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Delirium and Confusion in the 19th Century: A Conceptual History

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Summary: Delirium remained a stable psychiatric category until the early 19th century when it underwent aetiological and phenomenological redefinition, precipitating the transformation of the functional insanities into psychoses.

Confusion, introduced by French workers during the second half of the century, referred to a syndrome wider than (but including) delirium. It emphasized chaotic thinking and cognitive failure. The notion of clouding of consciousness (and temporo-spatial disorientation) established a common denominator for the two concepts, while Chaslin and Bonhoeffer redefined confusion and delirium as the stereotyped manifestations of acute brain failure.

Part I: Delirium

Delirium refers to a cluster of mental and behavioural symptoms occurring in the wake of physical disease (Lipowski, 1980). Definitions in general highlight its transient, intermittent and stereotyped nature. This last feature (probably reflecting the biological basis of delirium) underlies its secular phenomenological stability and provides the historian with a clinical *point de repère*.

This paper will explore the relationship between delirium, confusion and psychological theory and their role in the formation of a viable psychiatric taxonomy; it will also contend that delirium and not paralysis of the insane (Bayle, 1825; Zilboorg, 1941; Leibbrand and Wettley, 1961; Ackerknecht, 1957), provided the descriptive and organizational paradigm for 19th century psychiatry. From the historiographic point of view it will assume that current psychiatry shares the same epistemological space with its 19th century counterpart.

The Beginnings

Reference to an association between physical and mental disease can be found in medical writing since antiquity. Amongst the Greeks, for example, the cognate terms delirium, phrenitis and lethargy, referred to severe disturbance of thought, mood and action associated with physical disease. Jones states: "The Hippocratic collection is rich in words meaning delirium: (1) those in which mental derangement is the dominant idea: and (2) those in which stress is laid upon delirious talk" (Hippocrates, 1972). On this Jones is right, as delirium has since that time been considered as resulting either from global mental impairment or from specific damage to the 'intellect'. In the Hippocratic Corpus the most frequent association of delirium is with phrenitis which (together with mania, melancholia and paranoia) constitutes one of the four categories of Greek psychiatric taxonomy (Roccatagliata, 1973; Simon, 1978). Some psychiatric historians have been anachronistic in assuming that the last three are semantically coextensive with current use (Zilboorg, 1941; Alexander and Selesnick, 1966; Starobinski, 1962).

The concept of phrenitis illustrates well how behavioural and medical symptoms were combined in 5th century B.C. Greek medicine (Garrison, 1929). For example, the absence of fever was used to separate conventional madness (e.g. mania) from delirious states secondary to physical illness. This criterion remained central to Western medicine up to the early 19th century (Cullen, 1785; Sutton, 1813; Middleton *et al*, c. 1780; Esquirol, 1814).

On this von Feuchtersleben (1845) wrote: "the question: Are delirium and insanity identical . . . has been answered thus: that acute delirium with fever must be distinguished from the chronic variety which is called insanity" (my translation). Noticing the insufficiency of this demarcatory criterion the Austrian writer went on to say: "but the presence or absence of fever, which is possible in every condition (cannot) decide the matter". He proposed a differentiation on the basis of natural history, symptomatology and aetiology: "Delirium . . . is a symptom which indicates the transition of a purely somatic disease into a mental disorder". With respect to the manifold classification

of delirium he commented: "it is fruitless, as has been frequently done, to consider differences in the object (of the delusion) as a ground for division . . . (as) . . . they do not express the essence of the disturbance" (my translation).

Concepts similar to delirium may also be found in other cultures of antiquity. For example, Hankoff (1972) examined medical concepts in the Talmud and identified a transliteration of the Greek term *Kordiakos* which was used to refer to a temporary madness associated with wine drinking, probably a form of delirium tremens.

