromes. Da Costa's syndrome and speech disorders will be found under separate sub-titles.

Miller (1941) presents four cases of cardiac disturbances deriving from emotional stress. It is shown that the symptomatology is often patterned after parental disabilities, and that at a deeper level, the parent of the same sex is represented as a powerful adversary towards whom the patient was impelled to adopt an aggressive attitude. This aggression is compensated for by guilt, fear of losing parental love and self-punishment by means of the cardiac symptomatology. Herrmann (1942) concludes that disturbances of

psychogenetic and neurogenetic origin make up from one-third to one-half of all the disorders in cardiovascular consultant work. Weiss (1942) emphasizes the multiple factors in the aetiology and pathogenesis of essential hypertension. He stresses that while the physical problems should not be neglected, the emotional component is intimately related to its development. Although all varieties of character and neurotic disturbances occur in hypertensive individuals, he finds that a common problem appears to be the presence of emotional tension due to chronic repressed hostility. In his opinion this inhibited aggression (chronic rage) bears a specific relationship to hypertension.

French (1939) made a study of a series of cases of bronchial asthma. He concludes that psychological and allergic factors stand in a complementary relationship to each other in the aetiology of this condition. In some cases asthma attacks are precipitated by allergic factors alone, in others by emotional factors alone, and that in still other cases co-operation of allergic and emotional factors may be necessary to produce attacks. Regarding the emotional factor, he finds that asthma is precipitated by a temptation which threatens to estrange the patient from a mother figure, and that the personality of the asthmatic is built up in a large part around the task of mastering by one means or another the fear of being separated from the mother. In some cases it was found that the substances to which the patients were allergically hypersensitive proved also to play a role in their psychological material—that is, the substances had a symbolic meaning associated with the essential emotional conflict.

Basing his conclusions on a large series of cases, Morrison (1942) describes a distinctive psychosomatic ulcer pattern manifesting itself not only in the duodenum, but also in the digestive tract and in the constitutional behaviour of the patient. This pattern is characterized by hypersensitivity, hyperirritability and hyperactivity. He is of the opinion that psychological influences may represent an aetiological factor, though the mechanism requires further elucidation. Wilson (1939) made a study of 50 haematemesis patients, and found that they can be divided into several psychological types. The main group of about half the patients suffered from obsessional anxiety states or corresponding character disorders. The second group, about one-fifth, showed, in addition to obsessional features, hypochondriacal and hysterical phenomena. An intermediate group had shown a change from a predominance of hysterical to a predominance of obsessional reactions. Single examples of two other types are described. Common to all his patients was an abnormally high need of security. In the history of their sexual development and in their social relationships all showed evidence of emotional immaturity. Their reaction to illness and stress was with depression and the compulsive form of anxiety. From an examination of the precipitating situations it is concluded that patients with this disorder are hypersensitive to problems of security, independence and responsibility. In the majority of cases it was evident that a self-punishing tendency was finding expression in the gastric disturbance; only in the hypochondriacal group was evasion of responsibility the unconscious motive. In other words, the anxiety was due to fear of conscience, not fear of the instincts. Wilson does no more than suggest that ultimately the abnormal gastric

response to threats to security may arise as a late result of abnormal conditions during the period of development. Inadequate infantile histories prevented a verification of this.

Sleep disorders.—In an interesting symposium on neurotic disturbances of sleep, Fenichel (1940) sums up the psychoanalytic viewpoint. Relaxation is an essential concomitant of sleep and, in the neurotic, a state of tension exists. This state of mental tension is due to unconscious stimuli, which are not under the control of the conscious wish to sleep. Generally speaking, it may be said that the neurotic fears sleep because he knows that repressed impulses push forward with greater force in the state of sleep or falling asleep. Analysis reveals various psychological conflicts behind the fear of falling asleep; these include bed-wetting, masturbation and wet-dreams, memories of the " primal scene " and oral complexes. According to some of the writers of this symposium it is likely that oral instinctual conflicts are a *sine qua non* for all severe sleep disturbances. Melancholia, it is pointed out, where orality and super-ego dominance are paramount, goes hand in hand with the most serious disturbance of sleep. Besides fear of temptation the neurotic may be prevented from sleeping by fear of his conscience and of punishment. As a rule both fear of temptation and punishment are present together. As is well known, immediate conflicts and difficulties, the day's residue, will interfere with normal sleep, but it is only when these become linked up with repressed material that neurotic insomnia is induced. The other papers in this symposium are of considerable interest, but are more concerned with analysis of individual cases, *pavor nocturnus* and insomnia in hysteria anxiety and obsessional states, rather than general psychopathology.

