The Genesis of Delusions: Clinical Notes.

By COLIN MCDOWALL, M.D., Medical Superintendent, Ticehurst House.

MEN and women hold to and have faith in certain opinions as the result of long thinking around and along certain lines. Our social and political tendencies are the outcome of an analysis more or less critical, and believed by the individual to be impartial. A scattered phrase or an apparently insignificant incident may attract attention, and be the beginning of a prolonged mental conflict which is finally determined by a definite line of thought. It does not follow that the reasoning is always logical, or the argument conclusive to people of other opinions, but nevertheless a conclusion is arrived at, and it is final.

How this is borne out in every-day life may be seen in the following narrative: A boy of Scotch descent, bearing a distinctly Scotch name but born in Ireland, was sent to a school in Scotland. His schoolfellows pronounced him an Irishman at once. His accent was Irish, and he lived in Ireland, so his Scotch school companions would not admit him as a Scot though his parents had always fostered the idea that he was one. The view of his school mates was a rude awakening. When the International Rugby matches take place national feeling runs high in a Scotch public school. He found he was expected to support the land of his birth; the land of his name rejected him with scorn. This result had its lasting effect. The boy against his inclinations and early teaching had to range himself against what he thought was his own country. Years passed and the man remains the same: he supports the land of his birth, and when the character of the Scots is discussed, though admiring much in silence, he takes a partisan side and brings out all that can be said against the country that years ago rejected him.

A thoughtful and apparently honest man arives at a conclusion which another equally thoughtful and honest man will inform you is wicked, and nothing but the road to ruin for all those who think similarly. It is not necessary to pursue this subject, but it is mentioned because in those mental states in which distinct abnormality exists the mind of the patient works along the same lines, and false beliefs arise as the result of thought directed irregularly to experiences in the lives of the individuals. An incident may or may not have an abiding effect upon the course of anyone's life. Just as a chance phrase or sentence may influence for a lifetime the opinions of thinking persons, so may an incident be misunderstood and its effects misconstrued owing to lack of the sense of proportion in the mind of the psychopath.

Abnormal mental states arise in persons with a varying personal and family history. Probably the presence of hereditary taint is the most

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

important factor in the preparedness of anyone to become mentally disturbed or actually insane. Heredity is therefore important, as also are other predisposing factors, but these agents alone do not determine the course which the disability will take. The tendency to insanity exists, and it is the personal experience which goads the intellect along an illogical and unreasonable path. Just as reasoned thought, stimulated originally by an expression or form of words, produced a complicated line of thought which was held through life as an opinion or belief, so in the psychopath an incident may start a complicated system of delusions. The result is, after a space of time, a state of affairs very unlike the original condition. Delusions and hallucinations do not arise accidentally; they have a definite basis, the foundation of which is in the personal experience of the sufferer.

It is the duty of the medical man to analyse the mental processes by which the abnormality has arisen and work back to what may be called the taking-off point. It is not my general experience that these causal factors are always difficult to bring to light. A great step towards removing the difficulty is to gain the complete confidence of the patient, and there is no easier method to attain this end than to have the subject of one's examination constantly intermingling with patients in whom treatment has previously been successful. Some of my most interesting cases have been encountered in dealing with enlisted soldiers. Whether the soldier is more readily made to talk than the civilian may not be easy of proof, but it is probable. In men the cause underlying a psychosis is often reached very quickly, whereas women are more reticent. Not only is this so, but I remember well a case in which a woman of good education deliberately invented what to her appeared to be a very satisfactory collection of dreams and association-tests merely to deceive me so that I might pronounce her recovered, and thus provide her with a suitable opportunity for suicide.

I have said that the determining factor in the mental abnormality may not be far from the surface. It may indeed be so insistent that it is always present in the thoughts of the patient. The after-results of the personal experience may conceal the relationship of the cause and the effect in the patient's mind, and he may describe his symptoms and almost in the same breath give the cause of all his troubles. The patient does not realise the relation of the one to the other, and cannot be expected to do so; and here it is the necessary duty of the practitioner to explain to the patient his symptoms and educate him by showing the interconnection of cause and effect. The means placed at our disposal is through mental analysis. By that I mean an examination which will not only investigate the conscious problems of the patient, but also bring to light the factors of subconscious origin.

