(4) Sherlock.—*The Feeble-minded*, p. 261.
(5) A. F. Tredgold.—*Mental Deficiency*, p. 277.
(6) *Op. cit.*, p. 221.
(7) J. Shaw Bolton.—*The Brain in Health and Disease*, p. 198.
(8) *Op. cit.*, p. 162.
(9) Tredgold.—*Mental Deficiency*, p. 226.
(10) "Lethargic Encephalitis."—Paper read before Med. Soc. of London by Col. E. Farquhar Buzzard, *Brit. Med. Journ.*, December 24th, 1918.
(11) W. A. Potts.—Quoted by Tredgold, *Mental Deficiency*, p. 47.
(12) Tredgold.—*Mental Deficiency*, p. 40.
(13) *Loc. cit.*
(14) *Loc. cit.*
(15) Goddard.—*Feeble-mindedness, its Causes and Consequences*, p. 437,
(16) Hutchison and Rainy.—*Clinical Methods* (*Superficial Reflexes*). p. 477.
(17) E. A. Schäfer.—*The Endocrine Organs*, p. 110.
(18) Aldren Turner.—*Epilepsy*, p. 31.
(19) *Op. cit.*, p. 38.
(20) *Op. cit.*, p. 38.
(21) Tredgold.—*Mental Deficiency*, p. 47.

(2) The so-called delayed primary amentia, in which there is a latent period of normal mentality, is after all only a sub-division of primary amentia, in which the potentiality for normal development is rather greater than in the typical cases of this group.—(3) "The co-existence of epilepsy and mental disease is thus of such a character as to indicate that both conditions are symptomatic of cerebral degeneracy" (*The Brain in Health and Disease*, by J. Shaw Bolton, p. 199).

Anxiety States Occurring at the Involutional Period.(1) By D. K. HENDERSON, M.D.Edin., F.R.F.P.&S.Glas., Senior Assistant Physician, Royal Asylum, Gartnavel, Glasgow.

A WIDOWER, æt. 69, was admitted recently to the Glasgow Royal Mental Hospital in an anxious, apprehensive, excited, restless state. The history of the case showed that he had come of a good stock, and that he had been a strong, healthy man. For a period of forty-six years he had been employed by the same firm of lawyers, and latterly had been their cashier. He had married twice; there were four children from the first marriage and two from the second. He had divorced his second wife on account of her unfaithfulness. In January, 1919, he resigned his position, sold his home, and made plans to live with his daughter. Three days after his home and furniture had been sold he made a determined attempt on his life by cutting his throat. One month later he was admitted to the Glasgow Royal Mental Hospital. Following his admission he continued in a state of abject misery, he

(1) Paper read at the meeting of the Scottish Division, March 19th, 1920.

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moaned and groaned, wrung his hands, resented any interference, and was very restless. He realised that he was in a hospital, but his mind was so occupied by his depressive thoughts and he was so miserable that he would not assist in a satisfactory mental examination. Physically he was in poor general health, his pulse was irregular and intermittent, and he had peripheral arterio-sclerosis. During the next few months he gradually improved in strength and general condition but mentally panics of anxious apprehension supervened from time to time, in which he became self-accusatory, and expressed hopeless feeling as regard his prospect of recovery. At the same time he was perfectly oriented, and his memory, general knowledge, and personality were all well retained. No particular attempt was ever made at psycho-analysis (his age seemed to preclude such a procedure), but nevertheless casual conversations were sufficient to allow him to give expression to his fears, and incidentally to show where his conflicts and difficulties lay. He complained of the other patients, said that they looked as if they could tear his bones out, that they wished to do him an injury, that they slandered him, that they accused him of incest with his daughter. At this point he began to defend himself with great warmth and emphasis, and said, quite unnecessarily, that the only thing that supported him was the consciousness of his own rectitude, that nothing had been further from his thoughts, etc. These matters were never argued out with him, but he was encouraged always to say what he had to say, and eventually six months after admission he was discharged as recovered.