One of the most interesting disorders of sleep is what has been termed the "narcoleptic-cataplectic syndrome." The syndrome consists of a number of constituents, one or all of which may be present in the same individual, but which are believed to have a common psychopathology. There have been several papers on the condition in recent years. Brock and Wiesel (1941) define narcolepsy as a type of irresistible sleep or a trance-like state which may correspond to the polyphasic sleep seen in lower animals and infants. It is indistinguishable from normal sleep, save that it may occur under circumstances not usually conducive to sleep. In cataplexy the individual undergoes a partial or complete atonic deposturing, most frequently in reponse to emotional reactions. He is in complete control of his mental faculties, but manifests all the physical attributes of deep sleep. It may be followed by " mental " sleep. Sleep-paralysis (Wilson) is similar to cataplectic paralysis, but follows or precedes normal sleep or narcolepsy. Somnambulism and somniloquism are often found in these individuals. A further constituent is sleep-hallucinosis, where fearful dreams are experienced in the hypnagogic state before or after normal or narcoleptic sleep.

Brock and Wiesel support the view that sleep is composed of two parts, the mental and physical. In the narcoleptic-cataplectic syndrome there is an excessive and dissociated reaction of the sleep mechanism; composed of a number of constituent parts (*vide supra*). The fundamental cause of the syndrome is unknown, but these authors favour the view that it is an organic

disease. Again the area of the brain involved is a matter for speculation. One of the two cases of sleep hallucinosis, here described, subsequently developed a paranoid hallucinatory psychotic state on the basis of the abnormal dream content. They also note the resemblance of these conditions to hysteria. Lichtenstein and Rosenblum (1942), discussing the psychopathology of sleep paralysis, agree with Pavlov that it is a manifestation of localized sleep; the motor centres are "asleep" while consciousness is awake. They consider that when it accompanies natural sleep it is a benign condition, and they advise that the patient should be assured that it has never been known to result in permanent paralysis or other form of disease. No view is expressed as to its organic origin. Murphy (1941) concludes that narcolepsy is a border-line syndrome common to cases of both functional and organic brain disease. The pathogenesis is the same in both cases, and consists of the release of a primitive type of sleep mechanism. Narcoleptic sleep is indistinguishable in appearance from normal sleep. Levin (1942) presents a case in which forgetfulness and difficulty in learning were associated with narcolepsy. He concludes that the presence of such symptoms, often not observed, supports the theory that narcolepsy is due to cerebral inhibition. Hadley (1942) describes a case of narcolepsy in which a diagnosis of glioma was made by ventriculogram. The glioma was removed, the pressure symptoms relieved, but the attacks of narcolepsy persisted. He considers the glioma to have been coincidental. The various theories, functional, cortical, diencephalic, symptomatic of gross brain lesion and endocrine are reviewed without comment. In the present state of our knowledge this is probably the safest attitude.

Speech disorders.—According to Bender (1942), experimental evidence of the personality of post-pubertal male stutterers, i.e. morphology, mental capacity and temperament, indicates that they have characteristic aspects of personality.

In the more stable aspects, e.g. physique, blood chemistry, the evidence is the strongest. For instance, it is found that the body build is leptosomatic and never pyknic. In the less stable aspects, e.g. intelligence, perseveration, the evidence is significant. Stutterers are found to be afflicted characteristically with perseveration and to be more intelligent than non-stutterers. In the least stable aspects, e.g. temperament and personality traits, the evidence is not so strong as in the other two. It is found that stutterers are more emotional, more introverted, less sociable, less dominant and less self-confident. It is thought that the stuttering personality traits of the last group are a result and not a cause of the affliction. Greene (1942) points out that the majority of so-called functional conditions are not speech or voice defects in the usual sense of the term, but are merely peripheral manifestations of some more serious underlying involvement. This is more particularly true of stuttering, which is defined as "a disorder characterized by repetitions or prolongations of syllables or words, or by mouth contortions, all of which produce interruptions and breaks in the rhythm of speech." He isolates clonic, tonic and mixed types. The last approximates to a localized epileptic fit, but the author is not prepared to say that there is a common cause.

