of scene, agreeable companionship, and simple attentions to the health may then in a few days or a week or two be the means of averting a threatened attack. The mental as well as the physical health of these individuals and families should be in the mind of the family physician.

The Pathogenesis of a Delusion.[1] By HENRY DEVINE, M.D., B.S.Lond., M.R.C.P., Senior Assistant Medical Officer, West Riding Asylum, Wakefield.

THE case which forms the subject of this paper presents no rare or unusual features, being of quite an ordinary type such as one may meet with every day. Its relative freedom from complexity is the feature which makes it especially suitable for analysis. The delusional formation was strictly localised and showed no tendency to spread into other fields, and but for the one morbid theme the patient could be regarded as normal. It is from the less complex forms of mental disturbance that one may hope to obtain the most insight into the development of abnormal mental processes, and it is for this reason that the case which I am about to bring to your notice has been chosen for consideration.

There has been a tendency in the past to regard classification as the ultimate aim of clinical psychiatry. Provided a suitable label could be attached to a case, its investigation has been regarded as complete. Now while the separation of mental disorders into certain broad groups has very obvious uses, classification is in itself not a very vital point, and it does not take us far in the understanding of our cases. Even if a certain grouping carries with it some degree of prognostic significance, as in the conception of dementia præcox, it does not serve to explain and account for the particular form and content of the symptoms which may be present. Such symptoms are only regarded in a general way as being indicative of a disordered brain, and the hallucinations, delusions, emotional disturbances and the like have no particular meaning except in so far as they serve to differentiate the case from other types of reaction. The case is only viewed from the outside, as it were, and no attempt is made to understand the patient's point of view or elicit the personal significance of

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the abnormal ideas and reactions which form the content of the psychosis.

In contrast to this limited point of view, it is being increasingly recognised that a case should not be regarded merely as one of a group but rather as an entity in itself. Though the clinical pictures may bear a resemblance, no two cases of insanity are alike. The contents themselves depend on individual factors, and their significance can only be understood by a close scrutiny of the particular conditions to which the personality has been subjected. The study of the functional psychoses is the study of personality, and the insane are to be regarded as types of mental variation rather than as beings entirely removed from the normal.

Whether one is dealing with the thoughts and actions of the sane or the delusions and impulses of the insane, they both represent the reaction of the individual to experience, however imperfect the form of adaptation may be. Abnormal mental processes cannot be regarded as accidental and insignificant in respect to their content. Like all other psychic operations they have their motives and chains of psychological antecedents, however bizarre and senseless they may appear. A delusion has a mental life-history like any other conception or idea, such an assertion being only in keeping with the principle of determinism, which must hold good in a psychological as in a physical series. (1)

These preliminary observations indicate the purpose of the following brief study, which it is hoped will serve as an illustration, however imperfect, of the principles which have been suggested.

The patient, Miss R—, is a woman æt. 25. The family history reveals a strong hereditary taint of insanity. The father died twenty-one years ago in an asylum, and nine years since her mother had been also insane for a period of a few months. Owing to pecuniary troubles she had become apprehensive and fearful of disaster, and when admitted to the asylum, where she was sent, was in a state of diffuse anxiety and unrest. Her progress towards recovery was rapid, and since her discharge there had been no relapse. The patient is the only surviving child of four. Two had died shortly after birth and the other a little later of "water on the brain."

The mother had been left a widow in somewhat straitened

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circumstances at a comparatively early age, but she was energetic and capable and managed to keep a home together for herself and daughter. For a time she had been employed as a cook, but had later taken a well-furnished house and supported herself by letting apartments. Just before her attack of insanity her prosperity had somewhat diminished, this being the immediate cause of her mental breakdown which has already been mentioned. She had become very worried and thought that ruin was inevitable.

Her great interest in life had been the future of her daughter, and by means of considerable self-sacrifice she had been enabled to educate the girl as a schoolmistress. This devotion had been amply repaid. The patient had been intelligent, painstaking, and industrious, and owing to these qualities had obtained a responsible post as a teacher. The two had lived alone together for some years, the daughter being the sole support of her mother.

Until the present attack the patient had shown no abnormal mental symptoms and her career had been praiseworthy but uneventful. Her chief interests were her school work and home ties. She was a favourite with her companions, amiable in character, and possessed of normal religious sentiments. She had appeared to be contented with her position in life and had shown no undue inclination towards gaiety or frivolous pursuits.

