(3) The application of "dementia" is unsatisfactory to cases in which loss of memory is not a prominent early symptom.

(4) The term does not state whether it is the terminal stage or the stuporose condition which is of primary importance.

(5) The qualifying adjective "præcox" is equivocal, in so far as it leaves it doubtful whether the diseased condition evolves precociously, or whether it is stated to occur in early life or youth. It is therefore a vague and indefinite term, as these symptoms are also known at maturity and even at the menopause, and therefore they should find no place in a scientific or logical classification.

(6) A term which implies a definite entity, and which is with some becoming more accepted as such, should be distinguished by definite pathological findings, which is not the case.

(7) Finally, it is more in harmony with practice and of greater help to diagnosis and treatment to use in place of "dementia præcox" the term "adolescent insanity," suitably subdivided as at present.

Dementia Præcox. By A. R. URQUHART, M.D., F.R.C.P.E.

FRANCISQUE SARCEY says that originality consists, not in thinking new things, but in thinking for yourself things that thousands of generations have thought before you, and that your idea will appear new because you will strongly impress upon it the turn of your mind and tinge it with the colour of your imagination. Something of this kind has occurred in the presentation of dementia præcox. Kraepelin does not even claim the term as his own invention, but refers to it as the original proposal of Pick. We have duly recognised the distinguished position attained by them both, and appreciated Kraepelin's work, especially in investigation and teaching, and his achievements in elucidating morbid mental phenomena. If one is led to differ with him in the light of observations already made in this country and years of personal experience, that difference must be expressed in terms of esteem and respect.

Have we really advanced, in the matter of classification,

at least, beyond the position attained by Griesinger in 1861? I think not. The main divisions of ordinary insanity are still representative of states of depression, states of excitement and states of weakness. Sankey's great generalisation has been revived and quickened, and rendered fruitful in a measure which is a gratifying tribute to his memory. Apart from distinctly pathological groups, these three phases may be successively recognisable in one insane person, while another may present but one or two. The progressive nature of mental disease is thus set forth. Much complicated writing becomes less difficult to understand. No doubt similar cases may be advantageously grouped under special designations as subsidiary to the main generalisation; but we have been, all along, too much occupied with protean, kaleidoscopic appearances, too much distracted by irrelevant or unimportant details, too much set upon the discrimination of variable and varying symptoms. Our hopes lie rather in the methods of physiology, a clinical procedure relevant to the underlying facts and a pathological knowledge which shall issue in a pathological classification. The toxic nature of insanity, even the toxic nature of fatigue, offers an explanation of morbid mental phenonena which Kraepelin has been quick to recognise, and on which we may more securely advance. Consequently, I have consistently advocated the simplest form of classification of symptoms in terms of time, except for those conditions, such as general paralysis, which are already known to be grossly pathological—although even that disease is conveniently regarded as melancholic, maniacal or demented in its various phases.

No doubt such a term as *melancholia* would be rejected to-day if it were proposed for the first time. *Black bile* is not a desirable designation, but it has been so long in use that the group of symptoms which characterise the condition is never, in practice, referred to the malevolent bilious secretion. It is a term consecrated by use. The difference is marked when a new name is offered for acceptance. Derivation and first-hand meaning are closely scanned, and it can only win its way into our nomenclature by express and undeniable suitability.

Dementia præcox has thus been offered, and its passport, its letters of credit, are carefully scrutinised. Is it *dementia*? Is it *præcox*? Or is it something else disguised under a classical garb? *Adolescent insanity* has long been familiar to us as

indicating a fairly constant group of cases. Is the Association to indicate a preference for the new importation? I hope not.

Let us see how dementia ends in my experience, which was certainly not recorded with such an investigation in view. I have considered all my cases diagnosed as demented during the last twenty-nine years. All have proved incurable with the exception of five. Those five are instructive; they were each and all deeply alcoholic. They recovered. To the alcoholic it would seem nothing is impossible—they conform to no rule. Three were men, of whom two continue sane and sober; two were women, of whom one continues sane and sober. The others have been lost sight of in the course of years. Therefore, dementia has been in my experience an incurable condition, invariably incurable but for those alcoholic exceptions.

No such results can be formulated in regard to dementia præcox. The condition is not thus hopelessly incurable. Kraepelin himself states that the disastrous ending of ordinary dementia is not by any means the rule in dementia præcox. The exceptions are too numerous to establish any such definite failure of medical skill. It follows that dementia præcox is not really dementia; and further, that there is a serious disadvantage in thus confusing the issues, an unnecessary and objectionable labelling of patients as hopeless and already doomed. I trust that I shall not be misunderstood. All insanity is mental weakness, more or less pronounced, but all insanity does not touch that lower level of mental degradation which is classed as dementia—that final wreckage of mind which, at least in my experience, permits no opportunity of salvage. I am free to confess that there was a time when I thought that Clouston painted with too big a brush, and that his sweeping assertion that dementia is altogether incurable might be modified on careful scrutiny. Now, I can only say that my experience corroborates his ultimate assertion, since my register of medical facts has been completed and examined with an open mind. In this register are recorded, *inter alia*, the ages on first attack, and those persons of less than twenty-five years of age, as adolescent. A brief examination of these records is of interest, and I make this *resumé* of them not as applicable to asylum life only, but as they are entered from the time of the first attack until the present, so far as I have gained that information. Inevitably a certain number have disappeared

from our purview in the course of years, but these are comparatively few. I would note also that the figures represent all cases admitted down to the moment of writing.