How is such a case to be interpreted? Is it sufficient and satisfactory to think of it as a case of anxiety and depression in a senile suffering from arterio-sclerosis who recovered mentally as his general condition improved? I do not think this view is helpful in any way. This man of sixty-nine years had determined to break with his lifelong associations, and when the time came could not adjust himself to the new situation; a depression, not unnaturally, took possession of him and he attempted his life.

The question then arises as to whether this case was manic-depressive in type, being one of the so-called "mixed" states? There is still another view which can be taken. The patient, in addition to his depression, gave expression to certain complex material which might bear a close relationship to his anxiety and apprehension and his righteous self-justification, suggesting involutional melancholia, or better, the anxiety-reaction type.

I have examined the hospital records for a period of five years from January 1st, 1915, to December 31st, 1919, and find that as regards the age-period 40 to 70 years 299 patients—160 women and 139 men—were admitted.

The types of mental disorder were:

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	Women.	Men.		Women.	Men.
Anxiety states	65	32	Dementia præcox	3	4
Mania	12	6	Mental deficiency	2	2
Manic-depressive	27	11	Delirium	1	1
Paranoid states	26	10	Epilepsy	—	4
Organic brain disease	23	69	Psychasthenia	1	—

It will be seen that 65 women, or roughly 40 *per cent.*, and 32 men, or roughly 23 *per cent.*, had a psychosis in which anxiety in one form or another was the predominating symptom. The majority of these were first-attack cases. On the other hand, the manic-depressive cases, the great majority had had either one or several attacks at a much earlier age. I might have included in the manic-depressive group the 12 female and 6 male cases of mania, but I have considered it better to keep them separate so as to make the contrast between the depressive and maniacal attacks occurring at this period of life more striking. The fact that 69 men and 23 women showed symptoms of organic brain disease is only what one would expect. None of the other groups call for any special comment.

Of the anxiety cases, 59 *per cent.* women and 56 *per cent.* men either recovered or definitely improved as follows:

	Women.	Men.
Recovered	26	13
Relieved	12	5
Not improved	6	3
Under treatment	19	4
Died	2	7
	65	32

These statistics go to prove that anxiety states occurring at the involutional period are a relatively frequent type of mental disorder, and furthermore, that anxiety is a benign type of reaction. That being so, it would be profitable to inquire more closely into the mechanism of the disorder as helpful to treatment.

It is generally accepted that the involutional period, as the name implies, is a physiological epoch when the body-chemistry commences to undergo certain changes. It is the period of life when the sexual glands begin to lose their functions, the bodily processes to decline, and the organism to fail. The person loses his vigour and elasticity; he can no longer adapt himself to new events and situations of life which entail stress and strain and give rise to careful thought, and, maybe, anxiety. Just as the future looms large, so also does the past assume a proportion which it never previously possessed, and "what might have been" gives cause for reflection. We thus conceive the

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involutional period as a time of life when new adaptations have to be made, and to those unfortunately possessed with unstable nervous systems we can readily understand how fraught with danger such a time is. Trifles, petty worries, and difficulties of all kinds which formerly hardly gave a moment's thought now seem overwhelming, the prickings of conscience are in the foreground, the sins and misdemeanours of the past assume tremendous proportions, feelings and thoughts which have been carefully repressed and apparently forgotten come uppermost, and often find expression in crude sexual beliefs and ideas. Such a conflict of instincts soon brings about a more definite psychic state, with anxiety, fear and apprehension as the striking symptoms. Insomnia becomes distressing, delusions are freely expressed, and attempts at suicide are not uncommon. With all this the personality of the individual remains practically intact, the memory is good, and the sensorium is relatively clear. Kirby, in his discussion of anxiety states, goes a step further, and attempts to differentiate the following groups: (1) Cases showing a simple form of anxiety or general uneasiness, apprehensive anticipations, with or without ideas of sin; (2) a severer form showing anxiety with fear, perplexity, and allo-psychic concepts. (3) cases presenting the sensory somatic complex, abnormal bodily sensations, hypochondriacal trends, and feelings of unreality; (4) cases developing with arterio-sclerosis.