When dealing with numbers of men suffering from war neuroses it

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

was noticeable that as a general rule the functional condition required a great deal more probing to arrive at something satisfying than was necessary in the more organised state of mental inability. And it may be added, paradoxical though it may seem, the functional condition is much more easily treated than the state in which delusions or hallucinations have begun to assert themselves. The mere elucidation of the cause is not enough to effect a cure, and the patient should be taught to follow in their logical sequence all the ideas which he had misinterpreted and misunderstood.

A man was admitted to Maghull Military Hospital showing all the signs of acute depression and considerable confusion. He had been in the trenches for four months in the early part of the war. There had been a mental breakdown nine years previously, in consequence of which he was invalided out of the Navy. He was a married man with three children. In addition to the general signs of depression there were delusions; he said he had only half a body, that the food he took did him no good as it ran out of him. When questioned as to what these ideas meant he explained he had had diarrhœa in the trenches and it had so weakened him he was only "half his old self." The food could not be retained as he thought his rectum had "dropped out, I suppose." The idea that his diarrhœa persisted was incorrect. He had a stool once a day as a matter of fact. Further inquiry elicited the following facts: He was an old naval man living at a seaside town and yet he had not rejoined his old service. He did not try to rejoin: he "wanted nothing more to do with the Navy." He complained he heard a voice saying, "You ought never to have done these things." The patient for a time would say no more about himself. Later he related how he had joined the Navy at fifteen, and had received money regularly for allowing certain practices to take place. The clear relationship of the acts of his youth and the delusions of manhood is evident. The patient had begun to rationalise his bowel sensations and to misinterpret the normal bowel action. After a certain amount of instruction, and the explanation and interpretation of his symptoms, improvement set in. He said to me the voice was no more than his conscience—a correct estimate of the condition.

The hallucination was a very helpful hint that there was more in the case than a superficial examination would show; he thought his food did him no good, that his rectum had dropped out. The man's explanation of his delusions was only a rationalisation, and might have been considered satisfactory. He had passed through four months of strain and stress in France; terrifying experiences disturbing to the emotions would have had time to act upon a man who had previously been insane, but the hallucinations at once pointed the path along which further investigation should go. The patient was suffering from

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

remorse in an aggravated form. His attitude was one of shame. He was unsocial and avoided others—even his own wife when she visited him. The hallucination was the product of his own thoughts.

Hallucinations do not occur in states of depression at an early stage of the malady; delusions develop earlier. A simple anxiety state with depression may develop into a condition associated with delusions, and this is the more likely to happen if the case is untreated. There are quite enough causal factors associated together in modern warfare to cause a psychosis to develop. The patient, already tormented by a state of anxiety, begins to revert to these gloomy and sordid experiences of his life. Finally, one memory is able to take possession of all his thoughts, and round this subject he will weave his net. The hallucination, "You ought never to have done these things," cannot be said to be in relation with a subconscious thought; quite the reverse. It is in relation with a painfully clear memory. The hallucination as it stands means nothing, and it is only when the man's life episodes are revealed, and the personal matters are sifted, that it can be made intelligible. The presence of hallucinations may be taken as the measure of the intensity of the causal memory image. Just as dreams are helpful in the purely functional case, so hallucinations will surely point to a causal factor of the first importance. The subject of this case made a good recovery, although during his convalescence his wife died somewhat unexpectedly.

The case just recorded may be said to be one in which the personal experience acted as a secondary or indirect agent in the production of the psychosis. In the story which follows the experience was the direct factor, and the mental state arose from looking at the occurrence from an altogether wrong point of view.

The patient was a man æt. 41—a north countryman. He had taken alcohol in the pre-war days rather freely. A reservist, with no previous experience in warfare, he went to France in August, 1914. He was invalided to England with rheumatism in February, 1915, was sent to France a few weeks later, but returned, as the rheumatism recurred in Havre. After some time in an English hospital he was given leave. He remembers getting his papers, but nothing after that.

