On so-called Paranoia. By E. L. DUNN, B.A., M.B., etc., Wakefield Asylum.*

The class of cases described under the term Paranoia have long been recognized in England, though, perhaps, they have not been studied to such an extent as on the Continent, and have, no doubt, been looked at from a different point of view. The word in Greek literally means "madness;" we find it employed by authors synonymously with the terms Wahnsinn and Verrücktheit, and on account of the confusion existing between these, Mendel, in 1881, and Werner, in 1889, proposed to substitute "paranoia" for them. In this sense it may be taken to mean "systematized insanity," a definition which covers all classes of paranoia.

The first difficulty which one encounters in studying the literature of paranoia is the question of the acute and chronic forms of the disorder. The acute form, first described by Westphal in 1878, has been admitted by Meynert, Amadei, and Tonnini, and others. Under this heading we find included cases ranging in variety from acute hallucinatory insanity with delusions, to cases of melancholia with stupor and the katatonia of Kahlbaum. Truly this is a protean disorder. On the other hand the existence of an acute form of paranoia is denied by Krafft-Ebing, Mosselli, Tanzi and Riva, and other alienists. With the latter we are disposed to agree; we are unable to find any sufficient connection between the forms described and chronic paranoia to warrant their being classed under that heading. Many of the forms described as acute paranoia have few or no common pathognomic symptoms, and in addition show few points of differential diagnosis from the received acute psycho-neuroses. The introduction of the term is to be deprecated as rendering more complex an already involved subject.

Chronic paranoia is, by those who admit it, divided into two forms—Primary or originating de novo, the most important and typical form, and secondary, the termination of a previous psycho-neurotic state.

Of the forms of paranoia generally recognized, that of paranoia persecutoria is the most important. This corres-

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ponds roughly to the délire chronique of Magnan and other French authors. It is described by MM. Magnan and Sérieux * as a primary disorder always identical with itself, which runs through four definite stages, always succeeding one another in a fixed order. First, the incubation period, characterized by restlessness and suspicion. In the second stage the delusion of persecution appears and the delusional conceptions become systematized under the influence of aural and other hallucinations. The third stage is characterized by the appearance of ideas of grandeur, and the fourth by dissolution of the delusional states and weak-mindedness. Magnan states that the disorder often attacks those free from hereditary taint, and who previous to the attack have been of fully developed intelligence and have shown no sign of moral or intellectual anomaly. Before proceeding to discuss this form of paranoia further it will be well to give a short resumé of the history and principal views held on the subject.

Lasègue, in 1852,† described systematized ideas of persecution, the first clear description of the subject. He included in his délire de persecution cases without prodromal period, cases without hallucinations and some subacute alcoholics.

Morel, in 1860,‡ in his two classes of hereditary insanity described almost all classes of primary systematized delusions. He describes the peculiarities of these subjects, and insists on the great frequency of systematization in these forms, and the rapidity of appearance of the delusional ideas in some cases and their slow evolution in others. In his chapter of hypochondriacal neuroses he describes persecuted patients who became exalted, but insists on their having been hypochondriacal at first.

Griesinger, in 1861, described systematized insanity, considering it always secondary to mania and melancholia. In 1867 § he retracted this opinion and admitted with Snell ‖ the primary origin of mixed states of persecution and grandeur (Primäre Verrücktheit). He described also the hypochondriacal and erotic forms.

Sander,¶ in 1868, described a form of Primäre Verrückt-

* "Délire Chronique," Magnan et Sérieux, Paris, 1892.
† "Archiv. Gen de Méd.," Fev., 1852.
‡ "Traité des maladies mentales," 1860.
§ Griesinger, "Archiv f. Psych.," B. 1, S. 148, 1867.
‖ Snell, "Allgem. Zeitschr. f. Psych.," B. xxii., p. 368, 1865.
¶ Sander, "Archiv f. Psych.," B. 1, S. 387, 1868-69.

heit, which he calls "originäre." These patients manifest intellectual anomalies due to heredity from infancy. They form into two classes. Some arrived at the period of puberty are seized with hallucinations and delusions and fall rapidly into dementia. Others live for some time in society conspicuous for their eccentricities; the morbid subjectivity of which they are the prey increases, and from this they ultimately develop ideas of persecution and poisoning.

Foville,* in 1871, described the delusion of grandeur, megalomanie. In this he includes both persecuted patients with long incubation periods who have become exalted and also cases with primary exaltation, and others without hallucinations.

Westphal,† in 1878, divided systematized insanity into four classes—the hypochondriacal form of Morel, the chronic, acute, and originäre forms, the latter being the only one in which he admits a degenerative basis.

Mendel,‡ in 1883, insists on primary paranoia. He divides it into simple and hallucinatory, acute and chronic. He also describes originäre paranoia (always hereditary and degenerative) and the quarrelling insanity. He further admits secondary paranoia, but insists on its rarity.

