29, had been attacked with mania followed by melancholia, and then by apparent recovery. Later, another attack occurred with the sequence mania-melancholia-stupor. He wished to know if this was a case of maniacal-depressive insanity.

The HON. SECRETARY alluded to the prominence of pseudo-logical reasoning in cases of folie circulaire. He expressed dissent from the theory of maniacal-depressive insanity as defined by Kraepelin.

Dr. MILLS had never recognised this entity amongst the patients at Ballinasloe Asylum, the majority of whom were persons of weak mind in a stuporose state.

Dr. DONELAN said that a number of cases only had one attack, and wished to know if they were supposed to go through all the phases in such a single attack.

Dr. COTTER stated that in his paper the word "attack" meant "admission." Melancholia was the first stage and then mania. Eight of his patients should, in his opinion, be classed, not as maniacal-depressive cases, but as cases of recurrent melancholia.

Dr. DRAPES thought that the irregularity of these cases was an argument against maniacal-depressive insanity as an entity, and advocated the use of the term "mixed insanity" to cover all cases of that type.

The Case for Dementia Præcox.—By THOMAS JOHNSTONE, M.D., M.R.C.P.

BEFORE submitting to you my ideas on the much-disputed question of dementia præcox, there are one or two points in the papers of Drs. Jones and Urquhart to which I should wish to draw attention. I will take them in the order in which they occur.

We need not ask Dr. Jones to seek for the origin of hebephrenia in any such romantic source as the goddess of youth. In common with many medical terms this word might be derived from a mixture of Latin and Greek, *viz.*, "hebes," dull or stupid (old English "hebete"), our English word "hebetude" being from the same source; and the Greek "phren" with its ordinary signification.

As far as I can see, the derivation of paranoia comes from the Greek verb "paranoio," meaning "to understand wrongly" (a similar word, to which I will refer later, was in use in English medical books half a century ago). "Paranoia" is thus a more accurate term by which to describe that particular condition than is "monomania," for though its victims may understand, they understand in a wrong way, and this peculiarity is not confined to one subject only as the term "monomania" would imply.

Later on I will deal with other words which would appear to be as stumbling blocks to Dr. Jones.

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Not till we have gone through two-thirds of Dr. Jones' paper do we come to his denial of dementia præcox as a separate entity, yet, in the last sentence of the same article, he tells us that "it is more in harmony with practice and of greater help in diagnosis and treatment to use in place of 'dementia præcox' the term 'adolescent insanity,' suitably divided as at present"! From this it would appear that the question of entity or non-entity for dementia præcox is determined by the name it bears.

In dealing with adolescent insanity, Dr. Clouston says that the inmates of public asylums consist of about 50 *per cent.* of such cases, and Professor Kraepelin puts the figures even higher for dementia præcox, but Dr. Jones says that at Claybury, with 2,500 occupants, not ½ *per cent.* of such cases could be found. This is very remarkable, and might be explained in different ways. With a discrepancy of over 50 *per cent.* in statistics there ought to be some explanation.

Dr. Urquhart's paper contains much valuable information—though not always bearing directly on the subject at issue. In it he ascribes to me the following quotation (1): "evolution and development are active up to forty years of age," whereas, he continues, anatomists and physiologists say they cease at twenty-five. I have no recollection of using these words. What I did say, and still adhere to, was that dementia appearing before the age of seventy is premature. Who among my hearers would think of asserting that the mental evolution of, let us say, Dr. Clouston, or of Dr. Urquhart himself, terminated at twenty-five? Most of the best and finest intellectual work is the product of brains very many years older than twenty-five.

Dr. Urquhart also misquotes me (1) when he states that I said the diagnostic feature of dementia præcox is a peculiar and fundamental want of any strong feeling of the impressions of life. This is only part of the sentence. My remark was, "that Kraepelin describes the condition as a peculiar and fundamental want of any strong feeling of the impressions of life, with unimpaired ability to understand and to remember"—a very different condition. Further, Dr. Urquhart takes objection to Kraepelin's including a case aged 56 years, inasmuch as this has not hitherto been regarded as a precocious period of life. In a healthy life this may be true, but it is equally true that it is a premature or precocious age at which to become demented. Paragraph 4 deals with a sympathetic hand as to whether the

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term "adolescent insanity," or "dementia præcox," shall be the survivor, and ends with the hope that the latter may not supersede the former. Adolescent insanity was known, and adolescence recognised as the cause of it, years before Dr. Clouston wrote on the subject. Moreover, Dr. Clouston limited the time of such cases to twenty-five years of age, but experience proves that similar cases occur later in life, and that the original term is inadequate, and does not cover the whole ground. Why, then, should Dr. Urquhart, or, indeed, anyone else, hope that "adolescent insanity" should not be replaced by the more elastic term of "dementia præcox"?

It is to be regretted that in both papers the authors confuse dementia with dementia præcox.

Having disposed of these little inaccuracies, let us now turn to our subject.

Dementia Præcox.

If asked "what's in a name?" the following answer might fairly satisfy a scientific assembly like the present: in a well-chosen name is comprised our knowledge of the thing named. In the infancy of all the sciences terms are few and indefinite. But in the progress of a science, as discoveries and inventions are made, old terms may have their meanings altered, and new terms may be coined, until a more or less technical vocabulary is obtained. In the words of that great pioneer in medical psychology, Professor Laycock (1), teacher of Sir J. Crichton-Brown, Dr. Clouston, Dr. Hughlings Jackson, and many others to whom we owe so much, "Unscientific persons and unlearned practitioners usually display an ignorant impatience of these scientific languages, and demand that the man of science shall express his knowledge in plain English. But experience amply shows that our Anglo-Saxon mother-tongue has so degenerated in its inflexions as to have become too unpliable for this purpose; it is principally the German language, of modern tongues, which is capable of this scientific development." Hence the necessity for Greek and Latin roots. Even our elementary school books are full of such words as "syntax," "prosody," "multiplication," "algebra," etc. This being the case, considerable latitude must be given to the introduction of new terms when dealing with a progressive science.

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About a generation ago many of us can recollect the position occupied by phthisis in the medical mind. Tubercular meningitis was one disease, tabes mesenterica another, while phthisis pulmonalis, white swelling, and strumous glands were yet others, though all were in some way connected. Still it was not until Koch's great discovery of the tubercle bacillus that those various conditions were woven into one harmonious whole, and their identity proved. So it was until quite recently with dementia præcox. You had adolescent insanity, infantile insanity, pubescent insanity, hebephrenia, katatonia with stupor or excitement, and so on. It was reserved for Kraepelin, by his wonderful powers of observation, painstaking attention to detail, and ability for classification, to recognise in these apparently separate entities certain salient points common to all, and to marshal them provisionally, for want of a better name, under the heading of "dementia præcox."

Now, to the best of my knowledge, to assert that in any text-book in the English language there is to be found a description of dementia præcox at all comparable to Kraepelin's (2) is as irrelevant to the elucidation of this discussion as to say that either he or his followers pretend to diagnose dementia præcox simply by shaking hands with the patient.([3])

Dementia præcox must be regarded as a general disease of the nervous system, and is the disease most common among the insane. It may occur at almost any age, cases being reported approaching sixty years, and though both sexes suffer, those cases occurring between eighteen and twenty-five years of age are more frequent among males, possibly, as Manheimer (3) suggests, because this is the age at which the responsibilities of life increase, and poisons, tobacco, alcohol, and the like begin to be more freely indulged in. If the toxin be a general one—a blood poison—then various parts of the cerebro-spinal centres may be attacked, either vicariously or altogether. If the motor and sensory centres be affected in turn this must not be regarded in the light of cause and effect—that is to say, if a motor centre be affected, and subsequently a sensory, the former has not caused the latter, but the result is due to the general poison first attacking one part and then another. If the muscles of the limbs were alternately stimulated to extension and contraction clonic spasms would result. If the flexors and extensors were equably and continuously active

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then there would be tonic spasms. This also applies to the muscles of the mouth, face, eyes, trunk, etc. Again, just as early eye symptoms may appear in locomotor ataxia, and spinal symptoms in general paralysis of the insane, so may the poison in dementia præcox attack an unusual set of muscles. This will help us to understand the immense variety of the motor symptoms—spasm, "snout-cramp," laryngeal noises, catalepsy and the like. Here I would mention that up to the present nothing reliable has been established about the pupillary signs, as Bianchi has pointed out.

Dementia præcox may begin slowly and so insidiously that the antecedent symptoms may be overlooked until the disease is fairly developed, or, though the patients may not actually break down in health, a general and decided change in their nature and disposition takes place, or hallucination or delirium may suddenly begin. There is usually some failure of nutrition as an exciting cause combined with a well-marked history of neurotic inheritance. Irritability, apprehension, desire for solitude, depression, excitement, or those two last indications varying rapidly or replacing each other, are early symptoms. As the disease advances other phenomena, such as a kind of moral anæsthesia, emotional indifference, carelessness and slovenliness as to personal appearance, habits, or the ordinary observances of civilised life appear. The sensory symptoms, according to Masselon (4), may be thus described: "an habitual state of emotional apathy; these troubles are intimately connected with the troubles of intelligence—they are of the same nature—the patients no longer manifest any desire—all volition is interrupted, remittent or spasmodic—the disappearing of desire is connected with all the other troubles of mental inactivity—a real torpor of cerebral activity; the elements of the mind have a tendency to live an individual life, being no longer systematised by the inactive mind."