I will now consider the case I have reported in the light of these facts.

It has, I think, been definitely proved that peripheral arterio-sclerosis can exist apart from cerebral arterio-sclerosis, so that in a given case where peripheral arterio-sclerosis is present we should hesitate before coming to the conclusion that the mental condition is arterio-sclerotic in nature. Arterio-sclerotic brain disease is an entity accompanied by such definite physical and such marked mental symptoms that we should never confound it with such conditions as anxiety-states. Transitions must and undoubtedly do occur, but the diagnosis of arterio-sclerotic brain disease should be limited to those cases with a history of headache, vertigo, convulsive attacks, and a defective memory. It is because of the absence of these pathognomonic symptoms that I have kept the case described apart from the arterio-sclerotic group.

The second and more difficult point is the relationship of such a case to the manic-depressive reaction type. When Kraepelin differentiated between manic-depressive states, dementia præcox and the other functional groups he kept apart cases of melancholia occurring at the involutional period, and reserved for them the term "melancholia." A few years later one of his pupils, Dreyfus, reviewed some eighty of Kraepelin's cases, and sought to prove that these were really manic-depressive cases. Kraepelin accepted and concurred with the findings

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of Dreyfus. Dreyfus made a special point of proving that cases of pure depression and excitement were not so common as had been thought, and that the involutional cases corresponded to Kraepelin's mixed group of manic-depressive. He stated also that these involutional cases had the same good prognosis as the manic-depressive cases, and that the prognosis only became unfavourable when arterio-sclerotic brain disease occurred. The recovery-rate in his group of cases was 66 *per cent.*, and in one-third of the cases the duration was over three years. Kirby, to whose review I am greatly indebted, concluded by saying: "In a number of cases the manic-depressive symptoms were plainly in evidence, the cases having been improperly placed with the melancholias. In a considerable number of other cases the author's conclusion that manic-depressive symptoms were present is based on extremely meagre data." I am heartily in agreement with Kirby's criticism, which is supported by certain definite findings.

From the point of view of ætiology it is striking to find how frequently in anxiety states mental factors, *e.g.*, the death of a near relative, financial and business worries, unfortunate home conditions, the breaking up of the home, etc., are assigned as the precipitating or exciting cause. On analysing my cases the causes were as follows:

	Women.	Men.
Mental	37	23
Physical	14	4
Combined	14	5
	65	32

Thus in 57 *per cent.* women and 71 *per cent.* men the ætiological factors were mental, whereas physical factors were only of importance in 21 *per cent.* women and 6 *per cent.* men. William Mabon, in his *A Study on the Ætiology of Insanity*, found that in manic-depressive insanity the percentage of mental and physical causes was about equal, whereas in the involutional cases 47 *per cent.* were of psychic origin, 34 *per cent.* of physical origin, and 17 *per cent.* were due to these combined. These statistics have been confirmed by others. The manic-depressive reaction, on the other hand, is much more of the nature of a constitutional disorder.

Another point which might be brought into consideration is the fact that in rural districts the percentage of involutional cases is much greater than in metropolitan areas. Meyer has ventured the suggestion that this is possibly due to a narrower mental horizon. Whether or not his view is correct is not unworthy of study.

These two types—anxiety states and manic-depressive—may also be distinguished symptomatically. In anxiety states fear and apprehension dominate the picture, and the feelings of fretfulness and uneasiness

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and the expression of somato-psychic delusions are all very characteristic. The typical depression of manic-depressive insanity is much more of the sad slow retarded variety with a subjective feeling of difficulty in thinking. I do not mean to imply that this differentiation is absolutely clean cut, but in the main it seems to hold good.