About two months previous to admission she had become rather low-spirited. The mother said she had appeared to be depressed because one evening none of her pupils had attended at the evening class. The patient did not say much about it but seemed quite upset at the incident. Her general health became indifferent, her menstrual period began somewhat prematurely, and she complained of a curious empty feeling in the stomach after taking her food, and she thought that nothing she took did her any good. Her depression increased and she said she had some incurable disease, imagining later that it was contagious, and stating that her mother was also becoming infected. After a time she showed some tendency towards suicide, and was then sent to the asylum.

A little scene occurred during the admission of the patient. She became very hysterical, and tried to run away, protesting vehemently that she was not insane, she had been brought to

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the wrong place, that is was unfair to allow anyone to come near her, and that she was not in a fit condition to associate with other patients. After a short time, however, she settled down quietly, and soon began to employ herself in sewing and other occupations, though obviously sad and low-spirited.

In general she proved to be intelligent, animated, and quite willing to give information about herself. It was only when the question of her malady was broached that she became depressed and emotional. The account she gave was substantially the same as that obtained from the history. About two months ago she had begun to feel very poorly. Her period had been in some respects unusual, she had strange abdominal sensations, and felt somehow quite different altogether. The doctor had come to see her, but could do her no good. While brooding over her symptoms she remembered that some of her fellow-teachers had been away from duty owing to illness, and she began to think her mother looked strange. The conviction grew upon her that these coincidences must be due to herself, that the complaints had been caught from her, and that she was a source of contagion. She was now quite convinced that this was the case. There was nothing the matter with her mind ; her trouble was entirely physical. She had been a little depressed because she could not go to school, but that was only natural.

This belief was firmly assimilated to the personality. Though circumscribed, it had none of the characters of an obsession ; it was a typical delusion which repelled all counter-suggestion. The patient was hopelessly pessimistic about herself—there was no cure, and she could only regret that no steps were taken to isolate her. She was willing to listen to all the arguments that I could advance in order to convince her that she was wrong, but all to no purpose. The belief was not founded on any logical process of deduction ; she *felt* she had a disease, and could express no other opinion in spite of anything which might be said to the contrary.

For some time after admission the patient was often noticed to walk about with her mouth covered, evidently fearful of spreading infection. If any of the patients or staff were unwell she would become distressed and worried, regarding herself as the origin of their illness. These peculiarities soon vanished, however, and her conduct became to all intents and

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purposes normal. She entered with interest into the life of the ward, was obliging and pleasant, and seldom referred to her delusion unless questioned on this point. She said it was useless to talk about it or attempt to hold herself aloof from the others, because no one believed her if she said there was anything the matter. Her subsequent mental progress will be mentioned later.

Physically there was nothing special to note. There was no evidence of any physical malady. On admission she was somewhat poorly nourished, but gradually increased in weight. This was no source of comfort to her, however, and she attributed her improved condition to "unnatural fat" rather than to a normal and healthy increase of weight.

These are, then, the salient features of the case. One must now study the origin of the delusional idea which constitutes its most prominent feature.

In describing the evolution of a hypochondriacal idea it is usual to regard some change in organic sensation as being primarily instrumental in its production. An alteration in the vague mass of sensational experience which forms the background of consciousness, and which contributes so largely to the notion of personality, may no doubt become the basis of delusional formation. A vague change of sensation, which is felt but not understood, may become allegorised and interpreted from a delusional standpoint. Thus, in the present case one may say that the indefinite malaise, the feeling of "being different," played a part in the formation of the delusion. At the same time such an explanation is incomplete since it does not account for the particular form and content of the morbid idea, nor does it connect it with the antecedent state of the patient's mind. A delusion bears a more intimate relation to the personality than a mere change of bodily feeling, as will be demonstrated in the instance in question.