Take along with this Kraepelin's idea of emotional dulness, apperceptive weakness and inaccessibility, with comprehension and memory of a certain kind, and you have a fair picture of the mental attitude of these patients, but no word or phrase has yet been found to fully and faithfully designate the phenomena. It is the man himself, the ego-complex, who makes the effort of will, and not his consciousness of willing, which is a state coincident with evolution of force. Hence it happens that all

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those actions which indicate states of consciousness may occur independently of consciousness; they are, in fact, cerebral reflex actions strictly analogous to ordinary spinal reflexes. We cannot observe thoughts or feelings, but we can observe actions, and in practice, though we recognise certain actions, we may be in doubt as to the conscious state of the persons performing them. So long as the encephalic changes are healthy in responding to the environment of an individual nothing abnormal takes place, but by the faculty of imagination cerebral changes may happen which have no correspondence with external things, and when these are morbidly produced delusions and hallucinations as to events arise having no more foundation in truth than the more simple allusions of the senses, or mere phantoms. The physiological type of these sensorial changes is dreaming, and paroneiria (or morbid dreaming) has been compared by many modern writers on the subject to dementia præcox.

That dreaming is so nearly allied to normal intellectual life, and the transition from one to the other so rapid and apparently easy, should help us to expect and to understand the immense number and variety of the symptoms found in precocious dements, inasmuch as so many of them are simple aberrations from the normal, often only normal conditions exaggerated or lessened.

Jung (5) says, "The dream, which has so many analogies with dementia præcox, shows the same special condensation of whole sentences and situations." He mentions a simple dream of his own which shows at once condensation and neologism. Someone in his dream wished to show appreciation of a certain situation, and made the remark, "This is fimous." This is a corruption of (1) fine, (2) famous. This example reminds us of the "portmanteau" language in Lewis Carrol's "Through the Looking Glass":

> "T'was brillig and the slithy toves
> Did gyre and gimble in the wabe,
> All mimsy were the borogoves
> And the mome raths outgrabe."

If, like *Alice*, you wish to know the meanings of those words, you must refer to *Humpty Dumpty's* explanations. This is not the only instance in that book illustrating the behaviour of precocious dements. You may perhaps remember that when

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Humpty Dumpty explains these condensed words to *Alice*, he says, "You see its—like a portmanteau—there are two meanings packed up into one word."

It is a curious coincidence how a case of dementia præcox reported by Jung corresponds exactly with this. A patient of his who wished to assure him of her perfect health, said: "That I am well is handclear." As he says it may easily be seen that this formation comes from: (1) That lies on the hand (German *idiom* for "it is evident"); (2) that is as clear as noonday.

Lewis Carroll's story was that of a dream; and Jung says: "Let a dreamer walk about and behave like a person awake, and you have a clinical picture of dementia præcox."

The *materies morbi* in dementia præcox attacks the latest and highest point reached in evolution, namely the ego-complex —the individuality or personality—and disintegrates it. I do not say destroys it, because in those cases where cures result the personality is restored. In ordinary mental life any psychical activity that has a fixed aim—a resolution—is accompanied by contrasts; moderation and co-ordination demand this. Such a resolution would be followed by association of contrast, but if this occur in debility or disease, where there may be a lack of energy, and the individual cannot master the contrasts, only irresolution follows. This law of compensation or association contrasts is often visible in dementia præcox.

Thus we have irrepressible ideas in contrast to what Jung calls "withdrawal of thoughts"; fair comprehension in contrast to the patient's general inaccessibility; stereotypism, suggestibility and automatism (terms varying more in degree than kind), as a contrast to negativism.

The peculiar form of memory observed in precocious dements is almost valueless for practical use, for, being unaccompanied by attention, it is like that which happens in normal people when they are said to be "wool-gathering" or "star-gazing" instead of attending to their surroundings. Or it may be compared to the memory of a dream, when something subsequently arises to remind the dreamer of what took place in that dream, leading to the expression, "That is my dream come true."

The law of association of ideas becomes, in precocious dements, a law of dissociation of ideas. Hence the slowness,

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aimlessness, and utterly disjointed nature of their incoherence, as compared with that of ordinary mania, where, according to Clouston and Bevan Lewis, it is almost always possible to obtain some starting point or connecting thread. The reverse is the case in dementia præcox. So with negativism, which has been explained in different ways. Instead of being an aimless resistance, one has reason to suppose that it might be due to some real terror, or to some plan of the patient's, whose mental working we may infer, but cannot always see. Kraepelin (6) says: "One may, perhaps, venture to think that the absurd speeches of the patients (precocious dements) are not simply 'nonsense,' perhaps still less the wilful product of wanton ill-humour, but the expression of a peculiar disturbance in finding words, which seems to be nearly related to that of a dream."

Jung seems to think that in speech it is an effort to give an evasive answer, to talk "round" the question without touching the kernel, while in pure motor acts it might mean simple resistance. Some French authors ascribe it to lack of capacity to formulate an answer or reason. Bleuler (7) also divides negativism into two kinds, one with a reason for the behaviour, and the other from simple obstinacy. Probably each explanation may prove correct on occasion, and all are agreed that it may be both active and passive in any given case, the passive easily becoming active when the complex or tender point is approached. In ordinary life many never answer a question in a direct manner (the Scotchman is accredited with answering one question by asking another !), and others display much skill in trying to conceal the indirect methods they practise in the pursuit of their negativistic inclinations.

Stereotypism is the adherence to a continuous repetition or reproduction of certain actions, words or phrases, and is a characteristic symptom in dementia præcox. According to Spencer, stereotypism in the form of automatism is one of the most usual phenomena in the development of normal intellectual life, and is brought about thus: In order to work out anything special, in the first instance our whole attention is fixed on the idea, to engrave the process on our memories, but by constant repetition (practice) the action becomes automatic—the slightest touch setting the mechanism in motion. The naughtiness in children illustrates this.

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Accentuation of feeling in precocious dements, whose personality is almost lost, if repeated can develop stereotypism in an exaggerated form, and monotony if the complex becomes fixed. It seems most probable that both in dementia præcox and in hysteria those movements or acts of stereotypism may have their source in some antecedent thought which it is not always possible to trace. According to the Wallerian law that the line of degeneration is in the line of functional activity, those automatisms or stereotypisms tend to change somewhat by their very repetition. Thus, in a patient of Jung's, the act of combing the hair became stereotyped movements with the hands, but several inches in front of the face and chest. So, also, stereotyped phrases may become disjointed senseless monosyllables, and in this way is explained the disappearance in dementia præcox of paranoidal symptoms, and the modification of other symptoms as degeneration proceeds. Verbigeration becomes a "word-salad" (Jung) and the victims of the disease in its early stages often resent having to listen to the "gibberish" of the advanced cases.

The chief varieties or subdivisions of dementia præcox consist of the simple form, the katatonic, including katatonic stupor and katatonic excitement, and the paranoid. And here let me emphasise the fact that paranoia is a distinct and separate disease from that of dementia præcox with paronoidal symptoms. With the theory I hold of poisons being directed towards parts of the nerve centres, with varying virulence at different times and in different people, it is easier to comprehend why certain symptoms should be more predominant in one case than in another, and so cause the necessity for the subdivisions. Many of the indications mentioned in describing dementia præcox and its varieties are also made use of in describing the symptoms of other mental diseases, and this is not at all surprising. The same thing occurs in general medicine; for instance, pneumonia, pleurisy, bronchitis have many symptoms in common, so also have enteric fever, appendicitis, and gastro-intestinal catarrah, and the differentiation of some of the exanthems is often very difficult on account of the similarity of the signs; but in each example, by watching with care and patience the evolution of the disease, a true diagnosis can generally be obtained. So do we hold that a separate entity may be established for dementia præcox notwithstanding the general nature of many of the signs,

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inasmuch as it possesses well defined characteristics peculiarly its own.

In his article on "Sensory Insanity" even Bianchi (8) would deem dementia præcox worthy of a "nosological dignity" but for the fact that the appearances in the early stage are such that he is unable to give a true prognosis of the case. Alas! how many of our diseases would be nameless were this idea strictly adhered to. In this same article he cites two typical cases of the paranoidal form of dementia præcox. Further, he says, "It is to be added that the symptoms of dementia præcox are not peculiar to it alone, but belong also to the confusional states of youth and to many other morbid states—hysteria, epilepsy, organic diseases of the brain—and also for this reason there is no evident need for a new nomenclature." Surely confusional states of youth might in reality be dementia præcox, and symptoms common to hysteria, epilepsy and organic brain disease would, by their occurrence in such diseases, preclude any difficulty in diagnosis.

I have intentionally omitted pathological details, but have a few words to say with regard to toxins. The belief is generally gaining ground that dementia præcox is due to a toxin, but whether it is absorbed from without, or results from tissue metabolism, is quite an open question. Wherever a poison is engendered in the body it has a special disposition to attack the site where it has been developed, *e.g.*, the diphtheritic poison attacks the throat, etc. The poison developed in the nervous tissues, if retained there, would affect mental acts; it has been found that many who suffer from naso-pharyngeal troubles are prone to curious mental symptoms. Adenoids and thickening of the naso-pharyngeal mucous membrane, which becomes congested from slight colds, would prevent the outflow from the veins and lymphatics of the brain in these regions, and it is a fact that such patients frequently have strange dreams, are bad sleepers and somnambulists. I have never believed that all mental troubles associated with adenoids were due to a physical impediment in respiration alone.

Such, then, are my conceptions of dementia præcox. The condition may be compared to the infectious diseases, with early pyrexia and their sequelæ. Which of us diagnoses infantile paralysis at a first visit? And just as some of the well-known infectious epidemics show very mild cases, and

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other cases end in sudden deaths, almost before a diagnosis can be made, so we can have severe and rapidly fatal cases of dementia præcox, and also other cases mild enough to recover without asylum treatment. That in two cases apparently equal in severity one should die and the other recover is nothing new in medicine, and I could imagine a diagnosis impossible between a severe case of dementia præcox and an acute case, in a youth, of general paralysis of the insane. Often it is only after the subsidence of the acute symptoms, and the manifestation of those which are characteristic, that a diagnosis can be made.

