this paper. Up to the date of the paper (October, 1901) this disorder has persisted unchanged.

Questioned even on the simplest subject—whether he is married or single, how many children he has, how long he has been in the asylum, whether he has had his dinner, etc.—he answers that he does not remember, that he is "no good at remembering from one day to another." If told anything as a fact and then asked about it, he replies, "If you say so, it must be so." When asked if he is well, or if he is cold, he answers, "I am so-so, not very ill and not very well," or "I am not precisely cold and not precisely hot." At times he plays cards with other patients and acquits himself very fairly. On one occasion the experiment was tried of giving him no dinner; some time after, asked if he had dined, he replied that it was not yet the hour; told that the hour was passed and that he had dined, he accepted the statement. He has to be guided to his bed every night; if the effort is made to compel him to choose his place in the dormitory without help, he insists on his lack of memory and becomes excited. At no time, however, does he exhibit symptoms of *angoisse*. He asks for nothing, and appears generally apathetic.

Discussing the case, Angiolella rejects at once the hypothesis of simulation; it is negatived by the absence of motive, the long duration of the symptoms, and the fact that the patient is not a degenerate. On the other hand, it is difficult to imagine that so profound a loss of memory should not be associated with other evidence of advanced dementia. Moreover, the patient's attitude of ignorance refers not only to the past but to the present. The inference is, therefore, that the case is allied to the *folie du doute*—the patient will not venture to affirm anything, or to deny anything, for denial is also an assertion of certainty; he simply denies that he can affirm anything.

Angiolella discusses acutely, and at considerable length, the relationship of this peculiar condition to the obsessional *folie du doute*, and to the delirium of negation. His conclusion is that it depends on a special and limited defect in cerebral function, consisting in a weakening of the power of perception and retention. Impressions, accordingly, do not fix themselves firmly in the patient's consciousness, and thus do not furnish the elements of sure judgment. Out of this state of doubt and uncertainty is formed the conviction in the patient's mind that he has lost his memory, and this idea acquires the character of a fixed delusion. W. C. SULLIVAN.

The Mental State of the Subjects of Tics [*L'état mental des tiqueurs*]. (*Prog. Méd., Sept. 7th*, 1901.) *Meige and Feindel.*

The fact that tics only occur in individuals of the degenerate class has been recognised by most writers on these affections. The aim of the present paper is to describe more fully the special mental state which accompanies the tic. The authors find the most constant features of that state in a weakness and instability of the will and the emotions, recalling conditions which are normal in childhood. This state of *psychic infantilism* is expressed in an inconstancy and variability of ideas, to which corresponds a similar variability of tic movements. Tics localised to particular muscles or groups of muscles similarly have

their counterpart in such psychic abnormalities as fixed ideas, obsessions, etc. A tic may thus arise from an obsession if the besetting idea provokes a motor reaction; or, inversely, a tic may engender an obsession. The mental basis is similar in the two cases, and it is not rare to see obsessions and tics alternate or coincide in the same individual. The different varieties of phobia, the *délire du toucher*, hypochondriacal doubts, etc., are mentioned as forms of obsession, common in the subjects of tic. The authors urge that it is important to distinguish the tics which belong to the fundamental state of psychic infantilism from those which are related to these secondary mental disorders. In the latter, which are harder to eradicate, it is necessary to direct treatment specially to the mental condition.

W. C. SULLIVAN.

Differential diagnosis between Hysteria and Katatony [*Beiträge zur differential Diagnose der Hysterie und Katatonie*]. (*Allgem. Zeitsch. f. Psychiat., B. lviii, H.* 5 *and* 6.) *Kaiser, O.*

He describes at considerable length two patients in the Asylum of Alt-Scherbitz, one, which he calls a typical case of katatony, becoming finally *dementia præcox;* the other, a young student with hysterical convulsive attacks and hallucinatory states and delirium. Kaiser regards hysteria as an abnormal mental susceptibility of the nervous system, by which it becomes prone to yield either to outward suggestions or to fanciful notions formed within the mind of the patient. Through this hyper-suggestibility, whole association systems are diverted from their functions, and the activity of others heightened. The differential diagnosis between katatony and aggravated hysteria is stated to be, that in the former there is a childish mental weakness, a state of depression with few ideas, passing into dementia, which contrasts with the selfish caprice, cunning, and persistence of purpose in the hysterical patient.

In my opinion, katatony is a formal distinction into which it is difficult to squeeze a sufficient number of cases of insanity. To find katatony one must hold Kahlbaum's description in mind, and step into the asylum to seek for examples. It is like looking for faces in the fire.

WILLIAM W. IRELAND.

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6. Pathology of Insanity.

Changes in the Cerebellar Neuroglia in Progressive Paralysis [*Die Gliaveränderungen im Kleinhirn bei den progressiven Paralyse*]. (*Arch. f. Psychiat. u. Nervenkr., B. xxxiv, H.* 2, *p.* 523.) *Raecke, Dr.*

Fifteen cases in which the changes in the cerebellar neuroglia were specially studied are given in some detail. The results correspond generally to those of Weigert. In the molecular layer, Bergman's fibres are increased in numbers, but unevenly. Most of the new fibres run vertically, but some obliquely or transversely, the last often forming bands at two levels, viz. along the outer margin of the cortex and at the