Dementia Præcox.

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PERHAPS no other condition or disease is more frequently referred to than Dementia Præcox in the *Journal of Mental Science* for April, 1905. It might almost be thought that it holds the same position in psychiatry that the Fiscal Question does in modern politics. And though I may not be able to throw any new light on the subject, let me try to harmonise or conciliate some apparently discordant views.

Perhaps the mere name has much to do with this divergence of opinion, so first let us clear this up and know where we are.

Dr. Shaw Bolton defines dementia: "The mental condition of patients who suffer from a permanent psychic disability due to neuronic degeneration following insufficient durability." It is thus a degeneration or involution or reversion, and it is unfortunate that the word "development" should ever be coupled with it.

Again quoting Dr. Shaw Bolton: "If this *decrease in durability* be slight, neuronic degeneration ensues in old age; if it be more marked, it occurs at the climacteric; if it be still more marked, it will appear at maturity; and if it be very marked, it will appear evident at adolescence, or even at puberty." From this it follows that dementia may set in at varying decades of life, and anything of this nature occurring *prior* to 70 years of age—the allotted span of life—may be safely regarded as premature, so far as the dementia is concerned; and the earlier the appearance, the more hopeless the outlook, for an early onset means poor durability of the cortical neurones.

Now, a slight allusion to *præcox*, which may mean "youthful," "early," or "premature." Dementia præcox *may* be translated as adolescent insanity, in fact, most scholars would so translate it, and the writer of the Occasional Note in the *Journal of Mental Science* for April, 1905, does so translate it. But it would be better translated as premature dementia, and any dementia occurring before the age at which dementia would be diagnosed as senile, would be and could be called premature. The question whether dementia præcox should ever be applied to a curable condition seems to trouble some alienists. But

why should it trouble them? In ordinary medicine such things happen daily. A case is diagnosed pneumonia, and may recover, or it may run into acute softening, and the patient dies of phthisis; or rheumatic fever may be correctly diagnosed; still, if the patient be young, the heart may become implicated, and the patient ultimately die of acute ulcerative endocarditis; while, if the patient be advanced in years, the heart is less liable to attack, and the patient will make a good recovery.

Again, suppose we drop the term "dementia præcox" for "insanity of adolescence," we are not a whit the better, because cases diagnosed as the latter condition, which end speedily in dementia, ought to be diagnosed as dementia from the first, but they are not. It is surely as just to have applied dementia præcox to a case where *apparent* cure followed, as to apply "insanity of adolescence" to an undoubted case of dementia. Dr. Clouston, speaking of this uncertainty, says: "It seemed to be a 'toss up' between recovery and dementia, between mental life and mental death." But even the case referred to as having recovered was not an absolute cure, for after two subsequent relapses the patient succumbed.

As already stated, the earlier the onset the worse the prognosis, but coupled with this and perhaps qualifying it, must be taken the quality and quantity of work previously done, for certainly exhaustion produced either from the mental or physical side may cause the onset.

The following cases—freaks, if you will—illustrate the varying quality, resistance, or durability of the cortical neurones and large pyramidal cells in the prefrontal regions: Hermogenes, who at 15 years taught rhetoric to Marcus Aurelius and triumphed over the most celebrated rhetoricians of Greece, did not die early, but became demented at 24 years old. Henri Heinekem, born at Lubeck in 1791, was also a marvel. He spoke distinctly when 10 months old; when 1 year old he could repeat the Pentateuch by rote, at 14 months was perfectly acquainted with the Old and New Testaments. From hearing him converse in Latin even Cicero might have regarded him as an *alter ego*, and he was equally proficient in some modern languages, but died during his fourth year.

At the other extreme of life we have Hippocrates, Galen, and Asclepiades, all illustrious members of our profession, surviving 100 years, and leading intellectually healthy, vigorous

lives, with no indications of even a normal dementia, or postponed dementia!

In contrast with these we ~~have~~ the congenital imbecile or idiot, with no intellect at all.

Age is a relative term; a man is as old as his blood-vessels, and lives till his heart batters him to pieces.

Life also is a relative term, this idea, perhaps, being best set forth in the following lines:

> "Life's more than breath and the quick round of blood—
> It is a great spirit, and busy heart.
> We live in deeds, not years, in thoughts, not breaths,
> In feelings, not in figures on a dial.
> We should count time by heart-throbs. He most lives
> Who thinks most, feels the noblest, acts the best.
> Life's but a means to an end."