The 19th Century

Psychiatric observations culled from classical literature are epistemologically discontinuous with the present; nevertheless, the historian of psychiatry must analyze them and endeavour to extricate the psychological and behavioural happenings they contain. More importantly he must unravel the conceptual systems that made those observations possible. For example the fact that in the pre-Cartesian world no clear ontological distinction was made between physical and mental disease meant that, in practice no descriptive or aetiological difficulty arose whenever the two were found together. The 17th century acceptance of the Cartesian separation between thinking and extended substances forced a conceptual shift on insanity theories, and Western medicine began to puzzle about the association between physical and mental disease (Kenny, 1968; Sauri, 1969; Lain Entralgo, 1978).

The 19th century constructed in response to this its own psychiatric epistemology (Swain, 1977), and witnessed the development of a psychology that viewed consciousness as a non-material construct (Boring, 1950; Hamilton, 1859). Psychological symptoms therefore became 'signifiers' of disease and were conceived of as existing in a separate ontological realm. The old observation that mental changes may accompany physical disease did, for the first time, create a theoretical conundrum. Hence the need developed for (1) a phenomenological description of the mental changes themselves; and, (2) a mediation theory that could explain the causal link.

The history of how and by which mechanisms physical illness can produce mental symptoms must distinguish three areas of analysis: firstly, the development of the modern concepts of delirium and confusion, secondly, the formation of the notion of exogenous psychosis; and, thirdly, the metamorphosis of the term dementia. In this paper only the first area will be dealt with.

Delirium

The term delirium is present in Galen as coextensive with *mentis alienatio* (Siegel, 1973). In this guise it remained unchanged until the 19th century. Dr Johnson (1755) captured both the medical and non-medical usage: Delirious he defined as 'light headed, raving and doting'. His citation from Swift illustrates well the fluctuating and intellectualistic aspects of the concept: "the people about him said he had been for some hours DELIRIOUS, but when I saw him he had his understanding as well as ever I knew". (This quotation was to be incorporated into the O.E.D. a century later). Dr Johnson also defined delirium as 'alienation of mind' and quoted Arbuthnot: "Too great alacrity and promptness in answering, specially in persons naturally of another temper, is a sign of an approaching DELIRIUM. In a feverish delirium there is a small inflammation of the brain".

From the earliest usage recorded (as indeed its Latin etymology shows) the meaning of delirium has been associated with disturbance in the train of thinking. This intellectual interpretation (of what in practice is a generalized behavioural disturbance) reigned supreme until the early 19th century (Middleton *et al*, c. 1780). For example, when Sutton (1813) described the concept of delirium tremens, or shaking delirium, he felt the need to play down this old view of phrenitis: "As the disease advances, the faculties do not, generally speaking, show themselves in disorder, *by any extravagance of thought* (my italics). By including affective and motor disturbances in his description Sutton widened the concept of delirium and undermined the intellectualistic interpretation.

This theoretical shift did not occur in a vacuum. Since the beginning of the 19th century Associationism (the classical psychology of British empiricism) had come under the challenge of faculty psychology, a view contained in Wolf's psychology and in the Scottish philosophy of common sense and popularized by phrenology (Spurzheim, 1826; Klein, 1970). The gradual acceptance of faculty psychology led, in practice, to viewing the mind as a set of autonomous functions. In due course this provided a new classificatory framework (Esquirol, 1838; Billod, 1848; Bucknill and Tuke, 1858).

The ancient double meaning of delirium was present during the early 19th century mainly in French psychiatry (Ball and Ritti, 1882). For example Pinel (1809) used *délire* to refer both to a specific error of judgment and to phrenitis.

Esquirol (1814) took a similar line and developed a view of *délire* as primarily a perceptual disturbance. "A person is delirious when his ideas are not in keeping with his sensations etc." . . . "hallucinations are the most frequent cause of *délire*". In the same

article however, Esquirol shifts from talking about delusions to delirium proper. Georget (1820) used *délire* to refer to disorders of intellect or new ideas. Indeed he suggested as possible sources for *délires;* personality; antagonistic thoughts; and, intelligibility (*à la* Jaspers) in terms of the precipitant disorder and bizarre or morbid origin. Parallel to this he also used *délire* (as in *délire aigu*) to refer to "a disorder in intellectual (and other) functions resulting from general illness or illness of the brain" (Georget, 1820). He complemented this definition with a detailed table showing the differential diagnosis between *délire aigu* and *folie* and noticed the symptomatic, intermittent and reversible nature of the former. In a posthumous article (1835) Georget took a more syndromatic view and separated *délire aigu* (or febrile) from the *délire chronique ou sans fièvre* which he considered as tantamount to insanity proper. Impairment of consciousness, which was to constitute the crucial distinction during the latter part of the 19th century, is not yet included in these writings.