Among more recent writers on the subject, the following views have been published :—

Krafft-Ebing § considers paranoia solely a chronic disorder and never developing except in those with hereditary taint; in fact, the paranoia is often merely a hypertrophy of an originally abnormal character. He describes the incubation period as lasting months to years and characterized by suspicion; the actual disorder is marked by sense perversions and hallucinations.

The main symptom of the disorder is delusion devoid of affective basis, from the outset systematic and methodical, and the primary creations of a disordered brain. Other psychoses may occur in its course, and the disease terminates in a condition of psychical weakness, which is not true dementia. He divides the disorder into paranoia "originäre" and "tardive." The originäre commences in childhood as described above. The tardy form is divided clinically,

* Foville, "Étude clinique de la folie avec predominance de délire des grandeurs," 1871.

† Westphal, "Allgem. Zeitschr. f. Psych.," B. xxxiv., S. 252, 1878.

‡ Mendel, "Eulenberg's Encyclopædia," Nov., 1883.

§ "Lehrbuch der Psychiatrie," 1890.

according to the contents of the predominating delusion, into paranoia persecutoria and expansiva, the former being more frequent. But these can occur after, in conjunction with or isolated from one another. He makes a further sub-division of these forms etiologically. He describes the typical persecution form at length, and the transformation into exaltation, which he says occurs in one-third of the cases.

Kraepelin* considers that Verrücktheit develops in a soil of psychical invalidity with insufficient critical power. This may be congenital or have supervened in the existence of the subject. He finally divides systematized insanity into the expansive and depressive form.

Domenica Janni † expresses similar views as to the etiology and classification of paranoia, but distinguishes a secondary form.

Amadei and Tonnini ‡ describe a primary degenerative form of paranoia and a secondary. They sub-divide these into simple and hallucinatory forms.

Tanzi and Riva § insist on the degenerative basis of paranoia. They consider it always to be accompanied by hallucinations and delusions more or less systematized, but independent of the emotional condition. In only 14 cases out of 100 heredity was unknown, but not excluded. They consider paranoia a constitutional form, the delusion only a symptom; the anomalies of the degenerative constitution develop until they reach maturity at about 32 years, the period when the sound man is at his intellectual height. They divide paranoia into seven classes according to the contents of the delusion.

Snell || considers the essential character of paranoia is delusion based upon hallucinations and having the character of suspicion and persecution. The pure delusion of exaltation never occurs in paranoia. The ideas of exaltation may appear simultaneously with the ideas of persecution, may appear at the onset, disappear for a time to return later more marked, or may follow ideas of persecution after a variable time; the two then persist together. This is the usual relation.

* "Psychiatrie, dritte Auflage," Leipsig, 1889.
† "Manuale delle malattie mentali," Napoli, 1891.
‡ La paranoia e le sue forme, "Archiv Ital. per le malattie nervose," 1883-84.
§ "La paranoia contributo alla storia della degenerazione psychiche."
|| L. Snell, "Zeitschr. f. Psych.," B. xlvi., Heft. iv., 1889.

We may now turn to the fuller study of paranoia persecutoria, the most important and circumscribed type.

This disorder appears at from 35 to 45 years of age. It is more frequent in the female sex. Of the various somatic and other conditions somewhat empirically given as causes, the climacteric is most important.

The incubation period is long and often passes unnoticed, the patients at this stage rarely finding their way into asylums. Its symptoms are indefinite. The patient experiences a general feeling of *malaise* and discontent which he cannot explain. He sleeps badly and loses his appetite. He becomes nervous and excitable, and shows but little aptitude for his accustomed work. Gradually he becomes suspicious, and imagining that people look askance at him and despise him, remains for some time in the midst of various doubts which ultimately give way to delusional interpretations. It is remarkable, according to Lasègue, that the circumstances which cause the *point de départ* of his delirium are trifles such as would not annoy him in health, while great misfortunes may happen to the patient without causing him corresponding mental distress. He remains for a varying period ill at ease, suspicious of others and constantly seeking a cause for his abnormal feelings and finding it in the most insignificant details of life. Constantly on the watch, any scrap of conversation he may overhear he attributes to himself as abusive, and suffers from an illusion of persecution. The idea of persecution constantly before the patient's mind at length reacts on the cortical auditory centre; already prone to illusion, the mere ideation henceforth suffices to awaken its corresponding auditory sensation, and the aural hallucination is the consequence. The patient then enters on the second period of the disorder. This is characterized by the full development and complete systematization of the ideas of persecution, and by hallucinations of all the special senses of a distressing character, in the following order of association and frequency:—Hearing; hearing and general sensibility; hearing, general sensibility, taste and smell; and lastly hearing with taste and smell only. Visual hallucinations are extremely rare, and if present are usually not related to the systematized disorder.

