THE REACTIVE MANIC EPISODE: ITS IMPLICATIONS AND SCOPE.

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BLEULER, in his *Text-book of Psychiatry*, says that "Reactive mania is unknown." This statement occurs in the section devoted to the consideration of the reactive states; temporary psychoses, that is to say, where the ætiology is so clear and in such temporal contiguity to the onset of the symptoms that the illness can be definitely laid at the door of some recent alterationin the patient's total life situation.

In the same section Bleuler discusses fully the reactive depressions and considers that they are recognizable as such, although rare, and are usually manifestations of "manic-depressive insanity, and . . . psychopathies and neuroses."

This at once opens up a very large question, *viz.*, when are we entitled to regard any of the affective psychoses as reactive and episodic? Many of the depressions and exaltations which one sees clinically are essentially episodic and reactive in the sense stated in the first paragraph, but they recur from time to time in the life-history of the patient—similar reactions, separated temporally from each other by a longer or a shorter interval of normality. Consequently we are entitled to regard them as cyclic.

How many years or months must we allow to elapse between attacks before we consider ourselves entitled to regard episodes as clinical entities and not part of a manic-depressive psychosis or other condition? And this takes no account of the significance and weight we are entitled to lay on the clearness of the ætiology. Must we, as Wernicke suggested, make of our case-record a complete biography of the patient before we can truly evaluate any apparently episodic manifestations?

Here, however, we are concerned chiefly with the question of

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the reaction in the light of the thought-content during the acute illness, and the relationship to it of the supposed ætiological factor and the total life situation.

The problem of psychopathology presented by the acceleration of psychic tempo, with its alterations in affect, thought and centrifugality is a difficult one. In many ways it is even more difficult than an attempt at comprehension of the depressive counterpart, for all of us are more familiar with depression than with exaltation. It is a phenomenon of the psychic life of the normal which has commonly more introspection devoted to it than odd bursts of mild euphoria, even if the result of the introspection is merely a decision to take an aperient.

One difficulty which stands directly in the path of elucidation is the rush of talk, with its varying degrees of incoherence, found in the excited affective reactions. This has led to the belief that what can be made out of the stream of talk in these states has but a slender connection with the real mental trend, and that the reason for the elation breaks through only occasionally in a fragmentary way.

Another problem of equal intricacy is the question of a clear ætiology.

It is obvious that the endogenicity of any affective response is a difficult thing to assess. We must remember Freud's important principle of separating out cases where the cause is in the present from those in which it lies in the past. Psychological factors producing mood changes also may well work at a distance (speaking of time), and give a false appearance of a mood change without any present cause. The two most important suggestions as to this factor in the affective reaction types come from McCurdy and MacDougall. The former suggests that the onset of a manic or a depressive attack is in response to the fulfilment of a wish. If the wish is consonant with the personality's conception of a proper social setting and relationship, then the resulting affective release is in terms of excitement. If, on the other hand, the wish is such that it is anti-social, or against the ideals of the individual, the response is in terms of a depression.

To say that all manifestations of mental disease are the expression of difficulties in facing up to life is, by now, a truism. We can only add to the postulate by saying that if one person reacts to these difficulties by schizophrenic fantasy, another by the elaboration of a paranoia and a third by some predominatingly affective response, then the difference must be determined by factors of

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constitution and endowment. It is the old question of nature and nurture. This leaves us very much where we were.

McDougall's explanation of the phenomena is, naturally, along more definitely psychological lines of an almost academic nature. He says that in the depressive and excited phases respectively we can see the temporary overaction of the opposed instincts of submission and aggression. This couple, he says, normally form a balanced pair; from time to time they may be thrown out of equilibrium, and as a result we see the overaction of one or the other without (and this is the essential point) the braking effect of its "psychological antagonist."

Here is merely a guess at a mechanism; and we are as much in the dark as ever as to what the patient is trying to do with himself. It is a guess at a "how" but not a "why."

It is true to say that if the mechanism be a wish-fulfilment one and the affective response be in terms of gratification or fear, yet we can see only fragmentarily, and from time to time, the real thought-content underlying the condition. Still less often can we clearly make out a definite mental trend, and it is true to say that the schizophrenic, with all his mystery, is often really easier to understand than the affective psychotic—at any rate from the point of view of finding out what the patient's thought-content means to him.

It is essential for discussion of the affective psychoses to admit frankly that we can read no other meaning into the long-maintained depressions or excitements than that they are the expressions of endogenous mechanisms. And the slighter mood changes in normal subjects follow the same rule. The duration of the mood, however determined, we must, as has been said, regard as constitutional. Also to the careful observer it is clear that there are changes in an excitement and in a depression, fine, yet definite, so that we are entitled to regard the affective state as showing a predominating emotional tone which is not absolutely constant. It is the difference between the same tune played on the bass and on the treble part of a keyboard.