By 1860 differential usage had become established and *délire* was being used more and more to refer only to the aberrant ideas that accompanied delirium. This was consolidated by Lasègue (1852), Falret (1864), and Magnan (Magnan and Sérieux, 1911) and legitimized in Littré's dictionary (1877). The gap left by this specific usage of *délire* in French psychiatry, was after the middle of the century, occupied by the term *confusion.* This explains why its career in France has been far more enduring than, say, in British psychiatry where delusion and delirium were adequately separated.

Likewise in German psychiatry, there was no terminological confusion and delirium was used during this period to refer to the complete syndrome (Walther-Büel, 1973). The old High German *Wahn* (madness) underwent a readjustment to accommodate the narrow, intellectualistic notion of delusion (Ey, 1954).

In Great Britain the term delusion had been used since earlier in the century to refer to perceptual disorders (Conolly, 1830); after 1850, however, it began to refer to 'wrong beliefs' (Bucknill and Tuke, 1858; Clouston, 1887; Gowers, 1888).

Lipowski (1967), without any attention to the French literature states: "Tuke's conception of delirium, which antedates Bonhoeffer's influential work, contains the core of the modern definition of this syndrome". The entry to which he refers, however, was probably written by J. F. G. Pietersen, the superintendent of Ashwood House Asylum (who composed all short definitions from A to M in Tuke's Dictionary (1892)), and was 'inspired' by a similar entry in the New Sydenham Society's *Lexicon of Medicine* (Power and Sedwick, 1882). In fact Pietersen's short entry (1892) does not summarize well views on delirium in the early 1890's. For example it does not refer to the disturbance of consciousness which at the time was widely accepted both by continental and British writers.

Delirium versus Insanity

When the medicalization of psychopathological descriptions took place during the early 19th century delirium was already a stable category (Middleton *et al*, circa 1780). During this period, however, some called into question the fundamental distinction between delirium and the conventional insanities (Feuchtersleben, 1845; Brierre, 1845). The latter was an important figure in this regard and in a long and influential essay on acute delirium (1845) opted for a syndromatic view. He based this on some statistical evidence that showed, at least to his satisfaction, that delirium and the other insanities shared the same 'moral' aetiology; and also on his own post-mortem studies which either failed to find any pathological changes or found only unspecific alterations. He asked, therefore, "is it the case that acute delirium is just an acute form of (conventional insanity)?" He studied 19 cases (11 described in his paper) of which only 7 showed an acute onset, in the remainder the disturbance having appeared insidiously over a period of months. Cases 3 and 9 were patients in clinically acute catatonic states who, after persistently refusing to drink ("symptomatic hydrophobia" according to Brierre) seem to have died of electrolytic imbalance and terminal seizures. Likewise he included cases 3, 4, 5, 6, 7 and 8 simply on the strength of their terminal illness, disregarding their long lasting, pre-delirious lypemanic (depressive) state. This heterogeneous sample led him to call into question the usefulness of pathological and clinical criteria and even the presence of fever. Consequently he believed there was no way in which delirium could be separated from the rest of the insanities. "The state of consciousness" criterion, with its concomitant "spatial-temporal disorientation symptom" was not yet available. It became so after the term 'confusion' became popular during the latter part of the 19th century (*vide infra*).