Finally, I would point out that the sensory insanity of Bianchi and the dementia præcox of Kraepelin are, as far as one can see, much the same thing; it is only the names that are different. Time will not allow me to continue the subject to-day.

I must acknowledge my indebtedness for illumination on many points to Dr. Jung, of Zurich, in his essay on "The Psychology of Dementia Præcox."

(1) Laycock.—*Principles of Medical Observation and Research*, 2nd edition, 1864.

(2) Kraepelin.—*Lectures on Clinical Psychiatry*, authorised translation from the second German edition. Revised and edited by Thomas Johnstone. Second English edition, 1906.

(3) Manheimer.—*Les Troubles Mentaux de l'Enfance.*

(4) Masselon.—*La Démence précoce*, Paris, 1904.

(5) Jung.—*Ueber die Psychologie der Dementia præcox*, 1907.

(6) Kraepelin.—*Psych. Arbeiten*, Bd. v, H. 1.

(7) Bleuler.—*Psych.-Neurol. Wochenschr.*, 1904.

(8) Bianchi.—*Text-book of Psychiatry*, 1906. Translated by J. A. Macdonald.

(1) *Cf. Journal of Mental Science*, p. 347, April, 1905, and author's edition of Kraepelin, p. 29, etc.—(2) Since writing the above I have learnt that Dr. Stoddart has just brought out a book in which over twenty pages are devoted to dementia præcox, on much the same lines.

Dr. STODDART said: In taking advantage of Dr. Jones's kind offer to read his paper in our leisure moments, we find that his objection to "dementia præcox" appears to be against the nomenclature rather than the disease.

Now with regard to his objections to the term "dementia," which means permanent mental enfeeblement, I deny that there is any justification for limiting the use of this word to cases in which there is loss of memory.

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Mentation is so enfeebled in most cases of dementia præcox that the patients are totally incapacitated from ever more doing any useful work, in spite of the fact that their memory and perception are almost unimpaired. Nor is his objection to the appellation "dementia" in this disease justified by the fact that a few cases temporarily recover, for we know that the same may occur in dementia paralytica ; and further, many patients suffering from dementia paralytica die of their disease before any marked symptoms of dementia can be discovered.

And with regard to the term "præcox," may we not take this to mean that dementia sets in very early in the course of the disease, seeing that the original meaning of præcox has now become unjustifiable. Of course, our language teems with words whose meaning has changed with time.

But why is it necessary to attach any weight to the meaning of the component words? I think it was Dr. Pye-Smith who laid down the axiom that the name of a new disease should be meaningless. Let us, therefore, since we cannot at this stage change the name "dementia præcox," which has come to stay, regard the mere words as meaningless, and cease to ferret out the connotation which the word "præcox" (borrowed from a dead language) possessed two thousand years ago. We will then find no difficulty in accepting it.

The name "hysteria" is derived from an ancient Greek word, **ὑστέρα**, meaning "uterus," but we now know that this organ plays at most an insignificant *rôle* in the disease we call hysteria ; but the name is a very good one. And even men who would repudiate the name would never dare to follow up their repudiation by therefore denying the existence of the disease.

Dementia præcox is recognised by hundreds of the keenest workers in our branch of medical science on the continent, from Italy to the Pole, and from Russia to France, as well as in Canada and the United States of America, to say nothing of our own country ; and some have described characteristic histological features. On the face of it, is it likely that they are all wrong?

Dr. Jones has himself told us that the disease was recognised by Morel, by Esquirol who called it "acquired imbecility," by Christian who called it "juvenile *dementia*," and by Clouston who called it "adolescent insanity" ; none of which, by the way, are quite synonymous with dementia *præcox*.

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All that Kraepelin and his followers claim for dementia præcox is that it comprises many more cases than physicians have hitherto believed, because these cases present common symptoms peculiar to the disease. Of course it has been found necessary to give names to these symptoms, but at these names, again, Dr. Jones sees fit to jeer.

We consider that "adolescent insanity" and "juvenile dementia" are unsuitable terms, because the disease is not limited to the period of adolescence. Nor is it by any means the only form of mental disease occurring at this period of life.

As a matter of fact, Dr. Jones recognises the cases and describes them, but he objects that no hard and fast line can be drawn between the varieties of dementia præcox. That is our very reason for regarding dementia præcox as one disease and not three. That is why we recognise it as an entity.

One reason which was advanced—not by Dr. Jones—why this disease should not be recognised was that we are drawing unnecessarily fine distinctions, and we were treated to the new Shibboleth, "the unity of insanity." What is this? Are we to understand that we are serving no useful purpose in separating cortical disorders due to gliosis from those due to arterial degeneration, those due to the invasion of bacteria, those due to intoxication by fatigue products, internal thyroid secretion, anæmia, and those due to the encroachment of abscesses, tumours and what not?

If this is so, let us be consistent and apply the same principle to the whole of medicine and, when we are called to a patient, make no attempt to ascertain which organ is primarily affected, but let us recognise "the unity of disease" and cease to make such fine academical distinctions as has been done aforetime. What matters it that palpitation may be due to nervous shock, heart disease, indigestion or running for a train? What matters it that convulsion may be due to alcohol, general paralysis or epilepsy?

Dr. Bevan-Lewis said: I feel that members of the Association owe Dr. Jones a very considerable debt of gratitude for having so ably presented the subject. It was a very difficult question, but I think we shall all agree that the controversy that has so long prevailed over the connotation of the term dementia præcox, the solidarity of the symptoms which constitute it a special morbid entity, and its relationships to other neural affections which are avowedly and certainly distinct instances of nervous disease, has been of enormous utility. In the first place, in clearing up our ideas upon mental diseases generally; and again, in directing

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our attention to those wonderfully complex cortical fields in which disturbances and dissolutions of the higher associational tracts and centra issue in the remarkable congeries of symptoms, we denominate dementia præcox and its allied affections. For this, if for this only, we owe a great debt of gratitude to such men as Kahlbaum and Kraepelin. The symptom-complex to which Kahlbaum gave the name of katatonia, just as the syndrome constituting Korsakow's alcoholic polyneuritic psychosis, and yet again the more complex dementia præcox of Kraepelin, should always keep our minds alive to the fact that we are dealing here probably with simple symptom-complexes, and that the several groupings of symptoms may be infinitely varied in correspondence with presumed diversity of pathological findings. Kraepelin's classification is of course essentially symptomatological, and I doubt not that both he, as well as each one of us here, would not for a moment hesitate to consign the term to the limbo of forgetfulness could we but secure the true pathological basis upon which we might reconstruct a scientific classification of these psychoses. The term dementia has offended many minds, not alone because the gradually progressive emotional and volitional enfeeblement in many cases does not tally with their conception of classic dementia, but because so much stupor and confusion so often cloud the picture, masking the dementia for a considerable time, and so rendering it difficult to arrive early at a definite diagnosis and pronounce a decided prognosis; and also, because a moiety of such cases, and a very fair moiety too, according to Kraepelin, are recoverable, and recoverability is scarcely consistent with a disease which is designated a dementia. I do not, however, place much emphasis upon this objection, for all cases of dementia præcox if strictly limited to those cases originating at puberty and adolescence in my experience invariably, in the long run, betray notable mental enfeeblement of a grade which fully entitles them to the term of dementia. The qualifying term præcox is, in my opinion, still more open to objection, unless we strictly limit the definition to those cases commencing at the epoch of puberty and adolescence, and rigidly exclude all cases of later origin. In this later case the term adolescent insanity so ably defined years since by Dr. Clouston is more applicable, as it is strictly confined to those psychoses stamped by the characteristic and extraordinary exaggeration of features which are normal at this epoch of life, and because it emphasises the epochal stress which in the neurotic and degenerate subject is the all-important factor in the evolution of this form of disease, and at the same time excludes all those anomalous forms of a later origin which Kraepelin has been compelled to admit into his category of dementia præcox owing to the occurrence of certain symptoms regarded as characteristic, although he himself admits that they are of secondary or trivial value from a diagnostic point of view. Stupor and confusional states of all degrees, as we each of us know, are prevalent in diverse forms of mental disease, and at all epochs of life, whether as transient and functional, and dependent upon vascular neuro-inhibitory conditions or toxic agencies, or whether persistent and inorganic, indicating neurone degeneration or dissolutions and disintegrations of the higher associational strands of the cortex; such occur in epilepsy, in puerperal and alcoholic toxæmias, in general paralysis of the insane, and in senile disorganisations. Again, katatonic phenomena-muscular rigidity and spasm, cataleptic fixation, flexibilitas cerea, mutism, resistiveness, and all the katatonic features embraced by Kahlbaum and Kraepelin as negativism, whether psychic or automatic in origin, although far more prevalent in katatonic forms of dementia præcox, are, as we are aware, by no means restricted to the adolescent epoch, but frequent in other forms of mental disorder. Again, those speech vagaries—echolalia, verbigeration, staccato-utterances, jargon-aphasia—are also not peculiar to this form of disease; I need but indicate their occurrence frequently in epileptic insanity, alcoholic amnesia, senile dissolutions, arterio-sclerosis, and especially organic brain disease. In fact, Dr. Hughlings Jackson many years ago directed attention to what he called the "recurring utterances" of coarse brain disease, and these "recurring utterances" are of course nothing more than verbigeration and echolalia. In like manner those motor phenomena—echopraxis and stereotypy in all its forms—stereotypism of features, grimace, pantomime, pose, movements, gait, conduct, as well as of written and spoken language, are found at all periods of life, and in diverse mental disease in varied groupings. What we have carefully

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to bear in mind is this, that all these symptoms indicate the implication of an extensive cortical field which at this epoch is at the full tide of developmental activity; that our attention should be chiefly fixed upon the sensory speech centres and the linkages of these with the high associational centres or hypothetical conceptual centre of the cortex; and that we should regard the phenomena of this nervous affection as bringing it into the closest relationships with the several forms of sensory aphasia. In this way only shall we have the satisfaction of securing a sound pathological basis for our further clinical observations.