Most important of all is the need for getting all the facts before we call an exaggerated affective response "endogenous." With these considerations in view the case here considered formed a significant picture, if not typical, at least suggestive.

CASE I.—The patient was a single woman, æt. 29. She had a clean geredity as far as mental disease was concerned and she had a hood personality. She had been a post-office clerk since her

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early teens and was a good and steady worker. She was described as buoyant, thoughtful, unselfish, a fairly good "mixer" and having a marked musical bent.

After a short period, during which she was noticed to be below "par" physically and to have a degree of anæmia, she suddenly developed an excitement which soon became an acute mania.

At the outset of her condition, however, her thought-content was not so altered as to be undecipherable, and she is noted as declaring that she was Peter Pan, "the boy who wouldn't grow up," and wanted to fly away out of the window and to "get away from everything."

Here it should be mentioned that she had a peculiar home situation, in that she lived in dull and quiet family surroundings, where she had a good deal of care in the presence of an invalid mother. To this must be added the fact that her work at the post office was exacting and arduous.

The illness progressed to mania, and lasted almost without remission for two years. She fell ill in March, and from then till June she was continuously excited. She then improved, but was quiet, fatigable and lacking in concentration for a few days, after which she again became excited. Early in the first year she was noted to be wet and soiled. She finally recovered and remained well for eighteen years. During this illness, from time to time she had fever and gastro-intestinal disturbance with diarrhœa. The existence of febrile phenomena is significant.

After her recovery she remained at home, and never resumed her work but kept perfectly well.

One night her mother, now likely to die suddenly, called her to rise and do something for her. The patient, thinking something was amiss, rose hurriedly and fell, hitting her head against the bed-post and cutting it. In a few days the wound suppurated, and at the same time she was seen to be looking ill. She admitted that she had not been sleeping well. Then she became talkative and excited; she was so restless that her brother had to sit up all night with her. She told him that she felt as if she were rushing down a steep place, and that the past events of her life were coursing rapidly through her mind.

The excitement increased, she soon became uncontrollable and had to be removed to hospital.

On admission she was deeply narcotized and was on that account confused and disoriented. The stream of talk was slow and hesitant, and memory for recent events was lost, as

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was retention. As she came out of the narcotized condition it was seen that she was maniacal. Her mental trend showed the presence of a thought-content which compared interestingly with that found at her previous attack.

This was the presence of confabulations of the most detailed type. She began by telling a confused story of a visit paid by a relative who was far distant at the time, and then launched forth on a long story of considerable detail to the effect that she had, during the past few weeks, had a most enjoyable trip. She, with some cousins, had travelled across France by express to Marseilles and thence by boat to Port Said. There they had joined the ship in which the patient's brother was chief engineer. (He did in fact occupy such a post in a liner on the India run.) In this ship they had come home and then she had fallen ill. It was suggested to her that this was imaginary, and she laughingly said, "It might well be, for it is not like me to do an adventurous thing like that, but it is quite true."

Another brother related that the trip which she had confabulated had been for a long time talked of by the engineer brother, that it was quite a possible arrangement, and that it was tacitly agreed that it might come off when the patient's aged and invalid mother should no longer be a responsibility.

A clearer mechanism could hardly exist.

She rapidly improved, and was discharged a fortnight after the onset of her illness and has remained well. There were no regressive phenomena at this time. The recovery was smooth. She retained no memory for her confabulations, but agreed that she would like to make the trip she had imagined.

To sum up as briefly as possible, the case is that of a woman with a good external and personal background who has had two manic attacks. In each attack there are the same significant points. (1) The definite indication of a dissatisfaction with the actual life situation. In the first attack the difficulty was more unalterable. A young and healthy woman, she was faced with a life of exacting and uninteresting work. In the second, shorter attack the difficulty is the care of the invalid mother. "To end, when?" she asks herself, perhaps. At the end of this responsibility, there is the projected and long anticipated voyage; then the sudden call in the night, with the implication of some serious turn in the invalid's condition; the fall, and its consequences. (2) The toxic factor: In the first attack it will be remembered that she was fevered, toxic, albuminuric and anæmic. In the second attack

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there was a septic process with quite a definite general toxic reaction.