The hallucinations of hearing are at first simple, clocks ticking, buzzing sounds, etc., then come low voices and whisperings which the patient cannot understand. Soon

these develop into isolated words and whole sentences. The disorder of the cortical centre increases, voices now accompany the patient everywhere, and he holds imaginary conversations with his enemies. The function of ideation finally becomes automatic, and reacting on each occasion on the disordered auditory centre, calls forth the corresponding tonal image, and the patients complain that their thoughts are repeated before they speak them. Hallucinations of general sensibility may appear at this period or sooner, and tend to further systematize the ideas of persecution. The delusional ideas follow a regular course, at first vague, then soon become more definite. The patient explains his abnormal sensations according to his education and social status. He accuses in turn electricity or hypnotism as the cause of his distress, and various secret societies as the agents therein. Soon he becomes more exact and fixes upon some definite person. His reaction in presence of the delusional idea is at first passive, he merely takes precautions to avoid his enemies; soon, however, he takes on an active stage, and resolving to avenge himself becomes most dangerous. He may remain in this condition for many years, the delusion stereotyping and co-ordinating itself and developing a change of personality. In effecting this the hallucinations of general sense are most important. The patient, unable to account for the bundle of new sensations which he experiences, tends to realize a new personality which may co-exist with the old. Occasionally the phenomenon of loud thoughts assists in this change, the patients imagining that someone speaks in their head or stomach and lays hold of their thoughts. At this stage he often takes to the creation of neologisms, ordinary language being insufficient to express his unaccustomed sensations. The delusion of exaltation has now usually been for some time established; this may be merely a superadded symptom or occasionally monopolizes the whole disorder.

The transformation to exaltation, for which the patient is already prepared by his tendency to a change of personality, and for which the characteristic egoism of the disorder has rendered the soil ripe, may take place in one of three ways. (1.) By logical deduction. The patient, at a loss to account for his constant persecution, imagines that he must have annoyed some great or powerful person, or that people are envious of him. From this the transformation to the idea that he is a great personage himself is easy, and the mental

ease consequent on finding the explanation of his woes tends to further it.

(2.) In some cases the transformation may take place suddenly under the influence of a hallucination or illusion.

(3.) Others consider that the exalted idea is merely a morbid exaggeration of the patient's original traits. According to Mairet, these patients have always had a tendency to megalomania.

In any case the exalted ideas usually supervene, but it must be remembered that it is occasionally difficult to elicit, as these patients are often chary of discussing their ambitious ideas, though such may actually be present in full force.

The ideas of exaltation usually group themselves into three classes. (1.) Ideas of transformation of personality; they imagine themselves to be kings, emperors, or gods. (2.) Ideas of power; they have superhuman or mysterious powers, they direct the stars and control the elements. (3.) Ideas of wealth; they have enormous riches and immense possessions. Any two or more of these ideas may be present concurrently. In certain cases, however, these may not be of so marked a character. Occasionally death may cut off the patient before the stage of transformation of the delusion. In any case, however, it is rare for the persecutory ideas to disappear completely; they usually persist in some degree in connection with the exaltation.* This stage of exaltation may last a variable time, but ultimately the patient arrives at the terminal period of weak-mindedness.

On the occurrence of complete dementia as a consequence of paranoia, authors are divided in opinion. According to some the termination of paranoia is a condition of psychical weakness, in which the delusions and hallucinations lose their power to excite, the patient becomes apathetic and settles down to some form of employment, while retaining the power of conversing and reasoning rationally outside the sphere of his delusion. As, however, paranoia begins in middle life and requires from twenty to thirty years to run its full course, in the final stage one must consider the ordinary mental enfeeblement of old age when estimating the destruction of mental power due to the psychosis.

Prognosis.—Paranoia is generally admitted to be incurable. Krafft-Ebing has seen no cure in 700 cases. Metz and Roller have, however, in a recent number of the "Zeits. f.

* *Cf.* Snell, *loc. cit.*

Psychiatrie," published two cases of cure after influenza. Remissions may, however, occur with complete latency of symptoms. One must guard against confusing dissimulation on the part of the patient with these remissions. Exacerbations or acute psycho-neuroses may occur in the course of the chronic malady.

Pathological.—With a view to establishing the position of paranoia as a morbid entity, various hypotheses as to the seat of lesion in the brain have been suggested. The primary feature of the disorder consists in the morbid condition of self-reference without increased emotionalism. To account for this, Meynert supposes conditions of irritability in the bulb; these are supposed to cause anomalous hypochondriacal sensations, which, by keeping alive the egoism in morbid intensity, produce the characteristic symptom referred to. Wernicke suggests a focal lesion in those cell elements which have been regarded as the basis of reproductive imagination, causing incongruity of reproduced images with the normal impressions of the outer world. The conception of a psychical focal lesion was first introduced by Wernicke in 1874. Sensory aphasia afforded him a precedent. Neisser refers the hallucinations and the phenomena of loud thoughts to a central focal disturbance. Meynert explains the latter phenomena by supposing an irritation of the centres of the nervus acusticus; Cramer considers this symptom as hallucination of the muscular sense in speech apparatus.* These suggestions are purely theoretical, and are merely brought forward to show the possibility of referring the entire symptoms of the disorder to a definite localizable disturbance.