Brierre's views were influential. The *American Journal of Insanity* sponsored them twenty years later and offered a favourable summary (Leader, 1864) without however, giving the reference! Likewise in Germany, Griesinger (1876) included Brierre's views in the second edition of his textbook. Indeed the issue of whether acute delirium constituted a separate form of insanity or was just its acutest form went on until the end of the century (Ball and Ritti, 1882; Gowers, 1888).

However, Brierre's departure from the classical view was not widely accepted (Feuchtersleben, 1845). Since a psychopathology of consciousness was not yet available the only option open to reassert the organicity of delirium was to go back to the post-mortem slab. Calmeil (1859) in a voluminous work accused researchers of giving up too soon and wasting time over symptomatic differences. He re-affirmed the organic nature of delirium and concluded that delirium was a mild form of encephalitis and hence pathological alterations of varied intensity could always be found. Others remarked upon the rarity of delirium both in private practice and mental hospitals (Thore, 1850).

The differential diagnosis debate is very relevant to the history of the psychoses. As the anatomopathological view of disease gained popularity in medicine the old demonological or moral view was no longer acceptable. The discovery by Bayle (1822, 1825) of some recognizable pathological changes in general paralysis of the insane satisfied only the aetiological needs of the new model of disease but did not help to identify stable clinical patterns which could be brought in line with theories of normal function. Thus a reanalysis of the clinical picture of delirium was far more useful to the development of psychopathology than Bayle's aetiological claim. In the event delirium was found to be, in spite of its fleeting and fluctuating course, a microcosm of insanity, with pathological changes affecting cognition, emotions and action. Brierre's claim that delirium is only an acute, prototypical form of insanity supports this hypothesis. Indeed, Calmeil himself, beyond re-affirming an aetiological difference, did not state that delirium and insanity could always be separated clinically. Thus in the conclusions of his chapter on acute delirium he enumerates symptoms shared by both delirium and (what he calls) the functional insanities.

It is outside the scope of this paper to analyse the relevance of this issue to the concept of *Einheitspsychose* (unitary psychosis) as it developed around this period in German psychiatry (Llopis, 1954). Griesinger (1878) and Kahlbaum (1874) for example held a unitary view and some non-psychiatrists such as Gowers (1888) also believed that delirium was a form of insanity with known aetiology. Norman (1890) in Ireland suggested a continuum hypothesis. Others considered this was no longer acceptable (e.g. Worcester, 1889).

Later in the century the separation of delirium from the insanities was made on the basis of an involvement of consciousness. It would seem that this criterion stemmed less from empirical research than from conceptual readjustments required to explain the status and characteristics of the remaining insanities. These changes were performed in terms of the then current theories of disease (Sauri, 1972). The 1847 translation of Feuchtersleben's book (1845) seems to have introduced the term 'psychosis' into British psychiatry. The older meaning of psychosis as a general psychological concomitant of any neurological change remained, however, in use until the end of the 19th century (Baldwin, 1901). The fascinating process whereby the psychoses became gradually organic while the neuroses crossed over, in the opposite direction, towards the psychological pole has not yet been fully studied by historians of psychiatry. Lopez Piñero's book on the neuroses (1963) goes a long way to explaining their transformation.

During the last two decades of the 19th century the transformation of the insanities into the psychoses was consolidated by three additional conceptual innovations, two of which we owe to Magnan. Firstly, his notion of genetic stability explained how certain forms of insanity remained true to form either intra-individually or in successive generations; this put an end to Morel's progressive degeneration view (1857; Baruk, 1967; Pistoia, 1973). Secondly, his separation of insanity with acute onset and good prognosis from insanity with a chronic course, leading to eventual deterioration, i.e. *délire chronique* (Magnan, 1886) paved the way for a less pessimistic view of the psychoses. The third contribution was Kraepelin's view that the natural history of each psychosis must become part of its definition.

Consciousness and its Disorders

Three changes characterize the transformation of psychology into an autonomous discipline during the 19th century: (1) emphasis on the analysis of the contents of consciousness via psychophysics and introspection; (2) reconciliation of classical associationism and faculty psychology; (3) establishment of links with physiology and quantificatory techniques (Boring, 1950).