Among modern psychiatrists, Freud has probably been the most instrumental in throwing light upon the genesis of delusions, obsessions, and neurotic symptoms generally. It is obviously impossible to even summarise his views in this paper. Reference should be made to his original works or to some of the various papers which have been written to explain his principles (2), (3), (4). It is necessary, however, to mention briefly his views on the origin of neurotic symptoms, as they

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would seem to have some bearing on the case under discussion. His main thesis is that morbid mental phenomena arise primarily out of certain states of mental conflict. Such conflicts are produced by the existence of some complex,(2) conative trend or experience which is out of harmony with the dominant trends and aspirations of the personality. If the individual is unable to co-ordinate the painful thought with the rest of the personality, there is a tendency to avoid the conflict which it arouses in the mind by suppressing it out of consciousness altogether, by trying to forget its existence. This is effected by various forms of compromise or evasion, which may in some cases assume pathological characters, and take the form of delusions, impulses, or obsessions. The main point to be noted here is that these various morbid symptoms are the superficial expression of some deeper complex which they serve to conceal and suppress from consciousness owing to its painful nature.

In order to trace the connection between the manifest symptom and the complex from which it is derived, some form of *psycho-analysis* must be undertaken. Freud's technique for such an investigation is very complicated and laborious, but considerable assistance may be obtained by the use of association experiments, which have been brought into prominence in this connection by Jung (5), (6), (7). A number of words are called out by the investigator, and the patient is required to give the first word that comes into his mind. The reaction-time of the response is estimated by means of a stop-watch, and when the list of words has been completed the experiment is repeated and the responses again noted. The reaction has been found to vary considerably from the normal when the stimulus-word aroused some complex into activity, the emotion produced causing a disturbance of consciousness analogous to that observed in conditions of experimental distraction. The aroused effect induces a state of internal distraction, characterised by lengthened reaction time, alterations in the character of the response, and failure to reply with the same word on repetition of the experiment.

With this brief digression we may now return to the case of Miss R—. Acting on the assumption that the above principles are correct, and assuming that the delusion which the patient expressed was derived from some more or less concealed com-

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plex, I employed one hundred association test-words in order to discover if the nature of this complex could be experimentally determined. The following list of words is a selection from those employed, with the results obtained:

	Stimulus.	Reaction.	Time, secs.	Repetition.
1	Head	Feet	1	—
2	Green	Red	·6	—
3	*Angel*	*Heaven*	6	—
4	Long	Short	1·2	—
5	Plough	Field	1·2	—
6	*Friendly*	*Enemy*	8	*Unfriendly*
7	Table	Chair	2	—
8	Dancing	Music	1·4	—
9	Bread	Eat	1·2	—
10	*Wood*	*Iron*	5	*Trees*
11	Lamp	Dark	1·2	—
12	Grey	Hair	1	—
13	Salt	Food	1·2	—
14	*Sympathy*	*Kindness*	6·4	*Pity*
15	New	Old	1	—
16	Play	Games	·8	—
17	*Dirty*	*Clean*	5	—
18	Handle	Door	1	—
19	*Despise*	*Disgrace*	10	O
20	Wrong	Right	·8	—
21	Book	Read	1	—
22	*People*	*Crowd*	5	*Friends*
23	Stupid	Silly	1	—
24	*Tree*	*Wood*	4·4	—
25	Ink	Black	·8	—
26	*Proud*	*Pride*	6·2	*Foolish*
27	White	Black	1	—
28	Bad	Good	1·2	—
29	Low	High	1·2	—
30	*Wall*	*Enclosed*	8	*Stone*
31	Goat	Sheep	1·2	—
32	Flower	Head	1	—
33	*To meet*	*Appointment*	6	*Talk*
34	Big	Little	1·2	—
35	Hit	Strike	1·4	—
36	Cow	Horse	1·2	—
37	*To arrange*	*Neatness*	5	*Meet*
38	Coloured	Dress	1·2	—
39	Worry	Care	1	—
40	*Happiness*	O	—	*Unhappiness*
41	*To tell*	*Story*	4·8	—
42	Tight	Loose	1	—
43	*Engage*	*Marry*	4·6	—
44	Dog	Cat	2	—
45	Month	Day	1	—
46	Fire	Heat	·8	—
47	*Kiss*	*Love*	5·4	—
48	To smell	Nose	1·4	—
49	To sing	Music	1	—
50	*To talk*	*Talkative*	6	*To speak*

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In the above list it is to be noted that many of the reaction-times are considerably above the average, and that several false reproductions occur. Such phenomena are to be regarded as "complex" signs. They indicate that the stimulus-word has aroused into activity some emotion, producing a temporary disturbance in the mind of the patient. We may proceed to examine each of these reactions in order to elicit their significance.

