A

CLINICAL AND PSYCHOPATHOLOGICAL

STUDY OF SENILE PSYCHOSES.

By

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I. Introductory.

Mental disorders occurring in persons of advanced years have not received a great deal of attention from psychiatrists. The more modern schools of psychiatry, in particular, have little to say about them, and our understanding of them has not advanced very noticeably since last century. It is the object of the present paper to see whether modern psychopathological conceptions cannot profitably be applied to this branch of psychiatry, and to make a tentative beginning to the study of senile psychoses along these lines.

Much excellent work has been done in the form of descriptive psychiatry and pathology, and it seems advisable to start with a brief review of the more important contributions which are relevant to our theme.

Some of the best descriptions of the various forms of senile insanity are to be found in the textbooks of Clouston (1) and Kraepelin (2). Their views appear to differ as to the prevalence of these conditions; for while Kraepelin's statistics show psychosis to be rather rare in seniles, Clouston

points out that only 0.9 persons per 10,000 under 20 years old, but 11,4 per 10,000 over 60 years are sent every year to asylums in England and Wales; and that 9.6% of the patients admitted to Morningside over a period of 9 years were over 60 years of age, 6.3% being diagnosed as "senile insanity."

Evidence of heredity could be established only in 13% of the senile cases, as against 23% in the general statistics; but Clouston notes the difficulty in senile cases of obtaining reliable information on this point. However, a similar conclusion is reached by the statistical studies of Weinberger (3), who found that senile dementia itself was the only psychosis occurring more frequently in the families of senile dements than in the general population. His results were confirmed by Meggendorfer (4).

Out of 203 cases of "senile insanity", Clouston found that 69 (i.e., 34%) were depressed.

Kraepelin notes in connection with the memory disturbances that isolated events of early childhood often appear with astonishing vividness. The disturbance of memory and judgment gives favourable soil for the development of delusions, usually exaggerated fear of illness and senseless mistrust, or childish exaggeration of the patient's own importance. "He has no motion of the bowels; he is everywhere defective; the whole body is affected. He is in despair, has no thoughts, can do nothing, is losing his memory,

is becoming insane; he is no more use. Everyone wishes him ill, persecutes and tricks him, tortures him. He is robbed, has no more money, must starve. On the other hand there are ideas of grandeur."

Bleuler (5) recognises that the symptoms are not all directly attributable to cortical atrophy. One group of symptoms is the expression of the diffuse reduction of brain substance. The chief of these symptoms are:

(1) defect of memory,

(2) limitation of associations,

(3) lability of affects,

(4) disturbance of attention,

(5) slowness and uncertainty of apprehension.

In addition to this, he describes as accessory symptoms:

(1) Hallucinations, almost exclusively of hearing and sight (in my experience also often of smell and sometimes of taste),

(2) Delusions, appearing chiefly with affective disturbances. Their senselessness is characteristic, especially in states of depression, with hypochondriacal ideas.

(3) Sometimes intercurrent confused states.

He notes that the depressions are often accompanied by anxiety attacks.

With regard to the memory defect, Bleuler observes that the newer the patient's experiences are, the sooner and more completely are they forgotten, and

finally the patients live among their childhood memories, which become much fresher than formerly (a point which is often overlooked). This rapid forgetting of recent experiences is what is known as defect of retention (Merkfähigkeitsstörung), and Bleuler points out that in the ordinary form of test a great many things are involved besides memory, and that of the three memory functions involved, the impression, retention, and reproduction of an engram, only the last is seriously affected in senile dementia. He notes that the important factor is not whether the experiences are properly noticed, but whether they are fresh ones, these being the most readily forgotten; however, he does not draw any conclusion from this.

Confabulations, designed to fill in gaps in memory and readily forgotten, are pathognomonic for organic diseases, and he distinguishes them from the "hallucinations of memory" of schizophrenia. Definite amnesic gaps in an otherwise moderately preserved memory he reckons among the "accessory symptoms."

The limitation of associations is not like that of idiots, who cannot think of more complicated and unusual things; what corresponds to a current affect or striving is well or moderately well thought, but what is indifferent or contradicts the striving cannot be brought into the field of thought.

Bleuler gives a clear clinical distinction between the pure forms of senile dementia and arteriosclerotic

insanity, but admits that most cases are mixed.

Seelert (6) describes a characteristic mixture of paranoid and depressive symptoms, describing a case at length in which he concludes that the psychosis developed out of the peculiarities of the patient's psychological constitution - both paranoid and melancholic. The fact that paranoia of old age does not recover while melancholia does recover only shows that a peculiarity of the endogenous depressive (and manic) constitution is a tendency to recover.

Dombrowski (7) makes a clinico-pathological contribution to the question of senile paranoia, describing a patient who suffered from lymphatic oedema of the lower limbs, osteomalacia, and dyspnoea. She had no general psychic changes, no dementia, the disturbance being limited to the paranoid complex. She complained of burning in the neck and feeling a lump there, and later that a mouse was gnawing her body. She felt a mouse in her throat, which came out of her vagina at night and bit her in the legs and arms, and it often stuck her eyes out or ate her guts. She feared she would go blind. She said that a girl was saying terrible things about her - that she was going about at night with men, etc.

At autopsy there was a typical diffuse cortical atrophy, without signs of inflammation or senile dementia (i.e., senile plaques, Alzheimer's degeneration). The atrophy was very intense, yet there was

little senile alteration in the patient. Dombrowski suggests that sensations coming from the surface and interior of the body to regions of the brain altered by disease undergo false elaboration and give rise to pathologically distorted sensory impressions. The severe alterations in the legs, oedema, trophic changes in the skin, perhaps a senile pruritis vaginae, could easily be interpreted pathologically in an altered cortical elaboration sphere.

I have quoted this case at some length for two reasons. It demonstrates the possibility of gross cortical atrophy without dementia; and it is a good illustration of the limitations of the physiological method of approach to psychological problems, despite the ingenuity of the author. Although there is probably a good deal of truth in his theory, it is as one-sided a method of treating the problem as that of those who would explain slips of the tongue and pen on the basis of fatigue or distraction of the attention. The factors to which he calls attention are facilitating factors; the actual form of the symptoms is psychologically determined.

Krypsin-Exner (8) states that the psychoses of later years often show very complicated pictures, which sometimes do not allow of an undoubted classification of the case in any of the customary diagnostic schemata. The diagnosis of "late schizophrenias" or "late catatonias" cannot content us in such cases,

since the so-called schizophrenic basic symptoms cannot be demonstrated, though in some other cases these symptoms - disturbances of affect and association - are plainly developed. A special rôle is played in psychoses of later life by depressive - paranoid pictures of relatively long duration.

The painstaking work of Gregor (9) on the psychopathology of the memory is to be noted. He states that the particular form in which memory disturbance manifests itself in senile individuals is in the disturbed memory for names and numbers. In contrast to other forms of memory disturbance, the attention directed to the act of reproduction, and the formation of the impressions retained, are relatively intact. The volume of what is retained is reduced, rather than its logical connection. A certain ideational elaboration of what is received takes place, and what is retained is connected or expanded in a significant manner. The ability to learn is more disturbed than retention. In the learning of connected words there is no further improvement after only a few readings, whereas in Korsakoff cases improvement goes on until the onset of fatigue. Learning by heart gives rise to much more difficulty than comprehending what is read.

Thus, Gregor's observations contradict the generally current view that the memory defect of senility is essentially one of retention, and open up interesting possibilities of investigation into the actual nature of the disturbance. Gregor does not

mention the fact that many cases of senile dementia show just the Korsakoff type of memory defect. This is another problem that awaits investigation.

The psycho-analytical school has hitherto made little contribution to the problems of senility. Senile patients are of course unsuitable subjects for analysis, but the psycho-analytic point of view has been successfully applied to other conditions in which the same difficulty is present.

A little general work on dementia has been done by Schilder (10), but he was more particularly concerned with general paresis, and he observes that no analytic work has been done on the subject of senile dementia, and that such work is called for.

It was only after the work for this paper was completed, and the writing of it was nearly finished, that I found one direct analytic contribution to the subject, namely the paper published by Jelgersma (11) in 1931 under the title: "Die Psychoanalyse der Dementia Senilis." This deals almost entirely with senile dementia, whereas my paper is more concerned with the psychotic manifestations in seniles; but Jelgersma's conclusions are largely in agreement with those I had independently arrived at.