Dr. LEWIS C. BRUCE.—I have read Dr. Jones's paper and I also heard it read. The impression left upon my mind is that it is a criticism upon terminology, and not a criticism based upon the study of the clinical symptoms of disease. I agree with him that the term "dementia præcox" is unscientific and misleading, but, as I understand Kraepelin, he does not apply it to a definite disease, but to a group of diseases. The subdivisions of that unfortunate term, viz. katatonia, hebephrenia, and paranoia are, however, definite diseases, and are accepted as such on the continent, in America, and even in this country. It is true that the symptoms of these diseases often overlap, but this is not an uncommon experience in medicine, and it is not unreasonable to argue that in the insanities we may have mixed toxæmias, just as there are mixed toxæmias in other and better understood disease conditions. Dr. Jones's final summary, in which he states that it is a greater help to diagnosis and treatment to use the term "adolescent insanity" in place of "dementia præcox," can hardly be taken seriously. How can it possibly assist the advance of knowledge if all cases of insanity which occur in subjects under twenty-five years of age are slumped under a term which has no definite clinical meaning? What difference can it possibly make in the treatment of cases, whether they are called "dementia præcox" or "adolescent insanity," when, according to his own arguments, these two terms can be applied to similar diseases?

Dr. CLOUSTON said he had the peculiar advantage lately of being associated with a pupil and friend of Kraepelin, a man who had been for something like twelve months in an American asylum where Kraepelinism was dominant. That gentleman, Dr. MacFie Campbell, was on his staff, and he was in daily intercourse with him. He, Dr. Clouston, was, like everybody, exceedingly impressed with the fact that the term dementia præcox, as well as some of the other members of the Kraepelin classification, seemed to dominate the psychiatric world of America but not that of France or of Italy, and that it was rapidly taking possession of the minds and imaginations of the younger men in this country. And he said to Dr. MacFie Campbell day by day, "I place myself, as it were, at Kraepelin's feet, through you, in order to do him full justice; will you tell me whether this case is one of dementia præcox, or not? And if so, will you kindly tell me wherein you make it out to be dementia præcox?" That, he thought, was doing justice to Kraepelin, and informing himself at the same time. He was particularly anxious that justice in his own mind, so far as that was of value, should be done to Kraepelin, because Kraepelin's dementia præcox was manifestly outing his "adolescent insanity." The one was bowed out at the window, while the other came in at the door. He found that Kraepelin had changed his mind frequently in regard to what dementia præcox was, and was willing to change his mind at any time in regard to the meaning of the term. But Kraepelin was a great clinical observer; that was well known. He did not think they would describe Kraepelin as a pathologist or a man in whom pathological ideas lay at the foundation of his work. Kraepelin was oppressed with the idea, as they all had been—could he find out something, some series of symptoms, by which he could prognose the existence of an incurable mental state at the earliest stages? Every alienist had been oppressed with such an idea in the course of his work, and as the result of careful examination of his patients put a certain series of symptoms together as a symptom-complex—to use one of the new terms which had been so much spoken of—and this occurring in a certain young patient, enabled him to say that man was probably going to recover. If the young man's attention was alert, if his memory was good, if he was in that peculiar state of mania when he

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was chaffing his relations, and he was extra happy, it was dementia præcox which was going to recover. Or if it was the stuporose variety of dementia præcox it was not going to recover, or was not likely to. Kraepelin did not pretend that he was done with the subject of dementia præcox. He simply said that in the course of his careful clinical studies he had come to certain conclusions, and that those conclusions were valuable to him in regard to the prognosis and the understanding of his cases. He, Dr. Clouston, had endeavoured, so far as he could, to do justice to Kraepelin's idea, on information from an enthusiastic pupil of Kraepelin's. And what about the weak points of that mode of looking at disease adopted by that great man?—for Kraepelin was undoubtedly a great man. Dr. Jones pointed out, there was an extraordinary want of clearness in the symptoms of the cases which constituted the great group of Kraepelin's dementia præcox. The symptoms often seemed so contradictory. Supposing there was a disease with a symptom common to other disease, they were not all thrown into one group because they had one common symptom. Kraepelin, if he erred at all, erred in that respect. There was a common symptom, but the others were so diverse that he objected to their being thrown together and called dementia præcox, because the differences exceeded the likenesses. Also, Kraepelin manifestly disregarded certain elements in the cases of what he, Dr. Clouston, had called adolescent insanity. He disregarded the question of heredity to a very large extent. He appealed to Dr. Johnstone or Dr. Stoddart on that point. One seldom found the word "heredity" coming into Kraepelin's studies. A man who disregarded heredity to any extent in studies of mental disease, disregarded one of the primary elements of the whole situation. Then, next to heredity, if there was one symptom which was prevalent in the old adolescent insanity, it was that of recurrent periodicity. But Kraepelin said exceedingly little about periodicity in connection with dementia præcox. His studies were, if one might say so, too mental and too little physical; they were characterised by a far more subtle analysis of the mental symptoms than probably Englishmen or Scotchmen were able to follow—they were Teutonic in their subtlety. But in regard to the physical symptoms, and the way of looking at a case, he thought Kraepelin's method was singularly deficient in what Dr. Bruce might be regarded as a good example of—the purely clinico-pathological method—in his studies of cases. He need not say he agreed with Dr. Jones that it was a most evil thing that they should use the term dementia for anything except an incurable mental condition. It led to nothing but confusion, and it could not lead to anything else. That, therefore, was his third objection: that the use of the word dementia to describe a disease which was to a large extent curable was necessarily and of itself an objectionable thing. But with all that, and with all objections to Kraepelin's terminology and his clinical studies, there was no doubt that modern psychiatry owed an enormous deal to him. And there could be no doubt that, imitative as the Americans were, and fond as they were of following in the fashion of things, it yet could not be that all the young Americans were such psychiatric fools as to follow Kraepelin blindly if there were nothing in him. That had been impressed upon his mind strongly, and had made him endeavour to take a judicial-minded view of Kraepelin and his terminology. What if his terminology was wrong, if his facts were right? Therefore they must not be too critical with regard to the mere terminology of the words "dementia præcox." He thought that in a short time they would evolve and have clinico-pathological groups which were unassailable. Meantime they should be thankful for having got a little on the way through the agency of Kraepelin's studies and, if they pleased, through his wrong terminology.

Dr. Devine.—It is with some diffidence that I venture to take part in this discussion seeing that I am not in a position to lay claim to a very prolonged psychiatric experience. At the same time I should like to give expression to some reasons why the conception of dementia præcox seems to me to be of the greatest utility in the elucidation of certain cases of insanity, speaking from the point of view of a comparative beginner who is anxious to embrace ideas which are most useful to him in a complex subject. After all the question resolves itself ultimately into a matter of utility. To me the conception of dementia præcox is true because it enables me to resume the phenomena, which I observe in a patient, into a cohe-

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rent whole better than any other way. No doubt in years to come, with further knowledge dementia præcox will undergo modification, but at present it seems to be of more assistance than anything else and is therefore acceptable. No one will deny that one of the most essential attributes of a physician is a capacity for being able to furnish an opinion as to the prospects of recovery in any given case. To those who have had the advantage of many years' observation and experience such an act becomes almost an intuition, but those who have not reached such a position require certain signs and symptoms which are laid down as reasonably indicating that the prognosis is favourable or the reverse. In the large majority of cases apart from what Kraepelin has described I fail to find such indications, and for that reason alone would suggest that his scheme is of the utmost value. Let us see what he says himself in his *Lehrbuch* and what is the extent of his claims. These are his words, "Under the name of dementia præcox we may be permitted for the present to collect a series of clinical pictures whose common peculiarity is a tendency to mental deterioration of varying grades." This phrase deserves notice as it is practically his definition of the disorder. Objection has been taken to the name which is after all a matter of little importance. He himself suggests others (dementia simplex, etc.) but thinks it is provisionally a very useful expression. It must be remembered that the German meaning of the word "dementia" is not quite the same as ours. It has not of necessity the same significance attached to it by Dr. Clouston in the sense of being a permanent and organic state of mental weakness which the Germans describe by the name of Blödsinn, *e.g.* Alteroblödsinn = senile dementia. Dementia in the German sense is a somewhat ambiguous expression which may signify this organic enfeeblement, but also includes the term Verblödung, which simply means a state of mental weakness without implying that such a condition is irrecoverable or permanent. The latter time therefore refers to a particular state of mind at the time, in the same way as mania or melancholia may do. The importance or his conception is the significance he attaches to this peculiar state of "dementia." It means that in 90 *per cent.* of the cases where it is observed such mental deterioration will follow as will lead to a permanent incapacity to lead a useful life, and even in those cases which do so far recover as to be set at liberty careful examination will usually reveal some degree of mental enfeeblement which was not previously present. The three artificial syndromes he describes are shown to have certain features in common which need not be detailed as they are of course familiar. The important point is this, that when these features are observed one knows one is dealing with a disorder which is the commencement of a downward career leading to mental deterioration. Now this scheme of Kraepelin's is imperfect and admittedly provisional. It needs the criticism which he invites as to how far these various syndromes are indicative of what is going to happen in the future. One sees recoveries sometimes, but this does not destroy the value of the conception. It is necessary to carefully watch the future of the patient and to see if he is really as useful a social unit as he was before and if this is merely a remission, a temporary arrest as it were. If a case of disseminated sclerosis apparently recovers for some years is the conception of the disease "mischievous" and vitiating to knowledge?