(3) *Angel—heaven.*—The lengthened reaction in this instance was due to the existence of religious sentiments, which had since her illness acquired a painful significance. With some reluctance the patient confessed that she felt unable to take part in religious observances. She did not consider herself worthy to do so. This statement was confirmed by her conduct. She often displayed considerable reluctance to attend the weekly service, offering trivial excuses for wishing to stay away. That this was not entirely due to her fear of spreading infection was evident from the fact that she would go without protest to the entertainments which were provided for the patients.

(6) *Friendly—enemy*,[3] (14) *sympathy—kindness*, (22) *people —crowd.*—All these words showed a lengthened reaction-time and false reproduction. They may be taken together as they are associated with the same complex, *viz.*, the relation of the patient towards her friends. Thoughts about her friends produced a state of depression. She felt herself unworthy of their friendship, undeserving of sympathy. It had been noticed also that she would not write to her former companions; a letter would provoke tears and a mood of reticence and inaccessibility, sometimes lasting the whole day, and after a visit an emotional relapse was usual.

(10) *Wood—iron*, (24) *tree—wood.*—In both these words a lengthened reaction is to be noted, and in the former a false reproduction. The words arouse associations in the mind of the patient connected with the wood which surrounded her school. Such ideas were obviously of painful significance, since her career, which was now to some extent ruined, was closely bound up with the institution. She would not express any further ideas aroused by the word, and it probably touched a deeper complex associated with the incident related below.

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(17) *Dirty—clean*, (19) *despise—disgrace*, (26) *proud—pride*. —These reactions all display manifest complex-signs. They have a moral significance indicating some reason for lost self-esteem and feelings of moral unworthiness.

(40) *Happiness*.—This word failed to evoke a reaction. The patient said she could think of nothing to say. To some extent one would expect some complex-signs in this instance when a patient was isolated from her home and shut up in an asylum. Such a profound reaction, however, implies the existence of feelings of still deeper significance. This is actually the case. The word arouses associations the content of which has nothing to do with her position in the institution. A little investigation reveals again the existence of ideas of personal unworthiness. She feels she is undeserving of happiness; if she permits herself any enjoyment she excuses herself by saying that she must be getting "hardened," she has no right to feel happy, etc.

(41) *Tell—story*.—The lengthened reaction is possibly an instance of *perseveration*. This means that the emotion aroused by the previous word is still operative in influencing the subsequent stimulus. The reaction is also probably constellated by the conflicts in her mind resulting from conversations with myself in which she displays evasions and various forms of defence against certain concealed ideas.

(30) *Wall—enclosed*.—This curious reaction, with false reproduction and lengthened reaction-time, is determined by painful thoughts associated with being in an asylum. It will be seen later that the whole question of an asylum had a special significance for the patient.

Leaving for the moment the remaining reactions, the above may be briefly reviewed. One fact stands out quite clearly. The emotions and ideas which have a painful significance for the patient are not those which one would expect to find in an individual who actually was, or believed himself to be, suffering from some infectious disease. Underlying the delusion which the patient expressed is a complex giving rise to feelings of shame, loss of self-esteem and the like. The ideas accompanying these emotions are reflected in her conduct towards her friends and her attitude in regard to religious observances. This self-accusatory bearing, these ideas of personal unworthiness and apparently incongruous emotional reactions point to

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the existence of some moral trauma, some actual experience of a painful nature which has preceded the onset of a psychosis. This suspicion is confirmed experimentally by the remaining reactions, which may now be considered.

(33) *Meet—appointment* (*talk*), (37) *arrange—neatness* (*meet*), (50) *talk—talkative* (*speak*).—All these quite ordinary words provoked complex-signs as has been seen. The remaining two words—(43) *engagement—marry*, (47) *kiss—love*—are apt to produce emotional reactions in normal people and in themselves might be disregarded. Taken in conjunction with the above, however, they will be found to have a special significance.

