We are fully conscious of the imperfections of this paper, which is designed chiefly to elicit the experience and the views of others. The description of cases has necessarily been somewhat summary and the statement of theoretical views rather dogmatic in form. As to the latter, we put them forward tentatively as impressions which we hope we are ready to modify in the light of further experience.

(The discussion which followed will be found on p. 534, vol. lxvii, 1921.)

(2) We have to acknowledge the kindness of Dr. Gilfillan, Medical Superintendent of Colney Hatch, and Dr. Lord, Medical Superintendent of Horton, in providing us with information as to the condition of our patient's mother during the periods she spent at their respective hospitals.

Change of Phase in the Psychoses.(1) By THOMAS BEATON, *O.B.E.*, M.D., M.R.C.P.Lond., Senior Assistant Physician, Bethlem Royal Hospital.

CHANGE of phase is a well-recognised feature in the course of certain of the psychoses. In manic-depressive insanity it is on the phasic variation of the affective state that the separation of that type of mental disorder is based. So, also, in many cases of the chronic psychoses phase changes occur as the disorder progresses, and as the patient fits in new experience and builds up fresh mental content on the basis of the already existing delusional state.

Such changes, however, are to be regarded as part and parcel of the particular psychosis concerned. Apart from the interest of watching the gradually expanding self-regard of the paranoiac, or the gradually increasing inhibitory control of the maniac who is becoming quiescent, such changes have no value, and they bear no practical significance as regards the future of the case. The patient is still the subject of manic-depressive insanity whether he be exalted or depressed, and the paraphrenic battling with his difficulties as plain Mr. Smith, or reacting dominantly, as his condition advances, as Lord Smith of Smithshire, remains fundamentally a paraphrenic of whose mental future there is little doubt.

In this paper it is not proposed to consider such changes as those indicated above, but it is desired to draw attention to the occurrence of certain variations of phase which frequently may be observed in early psychotic derangements. These changes are fraught with the highest import to the subject, for not only do they often result in a totally changed attitude to the hospital environment, but not uncommonly they lead to a re-adjustment to social life.

The text-books on mental disorder, as is indeed necessary, are

(1) A paper read at the Annual Meeting held in London, July 14th, 1921.

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concerned with the exposition of more or less definite and distinct disease types, the underlying psycho-pathology of defined disorders being explained, and the evolution of the finished specimen followed step by step, from the initial departure from sanity up to the onset of the secondary dementia. On this basis, therefore, it should be possible in observing the early case to place the type of disorder with a fair degree of accuracy, and so to establish a fairly certain prognosis, but experience of the early case in clinical practice goes to show that this highly desirable state of affairs is far from attainable as yet. Personally, I have found that those physicians with the widest experience are those who are the most reluctant in coming to a diagnosis in any particular case. I consider that it is a striking testimony to the frequency of occurrence of these little-considered early-phase variations, as well as a distinct reflection on the position of clinical psychiatry as a branch of scientific medicine, that it is usually necessary to keep a case under observation for a period in many cases of from at least six to more than twelve months, before the conformation to type becomes sufficiently close to permit of a reasonable possibility of prognosis.

Bearing in mind this general experience, one is forced to the conclusion that the general types of chronic insanity which have been separated out are really to be regarded purely as secondary manifestations, and that whether the origins of the psychoses are to be found in individual incidents of psychic life, as is the teaching of the analytic school, or whether they rest in the more fundamental processes underlying the absorption of experience and the building up of the personality; such is the homogeneity of the human species that, in spite of the diversities of experience and of individual make-up, ultimately the final settled adjustments may be counted up on the fingers of one hand.

However, to return to the actual subject-matter of this paper: it would be impossible to deal adequately with the full range of the early phase changes within the limits of the time permitted, therefore I propose considering only that phase which is productive of the most marked effects on the mental condition of the patient, and, in my experience, the most striking changes are to be anticipated following the exhibition of a confusional phase.

It may be objected that in considering confusion one passes from the psychoses proper to quite another group of disorders, and that the fact of recovery following confusion is only in accord with the recognised course of events, in that confusional states of mind do tend to recovery. With this objection it is quite possible to agree, and, indeed, I wish to emphasise the fact that recovery is common in these states, as I feel that the significance of this has been largely overlooked in the general distraction of attention by the modern trend of psychological thought. In support, however, of the inclusion of a confusional phase in the

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course of a true psychosis, it is contended that it is at least as possible for a psychotic as for a rational individual to develop an exhaustion state, or, in view of the self-neglect so common in the psychotic patient, a toxic confusional state.

Now, in considering a case of early psychotic derangement, it is clear that, whatever be the cause, the subject is being confronted with a set of novel experiences which are very different from, and may be directly opposed to, any experience which had been undergone previously in the individual life. To the patient these experiences are, of course, perfectly real, and, from their very novelty and their personal application, they become the dominant factor in determining the direction of flow of the interest or attention. To them the patient attends, "willy nilly" he must think about them, he must reason them out. By the rationalisation which occurs the new experiences are built up into an organisation of new sentiments, and, owing to the strength of the affect all that conflicts with them must go by the board. So retrospection undermines what is left of the previous experience, and new perceptual experience is accumulated as the days go by under the influence of the prevailing affect, all to the effect of strengthening the delusional state and of removing the patient still further from the possibility of proper social adjustment.