Doubtless you recognise those lines as from Bailey's wonderful poem "Festus," written before he was 30 years of age. His cortical neurones and large pyramidal cells in his prefrontal regions did not give way, but the work done by him at the age of 25 represents the high-water mark of his intellectual activity and ability.

After all this, are we justified in drawing strict, hard and fast lines as to where and when intellectual evolution begins or ends in any given individual? Or during which decade in life shall we be justified in reckoning the intellectual ability as being simply adolescent or otherwise in any given human being?

In our every-day life we are constantly hearing of children being late in development, or precocious, or early in development. Are we, then, going to allow so much latitude to normal mental evolution in points of time, and to refuse similar time latitudes to the onset of mental diseases?

This disease—dementia præcox—attacks the highest intellectual centres, and its onset may be likened to a blight of cold on the blossoms of fruit-trees in a late spring. Such blossoms and prospective fruit are the highest indications of development of these trees, and may be absolutely destroyed, suddenly or gradually, or their development may only be arrested for a time, and dwarfed at maturity, according to the severity and persistence of the inimical climatic conditions. So, also, may cases of dementia præcox die of acute dementia, or evolution be only gradually or suddenly checked (for a

while), which causes a "dark period" of mental development—the reverse of the "lucid interval" in general paralysis of the insane, and at the end of this period, evolution, though delayed, may recommence, or the future mental endowment may be permanently dwarfed.

These results are produced by the quality of the nervous soil on which the disease or adverse conditions occurred, and by the virulence or violence of the disease, or its permanent or transient nature. In addition to this, however, a great deal of the prognosis depends on the question, as to the suitability of the treatment adopted, and the length of time it can be carried out, and also how, socially and financially, the patient may be protected from any adverse or annoying circumstances likely to engender a relapse.

As to the history of the term "dementia præcox," we find that Kahlbaum, in 1863, described a form of mental disease, occurring at puberty and rapidly terminating in dementia, which he termed "hebephrenia." In 1873 Dr. Clouston described such cases as insanity of adolescence, and in 1874 Kahlbaum described "katatonia," or the insanity of rigidity. These terms were not generally adopted, but in 1891 Pick, under the heading "Dementia Præcox," described cases, including hebephrenia with maniacal symptoms, followed by melancholia and rapid mental deterioration. It was reserved, however, for Professor Kraepelin to show the connection between hebephrenia, and the various forms of katatonia, and embrace them under the head of "Dementia Præcox and its Varieties."

Although Professor Kraepelin, in his *Lectures on Clinical Psychiatry*, devotes a Lecture to each of the following subjects, *viz.*, "Dementia Præcox," "Katatonic Stupor," "Katatonic Excitement,' "Paranoidal Forms of Dementia Præcox," and "Final Stages of Dementia Præcox," still, it is quite clear he regards them, not as separate entities, but as varieties of the same condition. In the Lectures referred to above, on page 32, speaking of Kahlbaum's katatonia, he regards it as a special form of dementia præcox. On page 35, § 1, there is a passing reference to dementia præcox, in explaining automatic obedience and negativism, as if it were a matter of course that katatonia and dementia præcox were intimately connected.

Again, on page 36, § 2, page 79, § 2, and page 80, § 2,

such references are made. Also compare page 81 on katatonic excitement with Lecture III on dementia præcox; so also page 203, § 4, and page 207, § 2.

At a meeting of the Italian Psychological Society last year Drs. Obici and Angiolella gave a paper on "The Psychoses at Different Ages of Life," which raised the burning question of dementia præcox. The meeting was very lively, but the views of Kraepelin were by far the most generally accepted. Dr. Manheimer, of Paris, in his book on *Mental Diseases of Children*, recognises *dementia præcox as a separate disease*, and gives as a reason for its greater frequency at adolescence the fact that at this period not only do the cares and responsibilities of life multiply, but this is also the age at which the free use of toxines sets in, such as tobacco, alcohol, etc.

In August, 1904, the French alienists held their annual meeting at Pau, when an interesting discussion on dementia præcox took place. No specialist who spoke at that meeting refused to look on the condition as a separate disease and one of a distinct type, though there appeared some divergence of opinion as to whether predisposing or exciting causes were the most active in its production. Dr. Denny, of Paris, defines the mental condition as a psychosis essentially characterised by an especial and progressive weakening of the intellectual faculties. It is a primary or universal dementia, being at first general, and affecting the great psychical faculties of emotion, intellect, will, and judgment.

Professor Kraepelin, of Munich, 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. There is a silly play on words, weakness of judgment, and flightiness, and a marked mental and emotional infirmity.