Jelgersma discusses first the deliria which may complicate a bodily illness in an old person, and the delirium of the dying. The content of such deliria consists essentially of a denial of the pathological condition from which the patient is

suffering. The dying person either believes he is well again, or by projection he sees the cause of his approaching end in the outer world and not in his own illness. Thus the pleasure-principle overcomes the reality-principle.

Jelgersma notes three conflicts of outstanding importance, centring round the patient's admission to a mental hospital, his bodily invalidism, and his mental dissolution. These three conflicts are resolved simply by repression and the denial of reality. The pleasure-principle seems to be the guide to the thinking of these patients. But some cases where the content of the delirium produces very unpleasant feelings and where anxious situations are experienced seem to show the influence of the compulsion to repetition rather than the pleasure-principle.

The fate of the instincts and the libido distribution in old age are then discussed. The libido is withdrawn from objects in the outer world and directed on to the self, with increase of narcissism. Old people show indifference about the fate of others, and increased interest in their own bodies - in the functions of eating, drinking, sleeping and the bowels. The oral and anal libido is strengthened. A quantitative reduction of libido is also probable in normal old people.

In senile dementia there is an even more extensive

withdrawal of libido from outer objects, and a continually increasing reduction in quantity of libido. The difference between the regression in senile dementia and in schizophrenia is partly one of quantity of libido, which does not appear to be diminished in the latter.

All senile dements whom Jelgersma questioned showed indifference towards the idea of death. He suggests therefore that the ego and self-preservative instincts also diminish gradually. Finally he makes the statement, which is quite contrary to my experience, that few, if any, delusional phenomena follow repression or withdrawal from reality in the case of the senile mind.

The alleged indifference to death is another point I am strongly inclined to doubt. Direct questioning seems hardly a satisfactory method of enquiry, and apparent indifference on the conscious level may represent nothing but a successful defence against underlying unconscious fears. Apart from this, my observations agree fairly closely with those of Jelgersma.

I am not aware of any other psycho-analytic work bearing directly on the senile psychoses. Mention must be made, however, of the work of Hartmann (12) on disturbances of memory, particularly in relation to Korsakoff's psychosis. His method of investigation was to read to the patients short stories of two

kinds, some being affectively of an indifferent character, while the others were calculated to arouse unpleasant affects in the patients tested. These latter had often quite a direct bearing on the patient's own life, for example on his alcoholic habits. It was then found that the indifferent stories were much better reproduced than the unpleasant ones. It thus appeared that the pleasure-principle and repression play a definite part even in memory defect of organic origin. I have applied this method on a small scale to senile patients, with results to be reported later.

Another piece of work which must be mentioned is that of Hollos and Ferenczi (13) on general paralysis of the insane, for the theoretical considerations of Ferenczi would seem to apply forcibly, with certain modifications, to senile dementia. It would take too long to summarise Ferenczi's theories, but the following extracts will give some idea of the general tendency.

"Our hypothesis now is as follows: The metaluetic brain infection, by attacking the central organ of the ego function, provokes not only symptoms of defect, but also disturbs as a trauma would do the equilibrium of the housekeeping of the narcissistic libido, which then makes itself felt in the symptoms of paretic brain disorder."

"If self-observation sends the report to the Ego Nucleus that not only important bodily capacities but

also the highest psychical capacities are being ruined, the Ego Nucleus replies to this loss in individual values with the particular depression here briefly described. If however the pain of this becomes intolerable, and it usually will become so, then the way lies open to narcissism to regress to periods of development, which in spite of their primitivity were once just (perhaps better rendered "acceptable") to the Ego-Ideal."

"If the Ego Nucleus (and its functions, self-preservation, knowledge, etc.) remains relatively exempt from displacement, then the enormous decline in the most various bodily and psychical capacities must draw after it strong psychotic reactions; but if, together with this general psychic deterioration, Ego criticism also fails, the disease will apparently present the picture of simple deterioration."

II. General Remarks.

From the foregoing brief outline of the outstanding work that has been done in this field, it would appear that the psychotic manifestations found in aged people have probably received less attention from the clinical psychologist than any other group of psychoses. There are no doubt good reasons for this state of affairs. In the first place, they are perhaps of less practical importance than psychoses occurring at an earlier age, since the patients have in many cases

already retired from the more active struggle of life, and their insanity has therefore a less dramatic effect on their social environment.

But more important in determining the psychiatrist's attitude is the fact that senile dementia is an "organic" dementia, with obvious pathological findings in the brain. It is on this account, I think, that work on the subject has been left very largely to the pathologist. It is felt that we have here a condition which can be adequately explained on an anatomical basis, and that there is therefore little or no room left for psychological investigation. I believe this to be a mistaken view, and would rather see here one of the more promising lines of approach to the fundamental problem of the interaction of body and mind.

It need hardly be pointed out that senile psychosis is no more a disease entity than physical disease of the senium. It is a collection of very heterogeneous conditions, and it is necessary in the first place to define what we are discussing. This means drawing somewhat arbitrary lines, and I propose to rule out any psychosis commencing before the age of 60. After this age a certain amount of mental deterioration is so common as to be almost within the limits of the physiological, and it is this involutional deterioration which I take to be the hall-mark of senility in the mental sphere. It is true that we

find psychoses commencing after the age of 60 which appear to be identical with the schizophrenic, paranoid, or manic-depressive reactions which occur at an earlier age, and with no signs of dementia; and it is very probable that some of these should not be classed as senile psychoses. Nevertheless, even in these cases it is pertinent to enquire why the psychosis did not appear earlier, and if it is not really connected somehow with the approach of senility.

There are some practical difficulties in the approach to senile patients from the point of view of modern psychopathology, particularly in the case of institution patients such as those upon whom this study is based. It is quite unusual to find relatives who can give any reliable account of the patient's early life, for the parents are of course always dead, and brothers and sisters and husband or wife are often either dead or too infirm to undertake a visit. One has therefore to rely on the information which the children or friends can give, or in many cases on nothing but the patient's own story. Apart from this difficulty, the time elapsed is itself so long that memory is uncertain. The usual methods of psychiatric investigation of the personality as well as of heredity are therefore difficult to apply, and one is thrown back almost entirely on the study of what the patient says and does, and must interpret that as best one can.

This paper is based on the observation of some 1,000 patients, both male and female, who have been under my care at one time or another in Tooting Bec Hospital. This is a hospital which the London County Council has set aside for the reception of senile patients. Non-certified patients of over 70 years are admitted, and a large number of certified patients of a chronic character are also received, many of the latter coming from other institutions. The great majority of the patients in the hospital (some 75%) are over 70 years of age.

From such a large number of patients one obtains certain broad general impressions which are of some value. To obtain any real insight I believe it is necessary to concentrate on a few cases, but I have endeavoured to select those which appeared typical, or at least showed features common to a number of other cases.

When one observes a large number of senile psychotic patients, the first thing that strikes one is that many are not, in the ordinary sense, psychotic at all, but are really suffering from varying degrees of general intellectual deterioration - that is, from pure senile dementia. At the other end of the scale one finds patients who show none of the ordinary signs of dementia - they are perfectly orientated for time, place, and person, their memory is quite good, in some cases much better than the average, and they

can give a perfectly coherent and rational account of themselves - but on the other hand they show a marked degree of psychosis of one kind or another, commonly with delusions. The majority of the patients, however, if examined carefully, will be found to lie somewhere between these two extremes. They show a certain amount of dementia or at least some deterioration of the mental powers combined with true psychotic manifestations. These are what I should regard as typical cases of senile psychosis, as distinct from pure senile dementia.

In order to obtain a more definite idea of the actual numerical relations between these different classes of senile patients, I have carried out a survey of 207 male cases and 204 female cases. These represent a fair sample of all the patients in the hospital whose illness began after the age of 60 and who were never previously certified, but I have eliminated those who are here only on account of physical feebleness.

The following are the results, expressed as percentages. "Dementia" includes arteriosclerotic dementia.

	Males.	Females.
Dementia without Psychosis	49	46
Dementia + Psychosis	40	42
Psychosis without Dementia	11	12
Total Dementias	89	88
Total Psychoses	51	54

It is extremely difficult to estimate how many of the cases of dementia were arteriosclerotic in origin. I have counted as arteriosclerotic only those in which there was clear evidence, apart from the dementia, of cerebral arteriosclerosis, the evidence consisting generally of focal signs. Such cases numbered 13 out of the total 101 male dementias without psychosis, but only 3 out of 93 similar female cases. It is true that a considerable number of the other cases of dementia were probably largely due to cerebral arteriosclerosis, so that we have here no index of the relative incidence of arteriosclerotic dementia compared with the simple form; nevertheless, the relative number of male and female arteriosclerotics does point to a very real predilection of the disease for the male sex.