When the patient is questioned as to the ideas aroused in her mind by the last five words she at once becomes reticent and evasive. She says no ideas seem to come at all; her mind is quite a blank, or nothing worth mentioning occurs to her. Such responses are indicative of some complex of ideas which the patient wishes to conceal. It is a method of preventing the intrusion of some painful thought into consciousness. Though willing enough to converse on general topics, directly one approaches the complex associated with the above words the patient becomes inaccessible, her replies only occur after some minutes, or she breaks down into tears and will say nothing at all. All this means that the incident, finally elicited with considerable difficulty from the patient, existed in her mind in a state of repression. The resistance she offers is due to the fact that she does not want to think about it at all: it is too painful, it is a secret which she wishes to hide. However, it was possible to break down the resistance sufficiently to elicit the following facts:

For some time the patient had been on terms of friendship with a Mr. X—. The acquaintance had lately developed into some degree of intimacy though the couple were not actually engaged. On one particular occasion, while in the company of her friend, the patient had behaved with less reticence than usual and allowed herself a greater display of feeling than was habitual. Though she had not behaved in a manner to which exception could really be taken, the incident assumed abnormal proportions in her mind. She considered that she had not acted with the degree of modesty which, according to her own standard of conduct, was necessary, and she became filled with feelings of shame and self-reproach.

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She thought she had been very wicked in allowing herself to express her emotions so freely. In teaching the children she felt that she was not really fit to be a guide to those who looked up to her as a pattern of rectitude and morality. She entertained similar notions in regard to her friends and felt ashamed to meet them.

Eventually this conflict disturbed her mind to such a degree that her conduct became seriously disturbed and she found it impossible to concentrate her attention on her daily work. After a time she became preoccupied by the feelings of malaise which have already been described and she felt so poorly that it became impossible for her to continue teaching. The obsession that she was seriously ill obtained increasing hold of her, and after a time she took to her bed.

One day while brooding over her troubles she remembered a story which had been related to her by a nurse. It was about a young girl who had left home and lived an irregular life in a neighbouring city. After a time she had returned home in poverty and distress, suffering from a disease which had been contracted from her mode of living. At the time (some two years ago) this incident had made no particular impression on the patient, but now it kept coming into her mind. The conviction grew upon her that her own obscure malady must infect others, as this girl's disease was said to have done, and she soon found evidence of this in the appearance of her mother as has already been related.

Now to a certain extent this confession explains the origin of the patient's delusion. The psychosis had arisen out of a state of mental conflict. An experience had occurred which had attained traumatic significance, and had induced a state of anxiety and unrest. The memory of this experience, antagonistic to all her preformed tendencies, had become a constant menace to her peace of mind, and had obtruded itself into consciousness however strenuously she had tried to direct her attention to ordinary pursuits. Unable to assimilate the painful thoughts which had become "over-weighted" in her mind, the patient began to turn away from the actual cause of her depression and commenced to ascribe it to physical disturbances. This process is technically known as *transference*, and is of considerable significance in the genesis of obsessions and delusional states. In this particular mechanism the painful

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affect becomes divorced from the ideas with which it is originally associated, and attaches itself to other irrelevant ideas which serve to divert the mind from the original incompatible experience. This is quite comprehensible. In ordinary mental life psychical magnitudes are often repressed by diverting attention to something else.

In the next stage of the psychosis another common mechanism becomes apparent. The prevailing mood brought into consciousness associations in harmony with it and the patient became obsessed by a story she had heard some years before. Eventually a process of unconscious *identification* took place, in which she developed the idea that her physical condition, though not the same, was analogous to that of the unfortunate girl she had heard about. The delusion, then, is the symbolic expression of underlying feelings of shame and self-reproach; as she had at first regarded herself as morally unfit to associate with others, so later she looked upon herself as a source of contagion and only fit to be isolated from the rest of humanity.

The idea of contagion which the patient had elaborated is not uncommon in a somewhat different form. Psychasthenics sometimes develop a compulsive neurosis, in which they display a continuous tendency to wash the hands, this impulse being based on the obsession that they are soiled or contaminated. Freud has shown that this obsession can usually be traced to some moral trauma, *e.g.*, masturbation. The obsession is thus the symbol of actual moral impurity. (8) In this connection it is of some interest to note that a similar idea is expressed in traditional writings. As an illustration one need only call to mind the Biblical significance attached to leprosy, which is frequently used as the symbol of sin and moral uncleanliness.

