CHRONIC MANIA.

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Originally used to describe any case of dementia with chronic excitement, the term " chronic mania " has been limited in its application to a group of cases described by Schott and others during this century. In the main, they apply it to cases of mania developed after the age of 40, and differing from an acute attack chiefly in their long duration. In the cases I describe I have confined myself to this usage, and have not included constitutional fluctuating hypomanics who have manifested this after their youth onwards, nor do I include prolonged manic phases in circular manic-depressive cases.

In the 9 cases of this nature that I have collected, the manic phase developed after the age of 40. Of these cases 3 developed mania directly from a state of health, all 3 having had earlier manic attacks. The other 6 cases developed a depression of an involutional character, which passed with or without remission into a final manic phase which lasted severally from 3 to 5, 12, 15, 17 and 24 years. In only one of this group had there been an earlier attack of mental illness. The family history of the 9 cases does not show a strong background of mental illness, and in many it is absent. There does exist, however, in the greater number of them a strong element of family pride and reserve. Contrary to the findings of Wertham, the patients show almost uniformly in their pre-psychotic personalities a high degree of intelligence, with responsiveness to literary, artistic or religious influences. They had led active, full existences and shown, in general, capacity for strong feeling, frequently held in control for one reason or another. With these qualities, however, they manifested a certain lack of sympathy and rigidness in their attitude and personality. In the cases in which a depression did occur as a preliminary, it was definitely of the involutional type—excessive agitation, delusions of unworthiness, and of death and destruction, of a horrific nature, with hypochondriasis and delusions of bodily changes occurred. In some cases auditory hallucinations or even vivid visual hallucinations were present during the night. These depressions showed in time some loss of affect with seclusiveness and eccentric behaviour, and then passed into a manic phase, or the manic phase supervened without any loss of affect having occurred. The

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final picture was characteristic, whether attained by way of an attack of mania occurring in a state of health or by an involutional depression passing into mania.

In their behaviour, when mania had developed, the patients were hyperactive mentally and physically, and the mood was of elation or excitement with irritability a marked feature. Flight of thought ranged in its result from irrelevance to incoherence in speech. Grandiose delusions, generally of a fugitive nature, and a strong paranoid element were invariably present. This paranoid element forms the subject of several articles in the literature. Specht held that paranoid suspicions were secondary to delusions of grandeur. Masselon attributed them to constitutional characteristics coming into prominence with the manic reaction. Greenacre has explained the paranoid delusions and delusions of unworthiness in manic-depressive cases as being dependent on the necessity for placing the blame for a situation that is inacceptable to the patient. In the one case there is a depressive reaction with self-accusation ; in the other a manic reaction with delusions of suspicion.

In more prolonged cases certain changes suggestive of deterioration developed. Poverty of thought occurred, and this, with the maintenance of pressure of mental activity, gave rise to continual recurrence of the same expressions and actions. In marked cases the end-result was a strong tendency to automaticity and perseveration. In several cases the patients showed a rhythmic quality in their speech and movement, which expressed itself in rolling, dramatic periods or resounding, meaningless expressions. The impression of marked dementia, further conveyed by the fantastic dress affected by many of them and a certain simplicity and childishness of action, was not, however, borne out by closer examination. One found that the restless, fantastically attired patient who greeted one daily with the same speech and mannerisms had a detailed recollection both of her early life and of more recent happenings, and had an appreciation of her own present position and details of hospital life and family life well beyond her immediate ken. Although impractical and absurd in their own affairs, they showed marked shrewdness in assessing the affairs of others.

From the physical standpoint, it was found that only two showed more than an average degree of arterio-sclerotic change, as estimated by radial pulse, retina, heart, blood-pressure, urinary findings and blood urea. In these two cases only was the blood urea above 70·mgrm. %. Two other cases had a history of hyperthyroidism, and another was slightly myxœdematous, the daughter of this patient being hyperthyroid.

The chief facts emerging from this survey are the close parallel that exists between chronic mania and involutional depression in the type of personality affected, the age of onset, the mental content and the prolongation of the illness.

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Discussion.

Prof. HENDERSON said he wished to thank Dr. Lewis very much for his most interesting and stimulating paper. He had referred especially to prognosis in manic-depressive insanity, but his studies were of much wider significance; he had covered a difficult field in a most comprehensive manner. His paper raised so many questions and the time for discussion was so limited that it was impossible to answer the questions in a satisfactory manner.

The general impression derived from Dr. Lewis's paper was that he had followed out a large group of cases, 61 in all, over a number of years, and it was from such studies as these, of large groups, that further progress in the understanding and diagnosis and prognosis of the manic-depressive states was likely to be made. It was well known that in such conditions when numerous schizophrenic symptoms were present, the assessment of prognosis would be more difficult and the attack would be more prolonged than was likely to be in the purer types. He was glad that Dr. Lewis had mentioned Strecker's work in Philadelphia, and the good prognosis which Strecker postulated for mixed forms of the manic-depressive state. He agreed with Dr. Lewis on that point. In contradistinction to Strecker, the speaker had found, as others had, that in the mixed forms the attack was a very long one, and it was difficult to determine the outcome. It might be that Strecker at a later date would modify his present judgment; his findings did not conform to the general opinion of those who had worked fairly intensively with similar conditions.

He would like to stress this further point which Dr. Lewis brought up. It was thought, he believed, among psychiatrists and among the public generally, that if manic-depressive cases were left to time, time would produce a favourable result irrespective of what was done for the patient. That was not the case. A great deal of active treatment was necessary.

Dr. Lewis had emphasized the necessity, after manic-depressive cases had been discharged following a good recovery, of continuing treatment. The point made by Dr. Lewis that these cases should be followed up and treated after leaving hospital was a very important one.

Dr. Lewis's previous articles on this subject in the Journal were comprehensive, and this further contribution to-day would be of value to members generally.

He would like to question something which Dr. McCowan said—and he said it with all respect. He could not quite see how Dr. McCowan distinguished between depressive, benign and katatonic stupors. He, the speaker, did not think such a distinction could be made. He also found fault with Dr. McCowan in establishing a hyperglycæmic index as a means of distinction between depressive stupors and benign stupors. It could not be said that the characteristic of the latter was apathy, and that that of the depressive was retardation. To attempt to differentiate on such a basis was, he thought, too arbitrary in dealing with such an intensely difficult subject as this. If apathy was a criterion of benign stupor, what was the characteristic of katatonic stupor? Did not apathy enter here also? He thought it was points such as those which were apt to be misleading, and to use the hyperglycæmic index in such a precise manner was dangerous. However, he was glad that Dr. McCowan only took the hyperglycæmic index as one factor, for he had said that he would not exclude careful clinical findings.

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