Now I maintain that this scheme is the most useful one which has yet been produced for resuming intelligibly a large number of cases of mental disorder, and if a contrary opinion is expressed it seems only reasonable to demand what equally useful scheme is offered in its place. Personally, I know of no scheme except this which helps me to predict, by observation of symptoms, what will probably eventually happen to a case. One is usually told that adolescent insanity as described by Dr. Clouston is a more useful and accurate conception of the type of cases known as dementia præcox. From such a view I respectfully but emphatically dissent, and do so on the ground that the two eminent observers in question are not describing the same thing. They are adopting an entirely different point of view, both illuminating and valuable, but not comparable in any way. The lessons I learn from Dr. Clouston's masterly description of the insanities of puberty and adolescence, a description which is now classical, is the influence which a developmental period has in the production and content of disordered mental states which occur at that period. He shows how such states, whether mania, melancholia, or confusion are coloured by the state of mind, which is normal at such a period. His point of view is, therefore, chiefly a biological one. Kraepelin,

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on the other hand is *not* describing the insanities of adolescence. What he is describing is a group of cases, the essential feature of which is a tendency to mental deterioration. It is true that such a group is more common in adolescence, but it frequently finds expression later in life, and if one limits his conception to a particular biological epoch its value is quite lost. The utility of Kraepelin's work consists in the fact that, given, let us say, a case of adolescent insanity, which may be one of several varieties of mental disorder, he has furnished us with something tangible, something by which one may judge if it is likely to lead to permanent mental enfeeblement or not. There is no time to mention the value of the individual symptoms as described by Kraepelin, it suffices to say that in my own experience his descriptions have given a meaning to the incoherent mutterings, the gait, attitude, conduct of even a terminal dement, all these features having acquired a significance which previously they had entirely lacked.

I cannot agree with the pessimistic view of Dr. Urquhart when he says that we have not advanced beyond the position attained by Greisinger in 1861 in regard to classification. I should feel much poorer, for instance, if I were robbed of the associations which are aroused by such terms as manic-depressive insanity, Korssakow's psychosis, hysteria, and so on. I am quite aware that such terms do not indicate any absolutely definite morbid entities entirely distinct from each other, but they each represent ideas which have been, and are, of the greatest utility in forming more coherent notions in regard to the various types of reaction displayed in disorders of the mind. It is thus I regard dementia præcox. Through it insanity has become more comprehensible, and it marks a step in the progress of the science making further advance possible. That this is so is shown by the extraordinary stimulus it has been to workers in this branch of medicine. One sees how such writers as Jung by adopting dementia præcox as a simple working basis, which is all Kraepelin intends it to be, have been enabled to analyse individual cases in a way that has hitherto been unattempted, and to formulate psychological conceptions which throw light on problems hitherto incomprehensible. One finds it hard to look on dementia præcox to which one owes so much as an "undesirable alien."

Dr. J. F. DIXON.—In the face of such scathing criticism and withering ridicule on the part of some of our eminent and experienced members, it requires no small amount of assurance in a junior even surreptitiously and "*in absentiâ*" to dare to differ. I do so in fear and trembling, buoyed up, however, with the stimulating knowledge that, as in all subjects which are matters of opinion, one finds oneself ranged both with, as well as against, authorities equally eminent. Dementia præcox as a separate entity has been assailed on many points, but its *title* seems the favourite spot on which to concentrate fire; and this appears to me the most hopeful thing for the besieged, who know that it is by no means the key of the position: neither, indeed, is it as vulnerable as the enemy appears to think. What is the use of quibbling over the meaning of the word "dementia" before we have arrived at any international agreement on nomenclature? As to "præcox," although the term rather suggests the inference that the disease is a form of senility, which, of course, it is not; yet why labour the point, as Kraepelin himself says the name is purely provisional (Johnson, p. 23)? Let me, in all humility, suggest "atavitic insanity" as a name which might be acceptable. It is curious to note in this connection that the one disease which we pride ourselves on some knowledge of, pathologically too, is commonly known as "G.P.I." Take again, in general medicine, the term "typhoid." We all know its interesting history, and that it is gradually falling into disuse in favour of "enteric." The conclusion that a term which implies a definite entity should necessarily be distinguished by definite pathological findings simply means, so far as insanity is concerned, that we should have to wipe out all existing classifications. But we must go along as far as we can with the light we have, and then pause till we get more light. Why refuse to move till daylight? Kraepelin has given us a light by which we can single out and arrange symptoms and signs which, no doubt, existed before, but in a dim, hazy, and confused mass. The adolescent insanity of Clouston, with its 66 *per cent.* recovery rate, cannot be the dementia præcox of Kraepelin. I am strongly of opinion that there *is* an entity such as Kraepelin has described, call it what you

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will; and that this disease, while occurring most frequently in adolescence, is separate and distinct from other forms which also occur at the same period. I deprecate the ridicule which has been thrown on such terms as verbigeration, echolalia, echopraxis, stereotypism, negativism, etc., most of which is quite beyond the mark, *e.g.* that negativism is only another term for resistiveness, whereas it is a much more subtle condition. In conclusion, I am much surprised that a distinguished scholar should go out of his way to the secondary, rather than to the primary meaning of a word, in order to throw ridicule on the term hebephrenia.

Dr. G. H. SAVAGE.—I feel a certain amount of difficulty in treating this subject for even in the last edition of my manual on insanity I have not made use of the term. Yet I feel that there is ground for adopting some general name for a group of cases which we now fully recognise. First, then, I think there is need for a term. Next, I think good rather than harm comes of selecting a name which, though it may neither be perfect in derivation nor complete in its connotation, yet brings together certain symptoms. Definition is like the outposts in a new country, it is an approach to the unknown and indefinite which will lead to more complete knowledge. A definition should be something which gathers but does not fix our experience, its use should be to enable us to advance. If we are to be satisfied with a *name* then a definition is a danger. That there is a definite entity, a real disease deserving the name Dementia Præcox I cannot believe, in fact, as most of you know, I am never tired of quoting myself in saying there is no such *thing* as insanity. I do believe that frequently there are groupings of symptoms which, occurring in predisposed persons, generally lead to mental weakness, I believe too that the symptoms not infrequently conform to certain types. That such cases are not all to be included in *adolescent insanity* I feel satisfied, therefore though many adolescents thus suffer we have to recognise that others than such persons may break down similarly. Next, as to the term Dementia it certainly leaves many with the impression that the disease must be incurable. Yet, I think by now people, doctors at least, have learnt that there is partial dementia and also that there is temporary dementia as seen following fevers, etc., therefore I do not object to the use of that word. As to "præcox," though open to some doubts, yet it is near enough expressing what we mean to satisfy any but the purist and he is never satisfied long with anything. Other objections have been raised because the word denotes a prophesy that the end will be dementia. As might be at once seen the same objection holds good in reference to General Paralysis. Sir Samuel Wilks, in the old days, when visiting Bethlem with me, used to say, "The most energetic and restless patients I see you call paralytics." That is true, but the term is still accepted. I fear I have not contributed much in the way of information, but I must say that as some term is needed for certain groups of cases provisionally, till we can find a definite pathological basis for them, let us fall in with the use of our neighbours.

Dr. HAYES NEWINGTON.—The title under which Dr. Robert Jones has brought this question before us usefully suggests its examination on the lines adopted in a court of law. A critical examination of this kind is most desirable, lest, carried away by the brilliance of clinical representations, we neglect to test the accuracy of the principles on which these representations are founded. Indeed, the questions that arise in testing the validity of a patent or of a claim to register a trade mark are quite applicable here.

Firstly.—Is there any idea, or group of ideas, in the conditions set before us by Kraepelin that merit special consideration and treatment? We can at once answer this question in the affirmative. He has with wondrously vivid words marshalled a series of well-recognised clinical facts in a method all his own, deeply analytical on one hand, industriously synthetical on the other, and entirely philosophical.

Secondly.—Can this arrangement of Kraepelin's be marked off or isolated from all others? Has it enough defined and consistent materiality to enable it to stand alone by itself as an entity of disease, efficiently occupying an allotted space in a considered scheme of classification? There is grave difficulty in answering these questions. The essential mental symptoms are in themselves

