
Marx
Machiavelli
Chesterton
Emerson
Joyce
Abbott
Hardy
Montaigne
Cooper
Austen
Defoe
Melville
Haggard
Hugo
Carroll
Christie
Eliot
Grimmer
Stoker
Molière
Wilde
Maupassant
Byron
Einstein
Fitzgerald
Engels
Schiller
Garnett
Hawthorne
Smith
Kafka
Goethe
Dostoyevsky
Cotton
Hall
Baum
Kipling
Doyle
Willis
Henry
Leslie
Dumas
Nietzsche
Flaubert
Turgenev
Balzac
Stockton
Vatsyayana
Crane
Burroughs
Verne
Curtis
Tocqueville
Whitman
Gogol
Vinci
Homer
Widger
Tolstoy
Busch
Darwin
Thoreau
Potter
Freud
Zola
Twain
Scott
Lawrence
Plato
Kant
Jowett
Stevenson
Dickens
Harte
Andersen
Burton
Hesse
London
Descartes
Cervantes
Poe
Aristotle
Wells
Voltaire
Hale
James
Hastings
Cooke
Bunner
Shakespeare
Irving
Richter
Chambers
Chekhov
da
Doré
Swift
Dante
Shaw
Benedict
Alcott
Wodehouse
Pushkin
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Benign Stupors A Study of a New Manic-Depressive Reaction Type

August Hoch

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BENIGN STUPORS

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TORONTO

BENIGN STUPORS

A STUDY OF
A NEW MANIC-DEPRESSIVE REACTION TYPE

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TO
MY FORMER COLLEAGUES
IN THE
NEW YORK STATE HOSPITAL SERVICE

[vii]

EDITOR'S PREFACE

A word should be said as to the origin and history of this book. When the late Dr. Hoch became Director of the Psychiatric Institute of the New York State Hospitals in 1910, he found there an interest in just the kind of psychiatric research which it was his ambition to further. His predecessor, Adolf Meyer, had developed the conception that the psychoses should be looked on as psychobiological reactions rather than rigid nosological entities and had inculcated the habit of scrupulously thorough examination and record of what the patient said and did. Meyer had broken away from the sterile habit of making diagnoses in accordance with the set terms used to label symptoms; and his work and that of his assistants thus led to a collection of valuable material which could serve as a useful starting point for the keen clinical investigation of Hoch. Specifically, attention had already been fixed on the study of the so-called functional psychoses, comprising what are generally termed Dementia Præcox and Manic-Depressive Insanity. An urgent problem in this field was to separate different reaction types in order to discover which were recoverable and which chronic or progressive. In order to understand psychological reactions, interrelation rather than [viii] mere coincidence of symptoms must be studied and, to aid in this, free use was made of the fundamental principles of unconscious mentation as exposed in the theories of Freud and his followers.

Almost at the outset it had been discovered that many patients presented clinical pictures that would not fit into existing diagnostic pigeon holes. Dr. George H. Kirby, whose skill and industry had made the most valuable contributions to the archives of the Institute, published in 1913 a brief paper in which he pointed out, not only that many cases with "catatonic" symptoms recovered, but also that clinically the behavior of stupor showed it to be related to manic-depressive insanity as well as dementia præcox. Dr. Hoch took up the problem at this point. Using Dr. Kirby's material and adding to it his earlier observations as well as current cases, he endeavored to work out the essentials of the stupor reaction. It was his ambition to describe stupor not only in its psychiatric bearing but also as a life reaction.

The significance of this task is to be realized only when one considers the general import of the functional psychoses. They are, biologically, failures of adaptation. The chronic and deteriorating cases give up the struggle permanently, while the temporary insanities lay bare the soul of man as he catches a glimpse of unreality but turns back to face the world as it is. When one realizes that emotional disturbances are characteristic of the benign psychoses, it is easy to imagine how much such studies [ix] may ultimately illuminate the problems of normal life.