I did not see the patient until he had been in hospital some weeks. On examination he showed considerable uncertainty of memory, and was obviously depressed, of anxious countenance, his forehead deeply furrowed, the face thin and haggard. He was solitary, avoided his comrades, went for long walks alone, and in short showed all the signs of a man brooding over some occurrence recent or remote.

For three months this man was with me. Any attempt at progress on my part was frustrated by an obstinate silence, or word manipulation.

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

He was not improving mentally, but after much persuasion the facts of the case were disclosed.

In the winter of 1914 he was sent out one night on a patrol. He was the leading man of six others. Suddenly he felt that he had lost touch with his companions. He was alone, but almost immediately he heard a voice say in English, "Give me your rifle." He could see nothing, but when the order was repeated he bent down and was able to make out against the sky-line the spike of a German officer's helmet. He had little time to make a decision, but holding his rifle in the middle, he drove it upwards at the man in front of him. The officer gave a "dirty laugh, a sarcastic, scoffing laugh." Our patient naturally enough thought he had struck into the lapel of the officer's greatcoat. The next moment the officer fell dead at his feet. He had stabbed him through the floor of the mouth and the bayonet stuck in the skull. The officer carried a sword in one hand, a pistol in the other. The movements and voices of an enemy patrol were heard and our man escaped to his trench. The telling of this story takes time, but the actual occurrence was all enacted in a moment.

Many emotions were stirred in this brief experience. The setting was fitting for a memory which can never leave the soldier. Fear firstly at finding himself isolated, the sudden voice asking for his rifle, the fearful thought that he had missed his man, as evidenced by the scoffing laugh, and lastly, fear of discovery as he attempted to regain his trench.

The soldier from the beginning took an altogether false view of his action. On his return to his trench he only told one man what had happened. He was ashamed of what he had done. He said to me "he would not have minded if it had been a fair fight in the open," and "if he had cursed me I should not have minded, as he would have deserved what he got."

Depression and confusion followed some months later. At night, when in a state between sleeping and waking, he would see the whole incident. The laugh would waken him at night. He would hear the sarcastic laugh also in the daytime. He could not sit in the billiard room of the hospital, as men often laughed in the same sarcastic way when a player failed at a shot. He went away by himself so as to avoid the possibility of having the image recalled by a comrade's laugh.

It is not quite easy to explain the sequence of events in this man's depression. Much would depend upon the mental make-up. He appeared to be a simple, kind-hearted man, but in no way a sentimentalist. He had lived a normal life of boyhood and youth, and joined the Army, as many men do, in order to see the world. On going on the reserve, he had married and worked on the railway.

The event in every-day life which to my mind is perhaps analogous

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

to this war episode is one connected with association football. In football, when a player within a certain area infringes the law, a penalty kick is given against him. That means virtually a certain goal to the opposing side. In popular football, with the thoughts of the crowd interested more in bets and points than in the play of the game, a cheer goes up at the decision of a penalty kick; but in a truly sporting crowd there is no such demonstration; the feeling created is rather one of resentment against the offending player. The true sportsman would rather not gain a point under such circumstances. Once the decision is given the penalty must be taken, and the player, however much he may have the sporting instinct, must do his best. Reverting to the soldier, he merely did what was his duty. To have done nothing would have meant his own death; he acted under enormous stress. There was at first uncertainty as to the nationality of his opponent, but once he had made a decision on this point he had to act. The common-sense conclusion is that he did right.

The method of treatment adopted was by explanation of his symptoms a comparison of his act with that of the football incident, and a strong appeal to the man's own common sense. The unburdening of himself of the long-kept secret had an immediate effect. The dreams stopped a most at once. Following the first interview after the facts had been obtained, the patient had the best night's rest he had had for months. Ultimately he lost all his depression and was sent home.

I have used this case as it shows what results can be obtained by mental analysis in a patient in whom there is no connection with sexual matters. It is unfortunate that to many mental analysis should have reference to this subject of necessity. Many cases, when analysed, no doubt, have to do with sexual things, but in very many the reverse is found.