Having reached this stage of the analysis one obvious criticism presents itself, *viz.*, the inadequacy of the alleged conditions to produce a state of mental conflict. A conflict arises when two wishes or conative trends are mutually antagonistic. In the present case the perfectly natural sexual impulse was opposed by conventional views on sex relations. Since, however, the patient's behaviour (sex-impulse expression) had not really been reprehensible at all, even judged by rigid standards, one could only suppose that the patient was possessed of a pathological degree of primness and viewed her own

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conduct from an abnormally rigid standpoint. Conversation with the patient did not serve to strengthen this impression, because while she displayed a becoming modesty and reticence, she was neither ignorant nor stupidly prudish about sex matters. Seeing, then, that she accused herself of wickedness on such inadequate grounds, I became convinced that her attitude must be due to the fact that she was suppressing some deeper complex.

It would take too long to detail the steps by which I was enabled to get behind these defensive ideas of unworthiness and discover what complex it was concealing. Suffice it to say that after a time the patient revealed the important fact that for many years *she had definitely made up her mind to exclude all thoughts of marriage on the ground that her father had died in an asylum and that her mother had been insane at one period of her life.* She felt that in these circumstances marriage would be unjustifiable.

Here, then, are all the conditions necessary for a severe intra-psychic conflict. Two entirely antagonistic wishes are present: on the one hand we have the natural sex instincts and desire for marriage, and on the other what might be called her conscience, consisting of motives which render marriage repugnant.

The solution of such a conflict may be attained in various different ways. The condition cannot persist indefinitely. Some form of adjustment must occur, the particular reaction depending on the type of mental organisation. Stronger individuals will react energetically, and solve the conflict by *subliming* the sexual impulses into other channels—ambition, self-sacrifice, devotion to others, etc.—maintaining clearly before the mind the resolve to remain single. Weaker personalities, especially those inheriting an unstable mental consitution, will tend to solve the conflict by taking refuge in evasions, which may be so far removed from reality as to constitute a psychosis.

Let us trace the sequence of events in the case of Miss R—. The conflict began when her affections became fixed on a particular individual. For a time she evaded the real issue, avoiding a definite engagement and attempting to regard the acquaintanceship as one of ordinary friendship. Feeling, however, unhappy about the matter (conflict), she at length,

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with commendable courage, informed her friend of the facts in regard to her family history, stating that she felt it was wrong to continue their relationship. Mr. X— treated the matter lightly, and said that what the patient had told him made no difference in his feelings towards her, and begged her not to break their friendship. Blinded for the moment by her affections, Miss R— decided that perhaps she was over-sensitive about her family history, and consented to remain on the same terms as before.

This decision was of momentous import, and from it the whole psychosis can be traced.

Finding her ideals had become impossible of realisation, the patient had *suppressed* the complex, wish, or determination to remain single, and attempted to act as if it were non-existent. Now, when a complex is suppressed in this way, it ceases to exert a conscious influence and cannot find normal expression. It still continues, however, to exert unconscious influence, and will manifest its existence in some indirect and distorted fashion. This is seen quite clearly from subsequent events.

Shortly after the patient had made her decision, the incident which she had at first related took place. It produced, as will be remembered, a condition of severe mental conflict. This could only be due to the fact that she was acting in opposition to the complex which she had striven to banish from her mind. Just the same feelings of unrest and depression tormented her as when the original determination was clearly before her mind.

Having lost sight of the cause of her depression the patient proceeds to invent reasons to account for it. She declares that she has been wicked, immoral, and is unfit to associate not only with Mr. X—, but also with the rest of her acquaintances. It will be seen at once that this is again a process of *transference*. The painful *affect* really associated with the suppressed complex has now become attached to another idea, which is delusional in character. The further development of the psychosis in which this idea became again concealed by the delusion of physical contagion has already been traced.

We are now in a position to summarise the analysis and discover the significance of the psychosis.

The delusion itself was merely a symbol. When traced

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back it clearly represents the deeper delusion of moral unworthiness, and this in its turn conceals and symbolises her original belief that she was unfit for marriage on the grounds of heredity.

The psychosis is a *compromise* between two antagonistic tendencies of the personality. Face to face with real conditions, the patient's life had become unbearable. Her instinctive feelings were in constant conflict with her highest ideals and neither would obtain adequate gratification. Failing to co-ordinate the two opposing impulses in contact with reality, and unable to solve the conflict, she takes refuge in a psychosis, in the erection of imaginary conditions. Unable to attain her ideas on rational grounds, she unconsciously attains them by elaborating a delusion which makes the question of marriage impossible. The psychosis had solved the conflict by indirectly gratifying the one wish (desire to remain single), and rendering the other (desire for marriage) inconceivable. The patient frequently expressed this by saying that her affections were now entirely changed; she had no desire to see her friend again, as her condition made the whole affair quite impossible.