The technical value of this work to psychiatry is more immediate. Kraepelin laid the foundations for systematic classification with his dementia præcox and manic-depressive groups. But the rigidity of the latter, allegedly descriptive, term has confused the problem of classifying many benign psychoses. It was Hoch's ambition to prove that, although elation and depression were the commonest mood anomalies in this group, they had no more theoretic importance than anxiety, distressed perplexity or apathy. These other moods, although less frequent, are just as characteristic of the psychoses in this group. In other words, the name "Anxiety-Apathy Insanity" would be as appropriate, theoretically, as Kraepelin's term. In 1919 Hoch and Kirby published a report on the perplexity cases. This present book was designed to show that the symptom complex centering around apathy is as distinct as that which is recognized by all psychiatrists as mania with its predominant characteristic of elation.

In 1917 ill health forced Dr. Hoch to resign from his official duties. He retired to California with the purpose of adding to psychiatric literature the fruits of his long experience and unrivaled judgment. His first task was this book. In the midst of this work came a sudden collapse. As I had been in close touch with his researches, coöperating in psychological speculations, and was free to devote [x] some time to it, he asked shortly before his death that I complete the book. This obligation is incommensurate with the debt I owe for years of inspiration, tuition and criticism.

The task has been mainly literary. I found the first five chapters practically completed, while it has not been difficult, as a rule, to discover from his copious notes what his intentions were as to the

details of the following chapters. I have been greatly aided by the assistance of Dr. Adolf Meyer and of Dr. Kirby. The latter has been good enough to read the entire manuscript, making invaluable suggestions and criticisms.

John T. MacCurdy.

New York.

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BENIGN STUPORS

CHAPTER I
INTRODUCTION AND TYPICAL CASES OF DEEP STUPOR

The fact that psychiatry lags in development and recognition behind other branches of medicine is due in part to the crudity of its clinical methods. The evolution of interest in science is from simple, obvious and tangible problems to more intricate and impalpable researches. Refined laboratory work has been done in psychiatric clinics, particularly along histopathological lines, but clinical studies follow antiquated methods. The internist does not say, "The patient has sugar in his urine, therefore he has diabetes and therefore he will die." He finds a glycosuria and looks for its cause. If this symptom is found to be related to others in such a way as to justify the diagnosis of diabetes, a therapeutic problem arises, that of adjusting the chemistry of the body. The prognosis depends not on the disease but the interreaction of the organism and the morbid process. Both in diagnosis and treatment an individual factor, the patient's metabolism, is of prime importance. Now in psychiatry, although the personality is diseased, this personal factor has been [2] almost entirely neglected. Text-books furnish us with composite pictures which are called diseases, not with descriptions of reactions brought about by the interplay of personal and environmental factors. Educated people are not satisfied with novels that fail to depict real characters. Clinical psychiatry, however, has been content with the dime-novel type of character delineation. This is all the more disappointing, inasmuch as the study of insanity should contribute largely to our knowledge of everyday life. This defect can only be remedied by looking on every case as a problem in which the origin of each symptom is to be studied and its relation traced to all other symptoms and to the personality as a whole. This is an ambitious task and we do not pretend to any great achievement, merely to a beginning.

No better psychoses could be chosen for a preliminary effort than benign stupors. Every psychiatrist has seen them, although they are wrongly diagnosed as a rule, and they play no small rôle in the world's history. Euripides represents Orestes as having a stupor which is pictured as accurately as any modern psychiatrist could describe an actual case. [1] St. Paul is chronicled as falling to the ground, being thereafter blind and going without food or drink for three days. While apparently unconscious he had a religious vision. St. Catherine of Siena had several unquestionable stupors, which are fairly well [3] described. In fact the mystics in general seem to have had communion with God and the saints most often when they seemed unconscious to bystanders. [2] The obsession with death, which seems so intimate a part of the stupor reaction, is a fundamental theme in poetry, religion and philosophy. The psychology of this interest is, speaking broadly, the psychology of stupor. So, from a general standpoint, our problem is related to the study of one of the most potent ideas which move the soul of man.