Finally, I would record another example of the close connection between memory of an action in boyhood and the fully developed delusion in manhood. The patient was a soldier, æt. 24. When he came under notice he was acutely depressed and was under the impression that people were accusing him of being a murderer.

His father was an alcoholic, and he himself had drunk very considerably. He has never been able to stand the sight of blood. When twenty-two he was sick when he saw an ox killed. He went to France in August, 1914, and felt sick and faint when he saw a man blown off a horse and killed. He was returned to England within a fortnight with rheumatism. In March of the following year he went to the Dardanelles, and there worked with his battery for four months. He became confused on Gallipoli, and wandered about aimlessly, so that he was sent home. His memory of the events of the voyage home is very incomplete.

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

When examined he was highly emotional, wept whenever addressed, and went on his knees praying for forgiveness of his sins.

A word analysis was tried, and it gave some interesting reactions. Many of the tests are omitted, and a few selected ones only given.

Tired—very, thinking how he has always to be pushed on to work.

Forget—never, the lessons he has had, all his past misdeeds.

Breath—holy, the breath given to us all is given by God.

Fire—hell, hopes to keep out of hell fire.

Mouth—river, after a considerable interval "no fastings." The need of fasting on account of his wickedness.

Happy—very, he should like to be very happy.

Broken—often, refers to his promises.

Hope—always, to do his duty and live another life.

End—never, world without end.

Death—an interval of twenty-four seconds, and then, "Death did you say?" Sting, later he said his first thought was "Beautiful," then "Envy," then "Happy" (these all refer to a sister's death).

It will be seen at once how the idea of self-reproach and unworthiness is running through many of the associated words. Some replies indicate his religion, and the tendency to seek relief from his present oppressive thoughts by an appeal through his spiritual beliefs. He shows in the words "end—never" that his outlook must indeed be terrible if his present misery is to last everlastingly; or possibly he means that his fate is unending as his sins are unforgiveable. Lastly, the reaction-time for the stimulus word "death" produces thoughts but no spoken word, except after a long interval. "Death" and "sting" are a normal reaction, and had the reaction-time not been taken the associated word would have caused no criticism. The man admitted, however, under pressure he had thought of three words and rejected each, as he did not want to talk about them.

He heard people calling him a murderer, and he said he was the wickedest man on earth. In addition, he said he often thought of his home, of his sister who died, and he had heard her say to him at night, "I am happy."

His youth had been a disturbed one. His parents were not of the same religion, and though he had embraced his mother's religion, his father often quarrelled with him about it. His sexual life was an unhealthy one. Living in the same room with two sisters, he had had incestuous relations with one and had attempted similar things with the other. His sister died of lung disease at a time when these practices had not ceased. She was quite young. He thinks that by these practices he had so weakened her that lung disease overtook her. He used a forcible expression, which I cannot repeat here, of his belief in this subject. He was an ignorant boy, poorly educated, and running

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

wild with little control as a youth. He had read, however, in pamphlets of the dangers of sexual matters when carried to excess, especially in the young and immature. He applies this theory to his young sister, and blames himself for her death. The word "beautiful" refers to the dead girl lying surrounded by flowers preparatory to burial. Happy—he is expressing the hope that she is happy in Heaven, and the hallucination, "I am happy," is nothing more than a wish fulfilment. Envy—how he envies his sister in the pure state of the life hereafter as compared to his miserable, sordid life on earth. Self-accusatory thoughts are very usual in depression, and the word "murderer" is only an exaggerated impression of his own view of the result of his own wrong action. Unfortunately I lost sight of this patient, but when I last heard of him the opinion prevailed that he was not likely to do well. His psychosis, however, is interesting, and shows the relationship of the human side of the patient's life and the later development of the delusion and hallucinations from which he suffered.

Without such a personal history nothing in these cases could be understood, and the opportunities for treatment would resolve themselves into improved hygienic conditions and rest.