The patient might have attained her aspirations in a more rational manner. Under precisely the same conditions another individual might deliberately withdraw herself from the conflict by taking a vow of celibacy and entering a convent. She thus solves the conflict by making the question of marriage impossible. This is a normal evasion. Miss R— attained much the same position, but she did so unconsciously. She had suppressed her wish, it had ceased to be a conscious directing factor in her life, and could only appear under a symbolic guise and obtain distorted and irrational expression.

The reason for the patient's pessimism is now apparent. She had no hope of cure and apparently no desire for such. Her delusion was a defence against reality. As long as she hugged it to herself she was effectually protected against actual conditions, and the conflict to which she had failed to adapt herself. She was forced to fall back on imaginary conditions because the facts of life had proved too much for her. The adaptation to reality (*fonction du réel*) (9), is the highest and most difficult psychic operation, and having once evaded real issues there is a constant resistance against facing them again. As one attempted to break down the succession of defences

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which protected her against reality, this unconscious resistance stood always in the way. Sometimes, especially as the patient was beginning to regain her sense of proportion, it seemed as if there was a dawning consciousness of this reluctance to face actual issues. At times, in conversation with her, I observed an unwonted irritability, and she would say, "You seem to think I like being here, I don't want to go home," though I had suggested nothing of the sort. This vigorous and unnecessary denial seemed to indicate that her remark was not altogether far from the truth.

The psychosis is thus a *wish-fulfilment.* This hypochondriacal idea has been traced back to one of the most potent directing forces of the patient's life. The belief that she was unfit for marriage had become so strong as to make her instinctive tendencies impossible of realisation without producing a condition of painful conflict. When her affections became too insistent to be ignored she attempted to give them expression by banishing the opposing complex from consciousness. This suppressed complex thus obtained indirect and distorted expression, which enabled her to solve the conflict in a manner that her true motives had entirely failed to do.

Now, this analysis is not of merely academic interest. It is also a method of treatment. I approach this subject with diffidence, knowing full well how many patients recover under what are termed "favourable hygienic conditions." It does seem, however, that apart from external assistance her delusion would tend to become chronic, seeing how far the patient had lost sight of her original motives for wishing to remain single, and that the perverted expression of these motives was in essence a defence against reality.

However this may be, it was gratifying to find that as the mechanism became clear to the investigator, so it became possible to lead the patient back to reality, and bring her once more face to face with the actual issues of her life.

The analysis is a process of re-education. By breaking down the succession of defensive delusions and discovering what lay behind them, the patient was enabled to understand why she had developed such ideas, and also see how foolish and irrational they really were. Her recovery was not merely a verbal statement that she had lost her delusions, but it was also accompanied by a readiness to converse upon those subjects

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which had formerly caused her so much pain. Before her discharge her general reaction had quite changed. She was able to take part in religious observances, showed no moments of depression, and conversed frankly with such friends as came to visit her.

This is the only rational form of psycho-therapy. Crude suggestion either in the waking or hypnotic condition cannot be permanent in its results. It is only by retracing the steps by which the patient has evaded reality, and helping her to understand her own mind, that satisfactory results can be obtained.

The future of the patient is not without hope. She has at any rate acquired a clear understanding of the two main issues of her life, and has been made to realise how it is possible to co-ordinate two apparently antagonistic impulses. By subliming her natural instincts, which cannot find full expression, into devotion to a mother dependent upon her and the care of the children entrusted to her charge, she may succeed in leading a useful and creditable career.

We thus return to our original contention, that insanity is a matter of personality. It is dependent on purely individual factors, wishes, aspirations, and secret conflicts. In the case which has been analysed we see not merely one variety of melancholia, but a personality, the victim of an unstable ancestry and her own ideals.

(1) Paper read at the Northern and Midland Divisional Meeting at Nottingham, April 27th, 1911.—(2) A complex is a system of ideas possessing a certain emotional tone and tendency to action in a definite direction.—(3) This reaction is also associated with a particular friendship noted later in the analysis of the remaining reactions.

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