Concerning the nature of consciousness the 19th century oscillated between two views. It was considered as either an extra function of the mind (i.e. as a separate ontological entity) or as an epiphenomenon, a kind of awareness inherent in each mental function (Hamilton, 1859). Clinical and classificatory needs rendered 19th century psychiatry increasingly dependent upon descriptions of the contents of consciousness (Berrios, 1981). This shift from behavioural to mentalistic description created a need for units of analysis of mental acts and states. These were provided, during the first half of the century, by the combinatorial epistemology of associationism. Hence, insane behaviour became fragmented into discreet symptoms (e.g. hallucinations, obsessions, delusions

etc) which in due course came to be regarded as the basic furniture of the psychotic mind.

The incorporation of psychopathology into the medical sciences led to a reinterpretation of the pathological as a quantitative variation of the normal (Canguilhem, 1975; Foucault, 1954). This continuity model worked well in the case of some units of analysis such as hallucinations (Ey, 1973) but less so in others such as obsessions, for no agreement could be reached as to what mental faculty was involved; obsessions therefore resisted integration and were considered as foreign bodies (Berrios, 1977).

This integratory strategy led to the complementary analysis, namely, to ask whether all mental functions could develop pathological alterations. Consciousness was one of these functions and since its description included a 'field', a 'central beam', a 'penumbra'; its alterations came to be referred to as blurring, constriction, clouding, opaqueness, obliteration, sharpening etc.; that is, as those pertaining to a kind of autonomous supra-perception. This view was consonant with faculty psychology principles and provided an explanation for clinical phenomena such as depersonalization and clouding. On the other hand, however the neurophysiology of the period demanded that each function was given if possible a cortical localization; consciousness was not an exception to this.

Localizationists were divided as to whether consciousness was located in the cerebral cortex or in subcortical structures (Davies, 1873). This debate took place against the backdrop of religious and evolutionary ideas (Young, 1970). By the 1870's however, the contribution of Carpenter, Maudsley, Jackson and Bastian tilted the balance in favour of a centrencephalic localization (Walshe, 1957). Bastian's article on consciousness (1870) set the conceptual scene for British psychiatry. Wernicke's article *Über das Bewusstsein* (1879) did likewise for German psychiatry (Heimann, 1974).

Clouding of consciousness became during the second half of the 19th century the clinical criterion to separate delirium from the rest of the insanities. The clinical observation that delirious patients may be disorientated, obtunded, retarded and unable to remember their experiences after remission had been documented in the classical literature (Dupuytren, 1834). No attempt had been made, however, to consider these symptoms as the central ones in delirium nor to explain them as resulting from an impairment of consciousness. The acceptance by classical psychology of a view of consciousness as a separate psychological function led psychiatry to reinterpret disorientation and confusion of ideas as a disturbance of this new function.

Part II: Confusion

The term confusion persists in British psychiatry (Fish, 1974) and has been enshrined in the *International Classification of Diseases* as acute confusional state (WHO, 1978). The French have also retained *confusion mentale* (Cottereau and Gaussel, 1971; Bernard and Trouvé, 1977), although it was not included in the 1968 INSERM classification (Postel, 1972).

Verwirrtheit is infrequently used in German psychiatry and no longer differentiated from *Verworrenheit* (Scarfetter, 1980). DSM III (American Psychiatric Association, 1980) and PSE (Wing *et al*, 1974) have dropped the term altogether. Writers on the organic states either disregard confusion (Lipowski, 1980) or confine it to a purely descriptive role (Lishman, 1978).

The term confusion has been used in legal language since Roman times, in logic since the mediaeval period and in epistemology since the 17th century (Eisler, 1904); in psychopathology since the 19th century (Grimm and Grimm, 1956). Confusion of ideas interpreted as a psychological aberration gained its earliest theoretical support from Associationism (Warren, 1921).