Psychiatrically, stupors have long remained an unsolved riddle. In the century prior to 1872 (See the digest of Dagonet's publication in Chapter XV) French psychiatrists wrote some good descriptions of stupor and offered brilliant, though sketchy generalizations about the condition. Two years later an English psychiatrist (Newington, See Chapter XV) improved on the French work. Little light has been thrown on the subject since then. The researches of the later French School showed that stupor often occurs in the course of major hysteria, but this left many of these episodes obviously not hysterical. When serious attempts were made at classification, this ubiquitous symptom complex was hard to handle. Wernicke wisely refrained from attempting more than a loose descriptive grouping. He called all conditions with marked inactivity and [4] apathy "akinetic psychoses" and said that some recovered, some did not. Taxonomic zeal began to blind vision when Kahlbaum formulated his "Catatonia" and included stupor in the symptom complex. The condition which we call stupor occurs in the course of many different types of mental disease. It is true that it is frequent in catatonia but is not exclusively there. Mongols have black hair and straight hair, but one cannot therefore say that any black and straight haired man is a Mongol. Fortunately Kahlbaum prevented

serious error by leaving the prognosis of his catatonia open. When Kraepelin included it in his large group of Dementia præcox, however, it implied that stupor could not be an acute, recoverable condition. [3] He unquestionably advanced psychiatry greatly but his scheme was too ambitious to be accurate. Many observers saw patients, classified as dements according to Kraepelin's formulæ, return, apparently normal, to normal life. Finally Kirby [4] published a series of cases which showed decisively that this classification was too rigid.

Since his paper is the foundation for this present study, it should be reviewed carefully. He first points out that Kraepelin's "Dementia præcox" [5] includes much more than it should with its inevitably bad prognosis. He shows how others have found patients with catatonic symptom complexes proceed to recovery and speaks of these symptoms occurring in epilepsy and even in frankly organic conditions, such as brain tumor, general paralysis, trauma and infections. Kirby's first claim is that there are probably fundamentally different catatonic processes, deteriorating and non-deteriorating. Lack of knowledge has prevented us from understanding the meaning of the symptoms and hence making the discrimination. He points out that stupor seems to represent an attitude of defense, similar to feigned death in animals, and that in a number of his cases it was clear that the stupor symbolized the death of the patient. Apparent negativism, he found to be often a consciously assumed attitude of aversion towards an unpleasant emotional situation. In cases where there had been no prodromal symptoms pointing definitely to dementia præcox the outcome was almost always good. To discriminate the cases with good outlook from those with bad, he discerned no difference in the stupors themselves, but observed that the mental make-up and initial symptoms differed sufficiently for diagnosis to be made. His most important point is, perhaps, that these benign stupors showed a definite relationship to manic-depressive insanity in that some patients passed directly from stupor to typical manic excitement, while in others a "catatonic" attack replaced a depression in a circular psychosis.

[6] Kirby introduces, then, the idea of stupor being a type of reaction which can occur either in dementia præcox or in manic-depressive insanity. The matter cannot be left there, in fact it raises

new problems: what constitutes the reaction? how are the various symptoms interrelated? are they different in deteriorating and acute cases? what is the teleological significance of the reaction? if it be an integral part of the manic-depressive group, how does it affect our conceptions of what manic-depressive insanity is? More than five years have been spent in endeavors to answer these questions and the results of the study are now presented.

Naturally the first point to be settled is: what constitutes the stupor reaction itself. We can say at the outset that it is seen in the purest form in benign cases, hence they make up the material of this book. To discover the symptoms of the disorder one cannot do better than to study them in their most glaring form in deep stupors, where consistently recurring phenomena may be assumed to be essential to the reaction.

Case 1.—*Anna G.* Age: 15. Admitted to the Psychiatric Institute July 25, 1907.

F. H. The mother and two brothers were living and said to be normal. The father died of apoplexy when the patient was seven.