Secondary Paranoia.—In this condition a small group of delusions may remain and become systematized, as the outcome of a previous acute psycho-neurosis, almost always melancholia. In these patients there is profound weakening of all intellectual processes, judgment and memory. They are apathetic as to their past and to all that was previously interesting to them. The delusions are more monotonous in character and their affective effect is not so marked. These patients generally terminate in profound dementia, with loss of social and æsthetic traits.

One other special form of paranoia deserves mention; paranoia alcoholica—Krafft-Ebing calls this a rare condi-

* C. Neisser, "Centralblatt f. Nervenheilkunde und Psych.," Jan., 1892.

tion. According to him, the delusions have often a sexual basis. It is marked by the frequency of visual hallucinations, the early onset of mental weakness, and the irritability and brutal behaviour of these patients.

As regards the differential diagnosis of paranoia, we may just contrast the idea of persecution as appearing in the melancholic and paranoiac state. Briefly, the *melancholiac* has ideas of sin and guilt, he bears his chastisement humbly, considering it deserved, and if he feels his altruistic feelings growing cold he regrets it. His delusions are secondary to the affective state; they revolve around a feeling of depression and are rooted in this. The *paranoiac*, on the other hand, is chastised for no fault of his own; he revolts against his persecutors, his altruistic feelings diminish, but his intense egoism prevents his regretting them. The affective state in paranoia is always secondary to the delusive, and is the logical reaction to it.

The hypochondriac may be confounded with the paranoiac *in the first stage*. The former, however, is wrapped up in his sufferings; he suspects no one and does not look outside himself for their cause.

In the second stage all delusions of persecution without hallucinations must be distinguished from paranoia; all cases in which the delusion constantly varies, and also cases of delusion arising suddenly without stage of evolution. According to Magnan, these cases bear the physical or moral stigmata of degenerescence.

From the third stage, we must especially differentiate primary delusions of grandeur, in which the prognosis is often good. The age at which paranoia appears, usually in middle-life, must be taken into account, but more especially the evolution of the delusions, their logical connection with one another, and their dependence on hallucinations.

If we turn again to the classification of continental authors above quoted, we find grouped together, by various authorities, cases acute and chronic, hallucinatory and non-hallucinatory, those with primary exaltation, and those where the exalted ideas are the result of lengthy evolution. We find described as different clinical types, under the head of monomania of exaltation and monomania of persecution, different stages in the same disorder—a state of affairs described by Magnan as a "clinical mosaic," where one seeks in vain for a constant cause or fixed prognosis. The same condition exists in the English Clinical Text-books.

It cannot be denied, in the face of so many eminent authorities, that there exists a large group of cases, originating primarily from a long period of incubation, following a constant course evolving through fixed stages, and the separation of which from others now ranked in the same class is not difficult. If we are to reclassify the old monomanias and take up a new terminology the classes renamed should be as distinct as possible. That class termed paranoia persecutoria by the Germans, délire chronique by the French, is admittedly the most typical of paranoias, and it would save much clinical confusion if the term were confined to that class only, admitting therein all cases whose slow evolution of delusion and logical systematization in connection with hallucinations of a painful and distressing kind, points from the first to a chronic disorder, whether the subject thereof may happen to bear the marks of a faulty heredity or the reverse.

Remarks upon the Influence of Intestinal Disinfection in some Forms of Acute Insanity. By John Macpherson, M.B., F.R.C.P.E., Stirling District Asylum, Larbert.*

Every asylum physician must regret the necessity that exists for the employment of narcotic hypnotics in medical practise among the insane, and there are probably few who have observed it who do not deplore the far too extensive use of sedative and depressing drugs, which is unfortunately the common custom in some asylums.

One is therefore readily led to consider whether some other means less injurious, more physiological, more permanent in action might not be substituted for narcotic remedies. Recently a form of therapeutic fashion has arisen in our specialty, which in its advocacy of certain new drugs, such as paraldehyde, urethane, sulphonal, etc., has sought to classify them as sedatives or hypnotics in contradistinction to narcotics. Anyone, not a partisan of the use of the drug, who has observed a patient under the full influence of such a drug as sulphonal cannot fail to be painfully impressed by the spectacle, and every doubt as to the alarming narcotic power of the drug must be dispelled. It is not, however,

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