Confusion has therefore carried both in logic and in psychology an intellectual interpretation. For example Esquirol (1838) used it to describe a state of intellectual disorder or chaos and J. S. Mill referred to the fallacies of confusion that resulted from "indistinct, indefinite and fluctuating conception of what the evidence is" (Mill, 1845). Baron Dupuytren (1834) used it to describe the disorientation that characterized nervous delirium.

Verwirrtheit, and the related *Verworren* and *Verwirren* also described states of mental chaos and ensuing behavioural perplexity (Grimm and Grimm, 1956). Heinroth, Ideler and Spielman (Wille, 1888) used the term to refer to states of mental disorder and Griesinger (1878) established its nosological status. Wille in his classical paper referred to it as "acute, rarely chronic, functional disorder of the brain characterized by confusion, hallucinations, delusions, disorder of consciousness and sometimes stupor". This is the same cluster of mental phenomena that Meynert (1890) described as Amentia (Pappenheim, 1975). The influence of Wundt's Associationism is clear both on Wille and Meynert. Confusion has no entry in Tuke's (1892) or in Power and Sedwick's dictionaries (1882).

The psychiatric concept of confusion developed during the 19th century both in France and Germany to refer to an abnormal state, found associated with delirium or the insanities, and consisting in a severe

defect in the organization of ideas (Chaslin, 1892). At the beginning it referred specifically to chaotic thinking and did not entail an organic aetiology. Hence, for at least 40 years it was accepted that confusion could accompany any form of mental disorder. Indeed in spite of Chaslin's efforts, some writers (e.g. Bleuler, 1911) still preferred the old syndromic view.

"Confusion" in French Psychiatry

The term 'confusion' can be found mentioned in relation to delirium as early as 1834 (Dupuytren, 1834) but was reintroduced into French psychiatry by Delasiauve (1851). He opposed Baillarger's views on the clinical identity between confusion and stupor, stating that lypemanic (i.e. depressive) and organic confusion were different; and to explain the apparent cognitive impairment seen in some depressions he advocated a concept similar to 'depressive pseudo-dementia'. Delasiauve compared confusion with dreaming, thus returning to 'onirism', a hypothesis present in French psychiatry at least since Baillarger (1843).

Confusion did not come into common use until late in the century but the concept, as Chaslin remarked in 1892, had been all along contained in the German notion of *Verwirrtheit*. This delay was due to the success of Baillarger's view that confusion was a form of melancholia (Camuset, 1897). The gradual contraction of the concept of melancholia led to the breaking away of the confusional state; Chaslin wrote his first paper on the subject precisely during this period. Only two years earlier Conolly Norman had published his paper on "Acute confusional insanity" (1890) containing most of the clinical elements later expanded by the French writer. The Irish psychiatrist defined the syndrome as having rapid outcome, impairment of consciousness and hallucinatory experiences. Chaslin did not pay much attention, at least overtly, to Norman's work. The category survived into the 20th century e.g. Bolton (1906) or Bruce (1935), a Maudsley Lecturer who studied its physical accompaniments.

Chaslin's first paper on *Confusion Mentale Primitive* (1892) was an expanded version of a communication written by him but read by Seglas at the Psychiatric Congress of Blois the previous August. From the start he used *confusion* (under the influence of Wille) as tantamount to delirium and in a wider sense than the traditional intellectualistic one. He considered mental confusion as a basic symptom in the wake of which hallucinations, stupor, delusions and physical symptoms might follow. He differentiated this from superficially similar states accompanying mania, melancholia, *délire chronique* (i.e. schizophrenia) and febrile delirium. He speculated that confusion might be due to cerebral weakness.

Chaslin's paper struck the right chord. A year later at the psychiatric congress at La Rochelle, a number of studies on confusion were read supporting his views. Seglas (1894) in his Salpetrière lecture acknowledged Chaslin's contribution and regretted the fact that Delasiauve's early usage had fallen into desuetude. This he also explained on the basis of the persistent popularity of Baillarger's and Morel's ideas. He also remarked on the usefulness of the German terms *Verwirrtheit*, *Amentia* and *Dysnoia* for they referred "in the strict sense of the term not to a banal symptom accompanying all forms of insanity but to a very specific impairment . . . consisting in the loss of voluntary control upon the intellectual faculties" (my translation).