P. H. The patient was sickly up to the age of seven, but stronger after that. It is stated that she got on well at school, though she was somewhat slow in her work. She was inclined to be rather quiet, even when a child, a bit shy, but she had friends and was well liked by others. After recovery she made [7] a frank, natural impression. She was always rather sensitive about her red hair. She began to work a year before admission and had two positions. The last one she did not like very well, because, she alleged, the girls were "too tough."

Three weeks before admission she came home from work and said a girl in the shop had made remarks about her red hair. She wanted to change her position, but she kept on working until six days before admission. At that time her mother kept her at home as she seemed so quiet, and when the mother took her out for a walk she wanted to return, because "everybody was looking" at her. For the next two days she cried at times, and repeatedly said, "Oh, I wish I were dead—nobody likes me—I wish I were dead and with my father" (dead). She also called to various members of the family, saying she wanted to tell them something, but when they came she

would only stare blankly. For a day she followed her mother around, clung to her, said once she wanted to say something to her, but only stared and said nothing.

Four days before admission she became quite immobile, lay in bed, did not speak, eat or drink. She also had some fever.

The patient herself, when well, described the onset of her psychosis as follows: She knew of no cause except that her brother, some time before the onset (not clear how long), was run over by an automobile and had his foot hurt. She claimed that while still working she lost her ambition, lost her appetite, did not feel like talking to any one; that when she went out with her mother it merely seemed to her that people stared at her. The day before she went to the Observation Pavilion her cousin came to see her, and she thought she saw, standing beside this cousin, the latter's dead mother. She also thought there was a fire, and that her sister was sweeping little babies out of the room. Then, she claimed, she felt afraid (this still on the day before going to the Observation Pavilion) because she had repeated visions of an old woman, a witch. This woman said, "I am your mother, and I gave you to this woman (i.e., patient's real mother) when you were a baby." She also was afraid her mother was "going away."

At the *Observation Pavilion* she was described as constrained, staring fixedly into space, mute, requiring to be dressed and fed.

[8] *Under Observation:* 1. For five months the patient presented a marked stupor. She was for the most part very inactive, totally mute, staring vacantly, often not even blinking, so that for a time the conjunctivæ were dry. She did not swallow, but held her saliva; did not react to pin pricks or feinting motions before her eyes. Sometimes she retained her urine, again wet and soiled the bed. Often there was marked catalepsy, and the retention of very awkward positions. As a rule she was quite stiff, offering passive resistance towards any interference. She had to be tube-fed at first. Later she was spoon-fed, and then would swallow, in spite of the fact that during the interval between her feeding she would let saliva collect in her mouth. For a time she had a tendency to hold one leg out of bed, and when it was put back would stick the other out.

Sometimes she walked of her own accord to the toilet chair, but on one occasion wet the floor before she got there.

During the first month after admission, this stupor was interrupted for two short periods by a little freer action: she walked to a chair, sat down, smiled a little, fanned herself very naturally when a fan was given to her, though even then did not speak.

There was, as a rule, no emotional reaction, but after some months she several times wept when her mother came, though without speaking. Once when taken to the tub she yelled.

Her *physical condition* during this stupor was as follows: She menstruated freely on admission, then not again until she was well. Several times she had rises of temperature to 102° or 103° with a high pulse and respiration; again a respiration of 40, with but slight rise of temperature, though the pulse had a tendency to go to 130 and over. She was apt to show marked skin hyperæmia wherever touched. With the fever there was found a leucocytosis of from 11,900 to 15,000, with marked increase of polynuclear leucocytes (89%). She got very emaciated, so that four months after admission she weighed 68 lbs. (height 5' 2").

2. About five months after admission she was often seen smiling, and again weeping, and she began to talk a little to the nurses, though not to the doctors. She also began to eat excessively of her own accord, and rapidly gained weight, so that [9] by January she weighed 98½ lbs., a gain of 30 lbs. in two months. Yet she continued to be sluggish.