Regarding the psychopathology of the stutterer Greene concludes that

stuttering speech is a "somatic manifestation of an emotional disorder based on a definite psycho-biological variability involving the organism as a whole." Because there are certain characteristics common to stutterers as a group he is inclined to isolate a stutter type.

The stutter type demonstrates "a basic tendency towards excitability and disorganization, an exaggerated capacity for response to stimuli, and a relatively high potentiality for the spread of emotional tension. Their mental and physical activities are continually being disturbed or inhibited because of uncontrolled reactions. This disturbance is manifested (in psychosomatic performance) by arrhythmia and hesitancy, which is in fact a form of stuttering."

This hesitancy, besides expressing itself in speech, may also be shown in other voluntary activities and may also involve the automatic system. The exact mechanism underlying stuttering is unknown, but there is strong evidence of a constitutional factor predisposing to emotional instability. Over 50 per cent. of the writer's patients showed a family history of stuttering, and when other forms of psycho-somatic disorder are included the percentage is much higher. Greene believes, however, that stuttering will not occur in the absence of an active precipitating factor. There must, therefore, according to Greene, be three factors present before stuttering can occur—constitutional emotional hypersensitivity, a precipitating psychic trauma, and to determine the choice of organ an inherent weakness of the vocal mechanism.

Psychophonasthenia presents much the same problem as stuttering. It usually occurs in late adolescence and adulthood, especially in professional men and women. Patients complain of a tight, constricted throat and of an uncontrollable choking sensation while talking. "The voice is pinched and grating, and cracks frequently, breaking suddenly to another key or choking off completely." This condition also is of psychical origin, a symptom of neurotic anxiety—"anxiety which has been physiologized in the vocal tract." The onset can usually be traced back to some psychical trauma, though there had been in nearly all cases a neurosis before the voice symptom developed.

In hysterical aphonia, again, minor psychic conflicts are converted into vocal dysfunction. It is usually a negative reaction to some environmental situation which is distasteful or which threatens security or happiness.

Regarding "falsetto voice," Greene finds that in the majority of cases it is a neurotic manifestation of excessive sensitivity at the pubescent period. The popular stigma of doubtful sexuality is, in the majority of cases, undeserved.

In general Greene finds that while the stresses and strains of puberty may precipitate these vocal and speech disorders, the essential cause, personality and behaviour maladjustment, will be found to have been developing long before. He further associates the various speech disorders with specific personality types, given the other necessary aetiological factors described above. The nervous, emotionally hypersensitive, disorganized child will become a stutterer; the inhibited, fearful and seclusive child will develop psychophonasthenia; the timid, sensitive, effeminate child falsetto voice; and the flighty, hyperemotional type with temper tantrums hysterical aphonia.

Suicide.—In a series of 150 cases of suicide Siewers and Davidoff (1942)

find that a large majority showed defective personality integration. About 20 per cent. were psychotic, and an organic disease was present in about 33 per cent.; in 29 no classification could be arrived at. More women attempted suicide, more men actually committed suicide. Successful suicide was more common in older people. Sex difficulties and lack of occupation were frequently encountered as factors in the aetiological constellation. The authors consider that attempted suicide is a manifestation of the catabolic phase of the life process. In this state the catabolic processes, including the psychological component, take precedence over the anabolic forces. The mal-integration of the personality or the occurrence of psychosis or physical illness, as observed in many of the patients, indicates the presence of a catabolic process which exceeds the anabolic. In advancing years and in senescence where the catabolic process is progressive and irreversible, the likelihood of successful suicide is increased. If this means that in the suicide the desire to die outweighs the will to live, it will probably be generally conceded.

Palmer (1941) made a study of 25 suicidal attempts. He finds that the alleged "cause" is at most only a precipitating factor, and that the essential motive is to be looked for in the early formative years when the structure of the ego and super-ego were being formed. He believes an arrest in psychosexual development to be the basic mechanism in a majority of suicidal attempts. This arrest is often due to the unavailability of one or both parents as love-objects, as "stepping-stones" in psychosexual development and as active forces in super-ego formation. The unavailability is usually due to death, but it may follow separation, divorce or social deterioration of one or both parents. In Palmer's series 16 patients lost a parent and one patient a sibling before the age of 14 years—a percentage of 68. Reitman (1942) also investigated 25 suicidal patients, and in his series the coincidence of suicide and early loss of a parent was established in 60 per cent. of the cases. Reitman admits that the numbers are too small to be of statistical value, but they do, however, support the probability of a prediction of suicide based on this fact.