Chaslin's monograph appeared in 1895. There he considered *confusion mentale* as resulting from psychological automatism, i.e. an explanatory category that after Ribot and Janet had become central to French psychopathology (Baruk, 1972). Psychological automatism stemmed from the release of lower functions resulting from a dissolution of higher ones. Ribot's interest in Spencer had led him to Hughlings Jackson (Delay, 1953). The hierarchical model of the mind that Chaslin borrowed from Ribot was therefore Jacksonian in origin. His associationist views (resulting from Wundt's and Ribot's influence) were noticed both by a British reviewer (*Brain*, 1896) and by Camuset (1897) who confirmed the impact of Chaslin's book on French psychiatry. Another British reviewer (anonymous, 1898) felt that Chaslin's reliance on Meynert's theory was unjustified.

The term acquired international circulation as a result of Régis and Hesnard's (1911) contribution to Marie's "Traité International de Psychopathologie". They identified three stages in the evolution of the concept: a first period up to 1843 during which confusion, dementia and *stupidité* were conflated (Berrios, 1981); a second period beginning with Baillarger's paper (1843) during which stupor was redefined to include the confusional states; a third period starting with Delasiauve (1851) and completed by Chaslin, Charpentier, Hannion, Seglas, Marandon de Montyel and others that considered *confusion mentale* as a separate syndrome.

In his next paper on the subject Chaslin (1915) departed in three ways from his original position by referring to confusion as a *syndrome* and not as a *maladie;* describing it as a global disorder of mental function and not only of intellect; and highlighting its organic aetiology. This latter point he made in the context of a debate with Eugen Bleuler who still believed in the syndromic view of confusion and who

had criticized Anglade (one of Chaslin's disciples) for stating that true confusional syndromes (organic) were different from schizophrenic pseudo-confusion (Bleuler, 1911). Régis (1906) in Bordeaux also expressed a Bleulerian view and so did Toulouse *et al* (1920).

The French debate on this topic occurred in 1920 and is reported in the minutes of three successive meetings (29 March to 31 May) of the *Société Médico-Psychologique* (1923). Chaslin therein outlined, for the last time, a view of confusion which has survived unchanged to this day. His intervention followed the claim by Toulouse *et al* (1920) that confusion and dementia were not clinically differentiable because both resulted from the same pathology, namely a disorder of 'autoconduction'. The latter was a psychological category that enjoyed some popularity in France around the Great War and meant something between self-deportment and ego self-organization. It referred to those voluntary and involuntary aspects of the personality which in dynamic terms fulfilled an adaptational function. Toulouse *et al* also criticized the structureless interviewing techniques used in psychiatry at the time and considered them too crude to detect any diagnostic differences that might exist. They proposed the use of standardized techniques based on the questionnaires and personality analysis of the kind Binet had proposed years earlier (Wolf, 1973; Binet, 1892).

Chaslin (1920) reiterated the view that the crucial psychological disturbance in the confusional state consisted in a loosening of synthesis affecting intellectual, affective and volitional functions and stated that Toulouse's auto-conduction was just another name for the old, associationist notion of synthesis. He believed that the origin of the misunderstanding by Toulouse *et al* did not stem from any clinical or pathogenic similarity between confusion and dementia but from the recently developed fashion of using dementia as a prognostic tool. He warned that prognosis was unsafe when made on the basis of cross-sectional examination. Indeed one of the central issues in the 1920 debate was whether a cross-sectional analysis of mental state was sufficient for diagnosis and prognosis. Toulouse *et al* postulated that it was if properly conducted. Chaslin defended a historical approach.

An offshot of the 1920 debate was that mental confusion also became linked to the notion of clouding or obnubilation of consciousness (Porot, 1975). This effectively made it synonymous with delirium; hence later attempts to separate the two, either in terms of severity or type of mental functions involved, were bound to fail as both concepts referred to the same biological phenomenon. The only difference was a theoretical one: confusion referring to incoherence of ideas; delirium to perceptual and motor disorders.