3. For two more months she was apathetic and appeared disinterested, often would not reply, again, at the same interview, she would do so promptly and with natural voice. This condition may be illustrated by the summary of a note made on January 29, 1908, which is representative of that period. It is stated that she sat about apathetically all day, appeared sluggish, but was fairly neat about her appearance and cleanly in her habits. There was at no time any evidence of affect, except when asked by the examiner to put out her tongue so that he could stick a pin in it she blushed and hid her face. When asked whether she worried about anything, she denied this. When questions were asked, she sometimes answered promptly and in normal voice, again simply remained silent in spite of

repeated urging. On the whole, it seemed that simple impersonal questions were answered promptly; whereas difficult impersonal questions or questions which referred to her condition were not answered at all. She proved to be oriented. Thus she gave the day of the week, month, year, the name of the hospital, names of the doctors and nurses promptly. She also counted quickly and did a few simple multiplications quickly. But she was silent when asked where the hospital was located, how long she had been here, whether she was here one or six months, how she felt. Questions in regard to the condition she had passed through, or involving difficult calculations, she did not answer. However, some questions regarding her condition asked in such a way that they could be answered by "yes" or "no" were again answered quite promptly. Thus when asked whether her head felt all right she said, "Yes, sir." (Is your memory good?) "Yes." (Have you been sick?) "No, sir." (Are you worried?) "No."

4. This apathy cleared up too, so that by the middle of March she was bright, active and smiled freely. With the nurses she was rather talkative and pleased, though this was not marked. Towards the physician only was she natural and free. She then gave the *retrospective account* of the onset detailed above. When questioned about her condition she claimed not to remember the Observation Pavilion, although recalling vaguely going there in a carriage. She was almost completely amnesic for a consider [10] able part of her stay in the Institute. She claimed it was only in November or December that she began to know where she was (five months after admission). In harmony with this is the fact that she did not recall the tube- and spoon-feeding which had to be resorted to for about four months of this period. No ideas or visions were remembered. As to her mutism she said, "I don't think I could speak," "I made no effort," again "I did not care to speak." She claimed that she remembered being pricked with a pin but that she did not feel it. She remembered yelling when taken to the tub (towards end of the marked stupor) and claimed she thought she was to be drowned.

When she went home (March 24, 1908) she got into a more elated condition. She was talkative, conversed with strangers on the street, said to her mother that she was now sixteen years old and wanted "a fellow." When the mother would not allow her to go out, she said

it would be better if they both would jump out of the window and kill themselves. She then was sent back to the hospital. In the first part of this period after her return, she was somewhat elated and overtalkative, though she did not present a flight of ideas, and was well behaved. She soon got well, however, and was discharged, four months after her readmission, fully recovered.

After that, it is claimed, she was perfectly well and worked successfully most of the time with the exception of a short period in the spring of 1909, when she was slightly elated.

In 1910 she had a subsequent attack, during which she was treated at another hospital. From the description this again seems to have been a typical stupor (immobility, mutism, tendency to catalepsy, rigidity). According to the account of the onset sent by that hospital (it was obtained from the mother), this attack began some months before admission, with complaints of being out of sorts, not being able to concentrate and fearing that another attack would come on. Finally the stupor was said to have been immediately preceded by a seizure in which the whole body jerked. She made again an excellent recovery.

The patient was seen about two years after this attack, and described the development of the psychosis as follows: She claimed she began to feel "queer," "nervous," "depressed," got sleepless. Then (this was given spontaneously) she suddenly [11] thought she was dying and that her father's picture was talking to her and calling her. "Then I lost my speech." As after the first attack, she claimed not to have any recollection of what went on during a considerable part of the stupor but recalled that she began to talk after her brother visited her. It is not clear how she was during the period immediately following the stupor.

She made a very natural impression and came willingly to the hospital in response to a letter and was quite open about giving information.

Case 2.—*Caroline DeS.* Age: 21. Admitted to the Psychiatric Institute June 10, 1909.

F. H. The father died of apoplexy when patient was nine. The mother had diabetes. A paternal uncle was queer, visionary.