In contradistinction to the general view, Prudhomme (1941) finds that the suicidal rate among epileptics is more than twice the mean rate found in the general population. His figures are those for Craig Colony for a period of 14 years. In his opinion, epilepsy is a psychobiological reaction type, the "fit" being considered a temporary escape mechanism. The epileptic, it is pointed out, often experiences a symbolic death in the "fit," and as a result much of the fear of death has been removed. The tonic and clonic stages represent symbolically an organismic struggle between the two basic instincts of life and death. It is suggested that such repeated episodes and the temporary relief that they bring prompt the epileptic to seek suicide as a final and complete deliverance from his troubled existence.

Pescor and Spurgeon (1940) made a study of the suicidal motive in 28 hospitalized drug addicts. As a result they were able to distinguish two personality types. The first group were genuine suicidal patients, and were men round about the age of 40. They had usually become addicted through physical illness many years prior to admission. Childhood adjustment, economic and domestic adjustment before addiction were all satisfactory.

The suicidal episode, usually preceded by severe depression, occurred when the patient was no longer dependent on drugs. The second group were those who made a histrionic gesture at suicide. The average age was some ten years younger, and the history was that these patients had become addicted either from curiosity or association. Childhood, economic and social adjustment were invariably unsatisfactory. The patients were usually found to be largely dependent on illegitimate sources of income or to sponge on relatives and friends. Sexual adjustment was unsatisfactory, often with a leaning towards homosexuality. Many had a psychotic heredity and/or a history of previous mental illness.

In a less ambitious paper, which does not attempt to explain suicide, Thorner (1938) provides an interesting contribution to the subject in a study of two cases. What he shows very conclusively in his cases is that the choice of method is determined by the subject's phantasies. In the first case, with a wealth of phantasy about food and eating, poisoning is attempted. In the second case, where phantasies and fears regarding voice production predominate, strangulation is the method of choice.

War and psychopathology.—In the causation of mental illness the psychopathologist would very much like to know more about the relative importance of constitutional and environmental factors. From the point of view of theory it would be particularly interesting if it could be shown that severe mental stress, sudden or prolonged, such as is met with in war, could produce mental abnormality in a constitutionally healthy adult. As is to be expected, at the present time, there have been a large number of papers in which these and other psychopathological problems associated with the war have been investigated.

In *The Neuroses of War* (1940) E. Miller provides an excellent chapter on "Psychopathological Theories in War-Time." Actually there is only one theory, that of Miller, though this takes its origin from a number of sources. His thesis is that whether the instinctual apparatus is explained by reflex mechanisms or not, we must assume the existence of inborn needs which are the instruments for man's survival. Man's cultural achievements to some extent mask these needs, but the whole range of psychiatric and psychotherapeutic practice gives illustration of disorders in which hidden biological needs are not clinically obvious, but in which unsatisfactory adjustments to social and private needs are certainly inferred. In the war neuroses in particular there are conditions of life which frequently place an immediate and overwhelming strain upon the instinctive endowments. His main point is that though circumstances of war often allow considerable latitude to certain instinctive demands, this is offset by the fact that the individual soldier in the release of these urges must conform to a very strict pattern of behaviour. For instance, the instinct of aggression may have great opportunities for expression, but only under the restricting influence of discipline. Again, the instinct of self-preservation may be very much to the fore, but it must not override "retreat according to plan." The individual soldier comes into a war with a fully formed personality and individual mechanisms by which he reacts to difficulties. As to how he will conform to army regulations and discipline will

depend upon the resilience of his personality, and upon whether he has built up defence mechanisms against stress that are within normal limits. Certain types, particularly the narcissistic and those troubled by guilt feelings, will find it especially difficult to fit in with military discipline.

Sargant and Slater (1940) made a study of men suffering from acute "shell-shock" following the evacuation of the B.E.F. from Dunkirk. They found that patients admitted between the outbreak of war and this episode had broken down under the comparatively trivial stresses of life abroad under army conditions, without any of the severe strains entailed in actual fighting. In these the past history in the majority showed personality deviations, constitutional instability and lack of stamina. On the other hand, the acute war-neuroses demonstrated that men of reasonably sound personality may break down if the strain is severe enough. Even in this group it was thought that there was an excessive proportion of men who had suffered from nervous trouble in earlier life—larger, that is, than would be expected from a sample of the general population. Therefore here, too, constitutional factors could not be denied. They conclude that while these men might have remained mentally healthy under normal strain, the excessive physical and mental stress to which they had been subjected was an important aetiological factor.