The Aftermath

With Kurt Schneider (1948; Conrad, 1960) clouding became 'axial' to the German school; its clinical counterpart being temporo-spatial disorientation. The simplistic use of this notion has often concealed its complexity (Levin, 1956; Benton *et al*, 1964; Lipowski, 1980; Marchais, 1981). The urgency of achieving an understanding of disorientation is determined by the fact that it carries, at least in English-speaking psychiatry, the burden of being the clinical concomitant of 'clouding', a metaphorical description still considered as the fundamental feature of delirium (Lipowski, 1980).

The perceptive observation by Chaslin that acute organic states can occur without clouding was rescued by the German school when in the 1950's it recognized the *Durchgang* or transitional syndrome (Wieck, 1961) as a reversible symptomatic psychosis without clouding of consciousness. This has been supported by continental writers (Alonso Fernandez, 1977). Interestingly enough this view has influenced the relevant nosological categories in DSM III (e.g. organic delusional or affective syndrome).

It is beyond the temporal limits of this paper to explore the way in which the evolution of delirium, confusion and clouding of consciousness converged in the work of Bonhoeffer (1910) and related to the vexed issue of the false exogenous-endogenous dichotomy. From what has already been said it can be surmised that I believe that Bonhoeffer's contribution has been somewhat overrated and that the crucial conceptual issues involved in the organic states had been sorted out by the end of the 19th century. The over-estimate of Bonhoeffer results from too linear a historical interpretation and a complete disregard for French sources (Bleuler *et al*, 1966; Zutt *et al*, 1969). Perhaps an explanation for the rapid acceptance after 1910 of Bonhoeffer's stereotyped view of delirium and cognate syndromes can be found in the quality of his monograph, or even in Aschaffenburg's prestige. This is not very plausible, for Redlich's monograph (1912) in the same series is far more impressive than Bonhoeffer's.

A better explanation is suggested by the evolution of the concepts themselves. The acquisition by the functional psychoses of their own organizational principles in the post-Kraepelinian world led to a conceptual neglect of delirium and confusion as they no longer had to provide a paradigm for the psychoses or indeed define themselves in fine psychopathological detail. Consequently the stereotyped view became

sufficient (Evidence for this will be offered in a future paper).

Summary and Conclusions

The acute organic states in psychiatry with attendant categories such as delirium and confusion are important from the clinical and theoretical point of view. Adequate historical studies on the evaluation of these phenomena are needed before more complex historical accounts are attempted.

The following points have been made:

(1) That changes in the concept of delirium during the first half of the 19th century resulted from the separation of the narrower notion of *délire* (delusion).

(2) That delirium was redefined by the new psychopathology as a disturbance of consciousness, its accompanying symptoms being considered as secondary or release phenomena and its aetiology as organic in a strong sense.

(3) That this redefinition of delirium led to its successful separation from the functional insanities, thus accelerating the conceptual transformation of the latter into psychoses.

(4) That 'confusion' is a contribution of the 19th century. At its inception it constituted a narrow intellectual notion, deemed to result from a disturbance of synthesis. Thence it could accompany either organic or functional states.

(5) That *confusion* has survived in French psychiatry because it fulfils a conceptual role, the same that delirium serves in British psychiatry.

(6) That from the historical viewpoint the concept of confusion illustrates better than delirium the efforts by 19th century psychiatrists to elucidate the psychological dysfunction that characterizes acute organic states.

(7) That the concept of clouding developed as an offshot of 19th century views on consciousness, providing delirium with a symptom core far more flexible than the intellectual interpretation of confusion. That temporo-spatial disorientation has proved to be an unreliable clinical feature to ascertain the presence of clouding.

(8) That the concept of confusion and the newer one of transitional syndrome may acquire new usefulness if reinterpreted in terms of the 20th century psychology of cognition and adequately supported by empirical evidence.

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