Apart from arteriosclerosis, it will be seen that the figures are practically identical for the two sexes. Nearly 90% show evidence of dementia, and rather more than 50% have psychotic manifestations. It is admittedly difficult to say whether a demented

patient is really psychotic, and a good deal must depend on the personal factor of the examiner. For example, if a patient of 80 years tells us he is 40, he came here this morning, and the ward is a workshop where he works every day, are we to say he is merely demented, or does he suffer from delusions? I am inclined to think that no hard and fast line can be drawn between the two, but I have included doubtful cases of this sort rather among the pure dementias than among the psychoses. There is no doubt, also, that more careful investigation than is possible in routine examinations would reveal an even greater number of psychotic manifestations in the form of carefully concealed delusions, hallucinations, etc. It follows that the figure of 50% of psychotics among all the senile patients is a very conservative estimate. I think this high incidence has not previously been sufficiently emphasised. From the textbooks one gains the impression that most senile patients are merely demented; an occasional case has delusions or hallucinations, etc. This is quite erroneous, though it must be remembered that admissions to a hospital are a selected group, and the psychotic patients tend to require removal from home more often than simple dements.

In speaking of psychosis, I refer to conditions which, occurring in a younger person, would be so described. Whatever be the ultimate definition of

psychosis, its recognition is at present at least a purely clinical matter. One recognises it without being able to define it accurately. Some of the ordinary formulations would certainly include many cases of dementia, which frequently show complete lack of insight and failure to distinguish between phantasy and reality. In this sense/dementia should perhaps be included under psychosis, and certainly it merges gradually into psychosis. My separation of the two is at present purely descriptive, and really corresponds roughly to intellectual disturbances on the one hand and affective disturbances on the other.

Owing to its history, developing as it did from the study of the psychoneuroses, psychopathology is much more at home among the latter than among the former class of disturbances. So much is this the case that some would probably deny it any place or value in the study of intellectual enfeeblement. But after some forty years of psycho-analytic emphasis on the unconscious and on libidinal factors - emphasis which was necessary because they had been previously quite neglected - attention is now being turned increasingly to the ego and the intellectual functions, whose importance has never been called in question by Freud.

Let us consider first, then, the psychoses of the senium. I shall make no attempt at rigid classification, which would give a very misleading impression of

this somewhat miscellaneous group of conditions. It is true that one occasionally meets with fairly typical manic-depressive or paranoid cases, and more rarely even schizophrenic forms, but these are the exception rather than the rule, and atypical forms are much more usual.

The commonest psychotic manifestations are: (1). Persecutory ideas in the widest sense. They vary greatly in form and degree, and at the lower end of the scale of intensity they merge into normal grumbles about insufficient or unappetising food, noise at night, or enforced captivity. Then there are ideas of having been kidnapped and plotted against by relatives who have stolen the patient's money. At the other end of the scale are the most intense and painful states of apprehension and terror, often of would-be murderers, who appear in the form of auditory and visual hallucinations, and attack the patient by poisoning his food, blowing gases on his bed at night, or accusing him of having committed a crime, or of being diseased. Many patients complain that they are "knocked about" at night. Some make attacks on their supposed tormentors, who may be identified with the patient in the next bed or with the nurse. The commonest idea in the more fully developed cases is that the patient is going to be murdered. The patient himself is often accused of having committed a murder, typically of a child; or else he is accused of sexual

immorality of all kinds, and of being infected with venereal disease. There is nearly always an indignant denial of these charges.

(2). Depression of varying degree. Very severe depression is rather uncommon, for the affect of the senile patient is typically labile. He is easily moved to tears when he thinks about himself and his unfortunate condition, particularly when the persecutory ideas just mentioned are prominent, and a moderate degree of dull depression is very common, but one has the impression that the patient is somewhat apathetic and does not feel very keenly the depression which he shows in his expression and his tears. Apart from actual cases of paralysis agitans, which are not infrequent, and are often combined with depression, lesser degrees of the Parkinsonian facies are quite common among these depressed patients. Others show a more typical melancholic facies. Agitation and restlessness is very common and may reach an extreme degree, more particularly in patients who have also persecutory ideas. They feel they must get away, and are continually getting out of bed and wandering about in an aimless way. I am not in a position to make any statement about the frequency of suicidal ideas and attempts, as seriously suicidal patients are excluded from Tooting Bec Hospital.

(3). Hypochondriacal ideas and delusions. These most

frequently concern the bowels, and they are very common. Indeed, it is astonishing how many otherwise sensible patients will tell one that their bowels have not moved for a week, when there is no foundation whatever for the statement. Less commonly there is a definite delusion that there is a blockage of the bowels, and that nothing can pass through. Other hypochondriacal ideas are fairly frequent, as that the whole body is rotten or stinking, or that the genitals are falling off - these are usually associated with the idea of venereal infection.

These three groups of symptoms are of course not mutually exclusive, but rather the reverse. The most typical picture consists of a combination of all three. It is particularly the combination of persecutory ideas with depression that seems to me to be most characteristic of the senile psychoses. The two mechanisms of melancholia and paranoia seem to be interwoven and to have modified each other. Thus, the patient is depressed and agitated, he believes something dreadful is going to happen to him, probably he is to be killed; but he denies that he has done anything to deserve this fate, though occasionally he is not quite sure. As a rule, however, he has no feeling of guilt or unworthiness, believes himself to be unjustly accused or attacked, and has a grievance against someone, from whom he desires to escape. On the whole, the mechanism of projection is more favoured, but there is all the

time the tendency to introjection, depression, suicidal ideas and hypochondria. The projection seems to function as a defence mechanism against this.

Confusion is another very common symptom, but belongs rather to the symptoms of dementia proper.

Other types of reaction are distinctly less common. A small group of patients shows elation, and quite a considerable number have ideas of grandeur, often of a grotesque nature.

In order to obtain a rough idea of the relative frequency of the commonest types of reaction, I have made an analysis of the case papers of the psychotic patients mentioned above (106 male and 111 female), with the following result:

	Depressed.	Persecuted.	Hypochondriacal.
Males	23%	57%	24%
Females	31%	47%	18%

It will be seen that there is scarcely a significant difference between the male and female figures. There is probably more tendency to persecution in the males, and to depression in the females. This corresponds also with my general impression.

III. Case Reports and Commentaries.

The following material taken from case histories is illustrative of some of the commoner types of psychotic reaction.

Case I. Mrs. W——. Aet. 76.

A very miserable, depressed and solitary old woman, who is partially blind from bilateral cataracts. She was apparently perfectly well mentally until her admission two years ago, but she has no friends, so that details are lacking. She has been in the present condition since admission. She always sits alone, apprehensive, often muttering to herself, and disinclined to converse. She has a pronounced stutter, especially when excited, and the following is a typical example of her conversation.

"Th-they're n-not g-going to m-murder me, now then! (How did you think they would do it?). They are going to cut me up and burn me. They are going to take out my organs. (What organs?). You're a doctor, you know what organs. I am not going to be murdered, to have my insides taken out. If I'm going to be killed, why don't you take me down to the courtyard and shoot me and be done with it? No, they're not going to burn me either. They put things on my bed and burn it at night."

"They say I'm mad. They're all down on me. The action has been stopped. (What action?). The back passage. If the bowels are stopped, what is the consequences? That's the cause of a good deal."

"I didn't think I was coming to this end - to this sort of thing - to be murdered, and it's not a natural sleep, that's certain. My sleep isn't like

it used to be. It is strange. They seem to say I talk and I do all sorts of things."

"I had a touch of paralysis, and my mother died of paralysis. That's how I came into the Infirmary over there. Bronchial is another thing I had. I got over that splendid - that was four years or more ago."

"Why don't you take me downstairs? I don't want to be up here and knocked about and made a laughing-stock of. Why, this is terrible. All this steam and boiling water and freezing in the ward, taking my head out and my chest. They say I say all this. How could I get out of bed and talk like that? - its an absurd idea."