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hardly of sufficient importance to be treated apart from other forms of *hebetude*. The real importance of the condition lies in their neuro-muscular developments. We will take first for consideration the most marked of these—katatonia. At a very early point of our study we find it extremely hard, I might say impossible, to ascertain the precise relations of katatonia to dementia præcox. Is the former entirely enveloped by the latter, or is it an independent disease, as seems to be implied by its position in Dr. Kraepelin's classification? He himself writes thus when treating of katatonic stupor:—"In the main Kahlbaum's long-contested description has proved to be right, though I have to assume that the descriptions of disease summed up by him as katatonia are only special forms of dementia præcox. At all events, in katatonia also disturbances of the emotional province and of action control the condition, while comprehension and memory suffer little in proportion. But then we meet with the katatonic symptoms, negativism, stereotypism, more especially the automatic obedience already described, the strange behaviour, and the sudden onset of senseless impulses—in all gradations in the different forms of dementia præcox." A logical interpretation of this passage must be that true katatonia does not exist apart from dementia præcox. This statement is borne out by all the cases cited under either condition. Even in a pronounced case of katatonic excitement the development of dementia præcox on a foundation of early weakness of intellect is specially pointed out. With one exception, other references to katatonia are, as far as I can see, invariably accompanied by clear symptoms or by pointed demonstration of dementia præcox. Thus it is in a case of puerperal insanity, aged twenty-nine, which supervened on a third pregnancy. Thus it is again in a male case of delirium, aged twenty-six. In passing one may advert to the inconvenient fact that in each of these latter cases at least two first-class mental disorders are assigned, while in the case of delirium the two disorders thus brought together are, in their psychological essentials, mutually repugnant. The exception alluded to above is that of a female senile dement aged 60. Of her it is written "We are met by a number of symptoms which we have already seen in katatonic illnesses—dumbness, negativism, catalepsy, extraordinary attitudes and actions, abrupt alternations of stupor and accessibility, with consciousness of illness, and, finally, hallucinations. If, in spite of this, we hesitate to suggest katatonia at once, it is because we almost always see that disease appear at a much earlier age, and there are certain features in the case which are characteristic of senile dementia —namely, suspicion, defective ideas of time, and rapid loss of former knowledge." It was not possible to test the patient's memory on account of her obstinate and apathetic behaviour. But Kraepelin adds a third and startling reason for refusing the diagnosis of katatonia in saying that this was not a case of katatonia. Single katatonic features do not make katatonia. In spite of dumbness, negativism, catalepsy, extraordinary attitudes, etc., combined with that apathy which is so suggestive of dementia præcox, he will not have the case confused with true katatonia. It must be classed as a katatonic form of senile dementia. One wonders what the precise number of swallows is that constitutes a summer. Be it observed that there is no question of the genuineness of the symptoms themselves. In the light of this case can it be maintained that katatonia is in reality a special form of dementia præcox? Until this point is settled we hardly know where we shall be taken by the use of this latter term. The blend under the head of paranoidal forms of dementia præcox is another instance of combining two diseases founded on two essentially different psychological conceptions. It suggests error or want of precision in definition somewhere. It is difficult from the book point of view to contemplate the co-temporaneous existence in one brain of morbid apathy and active, though misguided, cerebration. There is a little difficulty, too, with the important symptom of negativism, of which we are told that, apart from senile cases, such as the foregoing, it comes under observation virtually only in dementia præcox, though occasionally also in general paralysis. Looking up the definition of the term, which, curiously, is found under katatonia as a symptom additional to those before described under dementia præcox, we find that it is "senseless resistance against every outside influence, which we recognise in mutacismus, *i.e.* forced dumbness—as well as in the whole persistent obstinacy of the patient." I think that many of us have seen that phase in a good number, who are neither young, nor aged, nor paralytic.

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Thirdly.—Is the character of the subject conveyed clearly and without confusion by the name attached to it? We really need not trouble much about the dementia. It is Kraepelin's conception of dementia that is before us, not our own. The curability of dementia forms another issue altogether. He certainly uses the word here in a sense different from that adopted by many, just as he uses amentia. This in one plaee he describes as acute bewilderment, in another as hallucinatory confusion. He is not, however, very consistent in the view that he takes of dementia, as in one place he writes of a case ending either in recovery or in dementia, while in this connection he speaks of dementia ending sometimes in recovery. "Præcox" is certainly equivocal, as Dr. Robert Jones says. Even if we assume that it refers to age period only, it is yet not clear whether it is intended to connote a form of dementia which occurs so frequently in the earlier years of life as to warrant its being spoken of as typical of the period, or whether it affirms that it is in a form which is never found outside the same period. We have seen that in the katatonic element of dementia præcox senility has been treated as a direct bar to diagnosis of its presence. There is, I think, a special grievance about the whole title, in that the German use of it bars its appliance where it would have been so natural, descriptive, and helpful. I mean that it would admirably denote the quiet collapse of jerry-built brains under the strain of their own weight, or of the first contact with the responsibilities of adolescent life.

Fourthly.—Will it be to the general advantage to receive and adopt dementia præcox as part of our own nomenclature? If we adopt it, we must remove something to make place for it. This we cannot do until we know exactly what is included under the terms in dispute. Further, this disorder is a fragment of a conception which materially differs from our own conception of classification. Do we need to mend our scheme? If so, shall we use some of our own material, or shall we patch it with pieces of this other material? If we take over the whole of the German ideas of classification well and good, but we cannot take bits like this form and paranoia without causing hopeless confusion.

Finally.—Judgment, I suggest, should be that we cannot accord to dementia præcox the full rights of an entity that are claimed for it. But with a suitable name we could thankfully receive and register it as a type or occurring combination of morbid conditions. We cannot receive it as a finished picture, but we can welcome it and katatonia and paranoia and other similar elements as pigments, by means of which a true artist, such as Kraepelin, can portray stirring pictures from real life. When all is said and done, he has put all of us under deep obligation by his clinical teaching.

Dr. W. F. Menzies.—I do not think it is possible to say much on this subject which has not already been many times better said by others. At the same time one's purely personal feelings may add a mite to the general experience. We are perhaps at times apt to lay undue stress upon book types, and lose sight of the average run of cases, by which in the long run the value of a system of classification must stand or fall. And if we analyse our procedure in the diagnosis of dementia præcox we shall probably find that a few cases seem to argue the existence of such a state. We have, for example, at Cheddleton at least one almost perfect example of each form except the hebephrenic, that is of the simple katatonic and paranoid types, cases which for class demonstration purposes cannot be beaten, and which show the physical as well as the mental characteristics. But one swallow does not make a summer, and I am sure all of us have experience of large numbers of cases which from the diagnostic point of view of neither here nor there, which far outnumber the book types, and which we find great difficulty in placing in any one category. This, as it seems to me, strikes a fatal blow at the entity of dementia præcox. In addition to this, although most of the alleged cases of dementia præcox are adolescents, yet I find one very typical case commencing at thirty-three. My own personal procedure in diagnosis is as follows:—I first eliminate those with well-marked stigmata of mental and physical degeneration, the medium-grade aments with a superadded attack of recent insanity. These are called adolescent insanity or congenitals according to the predominance of one or the other feature. Next I look for hereditary general paralytics, which are by no means uncommon. Next I find some apparently well-developed chil-

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dren who develop acute mania at puberty or later on stupor at or about adolescence. About these I say, call them dementia præcox if you like, but I prefer to follow the trend of opinion in this country as enunciated by Clouston and others long ago, and so they are called adolescent insanity or adolescent stupor. Now many of these cases do not recover, and become ordinary secondary dements, but some after recovery keep well and later relapse. Then and not until then are these relapsing cases admitted to the dementia præcox class, because we then know that, although they may have another or even a third remission which permits of the resumption of home life for a time, yet in the end, say, by forty, very few of the survivors but are in an asylum. Having eliminated from our young cases the above types we lastly find a good many cases where the stupor is not anergic but katatonic, or where the dementia, perhaps after an imperfect apparent recovery, becomes progressive. For such one acknowledges that the term dementia præcox is useful, for it stamps them as irrecoverable and as progressive, fixes in fact a type upon our mind whose general course we can predict with fair certainty. And there is no other term which does this, wherefore I think the term allowable even if illogical. Nor need we cavil at the age period, for the convalescents, if the most numerous, are not the only components of the class, and dementia is always premature except in old age. Again, there is no need to confuse these cases with secondary dementias sequent upon, say, the primary adult insanities, nor with the primary dementias following prolonged alcoholism or interstitial nephritis, to name only two of the many causes. As to pathology, we may accept Bolton's measurements of the outer fibre and pyramidal cell laminæ of the prefrontal cortex without accepting his theory of defective neuronic durability. Bruce's work, read in connection with Bolton's and Watson's, seems to maintain the oft-repeated dogma of the unity of insanity. I think the inference from the observations of Bruce, Rows, and others is that the two outer layers of the cortex go first, not because they are last developed, but because they are first exposed to diplococcal invasions from the pial lymph circulation. And in these cases of dementia præcox there seems to have been for a long time, perhaps for years, a moderate degree of coccal invasion, accounting if slight for the simple or hebephrenic or paranoid form, if more severe for the katatonic form. On the other hand, in cases of adolescent stupor there has been at the time of the attack an active invasion, which later on has ceased, and left the patient either recovered or non-progressively demented, according to the amount of pyramidal cell destruction it caused. So that from the pathological side also there is something to be said for the term dementia præcox, as signifying a class in which the dementia is progressive. As to why coccal invasions occur in some cases and not in others it would be going too far from the present point to speculate, but I suspect the ultimate explanation will be one of cranial geography, and not one of any impressed hereditary neuronic defect, in some such way as the formerly alleged hereditary tendency in tuberculosis has been accounted for. To sum up, our position is dictated by convenience, and is wholly illogical. We do not believe in the entity of dementia præcox, but the term is the best and least equivocal hitherto suggested to describe a certain class of case which is far from uncommon.

Dr. Percy Smith said that ever since the Committee sat which was charged with the classification of the forms of insanity for the purposes of the Tables of the Association, he had felt some doubt—partly from the criticisms of friends and others—as to whether they were right in omitting the term "dementia præcox" from the Tables. But the debate that day had convinced him more than ever that they were right in leaving out that term. They felt certain that, with the greatest possible respect to Kraepelin's work, with which of course he was familiar, the time was not ripe for adopting the term in this country. Before that Committee sat there was a Nomenclature Committee of the College of Physicians, and the question arose whether dementia præcox should be included in the terminology of mental diseases. And those who were on that Sub-committee of the College of Physicians decided against putting in the term dementia præcox. They did not feel that the time was ripe for adopting it. One term which they did adopt, was the term "developmental" as one of the sub-varieties of dementia. In that,