It is felt that the guessed-at psychological ætiology of the condition, and the existing toxic conditions, or states of low resistance, must be kept close together. They mean, so placed in juxtaposition, that we are dealing with a whole individual. It is a total reaction. From this rather remarkable syndrome of wish-fulfilment excitement, with toxic general disturbance, not as an initial phenomenon or a sequel, but as an integral part of the condition, we come to the consideration of the second case.

CASE 2.—This patient was a single woman, æt. 47. She was admitted to the Clinic on a stretcher. She was restless, throwing body and limbs about, striking, clutching and scratching those near her in a purposeless and confused manner. She was muttering incoherently and unintelligibly, and could not carry on a conversation. She was resistive, and had to have all her bodily wants attended to.

The illness had begun four weeks before, and she had been in the condition described for about ten days.

In the house where she lived there had stayed as a visitor a man of between fifty and sixty, accompanied by his two sisters. They all became very friendly and began to go about more and more as a party, until finally they were spending morning, afternoon and evening together. They were all vivacious, and there was a great deal of talk, activity, and stimulating conversation. The effect of this was to speed up the patient's responses; she became active, alert, euphoric, restless, sleepless, and this was intensified when the man made a tentative, but quite genuine, proposal of marriage to her. With arrangements for a future discussion of this they parted, and he returned to his own home.

The next day the patient was much upset to find an old lady who lived with her looking very ill. There was some fuss over the doctor's visit, and the old lady died. Within the next twenty-four hours the patient's sister was a little alarmed by the patient's quickness. She was talkative and extremely witty, making all sorts of penetrating remarks. She paid several calls and impressed her hosts with her appearance of great vigour and well-being. Subjectively there was a marked euphoria.

At the end of thirty-six hours the stream of talk was faster and her sister was sometimes unable to follow the train of thought. The patient began to mislay things and to wander hither and thither hurriedly, without plan.

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The physician prescribed a strong sedative, and as it was taking effect the patient said, "How glad I am to be resting like this." Twelve hours later she was in an acutely maniacal state, and there was marked interference with orientation, in all spheres. In spite of sedatives and nursing it was impossible to manage her in a private house, and so she was sent to the Clinic.

The family history was negative. The patient had lived all her life in the rather gossip-ridden small town where she had been born. Well educated and of middle-class stock, she had lived an uneventful life at home. For some years they had kept boarders. She had never had any psychic disturbances, love affairs or other crises of that type. From time to time after "doing too much" she would become "run down." The usual tonic was successfully exhibited. She had no other illnesses. This fluctuation in her general biological level is significant. She was the business head of the family, aggressive, active, determined, rather vain of her personal appearance, quick tempered, a trifle "affected," not over-religious, not living a very full intellectual life, but rather relying on tea-party talk for mental pabulum.

She was in poor physical state on admission. She looked toxic, the skin was sallow, and the tongue dirty. She covered her head, wept miserably, laughed foolishly, plucked and clutched at all objects. She muttered incoherently, "O Jesus Christ . . . it is thus that we do so . . . wherefore . . . it is so we pray . . . O Christ, I never, I never . . . ."

By the end of a week she had become very ill. The temperature ran up to 103°. There was diarrhœa, some melæna, evidence of dehydration, and an evanescent erythematous toxic rash on the flexor surfaces. Appropriate treatment abolished these in a week, at the end of which she gradually began to converse coherently.

This was the most striking period of her illness. She was completely disoriented, but was indignant at being where she was, as she wanted to be with her "husband." She referred repeatedly to her status as a married women and mentioned by name the man already mentioned. She wanted to rejoin him at once. In a few days her mental condition began to fluctuate. For some hours she would be oriented for persons (doctors and nurses), but not so well for place. At these times she was tearful and grateful. Then would come a spell of complete disorientation, with mis-identification, hostility, demands to get away, complaints of being separated from her "husband," and so on. At these times there was flight of ideas, distractibility, clang association.

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At the end of ten weeks she was perfectly well. When the question of after-care was being discussed she expressed a wish to visit the man who had played such an important part in her illness. There was no concealment; she freely described her feelings and wished to carry out their agreement. She was, however, persuaded to let the matter drop. She had a complete amnesia for her whole illness from the time when she was shocked to see the old lady almost dead.

The patient was discharged recovered.