"My face is not the same as it used to be - it don't feel the same. It's as if I was bilious. They're taking out wrappers - sheeting - out of the body - when you're born, I suppose, Stockinette, then. Well, that's very fine! They are taking these things out of my body. (Baby wrappers, is it?). Yes, stockinette, I suppose it's called. That is stockinette, on my thumb - fine, tiny spots, fine as fine can be."

"They say I look like the Devil and all that sort of thing. It's dreadful. I don't want to be killed. Lusty, they call you. I'm as lusty as ever. I don't do that sort of thing."

As regards intellectual defect, it is difficult to estimate, as the following report of an examination

will show.

Before any questions were asked, she began spontaneously:-

"They're going to kill me. They've been working on me. (How ?). Taking the body out, freezing and all this nonsense. Oh, I shan't say any more." (Where are you ?). Tooting Bec Hospital. (Date ?). I don't know what dates are now. (How old ?). You know. I don't know, then I'm sorry to be so abrupt."

"(How long here?). About 18 months (correct). Someone said 10 years. And why cannot I have anybody to come and see me, that's what I want to know!"

(Remember address - 138 Hamlet Gardens, Ravenscourt Park).

(After 3 minutes conversation). "138 Hamlet Gardens, Ravenscourt."

(Story of donkey which slipped in stream when carrying load of salt, then repeated performance with sponges, and instead of being lightened had its back broken).

(At mention of donkey). -"That's me."

(At mention of back breaking). -"And died."

(Asked to repeat story). "Well, there you are !. I'm being filled with water and my body's being taken out. (Story?). That's all, I don't know anything about it. Story!!" (with immense scorn).

(Melodramatic story of old man who died of a stroke on his 80th birthday). "That's what they call

a seizure. You're seized with something. My Mother died with paralysis and consumption. What's it got to do with you, my life?. Why should I be tortured?. (Story?). I don't know anything about that story. (Address?, after 10 minutes). 186, no, 138 Hamlet Gardens, Ravenscourt. Well, then, Park."

This case is a good example of that mixed clinical picture which seems to be somewhat typical of senile psychoses. In the first place, there is a mixture of psychosis and dementia. The dementia is of a peculiar type, and one is tempted to call it pseudo-dementia. Thus, retention is quite good for an address, but when it comes to repeating the gist of a story, the patient fails completely. I think it is clear in this case that the failure of reproduction is not so much a defect of memory in the ordinary sense as a refusal to think about the subject and a denial of all knowledge of it. There is a strong tendency to refer the story to herself, and I believe that this helps to explain the difference of reaction to the address on the one hand and to the stories on the other. She also denies knowledge of the date and of her age, though she has a good idea of how long she has been in hospital. These topics will be more fully developed later in the section on Dementia.

The psychosis itself is also mixed in type.

Ideas of persecution and influence preponderate, yet the general impression the patient makes is that of melancholic depression. She is very unhappy, solitary, weeps a good deal, and has the melancholic facies She believes something terrible will happen to her, that she will be murdered; indeed, she believes that these things are already happening to her. Thus, we get many hypochondriacal delusions. The action of her bowels has been stopped. Her sleep is unnatural and is evidently equated with death. Her face feels different, she is being frozen, she is having things taken out of her body.

But instead of accepting all these things as the just punishment for some misdeed, she rebels violently and considers herself grossly abused and illtreated. Everything is attributed to activities of vague persecutors, whom she calls "they" and is unable to specify more exactly. It is true, she is accused of misdeeds - hallucinatory voices accuse her of being "lusty" and of doing "all sorts of things" - but these accusations are indignantly denied. The bad people are all in the outer world. There is a suggestion of insight into her projective mechanism. - "They say I say all this. How could I get out of bed and talk like that - it's an absurd idea."

Passing to the content of her delusions, it is to be noted that they are chiefly concerned with the idea of being murdered, this idea being elaborated in various

ways. The elaborations are bizarre and phantastic, and bear a very striking resemblance to well-known infantile phantasies. Thus, she believes she will be burned, cut up, have her internal organs torn out, have her bowels stopped up. These correspond very closely to some of the infantile anxieties that have been described by Melanie Klein (14) as being the most terrifying, particularly for the female child; they represent the punishment for phantasied attacks on the mother. This patient says. "If I'm going to be killed, why don't you take medown to the court-yard and shoot me?." She has also requested the Medical Superintendent to do this. Evidently "shooting" (which we may take to represent symbolically the father's form of aggression) is preferable to the torture that the mother inflicts!.

The idea of things being taken out of the body is evidently connected with birth phantasies ("when you're born, I suppose"). The connection of birth phantasies with ideas of death is one which I have found in a number of senile patients, and it is of some importance, I believe.

Burning is, as always, in my experience, associated with the bed, and it is quite clear from a number of my cases that it refers to urinary phantasies connected with bed-wetting.

The following case, though very different on the surface, shows some interesting resemblances to the

to the previous one.

Case 2. Mrs. Katherine R——. Aet. 84.

Admitted at the age of 81. She was apparently not markedly abnormal until about this time, when she began to lose her sight from cataract, for which she was advised to have an operation. She refused operation, as she was afraid she might die.

She is now almost completely blind. She can just perceive light with the left eye.

She is continually persecuted in bizarre ways which may be described as anal, urethral, and oral. She is very suspicious, particularly at meal times, as she is convinced there is a conspiracy to poison her, and she always examines her food carefully with her hands and keeps them over her plate throughout the meal lest anyone should put any "soil" on it or squirt "petrol" on it. She complains of being starved, and that the food is made filthy in many ways by the nurses. She says Queen Mary sent her ½ lb. of sweets, which the nurse took, substituting a pennyworth, wrapped up in lavatory paper.

At night, petrol is squirted on her bed with a syringe by her nephew Dan (her father's name!). In order to prevent this, she says she has a fire-alarm under her bed. Sometimes there is a fire, and one night she got out of bed and "outed" it four times. She has also a brother called Dan ("big Dan"), who also persecutes her. When asked if he too squirts

with a syringe, she said "Don't be silly! Dan is the father of thirteen children, and he has more sense than to squirt with a syringe."

Asked her age, she replies, quite correctly, 84 or 85, but adds "I'm looking forward to live to be as old as my aunt, who was 202 when she died the other day. Laurie ripped her stomach up with a paper-knife. She was an old lady of 202. When she came here Danny hit her on the head and she fell down, Big Dan and little Dan did. The night before last, that was. She was taken very bad through that, and she went into a trance. They thought she was dead, but she wasn't dead at all." She states also that her father's sister is 104 years old. Her father's brother left £90,000,000 and this should come to her. If she could get out and get this money, she would have a good feed, a quiet life, and go to church.

She is quite well orientated for time, place and person, but retention is much impaired, and she is unable to remember a simple address for more than about a minute.

She made some attempt to reproduce the stories. (Donkey story). "It's like an Irishman going over a bridge with potatoes, and the horses couldn't get over the hill, so he put the bag on his head to lighten the load. (The story?). "About a donkey that had salt on its back and got into the sea, and

the salt was resolved. The salt was melted, of course. I didn't think about nothing like that in my head. If I read it half-a-dozen times I'd remember it."

(Old Man Story). "I suppose the blow killed him in his 80th year. He dropped dead. Fancy that! only 80 years of age - that's young, isn't it?" (You think so?). "It isn't young, of course. I'm 84, past his age. (The story?) "About an old gent of 80 or 81; he had candles all round, he lit them all, and the last one he dropped dead"(she laughs). (Why do you laugh?). "Why, because I've got nothing to cry for just now - I don't feel up to it. I feel a good steak pudding would do me good, something substantial."

Here we have again marked persecution, but this time with a distinctly manic type of reaction and ideas of grandeur. Many of her statements can scarcely be regarded as true delusions, but rather as extravagant phantasies, which she takes a great deal of pleasure in playing with. Nevertheless, her behaviour is greatly influenced by her ideas, and there is a profound loss of reality sense.

There can be no doubt that loss of sight plays a very important part in this psychosis, facilitating all kinds of suspicions and delusions. Indeed, it seems more than likely that the development of her cataracts, with the idea of operation and the fear of death thereby aroused, represents the exciting cause or trauma which led directly to her illness. Unfortunately, there

were no available outside sources from which corroboration could have been obtained.

The fear of death has been so thoroughly dealt with by projective and manic (denial) mechanisms that it appears no longer to exist. She is sure she will live to be 202, in spite of all the attacks and murderous attempts made upon her.