The greater the intellectual capacity, the wider the sphere of knowledge; the longer the new organisation is in existence, the more extensive will be the systematisation. For instance, the paraphrenic differs from the paranoiac in other ways than in mere mental content, the latter individual being invariably of a much higher intellectual capacity; also the chronically insane subject gradually changes his sentiments towards objects which previously had a high interest value, visits from relatives being received apathetically even if the patient has not earlier rationalised a hostility to all his friends, on the grounds that they do not come forward to help him substantiate his delusional ideas.

Meanwhile the patient is quite unamenable to any influence save that of force, he can be cajoled into behaving properly, and he can be persuaded into conforming to the rules of the hospital up to a point, but his new outlook on life, his new sentiments cannot be altered by the slightest fraction; such intellectual ability as he has is used to counter any attempt to argue him out of his beliefs, and the only effect of such an attempt is that the patient is stimulated to forge still more firmly those intellectual bonds which hold his delusional state together. It is highly probable in many cases, also, that the original cause which set off the whole affair subsides and is no longer operative, but the organisation of delusional experience has by this time become so firmly fixed into the personality that the condition is self-perpetuating, and consequently unalterable.

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So long, therefore, as the capacity for intelligent thought remains active, so long must the compound of delusional sentiments grow and cohere, until finally the element of novelty wears off, the patient ceases to think about his experiences, he takes them for granted and settles down to his new adjustment, which takes the form of one of the recognised types of the psychoses. This is the reason why it is found that many of the chronic patients in our county hospitals are quite capable of useful work under the hospital environment.

If, however, the patient develops a confusion for any reason, a very different course of events must follow. In the first place the continued addition of strengthening perceptory experience must cease because the processes underlying intelligent association are no longer operative. Secondly, the organisation of the new experience is badly strained, its intensity and clarity are markedly reduced in proportion to that of previous experience, according to the rule that the latest acquirement is the first to be lost. Finally, influence can now be brought to bear on the patient, who, owing to his difficulty of intelligent thought, cannot meet argument with argument and is therefore more capable of taking a suggestion. His perceptual experience is more likely to be dominated by the original compound of sentiments developed prior to his psychosis, and in consequence he is more amenable and easier to handle.

Compare, for example, two cases of what may be termed melancholia of the involutional period. The first was admitted to hospital with the usual ideas of depression, of financial difficulties (which were real enough), and with the conviction that he could no longer keep up the struggle of making ends meet. His delusional state developed, he was hopelessly lost, he was to be killed, his wife and family were to be murdered, etc. He was passively resistive to treatment but never developed any signs of extreme anxiety, and he has settled down to his position in hospital, smokes his pipe, reads the paper, but turns a deaf ear to any talk directed to showing the falsity of his beliefs. The second was admitted in a very similar mental state, with ideas of financial ruin and that he also was hopelessly lost. He, however, showed a more active resistance, it was difficult to ensure his proper nourishment, his expenditure of energy was much higher, and, within three months of admission he developed a confusional state which I regarded as an exhaustion. With careful attention it was possible to restore his physical strength, the confusion gradually cleared and he began to rationalise again. This time, however, he no longer built up on the basis of the former delusional ideas, he adopted the attitude that he was being kept, that he would never be allowed to go out again, that, far from being lost by virtue of his own condition, he was only being held back by the authorities of the institution. This attitude, though

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appearing to be delusional, was not an unreasonable one under the circumstances. Later on, when he was well enough, he was sent out to show him that it was not intended to keep him indefinitely, and with the removal of his doubts on that point he quickly reached a truly rational view of the whole question of his illness.

It is not always that the interception of a confusional phase results in readjustment to social life, as the following case shows: A very intelligent and well-educated woman, æt. 37, by profession a nurse, was admitted in a highly emotional depressed condition, the prominent affect being that of remorse. She had neglected her patients, she had fallen short of her religious ideals. She was quite inaccessible to argument, and she rapidly developed her delusional state. Finally she became convinced that she was to die, and she would fix the time at which "God would take her." This having arrived, she would go through the semblance of a death scene. As was to be expected she exhausted herself with the tremendous amount of emotional agitation she experienced, and in addition she contracted a rather acute colitis, the combination of circumstances resulting in an acute confusional breakdown. For a time her life was despaired of, but eventually the colitis was got under control and her strength began to return. Her attitude had changed completely when she again commenced to rationalise her position; instead of upbraiding herself she turned on her doctor and demanded to know what had been done to her, why she was made ill, why did she not receive any treatment, etc. Unfortunately it has not been possible to break through her hostility, but evidently her perceptive experience derived during the first phase of her malady has been quite obliterated.