Symptoms of dementia præcox.—If, as I have endeavoured to show, "premature dementia" is a better translation than "adolescent insanity," and the condition may set in at different decades of life, the mental symptoms must also vary greatly and cover a larger field. Thus, a patient of from 15 to 25 years of age would almost certainly present symptoms more or less distinct from a patient at an age varying from 35 to 45; or again, two patients æt. 25 would also present different mental phenomena if one were an honours' graduate in arts or

medicine, while the other was a hewer of wood or drawer of water.

Speaking generally, hallucinations and delusionary or delirious ideas appear more frequently in older people, and they are not so rapidly fatal as the cases occurring among the young. There is usually a history of neurotic inheritance. The symptoms in the early stages may be marked only by irritability, or a desire for solitude, or by slight states of apprehension, depression, or excitement, but as the disease progresses we get a kind of moral anæsthesia and emotional indifference, with carelessness and slovenliness as to personal appearance, or habits, or the ordinary observances of civilised life.

Later, so-called katatonic symptoms (the insanity of muscular rigidity or tension) appear, such as slowness and hesitation in movement from psychical restraint (an impediment of volition), a passive opposition to all motor impulses, *inertia* or *stupor*; then there may be abnormal suggestibility (excessive docility or imitative activity), restlessness, the continuous repetition of acts or movements (marching backward and forward like a beast of prey in a cage), or simply repetition of phrases of speech, fits of tears or laughter (without any obvious appearance of grief or joy); or there may be sudden impulses, extravagant gesticulations, or peculiar cataleptic or other attitudes. The most commonly observed are grimacing and smiling efforts at penning, negativism (resistance), stereotypism (foolish repetition), and automatic obedience, by some called automatism.

The patients' mode of shaking hands is peculiar; by a series of jerks they stretch their hand to meet the other person's, which they may touch or faintly grasp, but hardly ever shake. Occasionally automatic obedience and negativism are combined in the same patient; thus, when they do open their mouth to show their tongue, they roll their tongue back to the pharynx to prevent its being seen, or they may try to speak with their mouth tightly closed. They may have also what appears to be forced dumbness. These three combined symptoms are in reality psychological but not clinical contrasts.

The purely physical or motor signs are rigidity, increased knee-jerks, and occasional irregularity of pupils. When the disease attacks older people, in addition to the more frequently observed symptoms, other psychical manifestations or disturbances are, so to speak, "thrown in," such as delirious or delu-

sionary states, disorders of the senses, and alternating states of depression, excitement, or katatonic stupor.

It is in this way that subdivisions or varieties of the condition have been constituted, such as hebephrenia, paranoidal and simple states. This is perhaps to be regretted, because in ordinary medicine such subdivisions do not necessarily occur; for although it is well known that measles may terminate by acute laryngitis, catarrhal pneumonia, or a subsequent phthisis, and also that scarlet fever may prove fatal by acute nephritis or a septicæmia akin to rheumatic fever, these two diseases are not subdivided into varieties.

The evidence referred to would appear to be largely in favour of looking upon dementia præcox as a separate and distinct disease, the different ages at which it may begin giving greater varieties. Moreover, when once this degenerative condition has laid hold of the nervous system, other mental diseases may attack the cerebro-spinal centres, and join it. In practice the points to be remembered in any given case of insanity presented to us, in adults at least, are, Is this absolutely the first attack? If not, was the previous attack one of dementia præcox, puerperal mania, maniacal depressive insanity, traumatic insanity, toxic insanity, or the delirium or insanity of collapse? And the treatment, with prognosis, would be dictated accordingly.

Leeds.

Discussion

At the meeting of the Northern and Midland Division at York, May 4th, 1905.

Drs. Bedford Pierce, Middlemass, and Eurich joined in the discussion which followed, and

Dr. Johnstone, in his reply, pointed out that Professor Kraepelin used the term dementia præcox only provisionally; he also reminded his hearers how comparatively recently some of the infectious diseases had been differentiated, and he compared the state of our present knowledge with respect to them with that in the old days of pest-houses. In conclusion, he said the cerebral condition in dementia and dementia præcox had been well defined by Dr. Shaw Bolton; its pathology had been described by Klippel and Thermitte. The etiology being of such a general character, had led to its association with other mental conditions; but this was more apparent than real, for any disease attacking the brain would predispose to the subsequent onset of dementia præcox. The symptoms and relationships to other mental affections had been amply demonstrated by Professor Kraepelin, and the prognosis and treatment really depend on the severity of the changes in the nervous elements and their ability to be repaired; and having (if possible) restored them, these patients must be protected from any depressing or annoying circumstances likely to induce a relapse.