It is interesting to note the different rôles played by oral, anal, and urethral elements. Food is very much in the foreground of her interests, and it is regarded as something good in itself, but continually being spoilt by her persecutors - and spoilt in anal and urethral ways. Either "soil" from the lavatory is put on it, or petrol is squirted on it from a syringe, or the nurse substitutes an inferior article and wraps it up in lavatory paper. Good things are sent her by various exalted people - Queen Mary, "Lady Crauston", the Admiralty, etc - and they are always made filthy by Nurse R--- before she receives them. Queen Mary also dries the bed at night after it has been squirted on, and she is evidently a "good" mother figure, Nurse R ---, of course, being a "bad" one.

The memory tests show poor retention for addresses, but relatively good reproduction of the stories. The manic tendency comes out, however, in the manner of their reproduction. Only the happy part of the donkey story is remembered, and although she gives a very

good account of the "old man" story, it is all used to point the moral that she is not going to die. Finally she laughs at the idea of death and says she feels a good steak pudding would do her good.

The degree of dementia in this case is relatively mild, especially having regard to her age.

Case 3. Mrs. Marion H——. Aet 74.

This is a case of profound depression and agitation with attempted suicide, and without appreciable intellectual impairment.

History (obtained from daughter).

She was the youngest child of a prosperous house decorator. There were three brothers, two of whom became schoolmasters, and two sisters, who married well. The patient was considered the social failure of the family.

Her father died at the age of 55 when the patient was 6 years old. Her mother lived to the age of 72. There is no history of insanity in the family.

The patient had a good education up to the age of 17, and became a pupil-teacher. At about 19 she married a schoolmaster who was addicted to drink, lost his job and became a private detective and a Salvation Army Officer, They were always poor and he died young, leaving her with eight children, aged from 3 to 15 years. She had a very hard struggle, supporting the family by "charring", and the children all went to work at 11 or 12 years of age. About

this time she was told she had heart trouble - she used to have attacks of pain in the chest, combined with bilious attacks, and would have to lie down. She showed no particular depression or concern about her health.

She was perfectly preserved mentally until 5 years ago, and her advice was sought in all family decisions. She lived with a married daughter, (informant).

About 5 years ago she had an attack of herpes zoster, which terrified her; she thought she would die, and that perhaps she had cancer. Following this, she began to have attacks of depression, and would often say that she wanted to die and couldn't. She became self-centred and showed a certain lack of judgment, but her memory was unimpaired.

A little later she attempted suicide by gas poisoning. Discharged after a short period in the infirmary, she became much worse, agitated, restless and troublesome, expressing ideas of being burnt and of constipation, and saying the Devil was after her. She was finally re-admitted to the infirmary and transferred here.

Physical Examination.

Nothing abnormal found, apart from some chronic bronchitis and emphysema, and a blood-pressure of 190 mm. systolic, 110 mm. diastolic. There is no sclerosis of superficial arteries, and no symptoms

or focal signs indicative of cerebral arteriosclerosis.

Mental Examination.

She appears dull and depressed, but in a passive, apathetic way. She does not show the affect one would expect from her words. She often plucks at her apron, but/not, is actively agitated. Her mental condition varies considerably from time to time. Usually she is profoundly depressed and full of delusions of a melancholic and hypochondriacal type. Occasionally she has short periods of remission, when her affect is less depressed and she can give fairly rational grounds for being somewhat unhappy.

The psychological content is very rich in material, some of which is very obscure from the psychopathological point of view. Only a few samples can be reproduced here.

Her ideas are nearly all connected with death. The main theme is that her mother was a cruel and wicked woman and on this account her children were abnormal. Twin sisters were born before the patient and they died because they had no back passage. She believes that she is the same, or at least that there is some impediment so that she is unable to pass anything. She has heard it said that her mother ought to have got rid of her on this account before she was born. She is different from everyone else and has always wanted to die. She ought to have died years ago, but she can't. She has had pneumonia and

diphtheria twice and didn't die, and she is a curse to everyone because she lives. Death will never come to her unless she is destroyed, preferably by fire. She wants to go home and kill herself, otherwise she must suffer a worse death.

She ought not to have had any children, for the same destiny awaits them. When her son was killed in the War, she doesn't think he died - they must have buried him alive. The shock of being in battle must have made him go unconscious and they must have buried him alive.

The following are a few extracts:-

"I have been suffering a lot. I have plenty of troubles." (What are they?). "I don't understand them. I am puzzled about my parents." (What about them?). "My birth, sir. I didn't think I was normal. I think I was born the same as the other children born to my mother - not perfect in the --- not as they should be. They were born before me. They died. They had no passage. They couldn't pass anything."

"I want to die but I can't. I think I ought to have died years ago. If I had known what I know now I'd have committed suicide. I am perfectly sane. I have senses enough to hear what they say, and I know that they died. They die properly (referring to other patients in the ward). I don't think I shall ever do that. I'll have to be killed." (How?). "I'll be burnt. I'm sure I'll never die a natural death - positive."

"I wish I could understand life." (What about it?). "The end of life - death. Death will never come to me unless I am destroyed. It's not that I'd ask anyone to destroy me, I'd do it voluntarily. The harm done through my birth - I don't think I was ever meant to live. It's too terrible for me to think of."

"It came to me in the night. It seemed that I should have to be destroyed by fire and all my children. It seemed as though that was the destiny that it was to be. It was between my father and mother and the Birth - I ought not to have been born alive, that's all I can say."

"I was not born to have life at any cost, but I was to be like my two sisters. Ever since I can remember I have had great difficulty in evacuating anything. Sometimes I would take eight pills of a day. I never had a child delivered naturally - I was always two or three days ill and then instruments. The last one I was nearly a whole month."

"My sisters said our mother is so damned wicked, they didn't wonder she had children like that, she gives way to her temper so. I was very frightened of her."

"Mother said I'd have to be burnt alive because I'd never be at rest, It was her responsibility and she passed it on to me, and I'm passing it on to my children."

"I've seen children born very funny, and they

always told me that was the sins of the fathers and mothers. You couldn't drown yourself because you wouldn't sink in water. The rescuers might get drowned and you might be saved. Albert (her son) came home to me that night he was killed."

Intellectually she is very well preserved, if one disregards certain inconsequent contradictions in her delusional ideas. Orientation is perfect and she can give an excellent account of herself in her more lucid periods. Her memory for addresses is very good, and she repeated the donkey story perfectly, grasping the point of it at once, The response to the "old man" story was interesting. After the last words, "had a stroke and died", she said "I wish to goodness I could." When asked to repeat the story she told it very well until the end, when she said "and he had a stroke", then whispered to herself "I wish to goodness! What a place! (Anything else?). "Only that he was excited and thought a lot of his good health." (Nothing else?). "He had a stroke - and died, of course, he died. That was very fortunate for him, wasn't it ? He didn't have to suffer any more."

Asked about memory - "I seem to remember more about my younger days, because I get worried."

In this case, ideas of death are so obvious and important as to need no emphasis. Again we have a denial of death, this time a very paradoxical

denial. She is convinced, she says, that she can never die a natural death, that disease cannot kill her, because, as she once said, she has not enough vitality; the doctors told her that her vitality was too low for her to die of disease! Therefore, as she ought not to live, she must die a violent death, and she oscillates between the idea of drowning herself and of being burnt alive. But if she drowned herself she would float. This seems to imply that she regards herself as a witch and therefore burning is the appropriate form of death. The idea of being burnt is much over-determined, however. She was very impressed in the Salvation Army by threats of hell-fire. Also, she used to hear her mother telling her father that he drank himself to death and that she would set fire to him with a match. Ultimately, no doubt, the two ideas of death by fire and water are connected with urinary phantasies, as in Case 2.

It is clear that there is a very close psychological connection in this case between ideas about death and phantasies about birth. Her two sisters were born imperfect, with no passage, and they died. She was also born imperfect, therefore she should also die. The imperfection itself is also connected with phantasies about birth, for it is clear from one of the sequences that these are anal in type, difficulty in evacuation of the bowel being equated with difficulty in labour. Her own and her sisters' abnormality is attributed to her mother's cruelty and aggression. There is no answering hate and aggression on her own

part towards the mother. After describing how her mother used to tie her to the bed and beat her with ropes, she remarked: "She wasn't altogether kind to us." The fate of her own aggression is clear - it is turned inwards on herself. She ought to have died years ago, or never have been born; she and her children ought to be burnt alive, for she is handing her destiny on to her children, and they are also abnormal. Thus we have evidence of identification with the "bad" mother, and this explains how the aggression which should apply to her is turned upon herself, with resulting melancholic depression. One would surmise, of course, that the alleged aggressiveness of the mother is largely the product of the projection of the child's own aggression, but about this point evidence is wanting.

