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Correspondence

THE JOURNAL AND ITS CONTENTS

DEAR SIR,

I should like to join Dr. J. D. Sutherland unreservedly in his remarks on the future of the *Journal*. For far too long the *Journal* has purported to represent British Psychiatry. Those of us who are more interested in psychodynamics have had to turn to such journals as *Brit. J. med. Psychol.* and *Int. J. Psycho-Anal. The British Journal of Psychiatry*, however, enjoys considerable prestige among the younger psychiatrists who, having examinations to pass, find its contents more useful. For the most part these examinations demand knowledge of a "scientific method in which research is dominated by the rigours of statistical and experimental methods but with little apparent connection with what people are about".

Dr. Sutherland's suggestions would allow the young people to judge for themselves. Psychiatry is not a branch of medicine but an evolving science in its own right—it's time we stopped leaning on medicine for basic sciences and evolved our own—it's time we moved out of the 19th century into the 20th!

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DEAR SIR,

The Executive Committee of the Research and Clinical Section discussed the recent correspondence in the *Journal* concerning subject matter and editorial policy. It was felt strongly that in order to preserve a good *Journal* the editor must retain responsibility for the selection of articles for publication, with the advice of his editorial board, and that a policy of allocating *Journal* space to separate editorial subgroups would spell disaster for the *Journal*.

While according with the idea of broadening the subject matter published in the *Journal*, where consistent with the preservation of its high standard, the Committee wished to express its satisfaction with, and appreciation of, the present editorship.

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WHAT KRAEPELIN REALLY SAID

DEAR SIR,

Being fascinated rather than bored by the dispute between Professor Fish and Dr. Hoenig (*Journal*, November, 1967, p. 1321; January, 1968, p. 125; March, 1968, p. 356), your Honorary Librarian felt that a little study of what Kraepelin really said might enable him to reconcile the opposing views. In this he has been unsuccessful, and he must come down very firmly on the side of Dr. Hoenig.

May I first remind readers that the question at issue is whether Kraepelin "defined his nosological entities *on the basis* of the course of the illness or the prognosis", or, as Professor Fish puts it, whether he "used the *criterion* of incurability to establish his concept of dementia praecox"—*not* just whether Kraepelin thought that the disease had a poor prognosis or always left some personality defect. These are separate questions; for example, Addison certainly held that his "idiopathic anaemia" was always fatal, but no one ever maintains that this, rather than his observation of the symptoms in the living patient, was the *basis* of his discovery.

I will now turn, as Professor Fish has done, to the 5th edition of Kraepelin's textbook—though the 8th edition is not to be despised (*die achte ist nicht zu verachten!*).

Here we are confronted straight away with a crucial discrepancy between Professor Fish's successive translations; for in his original review he misquotes Kraepelin as saying (p. 425) that dementia praecox and allied conditions all *led to* a peculiar kind of psychological defect (or enfeeblement), whereas in his later letter he quotes him correctly: "the common feature of these conditions . . . is the *rapid development* of a peculiar kind of psychological enfeeblement (or defect)". Now, since the author is going to tell us that the duration of the disorder is one of many months or years, it is on the face of it likely that this "rapid development of a *Schwächezustand*" is something that occurs at or near the onset, and that the reference here is not to the ultimate outcome of the disease.

When we go on to read the rest of the paragraph, and the next four pages, which deal with the milder forms of dementia praecox, we find this inference abundantly confirmed. Kraepelin says: "By the term 'dementia praecox' we designate the development of a simple state of mental weakness (*Schwächezustand*)

of greater or lesser degree associated with (*unter*) the symptoms of an acute or subacute mental disturbance." Examples of this *Schwäche* follow: "The mental capacity of the patient is decidedly reduced; he may show the same industry or even more . . . but he can no longer grasp matters correctly, cannot follow complicated expositions of a subject, cannot concentrate his attention; he is absentminded, dreams and broods without any deeper interests or recognizable aim. . . . The elements of his experience no longer influence each other, no longer lead to any conceptions, judgments or conclusions. . . . In his actions, the patient is either slow and sluggish, or shows a peculiar childish silliness. . . ."—and much more to the same effect.