Sir GEORGE SAVAGE said the subject now under discussion had interested him for about half a century. He would have preferred to see the paper bearing the title he himself used many years ago, "Morbid Mental Growths." Taking it for granted that in nearly all these cases there was a starting-point—often of a physical or psychical nature—when one came to consider the growth of delusions it led one back, as an Irishman might say, to the present time, because psychic analysis and that kind of procedure led one back to the morbid mental growth. The development of former ideas from the subconscious was a very old subject of study. It had been generally recognised that nearly all delusions had a starting-point, and the influence the starting-point had upon any subconscious area was only that of moving it one step backwards. In treating of this subject he had said there were morbid mental growths which were simply inconvenient; probably most had similar morbid ideas—some obsession which did not really interfere—but all had seen individuals with one great dominant idea which influenced their whole life and yet destroyed nothing. These were innocent morbid mental growths. But there was another form of delusion—morbid growth it might also be called—which not only interfered with utility but probably with mental action, yet was not destructive. In the third group, however, there was destruction, so that the morbid mental growth seemed not only to invade but to destroy faculties. The manifestations varied according to whether there was hypochondriasis on the one hand or delusional insanity on the other. The hypochondriacal person, who was merely morbidly self-conscious, might yet not be mentally defective; but the person with delusions of persecution probably had a form of disorder which was very destructive. Most of the members knew, too, of the intermediate type, in which an individual had delusions growing out of his hallucinations, and yet such individual continued at his work. Thirty-five years ago, a gentleman who had occasionally attended the Association's meetings was acting as dispenser to a doctor in the south of London. The doctor consulted me about him, and I said to the doctor, "Good gracious, he ought to be locked up!" He had what was called "clair audience," "clairvoyance," and occultism generally. That individual had not been in an asylum, but had been treating the poorer residents of a suburb of London all this time. Here was a morbid mental growth which did not interfere with the man's usefulness. Deafness had frequently been associated with forms of disorder. He believed that one lady novelist was so deaf that she never

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

heard anybody contradict her, and hence she had very exalted ideas of her own power. It was, however, much more common for those who were deaf to have the impression that other people were talking about them.

Dr. HUBERT BOND, in obeying the President's invitation, said he did not feel he could add anything on the lines taken by the first speaker. During the reading of the paper, and while Dr. Stewart was speaking, he was thinking of how many of those present missed their revered *confrère* and former President, because of the magnificent opportunity afforded by such a paper as this for his criticisms and remarks on the relation between the branches of their work. As to the paper, he had a sense of very great encouragement as the result of the treatment detailed. There must be several men of standing in medicine present, and he assumed that they, like him, were taught the futility, if not the inadvisability, of attempting to reason with a delusional patient; that in a case of delusions and hallucinations the mind was not deluded because of hallucinations, but that both symptoms were the outcome of the morbid mental state. Was not that the case because the physician had no means of getting at the right topics of conversation when approaching the patient? And was not the lesson which had been learned, not only from Dr. McDowall's vivid description of the cases but also from other writings—some from war cases—that the profession now had before it the modern means? He was aware that some were inclined to scoffingly assert that there was in this nothing new, and that it was what had been taught when they were younger, but he did not feel it was so. The results of the last few years' experience had certainly taught him that they had now at hand modern means of attacking patients on the right lines and instilling reason into some of the most—apparently—hopeless cases, and in that way promoting their recovery. It was that feeling of encouragement which he wished to emphasise.

Dr. R. H. STEEN desired to thank Dr. McDowall for his paper. He, the speaker, wished to lay emphasis on the idea that delusions were often wish-fulfilments, and to ask if Dr. McDowall had noticed this fact in any of his cases. Of course, distortion of the wish existed in the case of delusions as in the case of dreams. A recent case which made a great impression on him he would relate, altering, of course, the names of the persons: A patient, Miss Smith, came into the institution, and he made a long and careful history of the case. It appeared that, years previously, she had known a Mr. Jones, a clergyman, and she considered that he was paying her special attention. But it could not be gleaned what form the advances had taken. She had once shaken hands with him, but had seldom conversed with him. She said that in his sermons he made remarks concerning her. A few months later he, the speaker, was surprised to learn that she had asked all to call her by the name "Mrs. Smith Jones," to emphasise what she stated as a fact—that she was now married to Mr. Jones. He related that as an instance of how the delusion came to be a definite fulfilment of a wish.