From the "talion principle" it seems likely that anal aggressive phantasies played an important part in infancy, so that as punishment her anus is closed up; but I think this punishment results also from the wish to close up the mother's anus so that no more children can come out of it.

In this case, then, aggression is dealt with by the mechanism of introjection, and a melancholic depression results.

Case 4. Mrs Rebecca A ___. Aet. 75.

This patient does not really come within the scope of this paper, as her illness began at the age of 52

and has continued ever since; but the case is in some respects illuminating.

No information is available as to how her illness began. Since her admission to Tooting Bec two years ago, she has been in a condition of chronic mania, with a happy though fatuous expression, some restlessness, and marked flight of ideas, so that it was difficult to record what she said. Her husband is dead and no relatives visit her.

I heard her one day talking to herself about everlasting life and saying she would never die. She said she was very ill once and thought she would die, but it was the change of life. She was born in the Tuileries Palace to the Duke and Duchess of Westminster, in the direct line. She talks to her husband and says she married her father. She crochets caps and puts them on her head to indicate that she is a queen, and on one occasion when her cap was taken away by an over-zealous official, she became very miserable and would not be comforted till she had it back.

On another occasion she began talking about the change of life. "About 50 years old it sets in, with haemorrhage. You take a purging draught and it takes it away - it passes through the W.C. - tiny wee children pass through. They pass through in the pans. There were seventy yesterday, tiny wee ones. They make human nature out of animals and feed them with them - they use the insides to bring on childbirth - its

wonderful. There's to be no more death - only a trance. Isn't it a wonderful institution?.... My husband lives in No. 40. They say he's a king and I'm a queen. They've been giving me £1,000 a year. My brain's rather funny - change of life..."

"They say it's only a superstition - they don't die, they put them under grass. Isn't it wonderful - oh! wonderful!... There was a husband who passed away, but they say he came to life again."

Asked her age, she replies "Fifty-two," that is, the age her illness commenced.

Clearly, this is an involutional case in which the menopause must have played an important part. Everything that has happened since then is simply wiped out as far as she is concerned and she has gone right back to childhood phantasies - she is married to her father, who is a king and she is his queen, and she produces seventy children every day in the W.C. Nobody ever dies - it is only a superstition. In short, she denies everything unpleasant - that she is an old woman past the menopause who can have no more children, whose husband is dead, and who must die soon herself.

On the surface there is no aggression here, for there is no need for it. She has everything she wishes for, everything she is really denied. This is the result when the mechanism of denial is completely successful, but at times one sees traces of underlying depression and persecution. Thus, when her cap, the

visible emblem of her royalty, was removed she became tearful and depressed; and she once complained that they give her none of the Government money - they do her out of £1,000 a year.

This patient is evidently considerably demented, but owing to the distractability of her attention and her flight of ideas, the intellectual functions could not be satisfactorily tested.

Case 5. Henry B——. Aet. 82.

History (obtained from son-in-law, who had known him for 30 years):

There is no history of insanity in the family. Both parents died when he was young. He would not go to school because he always stuttered and was laughed at. He has stuttered all his life, but it is much better now than formerly. He was rather excitable, but not of a worrying nature.

Up till recently he appeared quite normal. He was quiet and of temperate habits, and very keen on his work, which was formerly harness-making; later he worked as tent-maker and as packer. He left his work 3 or 4 years ago, and it was then that he started to break up and to become queer mentally.

He lost his wife 30 years ago, and missed her a good deal, but got over it and devoted himself to his two daughters, of whom he was very fond.

For some years he had complained about trouble with his water. Later on, he started threatening to

do away with himself, and one morning he was found on the side of a canal and said he was going to jump in. He said he was not fit to live, that he had some rotten disease. He was sent to Bethnal Green Hospital, where he became worse, and would say that he was going to be cut up and they were going to stew him. Opposite his bed was a chimney from which steam issued all day, and he said they were getting up sufficient steam to cook him.

All his life he was extremely clean, and would never sit down to table without washing his hands. He worried a lot about venereal disease, and was thoroughly examined at St. Paul's Hospital, with negative results. He was not satisfied and still says he is infected, and that maggots crawl out of him and attack the other patients. He also talks about being the father of cats and dogs, and being responsible for their death.

Physical examination reveals nothing beyond the ordinary evidences of senile deterioration natural to his years.

Mental examination. He is a morose, reticent, depressed and introverted little man, who likes to sit in a corner by himself, with face averted, and to pick the skin off his fingers. He shows some signs of agitation. He is unwilling to converse and is retarded.

He is very worried and apprehensive, evidently as

the result of hearing hallucinatory voices, which make accusations and threaten him with various punishments, but chiefly with castration or blinding, which seem to be quite synonymous for him. Sometimes he admits responsibility for the crimes, at other times he repudiates it. He is supposed to be the cause of all the sore backs in the ward, to be infected with syphilis, to have murdered a child, and there is also the delusion already mentioned about dogs and cats. The following is an example of the form taken by his delusions.

"They say they're going to give me a bath, and then I'll lose my eyesight. If they cut me, I will. I'm in proper danger here, I am. I wish I could get out of it. (What's the matter?) I've had a bad disease (he shows his genitals). It's here - kind of a pox or something like that it is. I got it sitting on a W.C., I think. It keeps on going, this complaint. I feel like little lumps down there, little spots. (What are you afraid of?) I don't want to lose my genitals. I don't want to lose my eyesight. (How will that happen?). They will take it off. I hope they don't do it to-night. I don't know why they want to take it off at all. It will be semi-blind, won't it? I don't want it. I shan't be able to see to do anything, shall I? They won't take take my legs away, will they? They'll only take one thing away. I don't want them to take it off."

Examination of the memory function gave the following results.

(What is your memory like?) "All right." (How long here?) "A year, about 9 months, 10 months, something like that." (5 months).

(Name of place?) "Tooting." (Tooting what?) "Hospital. If you'd give me a dose and do me in!"

(Given adress to remember - 138 Hamlet Gardens, Ravenscourt Park).

"I don't remember being there. I don't remember nothing about that case. When I saw the papers - and I was surprised to see what I saw. (What was it?) It was only a lot of muck altogether, that was. (What?) Tell you the truth, guv'nor, I don't believe I done the job. I used to be very fond of children. I never thought anything like that would happen to me. Someone else did that job. (What job?) Somebody said a child was murdered. I had too much love for them to do anything like that to them."

(Address? - after 5 minutes). "Some Gardens, wasn't it? (What else?) Just a number, was it 300 and something? (What Gardens?) I forget."

(101 Regent Street).

(How old?) "82."

(When born?) "1851, 51 or 50, one of the two."

(Date today?) "Haven't seen the papers." (Month?) "Not March, is it? (May). (Year?) "1933" (correct). "I wish I was in heaven and out of it."

(Address? - after 3 minutes). "Regent Street. (Number?) 92, wasn't it? 192, was it? (45, Piccadilly).

"What do I want these addresses for, sir? I don't

know what I want to remember all these for. I've disgraced myself. I got a bad name, I know, over it."

(Address? - after 1 minute) "45, Piccadilly, wasn't it?"

(Donkey story). "About a donkey going in water with a load of salt. It broke the donkey's back, and the donkey was much lighter after that."

(Old Man story). "I can't tell. I don't know nothing about that one, sir. I don't remember anything about it. (Nothing at all?) No. (What was it about?) Something about an old man being eighty. Something about me, I suppose. If you'd let me go out, that's all I wish.

The above account illustrates the difficulty of estimating the amount of intellectual impairment in cases of this sort. It is clear that he does not do himself justice on account of his preoccupation with delusional ideas, and yet there is obviously a considerable degree of dementia, as shown for example by the absurd rendering of the donkey story. His unwillingness to discuss the story of the old man was very marked.

As in a large number of male senile patients, mental breakdown occurred only after he gave up his work on account of age. There are probably several reasons for this, as for example that general mental deterioration is the cause for retiral. Then again there is increased opportunity for introspection and speculation; but I would suggest that an important factor is the

impression made on a man by his retiral that he is done, good for nothing any more, and that he might as well be dead - the same sort of impression as that so often made on a woman by the menopause.