The parallel between Cases 1 and 2 is sufficiently obvious, and requires no straining to make the facts fit the theories. In each case there is essentially a reactive excitement. In each there is the presence of some wish for an alteration in the life situation, which wish is in conflict with ethical considerations. In Case 1 there is the repugnance from wanting anything which could only be made possible by a mother's death. In Case 2 the death of the old lady meant a lessening of burden for the patient and more freedom to do as she wished. There is the presence in both examples of the "*choc émotif*," of something in the nature of "trigger energy" which fired off the charge. In both cases it is the question of the removal of a responsibility by death. The content of thought in each case bears exactly the same relation to what reality meant for the patient. In Case 1 it is a connected and confabulated story of a happening to which the patient had long looked forward. It is not too much to suggest that not only the voyage but the circumstances making it possible were both equally desired. It is noteworthy that no mention of the patient's mother ever escaped her when she was in her excitement. In Case 2 there is a home responsibility, a wish and a prospect of quitting it, by marriage, a late marriage, and one which was a little ridiculed by the patient's sister.

The toxic factor is important but difficult to assess. These women were both of the small, quick, active type, tending towards the thyroid-adrenal with a labile vaso-vegetative system. In each case there was, integrated with the syndrome, a toxic disturbance. The only way in which we can feel that this is something more than accident is by remembering that we are dealing with an individual, with a whole organism, and that to separate physiogenic and psychogenic is to cloak ignorance with words. Looked at thus, what do we have? In the one case a woman who receives a severe blow on the head and a scalp wound. She suffers some "shock." In the other case a rather frail little woman, exhausted

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by continuous excursions, work and talk, enters a room to find, apparently, a corpse. She develops a panic-like state. Subsequently both become a prey to bacterial invasion. In the one case a staphylococcus, in the other an unknown gastro-intestinal toxin. Along with this failure to control the infection there is with, and in, and through it an alteration of another function, the function of making reality a part of the individual. We have to take account of both processes. And this can only be done by regarding our cases as " experiments of Nature," as Prof. Meyer calls them.

These two women had a personality total to respond with. This cannot be expected to be at a constant. No biologist will allow that the potentialities of any living thing are as constant as those of a steam engine. It is the essential point of living structure, this curve of potentiality. Now here we have to consider two well-known curves. One is the general ebb and flow of emotional tendencies, and the other is what Prof. Meyer calls " the fitness curve." There is a general harmony between these two, and it will at once be seen to what extent this has been interfered with in the history of the respective illnesses. Especially we must remember the early health of Case 2. It would be meaningless to describe the cases as toxic exhaustive psychoses. The clinical picture is not that of a toxic disturbance. The content of thought in each case had a meaning, clear to everybody—not only to the patient. And the meaning was that a wish had been gratified without benefit of reality. The separation from autism and fantasy is clear. There is no distortion.

The invasion with toxins, *pari passu*, makes the way clear for us to feel that here is an organism and there a set of very complex stimuli. The two come together, and we get a result which affects the whole organism. It is a reactive excitement with, superadded, manifestations of invasion of the general system by what we can only loosely describe as a toxin.

From the purely " mentally " integrated point of view, that is, taking obvious psychological mechanisms alone, it is a point of importance to note the difference between the first and second attacks of Case 1. It is common to talk of the behaviour of an individual as a response or reaction. It is less common to realize that the individual makes adjustments of two types—long-term adjustments with subservience of the present to claims of the more distant future, and short-term adjustments dealing with the more immediate present. In Case 1 the first attack came in a typically

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long-term situation. The patient, a young woman, was faced with a life of uncongenial work. Escape was not easy; the situation was not easily modifiable; conscience and the financial position were in the way. Hence the long-drawn-out psychosis. It can be seen how this differs from the second attack. This, which is essentially a point of reactivity, is important. It seems to indicate that in the cases quoted there is some relation between the nature of the causal situation and the type of response. It remains for further research to confirm or refute this in the field of the affective episodic psychoses. Howbeit it is felt from the analysis of the cases quoted that excitement of the manic type does occur clinically in response to definite life-situation factors, and that in the thought-content of the patient there can be seen proof of this. It is suggested that these cases, episodic and with good prognosis, may justly be called episodic reactive manic excitements.

Summary.—The existence of reactive manias is denied by some authorities. The ætiology of the affective psychosis is discussed, and two cases are quoted in which excitement with manic features and toxic phenomena (indicating a reaction of the whole personality) appeared as a result of definite situational difficulties, the proof of this lying in the thought-content of the patient during the more acute stages of the illness.

The importance of the formulations which have been here made lies more especially in our ability to give a more definite prognosis in cases of this really quite common type. It is of paramount importance that if, as has been indicated, the content of thought has a very close connection with the total series of events in the illness, then a careful evaluation of these will assist us in deciding whether we are dealing with a condition of a long-term or a short-term nature. It is felt also that a more proper evaluation of toxic factors, as suggested in this paper, would to some extent clear up the status of many of those so-called delirium-like reactions which frequently do not belong to that category.

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