It is *these* symptoms of the early and florid stages that Kraepelin believed to be manifestations of *Schwäche* or *Verblödung* (the last term, incidentally, ought to be translated simply as "dementia", rather than by the question-begging "deterioration", just as *Altersblödsinn* is "senile dementia"). Of course, we may disagree with Kraepelin and hold that these symptoms do not indicate dementia; but that is another matter.

Now we come to the prognosis (p. 429), and here we find that, so far from forecasting progressive and inexorable deterioration in every case, Kraepelin says quite definitely that "in these milder cases dementia can be arrested at very different stages. . . . In favourable cases the disorder comes to an end with a moderate degree of mental enfeeblement (*Schwachsinn*) which generally remains unaltered, but occasionally, it seems, some part of the mental impairment may actually disappear. . . . There must be many people whose mental shipwreck through dementia praecox has passed unnoticed, because they have been able to rescue enough mental capacity to carry on the struggle for life in modest spheres of activity"—other examples of this diversity of outcome are, on the one hand, scholars who fail to fulfil their early promise, and, on the other, persons who drift into vagrancy and eventually arrive at the asylum via the workhouse.

Finally, diagnosis. Do we find Kraepelin warning us that a diagnosis cannot be made until the course and outcome of the case are known? Not at all; on the contrary, he tells us that an early diagnosis can and should be made (p. 440); and in differentiating from early periodic psychosis one should pay attention to the more insidious onset, the lesser vehemence of the symptoms, and *the signs of acquired mental weakness* without any profound disturbance of consciousness. Once again, we have "mental enfeeblement" used to denote an aspect of the early symptoms, not to indicate a terminal condition.

To sum up: Kraepelin did not rest his concept of dementia praecox on the course or prognosis of the disorder, or regard incurability as its criterion. He rested it on a definite clinical picture, of which he gave a masterly description, and, rightly or wrongly, he considered that certain of its features could from the outset be summarized under the heading of "a peculiar kind of mental enfeeblement". He recognized that the disorder could be arrested at any stage, although the majority went on to severe dementia, and he emphasized the importance of early diagnosis.

It should be added that, contrary to what is sometimes alleged, Kraepelin was not acquainted only with asylum cases, but knew all about the *formes frustes* patients who remained in the community; also that he realized the importance of "guarding the still remaining mental faculties against the threat of atrophy through disuse, by means of careful and well-planned exercise of those faculties so far as may be practicable" (p. 441).

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FAMILY AND MARITAL HYSTERIA

DEAR SIR,

The paper by Woerner and Guze (*Journal*, February, 1968, p. 161) draws attention once again to the concept of hysteria as a diagnostic entity. Few terms in medicine have adapted themselves so readily in the Carrollian sense of meaning just what we want them to mean. Few terms, beside hysteria, have had to do duty for so many different concepts.

Hysteria may be used to mean that the patient is considered to be deriving some subtle "gain" from his illness. Hysteria may be used to imply that we believe the patient's symptoms are directly derived from emotional conflict and so translated by the theoretical mysteries of conversion and dissociation. Hysteria may be called upon to "explain" any psychological complaint that is considered contagious, such as folie-à-deux or the "epidemic hysterias" of schoolgirls. Hysterical "overlay" is a favourite formula of physicians who consider that the patient is exaggerating his symptoms. Hysteria may be applied to the importunate patient, or to any patient with chronic neurosis who "refuses" to get better (and so applied gives the physician a retrospective bonus of solace for his therapeutic failure). Laymen and many medical men consider that hysteria and malingering are scarcely distinguishable, and the term "hysterical attack" is beloved by the nursing profession as a way of conveying in their reports that