The most prominent feature of this case is anxiety, and it takes the form of undisguised castration anxiety. This is typical of a large group of male patients, and next to worry about the bowel function, it is the commonest way in which they express their anxiety. As in this case, it is usually combined with the idea of venereal infection, either accepted as a fact or projected in the form of hallucinatory accusations. Delusions and fears with regard to the genitals occur, of course, among the female patients also, but they are not nearly so common, or at least they are much less frequently expressed.

But other fears are also present in this case. There are more general ideas of being cut up, or stewed, there is the fear of the water in the bath, and there is the fear of losing his eyesight. At first one is perhaps inclined to consider this last merely as a symbolic expression of his castration anxiety (compare the self-blinding of Oedipus). It seems possible, however, that the converse might equally well be true - that is, the castration anxiety might be really a more tolerable substitute for other more primitive fears. This raises some very controversial problems, which it would be out of place to discuss here, but I am inclined to think that the castration anxiety of seniles is to

be regarded as a defence mechanism, and that the underlying anxieties are more primitive ones - the fear, for example, of having the whole body destroyed, cut up, burnt, or stewed. One might thus conceive of the phallus being offered up as a sacrifice in order to ensure the survival of the rest of the body. In this way, the typical anxieties of the female would be covered up and obscured in the male by castration anxiety.

Case 6. Thomas S——. Aet. 69.

History.

His mother suffered from delusions for two years before her death at the age of 60. She believed that her picture was put up on hoardings and that she was accused of being a thief. Apart from this, no other history of insanity in the family was obtained.

The only peculiarity of character that could be elicited was that he was inclined to be abnormally jealous about his wife, who is considerably younger.

About 20 years ago he had an accident at his work in a refuse destructor. His eyes were burnt and his sight gradually deteriorated. He was then put in charge of a men's lavatory, where he was once set upon by sailors, who inflicted further damage on his eyes. He claimed compensation from his employers, but the case had to be taken to the High Court before it was decided in his favour.

About 4 years ago he began to show signs of mental

illness. He became suspicious and developed ideas of reference and delusions of persecution. He said that the man who lived opposite him flashed a light into his room every night at 12 o'clock. Then he began to suspect that a neighbour several years older than himself had an intrigue with his wife, who slept in a separate room. He would hear the neighbour come out at two in the morning, clap three times, and say, "Come out, Pearl, I'm waiting for you." Later he began to be afraid that he was going to be murdered and put down the sewer. He was also continually persecuted by people accusing him of having venereal disease.

Present condition.

He is actively hallucinated, and hears voices on the telephone saying he is rotten and poxed. He believes that his wife and children are also being told this. Sometimes it is the neighbour, sometimes a doctor, who, he says, poisoned him in his previous hospital; more often it is simply "they" who persecute him in this way. He spends several hours every day shouting out of the window at these people. When examined, he shouts all the time, so that it is difficult sometimes to get a word in; and he usually becomes somewhat violent, throwing his arms about and beating himself violently on the abdomen or chest, or pulling at his genitals or flesh generally in order to demonstrate their soundness.

The following is a sample of his conversation:

I'm tired of life. I wish they would put me out of it. A man has brought a crime against me of dirty, filthy habits, and they say I've got a double disease, and there's nothing the matter with me here inside at all. They turn round and say I'm stinking and rotten and that I've got the bad disorder here (pointing to abdomen). I want you to put the tube up the front of me (pulls out penis) - you can do what you like, you can kill me if you like. Put me to sleep and don't let me wake no more, and cut me open and see if I've got any bad disease. My breath was terrible with the drugs I had in that hospital. That's what ruined my heart and made me smell so."

Later -

"Where can the rotten be - rotten, look! (he shows and pulls about violently his scrotum, penis and thighs) - rotten, look! They turn round and say I'm rotten and stinking, telling my children. I only want the doctor to shove the pipe up here and see if I've got any bad disorder. I'll tell you where my downfall is - my downfall is here, and here, where my food bag goes - my liver's gone to blazes, that's what causes me to smell. And I shall never be no good till they cut it out of me... If you're going to murder me as they said - put his eyes out, cut his head off, cut off his arms and legs, cut him in two - and if there's a murder, please stop the death certificate... If they're going to murder me, murder me in a proper manner. If they're

going to murder me and put me down the manhole and put the plate on - (What is a manhole?) You are a man of the world, you understand manholes as well as I do - Where the drain goes and all the filth is... They say I done something to a dog and to a cat. Now if you can prove I've got a dog under my heart or a cat in my stomach you can murder me at once. I've done no dirty filthy habits. (Do you mean connection with a dog?) So they say; they want to murder me."

In his calmer moods he can give quite a fair account of himself, though he shows some amnesia for recent events. He is well orientated for place, but is uncertain about time, though he can give his age correctly. Retention is considerably impaired when tested by giving addresses to remember, but the defect appeared to be largely one of comprehension. His affect is labile, and he becomes tearful when talking about himself.

Although the reaction in this case is so different, it is clear that many of the underlying ideas and anxieties are similar to those of the previous patient. His genitals bulk very large in the picture - he is continually talking about being poxed, showing them to the examiner and offering them, in a passive homosexual way, for his "satisfaction." But it seems even more probable in this case that these genital fears and reassurances are merely a façade. He reassures himself by proclaiming the integrity of his externals, his penis

and skin generally, against the real fears, of being rotten inside "where the food bag goes," and of being cut up and put down a manhole. He often admits there is something rotten and stinking inside him (his liver) and that he will never be any good till it is cut out, but he denies that it is a dog or a cat that he got there by "dirty, filthy habits" - in other words, he denies that this bad object got there by the guilty process of incorporation. Often he denies that there is anything bad about himself, and projects everything on to his persecutors. Thus he oscillates between introjection and projection, self-accusation and persecution, and so presents that mixed depressive-paranoid condition which has already been mentioned. Running through it all, in one form or another, is the fear of being murdered.

Case 7. Charles W___. Aet. 66.

On admission on 16-2-33, he gave a confused and contradictory account of himself, and had great difficulty at times in expressing himself. He said he had an accident a year ago, when he was burnt as a result of a petrol explosion, and that he afterwards attempted suicide by swallowing carbolic, on account of the pain. He showed no sign of depression at the moment. He was moderately well orientated; memory was somewhat defective.

Later, he expressed hypochondriacal ideas. He believes that the carbolic has damaged his bowels and

his throat, and that he will have to be operated upon. He says his bowels have not been open for seven days, and that he has difficulty in eating - if he eats meat it lodges in his gullet.

On 19-8-33 he attempted suicide by hanging himself in the lavatory. Artificial respiration was necessary. He expressed the determination to make further attempts.

Examined three days later (on my return from holiday) he was retarded and disinclined to converse. He said he wanted to die (Why?) "I'm poisoned from head to foot. I haven't had my bowels opened for two years. I swallowed my uvula. That makes me choke. My ears, nose and throat are no good. I can't swallow any food now. (When did you begin to feel you wanted to die?) My bowels not being opened at all. I'm rotten, sir. (What was the beginning?) The carbolic acid closed my bowels up, sir. (Why did you take carbolic?) I was so bad, sitting in the yard. I had a nervous breakdown. My wife had been cleaning the drains out with the carbolic and I picked it up. (What was the beginning of all the trouble?) When I was put off work I took it to heart so much. (When was that?) Two years ago. (What did you think then?) I thought I was no more good... (Why were you pensioned?) My age, 65. I'd like to die, I would. It's no use me living because my stomach and bowels are absolutely gone. I'm poisoned with the food I've been eating. (What is wrong with the food?) I've been eating and

eating and I've never been to the W.C.... I swallowed all my spine last Christmas. All my spine came up when I was burned with the carbolic. All my bowels and stomach is poisoned.

Here again we have the familiar hypochondriacal ideas, this time with a decidedly bizarre colouring. This is another case where the ideas of depression and of being no good seem to be connected with being pensioned off; but here again the situation is expressed in infantile, pregenital terms - he has eaten too much and can pass nothing through his bowels. In other words, there is an introjected object which he is unable to expel.

Summarising very briefly the outstanding points which these cases have in common, we may say that ideas of death and murder are very important in them all, and that they are manifested in general in two forms - denial of natural death and fear of murder. They show also a great wealth of regressive infantile phantasy in a remarkably clear and undisguised form.