The course of the disease is also different in the condition under discussion. Anxiety states as a rule run a much more acute course, the danger of death is greater, but again taken as a whole the prognosis is better than in the slow, depressive states occurring in manic-depressive insanity after the age of forty years. In both conditions there is a tendency to recurrence, but when an anxiety state does recur it is always in the form of another anxiety attack. Anxiety states run true to type, whereas in manic-depressive states the subsequent attack may either show excitement or a depression. The fact also that anxiety states do not as a general rule develop until the involutional period seems to point to these patients having less instability than the manic-depressive types. For the reasons enumerated I feel we are justified in not subscribing to the Dreyfus-Kraepelin doctrine. On the other hand, we are more or less forced to recognise the prevalence of a group of cases which may be called the anxiety reaction type. It is for these reasons that the case reported cannot be grouped with the manic-depressive psychosis.

What then is its relation to the anxiety neurosis as described by Freud. It has been urged that there is a very intimate association between the sex instinct and the emotions of fear, and Freud, in his investigation and description of the anxiety neurosis, states that the causes of this disorder depend on the fact that the sexual life of the individual had not been satisfied. Morbid anxiety was to be held as synonymous with unsatisfied love. In addition, Freud states specifically that in certain cases no ætiology can readily be determined, and in such cases he believes that it is usually possible to demonstrate a marked hereditary taint. The clinical picture of this state is described as one of general irritability with auditory hyperæsthesia, anxious expectation, and often palpitation with cardiac irregularity, disturbance of respiration, profuse perspiration, diarrhœa, trembling, vertigo, etc. As a result of his clinical experience and of the analysis of his cases Freud formulated the theory that these "anxiety" symptoms were due to somatic excitations which could not find a suitable outlet, and Jones has summed up this view by saying that in the anxiety neurosis the mechanism of the disorder consists in there being "an excessive afferent excitation with deficient efferent outflow." In the anxiety psychosis occurring at the involutional period the clinical picture is essentially the same as in the anxiety neurosis, but the conduct of the individual is less under control; the mechanism of the disorder seems to be

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essentially the same. The old gentleman of sixty-nine years whose case I have reported no doubt had been troubled with morbid, incestuous thoughts and had doubted his capacity to deal with them. This was proved by the fact that during his psychosis he frequently referred to the topic with great affect, and rarely, if ever, did he mention the breaking up of his home and the resignation of his position. His psychosis, in other words, acted as a safety-valve, because it allowed him to give expression to those doubts and fears which in normal life he had so carefully repressed.

Another case in point is the following: A married woman, æt. 53, who is in a state of anxious apprehension, is tearful, feels that she will never get better, that the hospital is not the proper place for her, that she should be given another chance, and that if she were she would exert more will-power and keep a better grip on herself. This lady's husband is a marine engineer who is constantly away on long voyages, and is only at home for a few days between trips. She has one child, a boy, who is now nineteen years old. Until this boy was sixteen years old, the patient devoted herself to him, learned the school subjects with him, and identified herself with him in every way. At this stage difficulties arose. The boy began to emancipate himself, and to form friendships and interests outside the home. This was the time that the patient's psychosis developed, and during the next three years she was in and out of several mental hospitals. The patient is refined, sensitive, and lady-like; on the other hand, her husband is a commonplace man. There seems to me to be no doubt that this woman's love-life has been unsatisfied, and that she attempted to compensate for this by devoting herself entirely to her boy. She has herself expressed the situation by saying, "It would have been so different, doctor, if I had only had a daughter." It is evident that when her method of sublimation was taken from her and she was thrown on her own resources she failed utterly to face the situation, and her repressions and difficulties gave place to anxiety and apprehension.

The psychosis in the first case went so far that all barriers were broken, and the patient got relief from his tension by the expression of his inmost thoughts, but in the second case the only thing one can hope for is that a satisfactory compromise may be effected.

The analysis of these two cases seems to prove that the climacteric, *per se*, and the precipitating mental and physical factors act by lowering the resistance of the individual, and give a chance for the submerged, repressed and "forgotten" trends to come to the surface; they have no specific action whatever. The great difficulty with involutional cases is that they have reached a time of life when they have lost their elasticity; it is no longer easy for them to unburden themselves of their conflicts and troubles, and for the most part they are totally unconscious of

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the connection between their repressed instincts and their anxiety symptoms.