It would clear the ground if completed histories in sufficient numbers were available for these inquiries, and the Association has been repeatedly urged to enter on collective investigations of the kind in order to establish statistics which would be more valuable proportionately to the extent and trustworthiness of the records. My present information is inevitably both faulty and incomplete, and can only serve as a general indication of results.

It will be convenient to adopt a tabular form referring to certified patients in the Perth Royal Asylum at the beginning of 1880, and since admitted, the whole numbers of these being 464 male and 442 female, total 906. Of that total the persons received after first or repeated attacks of insanity occurring between the ages of fourteen and twenty-five numbered 225, as follows:

	M.	F.	T.	M.	F.	T.
Persons admitted aged 14 to 25 on first attack	128	97	225			
The percentage on all admitted	...	...	...	27·0	21·9	24·8
Of whom neuropathic heredity was ascertained	102	73	175			
The percentage on adolescents being	...	...	...	79·7	75·2	77·7
Of these admissions recovered and so remaining	22	19	41			
The percentage on adolescents being	...	...	...	17·2	19·5	18·2
Of these recovered, relapsed, recovered and so remaining	14	13	27			
Percentage	...	...	...	10·9	13·4	12·0
Of these recovered, relapsed and so remaining	32	31	63			
Percentage	...	...	...	25·0	31·9	28·0
Of these no recovery was recorded	60	34	94			
Percentage	...	...	...	46·8	35·0	41·7
Total	128	97	225	100	100	100

Second only to the age period, the notable common factor in these cases is the neuropathic heredity as ascertained in *77·7 per cent.* On all kinds of patients my percentage is 71·81, but

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these statistical results are evidently understated owing to absence or falsity of information. Still, the fact remains that there is an adverse difference for adolescents of 6 *per cent.* This is in accordance with the general finding and it is not unexpected. It is recognised that those who suffer most deeply and hereditarily from gout are those who manifest the disease in early life—the stronger the predisposition the earlier the failure. It is the same with rheumatism, which is so constantly recorded among insane families. It is obvious that the constitutional defences of the individual are innately defective. Again, the "recoveries" from rheumatism bear a close resemblance to the "recoveries" from insanity. The recoveries, the relapses, the chronic incapacity are even statistically similar. Or, taking a wider view, the medical results of general hospitals are practically the same as those of hospitals for the insane. Since Professor Karl Pearson has shown that the expectation bears a mathematical relation to the antecedent facts, this need not be laboured further. The faulty heredity finds expression in 70 *per cent.* of failures, regarding *recovery* from mental disorders as the re-establishment of mental soundness in so far as to permit of return to ordinary life without need of the care and supervision of others. I have reason to believe that this test of recovery is not universally accepted, but the word is used in that strict sense in these calculations.

We see this early failure at an average age of 19 years on first attack, an average age at death of 48 years, and an average age of survivors still insane of 42 years, so far as ascertained. Thus:

Insanity of Puberty and Adolescence.

	M.	F.	T.
Average age on first attack .	19·6	18·1	19·0
„ „ death . .	40·8	60·3	48·5
„ „ of those alive and insane	40·6	45·0	42·5

Oliver Wendell Holmes said that "the angel of life winds up our brains once for all and then closes the cases of these seventy-year clocks," but the defective in construction notoriously run down before the wear and tear of the mechanism has well begun. The winding up has proved an ineffective job.

We are dealing with an affection which issues in failure

in 70 *per cent.* of the whole. On the other hand, recovery is gained in 30 *per cent.*, 18 *per cent.* after the first attack, and 12 *per cent.* after one or more than one attack. In the circumstances, therefore, there is already a reasonable chance of success, and the future may afford better results. It is evident that, like other classes of ordinary insanity, this affection of puberty and adolescence is not all dementia.