Dr. CARSWELL said he regarded it as a matter for great satisfaction that the younger men were devoting themselves to fresh clinical studies. He was sure the outstanding need of the specialty at the present time was for the men who had an opportunity for seeing a large number of cases to make fresh clinical studies, with minds free from the preconceptions of the past. By habit he had always felt himself drawn intensely to the progressive side, yet he had a feeling that, after exploring along the lines stated in this paper, they would come back to most of the old views; that they would not derive the satisfaction at present apparently promised by their theories, which were based on the conception of a conscious and subconscious mind. Nevertheless, good was bound to come of such studies as those set out in the paper. Of course, all the phenomena manifested in the cases related by Dr. McDowall could be explained without the nomenclature of the newer psychological point of view. They had all been familiar, because it was true to experience, with the fact that all delusional ideas had their origin in some experience. There was nothing which came to any man in the form of a fresh idea that had not had a basis in a previous experience of some sort; and the lunatic, or the person who became afflicted with a morbid idea, was simply basing his morbid idea on that past experience. To unearth that experience, to explain the road by which the patient had arrived at his false idea, was a very valuable thing to do, and he hoped it had been the usual practice, though he gleaned from the remarks of Dr. Bond that it had been avoided. No one could run a hospital for the

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

treatment of early mental conditions, before they arrived at the asylum stage, without feeling forced to adopt the method of quietly, calmly, and persistently seeking to explain to the patients the origin of their morbid ideas, and to surround them in the hospital arrangements with the pervading idea that they were suffering from an ailment, not a delusion in the sense of being a baseless alienation of the mind; that it was a disorder arising from some experience, taking on special colouring by some morbid emotional tone, and the whole associations connected with it being such as could be suitably handled by hospital methods, and by the educative methods so successfully adopted by the psycho-analysts.

Dr. J. G. SOUTAR said he thought one of the most interesting features of Dr. McDowall's paper was that he did not trouble his hearers very much with the sub-conscious, and he did not deal at all with what was termed "psycho-analysis"; rather he found a common-sense explanation of the growth of delusions in the really conscious life of the patient; his analysis was the ordinary simple investigation into the patient's life-history. In that way he had been able to bring out not really the genesis of delusion, but he had shown why it was that delusions took a particular direction and form. The author had not carried members back to what they really wanted to know—why a man who had hitherto been acting in what was termed the ordinary sound way, on the lines along which all their minds went, should, either suddenly or gradually, take on a morbid line of action, of which delusion was but one manifestation. The recognition of the pre-delusional stage—of that condition of mind in which delusions would be apt to flourish—was most important, for then it was that the patient was most amenable to treatment. He looked upon the delusions and the hallucinations as the later and obvious manifestations of an already unsound mind. The delusions did not arise only as wish-fulfilments. He thought many of them arose from the patient's past experiences, failures which had not given any trouble through a long period of life, but for some reason, some departure from health, were keenly remembered, and there were crowded around them appropriate emotional states. Dr. McDowall said delusions preceded hallucinations, though he did not think it was laid down as a general statement. He (the speaker) thought hallucinations often preceded delusions, and the latter took their form from the hallucinations. A patient heard voices or had perception of unpleasant odours—in fact, there were general sensory hallucinations. Then there came a period of acute depression, followed by a period of questioning as to why he was singled out for persecution. Then the other emotional state, one of exaltation, followed, along with the definite delusion that the person was an individual of great importance, otherwise he would not be so persecuted. With regard to the method of dealing with delusions, the re-educating of a patient was, he considered, of the greatest possible value. Dr. Bond referred to the old teaching that it was not desirable to argue with a delusional case. That was true were arguing in question. But re-education was a different matter, as that enabled a patient to obtain an insight into his or her condition, and was of the greatest value. If one could succeed, even to some extent, in modifying the baneful influence of a delusion upon a patient, one thereby did a great deal towards getting that person into a sound state of health, because a delusion was irritating and worrying, and was consequently affecting the whole health of the patient. Even simple worry produced a deleterious effect upon an ordinary person, and if this worry could by some means be alleviated something was thereby being done to break the vicious circle which was keeping up the ill-health of the patient. Dr. McDowall had put his cases in the most vivid way, and he (the speaker) would like to add one to the list of the cases which had to-day been related. A lady, the only child of people who were in a very good position, but were in straightened circumstances, when 22 years of age married a very old man, a widower with no children, who, for his property's sake, was very anxious to have a child. She married in face of her parents' strong opposition. In course of time both her father and mother died, as did also her husband, and there was no child. When between 50 and 60 years of age the lady herself broke down, and her delusion now was that she had got her father, her mother, and her husband in her womb. The association was easy to see, but the important question was, Why did that particular type of delusion arise? Indeed, why did she become deluded at all? What was the state of mind into which she had got? It was