We should learn from these cases of anxiety not to think of them too closely in terms of mental and physical factors, and of symptomatology and classification, but rather regard them from a broader, biological standpoint. We must try and fathom their real difficulties, how they have attempted to meet them, and how we can assist. By dealing with these cases in this way we have something definite to work with, we gain a more vital and stimulating interest in them, and we shall come to recognise that symptoms of fear and anxiety are unhealthy methods of meeting instinctive difficulties. It is these anxious, uneasy, fretful types of patients who are always so ready to explain their troubles on the basis of their environment, and never seem to realise that it is they themselves who are at fault. They cannot own up to the actual situation and hang their anxiety on any peg that offers. For instance, one of our patients, at present in a state of great anxiety and fear, and addicted to masturbation, told me that I had murdered her, had destroyed her body, and that only her face and hands were left. The fact is that she herself is afraid that she may have injured or destroyed her body by her auto-erotic habits, but instead of meeting the situation honestly she makes the doctor the scapegoat and accuses him of murdering her, *i.e.*, of destroying her body. A school teacher, æt. 48, reiterates over and over again that she has killed her sister. The facts are that several months ago her sister died in a general hospital following an operation for ovarian cyst. The patient's sister had confided to the patient that her abdomen was beginning to swell, but both sisters had been too prudish to consult a doctor until the swelling had become very noticeable. The patient now blames herself for not having acted more promptly, but a superficial analysis shows that she has simply seized hold of her sister's death as the explanation of her anxiety because she is quite unable to meet her deeper instinctive difficulties. It is no easy or pleasant task to attempt to delve into the inner life of a maiden lady of fifty years or thereabouts, and as a general rule I would not advocate it, but I do think that we should make some attempt to give such patients a better understanding of themselves, and of what their illness means to them. It is quite possible in most cases of the anxiety-reaction type to give the patient a general explanation in regard to how such attacks often originate from factors which he or she has been unable to adequately meet, and that therefore it is important that the whole life-history of the individual should be discussed. Just as a tubercular focus may light up when the general health of the individual becomes lowered, so also may repressed ideas again assert themselves and act as sources of irritation. "Where there is pus let it out" is as much a truism in mental disorders as in general medicine. To that end it is important

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to encourage our patients to talk openly and freely about their difficulties.

The physician cannot do more than put his point of view before the patient, and then the matter must be left to the patient's judgment as to whether it is to be accepted or rejected. If it is accepted, then whatever the patient offers spontaneously should be utilised vigorously, but such a method of treatment should not be forced arbitrarily. If it is rejected, then the best possible compromise should be attempted. It is worse than useless to tell such patients to exert their will-power, to get a grip on themselves, or to forget things. Emotional experiences which have played any important part can never be entirely forgotten, and will always possess a certain irritative force unless consciously and straightforwardly faced. In addition to the age of the individual the only other objection against this method of treatment is the time it consumes, but in regard to this I cannot do better than quote the words of Ernest Jones:

"When we consider how much trouble and time has to be spent in the orthopædic straightening of a deformed limb we should not grudge the same to the far more intricate task of the orthopsychic training of a deformed mind, especially when this results in converting an intolerable existence into a happy life, and a person paralysed by fears, doubts and sufferings into an active and useful citizen."

Occasional Note.

The Nosology of Dementia Præcox.

So many of our readers subscribe to the *British Medical Journal* and the *Lancet* that we do not as a rule epitomise original articles which appear in these publications, unless they are of outstanding importance or there is some other special reason for so doing. The same attitude is adopted, but to a less extent, as regards other English medical journals, most of which are easily obtained. Economy, always a necessity, is especially important at present. There are some subjects, however, including contemporaneous movements of moment affecting the psychiatrical world, it is important that members of the Association should be kept well informed of, hence the "Epitome" and many of the items published in "Notes and News."

Sir Frederick Mott's recent contribution to endocrinology,(1) which foreshadows the possible entry of dementia præcox into the endocrinopathies, although perhaps well known to our readers, falls well within this category, and the Journal would be incomplete without some reference to it.

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