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one was influenced largely by the writings of Dr. Clouston, and adopted the term out of compliment to that authority. He had always felt that Dr. Clouston's description of adolescent insanity, or developmental insanity, in the "Neuroses of Development," covered practically the whole of the ground which was now covered by Kraepelin. He had listened very intently during Dr. Stoddart's speech for a statement as to the symptoms of dementia præcox. He asked Dr. Stoddart whether there was any common symptom in all the group of what was called dementia præcox except dementia, which might not itself occur, or might not be persistent. And Dr. Stoddart said there was no symptom which was pathognomonic of dementia præcox. So they were in a difficulty. If there was no special symptom, what was dementia præcox? They recognised the clinical groups described by Kraepelin. If there was no pathognomonic symptom it was rather difficult to accept the term dementia præcox. He (Dr. Stoddart) said the one characteristic was a dissociation of receptive and executive sides of the mind; and someone suggested that the term dementia sejunctiva should be used. He would ask whether that was the only form of mental disease in which there was disassociation between the receptive and executive sides of the mind, because he could not grasp that that was so. He was very glad to hear Dr. Stoddart acknowledge that dementia præcox was a bad name. He (Dr. Smith) was always teaching his students that many alienists in this country did not like the term dementia præcox. They felt it to be a bad name, and he always referred students to Dr. Clouston's description of developmental insanity as being preferable, although one described all the varieties of dementia præcox as Kraepelin taught them, remarking that, on the whole, that it was adolescent insanity. They knew it in this country, but they did not like the term dementia præcox, and it was not yet persistently used. If it was a bad name, they were right in leaving it out of the classification recently compiled. Kraepelin himself acknowledged that his grouping was only provisional; he was an extremely open-minded man, who, as Dr. Clouston said, had changed his classification many times, and he might change his present one again. He had changed his views with regard to paranoia. He had taken out a large group of cases from paranoia and placed them, as dementia paranoides, in the dementia præcox group. He (Dr. Smith) made a few remarks on that in his Presidential Address in 1904. He had been very interested to hear Dr. Clouston's experience with Dr. MacFie Campbell, because he (Dr. Smith) quoted in his paper Dr. W. McDonald, who wrote a paper in the *American Journal of Insanity*, on "Paranoia," and he put in the sentence: "We not only accept Kraepelin's ideas; we bolt them whole;" and he did not think that in this country there was any desire to bolt things whole, but to carefully consider and digest them.

Dr. F. R. P. TAYLOR wrote as follows: I entirely agree with what Dr. Jones says in his paper and have never used the term "dementia præcox." To my mind the term "dementia" should signify mental enfeeblement. We have a large number of young patients admitted here, whom, I take it, by many would be said to be suffering from dementia præcox, but a large proportion of these recover and go out, and I certainly am unable in the early days to say who will recover and who will go on to permanent mental enfeeblement, and therefore I avoid entirely a term which to my mind definitely implies an unfavourable prognosis. The term "adolescent insanity" seems to me a much better one. I am also very pleased to see Dr. Urquhart entering a protest against the introduction of fresh terms for expressions that are well understood and sanctioned by long usage; to my mind the result is mischievous and tends to further complicate the study of a subject already sufficiently difficult.

Dr. BOLTON wrote that his views upon the subject were expressed fully in the *Journal of Mental Science*, July, 1907, and that he saw no reason to alter them.

Dr. JOHN TURNER: (1) Kraepelin's conception of dementia præcox has given a great impulse to the closer study of individual cases of insanity. If for this reason alone it would have justified in my opinion its existence. (2) Among those

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who in the main are in accord with Kraepelin regarding dementia præcox, the connotation of the term has a fairly well defined value. The substitution of the term "adolescent insanity" is, in my opinion, unjustifiable. Many cases of adolescent insanity are not dementia præcox, and some cases of dementia præcox are not adolescent insanity. Further, the connotation of the term "adolescent insanity" is vague, and synonymous merely with insanity in a young person. It requires a specialist to make a diagnosis of dementia præcox, but any man in the street can label an insane young person a case of adolescent insanity. (3) Is dementia præcox a nosological entity? The evidence, in my opinion, is not sufficiently strong, either on ætiological, clinical, or pathological grounds, to warrant an answer in the affirmative. But if we are going to quarrel with the conception purely on this ground we should also ask ourselves of what value are all the other items of our classifications of insanity? I anticipate that at some future time the terms signifying that there are distinct mental diseases will all be swept away, and for mania, melancholia, manic-depressive insanity, paranoia and dementia præcox, etc., we shall be able to substitute terms representing the physical substrata of disordered mental actions, recognising that these latter are merely shifting phenomena associated with disordered bodily conditions. In the meanwhile the conception of dementia præcox has proved too useful in the separation of different clinical forms of insanity to be discarded at the present time with advantage.

Dr. MIDDLEMASS said it was scarcely necessary for him to say anything on the subject, because Dr. Devine had summarised almost exactly the few points which he, Dr. Middlemass, had intended to place before the meeting—he did not know whether it was telepathy. Still, he would say a word or two. A great deal of the criticism which had been heard in the discussion was directed to the terminology of the disease. And perhaps that was right. It was desirable to be as careful as possible about terminology, to see that it was sientifically precise. But even in this country, the term "dementia," although it was supposed to be limited and strict, was not actually so. If one looked at Dr. Bevan-Lewis' textbook on mental diseases one would see he described a form of mental disease under the term of "acute primary dementia," and in the clinical description of the cases given, he gave one which ultimately recovered. That showed that even in this country—because no one could question Bevan-Lewis' scientific attainments—thc term dementia was not always applied to an irrecoverable condition. And he would emphasise the fact mentioned by Dr. Devine that in Germany the signification of the term was not quite equivalent to what it was held to be in this country. And Kraepelin, in his book, said he was not wedded to his term, but was willing to accept any other which might be suggested to him as being more satisfactory. He had been interested to listen to Dr. Stoddart's description of his cases in Bethlem Hospital that morning, because one of the chief difficulties experienced in connection with that subject was to grasp clearly the exact clinical picture which Kraepelin wished to present. He was well known to be a master of description, but anyone who endeavoured to picture to himself an actual patient by means of a written description would find it very difficult. If they were able to accompany Kraepelin round his wards, and see his cases, and hear his descriptions of them, they would find less difficulty in knowing the exact kind of case he wanted to give an idea of. To see the patients, as they did in Bethlem Hospital that morning, was the best way in which to grasp Kraepelin's meaning. He had read Kraepelin's book, especially the part dealing with dementia præcox, several times; and the more he studied it and compared the descriptions with one's cases, the more was he inclined to accept the views of Kraepelin. He feared that he was contradicting his own opinion of five years ago, because at that time he was very much against Kraepelin's views. He did not believe that authority was making a new grouping, but that the more Kraepelin was studied the more the student was likely to come round to his views.

Dr. YELLOWLEES said that he greatly admired Kraepelin's powers of acute observation and clear, succinct description, but he dissented entirely from his definition of dementia præcox. He had always believed that it meant a premature

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decay of mind due to organic degeneration of brain cells, and that it was found in a family of degenerates where one was probably a sot, another a blockhead, and another almost a genius. The subject of it had too little brain energy for the work of life, and it failed prematurely and hopelessly, the man outliving his mind. All this appeared to be changing now for no good reason. To-day Dr. Johnston had said that adolescent insanity and dementia præcox were the same disease, ignoring the fact that the majority of adolescent cases recover, while dementia præcox never does. He also asserted that dementia præcox might occur after the age of seventy; ordinary people, not under the Kraepelin mode, called this not premature dementia but senile decay. Dr. Yellowlees was surprised at the demonstration of dementia præcox given to-day by Dr. Stoddart, as few of the cases seemed to him to have the history and characteristics of that disease. He did not at all mean to put his opinion before Dr. Stoddart's, but it was evident that they had totally different ideas as to what constituted dementia præcox. It was of course inevitable that when classifications of insanity were founded merely on symptoms, there must be indefiniteness and overlapping. This was due to our ignorance of the pathology of insanity, but it was a great abuse when terms with recognised meanings were made to include conditions quite different. This multiplication and confusion in nomenclature had been nothing less than a curse to psychiatry. Symptoms which were found in many varieties of insanity were declared to be characteristic of a special group to which their name was given. Dementia præcox had been extended so as to include things quite different from it, and it really looked as if general paralysis were the only morbid entity which could boast a distinctive and recognised name. He concluded by detailing a case of confusional and stuporose insanity, and asked if that also was to be called dementia præcox; if so, the woman had three attacks and had three times recovered.

Dr. BEDFORD PIERCE did not think there was much overlapping in meaning between adolescent insanity as described by Dr. Clouston, and dementia præcox as described by Kraepelin. One read in Clouston's descriptions that the recovery-rate of adolescent insanity was 60 *per cent.* to 70 *per cent.*, whilst the recovery-rate of dementia præcox was very low, possibly under 8 *per cent.* Many of Kraepelin's pupils doubted whether there was any real recovery. Also, adolescent insanity was markedly hereditary, and this factor was said to be extremely important, whereas in dementia præcox the hereditary factor was probably by no means so important. It is evident that under the name "adolescent insanity" were included many cases that could not be included under the name "dementia præcox," cases which do not tend towards dementia. From his own experience he would say that Kraepelin's attempt to describe and mark off a new form of mental disorder had been of the greatest value. If he were to criticise the conception as now presented, he would say that dementia præcox had grown to include too many forms of disorder. He regretted the paranoid form had been introduced. It was of little assistance to the alienist, and he wished Kraepelin or someone would revive the original definition of the disorder and omit the paranoid forms.