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press

true that the ordinary changes were taking place in her womb, but beyond that there was no reason for it. Here there was no question of wish-fulfilment, but a recognition of the painful episodes of her life. There had been no reconciliation between herself and her parents, there had been failure to produce a child, and she had crowded her failure into her womb. Past experience was not wish-fulfilment, and almost any experience of the human mind was capable of being perverted into a delusional condition.

Capt. PRIDEAUX suggested that probably the treatment in the sense Dr. Bond gave it was not really what was used by Dr. McDowall in the treatment of his cases; it was really more the use of emotional processes. Persuasion was based upon the use of these, and he thought that if one went back to the genesis of delusions it was found in the derangement of the patient's emotional life. That emotion could produce dissociation in two ways—either suddenly, as in sudden fear, or gradually as a result of a prolonged mental conflict. To his mind the genesis of delusions seemed to be in the emotional sphere by subsequent dissociation, and for that reason emotional processes may form part of the treatment adopted. For instance, a state of fear was instantly changed by a state of anger; as soon as the emotional state was changed there was set up a different arrangement of mental processes: the association of mental processes was governed by the emotional state of the person. Some of these delusions seemed to arise when a man was in a state of dissociation already. He had one case in which the patient, whilst undergoing treatment for shell-shock in a hospital in France, developed the hallucination that he saw his brother walking about with his head under his arm. This originated from a letter written to him by his mother describing a similar hallucination she had had during a Zeppelin raid. After the origin of it had been cleared up he got perfectly well.

Dr. McDOWALL, in reply, said he understood Dr. Steen to mean that many delusions were wish-fulfilments. (Dr. Steen: Yes.) In regard to the case related by Dr. Soutar, he (Dr. McDowall) thought that could be made out to be a wish-fulfilment. Dr. Soutar asked what was the soil which would best grow delusions. That was the great difficulty in the whole medical world. We did not yet know that. His only idea in the paper was to give some examples of delusions and to point out that they were quite capable of treatment along certain lines. Dr. Carswell had referred to nomenclature, but he (Dr. McDowall) thought he had been very discreet in avoiding many of the words in use at the present day. At the same time they were all very useful words. His own view was that delusions did come as a result of previous experience. With regard to the subconscious mind, it was not always necessary to suppose that in insanity the subconscious mind should of necessity contain the determining fact of the psychosis. In the first case he referred to he tried to point out that the real disturbing element was far from being subconscious; indeed, it was very much on the surface. But the subconscious mind was, undoubtedly, a very important factor, and his view was that it had more to do with functional cases than had the true psychosis. Dr. Soutar had asked about hallucinations. The sentence he (Dr. McDowall) read about that was: "Hallucinations do not occur in states of depression at an early stage in the malady; in depressions delusions develop earlier." He believed that to be true. In maniacal states hallucinations occurred before anything else. But in true depression, simple depression came first, delusions followed and hallucinations came later. That was his feeling, though he might be wrong. With regard to the case referred to by Capt. Prideaux, the idea of the other boy who developed hallucinations regarding his brother came merely as a suggestion, and a man suffering from functional disorders such as he was was the very kind of case to be influenced by suggestion. No doubt he was already being treated by means of suggestion by someone else.

https://doi.org/10.1192/bjp.65.270.187 Published online by Cambridge University Press