As compared with the last war, Hadfield (1942) is struck by the difference in the picture presented of the neuroses in hospitals in this war. The increase in psychosomatic disorders was to be expected, for the importance of psychological factors as a cause of gastro-intestinal, cardiac and other somatic conditions had not at that time been so fully appreciated. He also notes an increase in the number of patients labelled mentally backward and of the "psychopathic personality" group. The most striking change is the greatly increased proportion of anxiety states as compared with conversion hysteria. In Hadfield's series of psychoneurotics in this war, 64 per cent. were anxiety states and only 29 per cent. hysteria. He cites a number of possible reasons for this. In the first place there were far more traumatic cases in the last war; and traumatic experiences, owing to their physical accompaniments, are more likely to produce somatic symptoms of the hysterical type. Secondly, owing to this war being nearer to the home front, many chronic neurotics who should never have been recruited, and who in the last war would never have found their way to France, break down and are admitted to the neuropathic hospital. Hadfield regards these as "civilian" cases and not as true war neuroses. Finally this change in proportion may be due to the opposite fact, namely, that the air-raids have brought us nearer to the front line; and the evidence goes to prove that the nearer the front line, the greater the proportion of anxiety states compared with conversion hysteria.

Hadfield next considers how far these neuroses are attributable to, or how far they are aggravated by, war service. In his series of 332 patients, in 60 per cent. of the cases the neurosis had little or nothing to do with war service, whereas the other 40 per cent. could be regarded as war casualties. In 82 per cent. of 326 cases there was a predisposition of a constitutional or acquired type. However, in a more detailed investigation of 100 patients only three showed no psychological predisposition. He concludes that precipitating

factors, even when as important as the traumatic experiences of war, seem incapable, except in a few cases, of producing a neurosis unless there has been predisposition.

Granting then that there is predisposition, Hadfield's next inquiry is as to the relative importance of constitutional and psychological predisposition. By constitutional he means innate, endogenous and dependent on the physiological and biochemical make-up of the individual; by psychological he means acquired and due to environmental conditions, especially in early childhood. The amount of predisposition was found to be about equal; of 289 cases, 49·4 per cent. were predominantly constitutional and 50·6 per cent. predominantly psychological.

Lewis (1941) employs the sampling method in order to estimate the incidence of neurosis in England under war conditions. His data were obtained from psychiatrists, clinics, general practitioners, medical officers of health and others. Some of the evidence is set out statistically; the rest is an expression of opinion. All the principal areas subjected to intensive air-raids are included. The conclusion arrived at is that air-raids have not been responsible for any striking increase in neurotic illness. There is, however, evidence to suggest that after intensive raids there is a slight rise in the total amount of neurotic illness in the affected area. It occurs chiefly in those who have been neurotically ill before. These reactions may not show themselves for a week or ten days after the bombing. They usually clear up readily. Anxiety and depressive states are the commonest forms of upset. The incidence has been low in civil defence workers. Statistical information obtained from the Board of Control indicates that insanity has not increased. If the war were producing an increase in mental instability an increase in drunkenness might be a sign of this. Lewis's figures do not suggest that there has been any striking decrease or increase in proceedings of convictions for drunkenness.

Hemphill's (1941) observations are based on the admissions to Bristol Mental Hospital during 1940. During the year that city was subjected to severe attacks by day, numerous minor and some "blitz" raids. Nevertheless it is found that the number of patients admitted showed a reduction on the preceding years. In only 29 out of 354 admissions was the war found to be even a minor contributory factor. Family or constitutional taints were found in most relevant cases. Hemphill concludes that the war has had little adverse effect on the mental health of the civilian population.

Glover (1941) provides an important paper on the psychological effects and immediate sequelae of air warfare on the civilian population. His data are based upon the experience of 20 analysts, who gave replies to a questionnaire. Three phases of the war are studied: (1) The Munich crisis, (2) the pre-blitz period, and (3) the "blitz." It is noted that statistically regarded the material was scanty and was selected mostly on the basis of private practice.