Dr. SEYMOUR TUKE said he did not think he could add very much to the discussion; but, speaking as an unscientific person, he would like to say a word or two. First, as to the kind of cases mentioned by Dr. Yellowlees. Twenty or thirty years ago one used to be dissatisfied with one or two things, and, on looking through the case books, several instances were found. One he came across last night entirely and absolutely bore out Dr. Yellowlees cases which he had just mentioned, and which were termed primary dementia. He referred to those cases which came on rather suddenly, which went on to stupor, in which the patient would sit still and say nothing, refusing food; and yet he would almost suddenly recover. One also saw those cases which, having lived up to a certain extent (some had been at the University and had been fairly useful in society), broke down, with a curious restlessness, followed by delusions, and then possibly hallucinations. Most of them had a strong hereditary tendency. He had always been inclined to regard them as more difficult to prognose than others, and the forecast generally had to be an unfavourable one. Of course, there were cases

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which got better, but which were not again quite as they were before. There seemed nowadays to be an attempt to sum up all such cases in the term dementia præcox. Yet one could not be quite clear about the cases which were said to be recoverable and those which were said to be absolutely hopeless, because he did not think there had been a distinction drawn between them recently. If dementia præcox was to include all those cases—the early cases—he could not say he felt it was satisfactory, because it did not give a true insight into what was going on. One could meet the cases in very much the same position as far as their motor symptoms and some of their sensory symptoms went, and yet not be clear when one had more experience. He did not think that anybody, from reading about dementia præcox, could definitely say, in the early stages of the disease, what the result was going to be, or what might be expected later on. Yet what was wanted by the friends, above all else, was a prognosis. And if they were to say that no case of dementia præcox would recover, and that his troubles would end there in the asylum, they would not improve their reputation or anything else. Those diseases were separate entities, and, therefore, there should not be an attempt to combine them under one heading.

Dr. Bond.—It is not my wish to contribute at any length to this discussion: not from any lack of interest or failure to realise its importance—on the contrary, I regard the assent by any of us to the use of such a term as "dementia præcox" as, so to speak, the parting of the ways in psychiatric nomenclature—but because before venturing to criticise in the light of my own experience, I should like a more extended opportunity to carefully follow up cases. One of the most valuable lessons taught by Kraepelin's methods is the advantage of an earnest endeavour to group our cases, not according to their clinical picture at any given time, but according to the impression formed by a study of the case spread over the whole life of the patient. An ideal opportunity for such a study ought to be afforded by the clinical records of an old asylum, which happens to provide the only accommodation for the insane of a considerable area where the ebb and flow of population is small. Several such could be cited, and the physicians of those asylums must have access to an accumulation of clinical material that would at this juncture well repay analysis. Much wordy warfare has been waged round the use of the words "dementia" and "præcox." We have been accustomed to believe that "that which we call a rose by any other name would smell as sweet," but there is no doubt that Kraepelin's triadic entity has, under the name of dementia præcox, anything but a sweet savour in the nostrils of many British psychiatrists. That, I submit, is unfortunate, and inevitably tends to obscure the real issue. Moreover, I feel convinced that some of the adverse criticisms of his doctrine are the outcome of an inexact knowledge of his teaching, and that we are in danger of quoting as his, views and meanings that he never intended. I confess that only quite recently did I grasp the precise significance of the word "dementia," as used in the German language. Apparently the English language has no exactly corresponding word. My colleague, Dr. Devine, has pointed this out in his remarks, and I will not labour the point further except to urge that we have no right to fall foul of the word as used by a German, on the ground that we, in this country, have, for the most part, attached a different significance to it. It would also appear to be a fact that even many of those on the Continent who accept the existence of an entity which they know, and to which they habitually refer, under the name "dementia præcox," do so in a considerably restricted sense. In this connection I have just received an interesting and important letter from Dr. Heinrich Schüle, of Ilmenau, who, I may remind the meeting, is an Honorary Member of this Association.

> Dr. Schule writes that he should like to correct Dr. Urquhart's statement(1) that Kraepelin adopted the term "dementia præcox" at the suggestion of Pick, and points out that the expression has been used in France by Morel ('Traité des malades mentales') and in Germany by himself ('Klinisches Psychiatric,' 3rd edit., 1885, pp. 451-2). He mentions that an historical account of this subject may be found in a note by Dr. Bresler in the 'Psychiatrische, Neurologische Nochen-

(1) The reference is given in Defendorf's *Clinical Psychiatry*, 1902, p. 152. "Dementia præcox is the name first applied by A. Pick, *Prager med. Wochenschr.*, 1891."

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schrift,' 1906, No. 9. He then explains that in these quoted references the clinical term "dementia præcox" is used only in respect to such cases of insanity in which a powerful psychic breakdown, early and suddenly (more rarely after puberty) occurs, with the character of a dementia (Verblodung). He concludes by saying that such cases would correspond to the first sub-division of Kraepelin's classification.

The PRESIDENT said that if no other member of the Association wished to discuss the matter, he would ask Dr. Robert Jones to reply on the whole discussion.

Dr. JONES said he understood Dr. Stoddart would reply first.

The PRESIDENT.—Dr. Stoddart also.

Dr. BOWER said the paper was Dr. Jones's, and therefore he thought that gentleman had a right to the last word in the debate.

The PRESIDENT pointed out that Dr. Stoddart read a supplementary paper; he had spoken in the discussion and he desired to make a statement.

Dr. STODDART said he did not wish to make a speech by way of reply, but only to correct what appeared to be a wrong impression. That morning he had in the room some cases of confusional insanity, and he showed them to indicate in what respects they differed from dementia præcox. They were not cases of dementia præcox.

Dr. YELLOWLEES said he was very glad to have that explanation.

Dr. STODDART said one of the other points on which he wanted to speak was concerning prognosis, as dealt with by Dr. Seymour Tuke. In regard to recoverable cases, one could sometimes form a rough conclusion as to the prognosis. If the dementia præcox symptoms were mild and the patient was evidently very ill, there was then a possibility of so building up the patient's general health that the præcox symptoms disappeared. In those cases the prognosis was fairly good. But if the case was like that of the healthy-looking girl shown that morning with mild symptoms and some catalepsy, the patient being in perfect health, the prognosis was quite hopeless.

Dr. ROBERT JONES said that after what Dr. Yellowlees had said, and the apparent effect of his criticism being to bury for ever the vague term "Dementia præcox," which the French and Italians have also declined to accept, there appeared to be no reason for a further reply from him, but as he had opened the discussion it seemed more regular for him to rise and offer a few remarks. In the first place it seemed odd that with nearly thirty years experience of every form of insanity he should now be confronted with a request to adopt a new nomenclature for cases already well known to every member of the Association who knew anything at all about practical lunacy and which fitted in well with the labels already accepted. The Special Committee of the Association appointed to bring out a classification of insanity comprised the names of those who were best known in our special branch—Drs. Savage, John Macpherson, Conolly Norman, Percy Smith, Goodall, Mercier and others. This committee declined to adopt the terminology of "dementia præcox," and the general feeling of the Association at its Annual Meeting accepted the classification presented. As Dr. Clouston had already said, all psychiatrists in this country recognised with gratitude the brilliant work of Kraepelin in Germany, who, however, was not the first to use the term, and although his general classification had been accepted by English-speaking physicians in America, in this country his terminology found no acceptance. In the first place there was no pathology to dementia præcox, and without a pathological basis it was unwise and undesirable to raise up an entity in disease. There was also in many of these cases grouped into Kraepelin's special class a complete recovery, and if there was to be any meaning to words we in this country recognised dementia to mean a permanent mental failure, a permanent mental self-insufficiency, but what did Kraepelin state? He considered recovery to be of frequent occurrence, and even in the most unfavourable variety, the katatonic form with inco-ordinate motor and mental symptoms, recoveries were reported up to a proportion of 12 or 13 *per cent.* If the dementia is precocious, is it age-precocity? If so, then why include cases up to fifty-five and sixty years of age? He preferred still to call his cases those of primary dementia, or adolescent melancholia, or mania. The general practitioner with his practical knowledge of medicine refused to be consoled by dementia præcox, and why? Because the

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great point with the friends and relatives of a patient was—"Is the case going to get well, and how long will the illness last"? Such being the upshot, it was not only inexpedient, but wrong, to label an illness from which convalescence may occur with the sign of irrecoverability. It would certainly militate against the patient's welfare and against the rays of hope kindled in his favour by his relatives and friends. I can't help feeling very strongly that our own language is rich enough and full enough without coining a fresh nomenclature, as is so frequently the case among mental specialists in Germany and America. In Kraepelin's own country there was a cry on the part of not a few neurologists and psychiatrists for a subdivision of the large and heterogeneous group labelled "Dementia præcox," and that the disease should be re-labelled according to whether factors outside or inside the disease process were uppermost. Anyone reading his description of the sub-groups would appreciate the difficulty there was in mutually excluding common symptoms; one description ran into another without any scientific accuracy, and he thought the general sense of the meeting agreed to bury this term, and he hoped it was not likely that it would be resurrected. At the same time such a discussion as the present helped them in their work; for they recognised each other's methods of investigation and learnt to respect views which they themselves could not adopt. Much credit was due to the Secretary for suggesting the discussion, and although a great deal of latitude had been allowed to writers and speakers, it was satisfactory from his standpoint that the feeling of the meeting supported the findings of the Committee, of which he had the distinction of being a member.

Clinical Notes and Cases.

Foreign Bodies in the Stomach and Liver of a Dement.

By A. D. THOMPSON, M.B., Assistant Medical Officer, North Riding Asylum, York.

IN the North Riding Asylum on May 11th, 1908, I was called to the Male Infirmary to see a patient, and found him dying. The only evident reason for his death was that he had reached the culminating point of a gradual progressive exhaustion, the cause of which I had been at a loss to expiscate.

The patient was demented; sometime a marine engineer, he had been admitted in 1895, as a case of delusional insanity; he had many delusions regarding a "power" he possessed of generating electricity in his body, and he had visual hallucinations also, *e.g.*, he said he saw spirits floating about, etc. As early as the beginning of 1898 he worked in the engineer's shop and he kept in his fixedly deluded, satisfactorily healthy, condition till the middle of 1903, when he was last noted as working in the smithy.

In August, 1904, he had an ischio-rectal abscess, which was opened, evacuated, washed out, and packed; it healed well.

In January, 1905, his bodily strength was first noted to be failing. In April, 1906, he was written down as "in good health and doing some ward work," but from May 8th to 18th of the same year he was in the infirmary, as his temperature had risen; after a purge he gradually regained his normal; no reason was assigned for the rise of temperature.

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