Clouston says that Kraepelin applies the new designation practically to the whole group of adolescent cases described by him in 1873; but some of us have been told that we do not understand the position. Perhaps that is so, for the extension to include persons arrived at forty years of age before the first attack and the indefinite characters of the syndrome are certainly difficult to comprehend in our insular ignorance. Perhaps we might be to some extent enlightened if Kraepelin could be induced to give us a clinical demonstration of patients whose histories had been submitted beforehand. Johnstone, however, is well qualified to instruct us, and he explained, three years ago (*Journal of Mental Science*, 1905), that we must admit that up to forty years of age evolution and development are still going on. That is a hard saying for the anatomists and physiologists, who have been teaching us that the limit is a quarter of a century only. Indeed, it seems to me to be a disturbance of settled beliefs which is unwarrantable, a confusion which is misleading. No doubt the sound mind in the sound body may continue to develop, but that development is not the process which finds the boy and leaves the man. Johnstone also tells us that the diagnostic point is a peculiar and fundamental want of any strong feeling of the impressions of life. That is an observation which can be made in any ward of any asylum from which dementia præcox has been rigidly excluded. I need not pursue the details further, for dementia præcox has been so fully and frequently discussed of late years that reference need only be made to the *Journal of Medical Science* and Conolly Norman's paper in the *British Medical Journal* of 1904.

One can appreciate an insanity somewhat differentiated by the adolescent period of life in neuropathic persons; one can recognise the general appearances of protean disorders of an immature brain threatened with irreparable damage, tinged with the half-fledged experiences of life in the turmoil of sexual development and the stress of physical development. That

these disorders are melancholic, maniacal, delusional, stuporose catatonic, destructive is evident enough and in accordance with daily experience ; but they are assuredly not exclusively the manifestations of dementia præcox nor of adolescent insanity. Indeed, Kraepelin has been forced to include a case beginning at the age of fifty-six, which has not hitherto been regarded as a precocious period of life.

One does not desire to be captious about mere names, but it is admitted, and it is on proof that this group is not uniformly characterised by dementia as understood in this country, but rather included in Clouston's memorable phrase—*a tendency to dementia.*

I believe that general malaise, dyspepsia, and depression almost invariably usher in an attack of insanity. Observations throughout a long series of years have confirmed me in this opinion of Griesinger's, and the importance of the teaching of Schroeder van der Kolk in this connection. Now, Kraepelin states that he would diagnose dementia præcox if he had ascertained that vivid hallucinations and confused delusions occurred in the very beginning of the initial depression. But I have recorded numerous instances of these early aberrations in cases quite unrelated to dementia præcox as authoritatively described, and yet Kraepelin claims to be able to predict the issue on the first attack, and immediately adds that the prognosis is by no means simple (Johnstone, p. 29). It is this constant confusion of statement which arouses antagonism and leads to the rejection of this proposed change in nomenclature. One can quite well accept *stereotyped movements* as a descriptive phrase ; but is there any need for us to substitute *mutism* for taciturnity or *negativism* for resistiveness? The excuse for scientific jargon is exactness of expression, but in these proposals there seems to be little to induce a change from what is already well understood in favour of any equivocal substitute. By *mute* we describe a person dumb from birth, not a person silent because delusional. By *imbecile* we describe a person mentally defective from infancy, and to write about acquired imbecility at this time of day actually prevents clarity of language.

The prognosis of a case of adolescent insanity is most difficult and uncertain. It cannot be formulated by means of any brief dictum or any outstanding symptom. There are too

many dissenters to admit of a short way with them. Prognosis can only be the mean result of a consideration of all the factors, weighed successively and in combination. It does not differ in all the various cases of insanity—one method here and another method there. We may possibly advance to a more exact prognosis provided it can be shown that we have to deal with different diseases, if the present variety of ordinary insanity can be sharply divided by pathological findings.

Bianchi definitely rejects the conception of dementia præcox as a clinical entity, because we get no clearer knowledge of the case by so endeavouring to discriminate. He cannot decide how the disorder will end. I cannot discover that Kraepelin has affirmed that it is a clinical entity; although he leans towards the theory of auto-intoxication it has yet to be shown that the toxic nature of the group differs in any particular from that of cases occurring in the maturity of life.

In what do we gain by accepting dementia præcox and rejecting adolescent insanity as clinical conceptions? We have found the latter term useful in selecting for study certain well-marked cases, but the former affords us no such definite content. Would it aid us in practice? Would it strengthen us in diagnosis, in pathological understanding, in prognosis, or in treatment? I see no grounds for such a hope. The principles and details of treatment are identical with those applicable to other cases of ordinary insanity, the pathology is vague and unspecialised, the diagnosis is elusive, the prognosis is uncertain. Much ink has been shed over dementia præcox, many contentions have ensued, and it would appear that we shall continue to regard this untimely birth as an undesirable alien. Dr. Jones would refer it to the wisdom of Solomon, but Solomon has already spoken—"I gave my heart to know wisdom and to know madness and folly. I perceived that this also is vexation of spirit." It made him tired.

NOTE.—The discussion on this subject was adjourned from the Annual Meeting till the next Quarterly Meeting, which will be held on the 19th November, 1908. The adjourned discussion will be opened by Dr. Thomas Johnstone, and his contribution will be followed by a series of short papers by other members of the Association.

The General Secretary will be glad if members who desire to contribute to the discussion, whether able to be present or not, will send him a synopsis of their papers.