(1) From a study of reactions at the time of the Munich crisis the following conclusions were obtained as to the probable reactions of the civilian population when actual warfare supervened. It was found that unconscious and deep preconscious factors determine the quality though not the intensity of war-time reactions in the section of the population which for one reason or

another requires psychological treatment. Despite the relatively scanty material, it is believed that the same can be said of the population at large. It is suggested that the reactions observed in pathological groups enable one to forecast, tentatively, the reactions of more "normal" groups. The findings suggested that, when actual warfare did supervene, the so-called normal population would show two distinct varieties of abnormal reaction. Ordinary people whose character is of an hysterical or neurasthenic type would react with varying degrees of anxiety or minor physical upsets; whereas those who have an obsessional, depressive or paranoid "make-up" would on the whole express their difficulties, not in the form of psychoneurotic symptoms, but in various types of social difficulty. These findings indicated that problems of civilian morale are not simply political or economic, but must be considered primarily from a medico-psychological angle.

(2) Observations during the pre-blitz year yielded few general conclusions. Clearly there was little justification for any very abnormal reactions., Such as did occur fell into the two same groups as the Munich reactions. Improvement in previous symptoms as the result of changed conditions was noted in both phases. The view that unconscious factors were the main determinants of such disturbances as did occur was confirmed. Again, the importance, as a precipitating factor, of changes in social setting was noted in both phases.

(3) In the "blitz" phase the following were the principal conclusions: The view current in official medical and administrative quarters that air-raids would give rise to widespread "war neuroses" proved to be a myth of an unconsciously apprehensive and appetitive type. As far as can be estimated, the actual incidence of pathological reactions to air-raids was no greater than might have been anticipated by a psychological assessment of predisposing and precipitating factors. Its apparently low rate was due to a number of reasons. Owing to the absence of trained personnel at the most suitable points a great number of cases were never observed or recorded. Many psychosomatic reactors were treated for "organic" illness. The predisposing conditions of civilian life were rarely so severe as those existing in the army. Only a very small proportion of the population in any raided area experienced severe traumatic conditions. Here again it was found that shock reactions could be divided into two main groups—anxiety, etc., and social reactions. The former group was divided into four sub-types: (*a*) major, corresponding to the classical "war neuroses"; (*b*) minor, qualitatively of the same type but usually capable of spontaneous resolution within a few days; (*c*) delayed; and (*d*) vestigial types. Although the two last presented definite "shock" features, the reactions were difficult to distinguish from those observed in the absence of real traumatic conditions. Social reactions met with were anger, resentment, grievance or aggressiveness, or reduced social capacity from undue passivity, confusion, lack of working capacity and of power of adaptation.

The actual traumatic factors most frequently observed were: (*a*) In severe cases, "near misses" and injuries and/or severe bombing over a long period; (*b*) in mild cases, severe blast, usually followed by some degree of physical injury. The predisposing factor most commonly observed in raid-shock was that of chronic mental disturbance. "Psychopathic" types (emotional instability,

maladaptation, lack of working capacity, character peculiarities) reacted most severely. Given satisfactory transference conditions, many psychoneurotic cases preserved a considerable degree of stability. Psychotic types showed little reaction unless directly involved in a hit. Other important precipitating factors were: (*a*) In severe cases, death of relations or neighbours in the same raid; (*b*) in mild cases, grave or fatal casualties among strangers, and extensive damage of the room occupied. In both types the following additional factors were observed; old age, previous evacuation or break-up of the family, lack of friends, isolation, responsibility for children, lack of efficient shelter protection, poor anti-aircraft defences, social and economic insecurity. Certain post-raid conditions acted as aggravating factors: prolonged burial under debris, poor rescue organization, disruption of social services, inefficiency of welfare arrangements, splitting up of family, extensive destruction of houses or shops, disturbances of work, economic difficulties.

The following were some of the more important inferences: (*a*) In most cases the anxiety factor was decisive. Realistic anxiety was proportionate to the real danger in all except children, psychotics and those suffering from excessive unrealistic anxiety. Unrealistic anxiety was, relatively, most pronounced in areas bordering on raided districts. (*b*) The "psychic situation" underlying most anxieties was a disturbance of the existing balance of transference. (*c*) Those individuals most frequently, and/or markedly, affected belonged to the anxiety-character group, the so-called "narcissistic" type and groups having strong unconscious homosexual organization. (*d*) In children, of an average age of two to three years, enjoying effective emotional contact with parents, no signs of traumatic shock were observed. Loss of parents or anxiety in parents resulted in anxiety or inhibition in the children.

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