A case which is of interest as showing the attempt at readjustment following a confusioual state is that of a woman, æt. 34, who was admitted to hospital in a state of confusion with excitement. She had vivid hallucinations of a terrifying nature, and her general effect was that of intense apprehension and fear. She became thoroughly exhausted and stuporose, but more amenable to treatment, until after about three weeks she began to take some notice of her surroundings. Attempts were made to explain her situation to her, for of course she had no idea of where she was or of how she came to be there. Her first endeavour at putting things together resulted in the idea that she had committed some crime, that she had disgraced herself, that her people would not have her at home, and she begged to be killed to put a stop to her disgraceful life. This state of mind was naturally accompanied by much agitation, and after a few days of incessant mental activity she became exhausted and again confused. In a week she was recovering again; this time her attitude was that she was being kept in prison, that her relatives were all being tortured, that she was to be

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tortured also, and finally killed. She no longer held her ideas of unworthiness, but put down the whole trouble to the authority detaining her and keeping her from her home. Her affective state now was that of acute fear, and this again was too much for her low stability, and again confusion recurred. With another interval of about a week she once more commenced to rationalise, she was still very apprehensive, but she was more suggestible ; and, finally, her confidence was obtained, and she began building up experience on the true basis.

It is very difficult, of course, to say whether a confusional phase is likely to occur in the course of any particular early psychosis ; in many cases it arises accidentally as the result of some toxic infection, but there are certain developments which are liable to lead to exhaustion. Such conditions as a rapidly developing paranoid state, an acute anxiety state or a remorse or self-reproach psychosis involve a great expenditure of mental activity by the patient, and are therefore liable to lead to exhaustion, while, on the other hand, phantasy developments are not associated with much emotional activity or intense intellectual effort, and therefore do not commonly exhibit a confusional phase.

The practical question presents itself as to whether it is advisable to encourage confusion in a case which is showing every evidence of building up an organised scheme of false ideas, and I feel that if a confusion can be induced early enough, the chance of obtaining access to a patient during the recovering period would justify whatever measures were taken. I was much impressed with the early recovery of many of the psychoses met with in service patients during the war, and I think that in most of them the explanation was to be found in the element of exhaustion with mild confusion which was almost invariably present. I will mention one case which came under my care. An officer of excellent past record and good physical health was sent to me with what appeared to be a well-established paraphrenic condition. He had the delusions that he was thought to be a spy, that he had given important plans away to the Germans ; he heard voices accusing him of various misdeeds, and he saw Germans wherever he went. There was no confusion, but he was intensely suspicious and hostile, and the circumstances of the hospital were such that he could not be placed under the requisite care and control necessary in his state. Eventually he was persuaded to submit to a hypodermic injection of morphine and hyoscine. Under the influence of the drug he was got to bed and kept there with an injection twice daily. This was continued for four or five days, during which he remained in a semi-stuporose confused state, then, arrangements having been made for his removal elsewhere, the injections were stopped and the patient allowed to adjust himself to his environment. It was then found that his suspicions had quite disappeared, his former delusions and hallucinations had faded to that

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dream-like intensity so characteristic of the recent memories of the confusional case, and within a few days' time the patient was perfectly readjusted with a good insight into his previous psychotic condition. In this case the derangement was caught at a very early stage, it could not have been in existence at the outside for more than two months, therefore the delusional compound was poorly organised and easily broken up to leave the field clear for a proper readjustment. One cannot assume, of course, that the case would not have terminated favourably under more usual methods of treatment, but certainly I have never observed such a remarkably complete recovery of sanity in so well developed a delusional state in the very brief period of time, and I feel that the case is exceptionally interesting from this point of view.

In conclusion, I would again emphasise the necessity of not allowing the systematic classification, which is applicable to long-standing cases, to obscure the fact that the early case almost invariably shows change of phase before the secondary final adjustment is reached; and I would draw attention in regard to the particular phase of confusion to that very old tradition that an acute infectious disease, probably accompanied by delirium, is often beneficial to a mental patient so far as his future mental state is concerned.

(The discussion which followed will be found on p. 546, vol. lxvii, 1921.)

The Goldsol Test in Mental Disease.[1] By P. W. Bedford, M.D., D.P.M., Assistant Medical Officer, West Riding Asylum, Wakefield.

General paralysis is often very difficult to diagnose, and the responsibility of coming to a decision is not lessened by the fatal character of the disease. Amongst the protean manifestations of neuro-syphilis, the early and definite recognition of this, its most deadly and intractable form, offers a problem in nice discrimination—a problem which is in the present tense and imperative mood. According to Southard, of 119 cases diagnosed as general paralysis, *post-mortem* examination revealed a diagnostic error of 26 *per cent.* If anyone had been able to devise a less intricate test for syphilis, the Wassermann reaction would never have survived to the present day. It is one of the most complicated methods that have been applied to diagnosis in medicine. Any simple test, therefore, which promises increased precision in diagnosis, is worthy of that careful investigation which is the half-way house to knowledge.

The general utility of any diagnostic method, and in a measure its reliability, is determined chiefly by the simplicity of its unspecialised

[1] A paper read at the Annual Meeting held in London, July 12th, 1921.

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