In Cases 2, 3 and 4, there is definite evidence that the beginning of the illness was associated with the fear of imminent death. In Cases 5, 6 and 7, mental breakdown followed on retiral from work, in two cases owing to old age, and in Case 6 owing also to incapacity from blindness. This last case was also complicated by the prolonged litigation, which must have contributed

to the formation of persecutory ideas. It was impossible to obtain any information about the beginning of the illness of Case 1, but from the internal evidence it appears likely that fear of death was of importance here also.

IV. Psychopathological Considerations.

It now remains to formulate our findings and to attempt, if possible, to come to some understanding of the genetic development of the senile psychoses. I propose first to outline how the typical content of these psychoses appears from the psycho-analytic point of view; and then, from our general knowledge of psychological mechanisms and symptom formation, to advance a theory, admittedly speculative, as to how the symptoms may have arisen.

As a rule, the first change noticed in senescence is an alteration of character. It is true that there are elements in this change which are common to nearly all cases, such as increasing conservatism and intolerance of new ideas or change of any sort; but this is not to say, as is implied by Jelgersma (11), that there is a specific senile character. It simply means that the already existing character is intensified; the change is a quantitative, not a qualitative one. For what is character, after all, but the permanent, relatively stable and unchanging part of the ego? As Henderson and Gillespie (15) say, "There is not so much a change

in personality as a caricature of it."

Now the character is regarded by psycho-analysts as being composed largely of reaction-formations - that is, permanent alterations in ego-structure designed to serve as a defence against instinctual impulses which would be dangerous or useless to the ego (16). The psychic representations of the impulses are unconscious phantasies. Hence, if we find an intensification of such defensive character traits, we may surmise that the anticipated danger against which these defensive methods are directed is the danger that the unconscious phantasies may break through into consciousness, and that the instinctual impulses may attempt to find gratification in reality. In this first stage, then, the defensive forces are successful, and the result is merely an exaggeration of character peculiarities.

The next change to be noted in senile patients is their increasing lack of interest in external objects, whether persons or things. At the same time, their thoughts tend to centre more and more on themselves, and everything in connection with their own persons becomes invested with undue importance. In other words, libidinal interest becomes predominantly narcissistic. It seems likely that this change should be regarded as normal in old age, and if we accept Jelgersma's (11) view that there is a quantitative reduction in libido, further explanation seems unneccesary; for the narcissistic libido, according

to Freud (17), is to be regarded as a reservoir from which the object libido is drawn. If the water dries up, as it were, it is natural that it should be preserved longest in the reservoir.

This increase of narcissism, however, involves relative independence of the external world and facilitates a more or less complete withdrawal from reality.

Thus the soil is prepared for psychosis formation. It is possible to neglect the "reality-principle" and arrange things in accordance with the "pleasure-principle." Unpleasant facts can be denied, and the patient retires into the world of phantasy. The mechanism of repression is of prime importance here. This denial of reality and repression is most obvious in the manic reactions, but I have attempted to show how it operates also in the depressed and persecuted types; what they fear is not the real danger but a phantasy substitute.

Perhaps the most striking feature of the senile psychoses is the very clear way in which they show libidinal regression. There is a great increase of interest in the excretory functions and in food; that is, an increase of anal, urethral and oral libido. But it is in the phantasies and delusions of these patients that we get the clearest evidence of regression. It is unneccesary to multiply examples, for they are to be found in every one of the cases I have described.

It would thus appear that at this stage of the

illness the exaggeration of character traits and reaction-formations has failed as a method of defence, and the phantasies against which it was directed have broken through into consciousness.

Along with this libidinal regression, we naturally find a predominance of the mental mechanisms characteristic of the pregenital phases of development, notably the mechanisms of projection and introjection. They are used, of course, in accordance with the pleasure-principle. Thus, everything distasteful is projected. If a senile patient falls and hurts himself, the usual story is that someone hit him. But the most striking thing, to my mind, is that the idea of death is projected. Natural death comes from something inside, whether it be disease or "death-instinct"; but the typical senile psychotic is apparently oblivious of this real internal peril, and is convinced that he is going to be murdered by some outside agent.

Introjection is most obvious in the hypochondriacal cases, Case 6, for example. Another very hypochondriacal patient told me he had a little man inside his head who caused him a lot of trouble. It is not always easy to observe this mechanism in the melancholic cases, possibly owing to the nature of the introjected object, which will be discussed presently. The characteristic mixed paranoid and depressive picture would seem to be brought about by the combination of these two mechanisms.

There does not appear to be anything about the

phantasies, fears and delusions themselves which can be regarded as specific for senile psychosis, unless it is that they are so largely concerned with ideas of death in one form or another. Very similar delusions and hallucinations were described recently by Bromberg and Schilder (18) as being characteristic of alcoholic hallucinosis.

We have now to consider why the abnormal mechanisms we have observed have been called into play. It has already been noted that the narcissism natural to old age acts as a facilitating factor. Perhaps it may do more than this.

Regression in general is held to be brought about by libidinal deprivation, that is, by the loss of a loved object (19). Anxiety is produced by the rising libidinal and aggressive tension, which cannot be discharged. If the situation becomes intolerable for the ego, it takes refuge in the defence measures we have mentioned. Regression is one of these, and it implies a retreat to an earlier libidinal position. The clinical picture produced will depend upon the level to which the libido has regressed.

But if, as in senile persons, the libido is largely narcissistic, it is clear that the object is the self.

The deprivation or disappointment to be looked for in seniles would therefore be a narcissistic one; the lost object must be the ego. A senile dement has ample cause for such disappointment with himself - he

has only to observe his own physical and mental deterioration. Freud (20) leaves open the question whether pure ego-damage can cause a melancholic depression. Hollós and Ferenczi (13) make this hypothesis the basis of their theory of the psychic disorder of general paresis.

But what of the cases where there is no dementia, and hence no ego-deterioration? Case 3 is a case in point. The traumatic agent here appears to be not so much actual deprivation as the threat of it. The threat is ultimately the threat of death, and the fear of death is the anxiety that has to be dealt with.

It is questionable, however, whether the fear of death is something self-evident, and requiring no further analysis. I think the attitude towards death must be determined by what it is unconsciously equated with, and it is likely to be an ambivalent one. In so far as death is equated with a state of peace and complete absence of tension, it must be regarded as something greatly to be desired. But it is clear that death is liable to be envisaged in quite a different way, namely, as a withdrawal not of all pain, but of all pleasure.

This state of complete deprivation is what Ernest Jones (21) has called "aphanisis". The dread of it is the most fundamental dread of all, and it is common to both sexes. Castration anxiety is merely a specialised form of this dread. The idea of complete

annihilation is foreign to the human mind, at any rate to the unconscious mind, so that this dread is not modified by the reflection that the person will not, in the case of death, be there to feel the deprivation.

This fear that everything worth having is to be taken away is called forth in its maximum intensity, I believe, by the idea of approaching death. It may be aroused by bodily illness, but also in a number of other ways, especially by circumstances which impress upon the patient the fact that his former capacities are leaving him. Thus, he finds himself unable to obtain employment owing to his age, his sight is failing, his potency impaired; in short, he sees himself approaching the stage of "sans everything."

æ Apart from general theoretical considerations, the clinical facts that have led me to regard the fear of death in some form as the most typical (I would not for a moment suggest universal) traumatic factor in the production of senile psychoses are two. First, the abundant evidence of repression of the idea of natural death in senile patients; and secondly the "return of the repressed" in the form of delusions of being killed.

I would also suggest that the traumatic, precipitating factor is probably relatively more important in senile psychoses than in other types. Heredity seems to play comparatively little part, and it seems on the face of it improbable that a person with a strong

predisposition to insanity should reach the age of sixty without breakdown. The ordinary stresses and strains of life have not upset the equilibrium of these patients. It therefore seems reasonable to seek the precipitating cause in some more or less specific senile factor.

V. Senile Dementia.

It is really outside the scope of this paper to discuss senile dementia quâ dementia; but the subject is so intimately connected with that of the senile psychoses proper that it seems advisable to touch upon it briefly.

Senile dementia is commonly supposed to be adequately explained as the direct result of cortical atrophy, as a mere symptom of defect. The connection of the two is obvious; what is not so clear is the mechanism by which the atrophy produces symptoms we recognise as dementia.

The leading symptom of senile dementia is memory defect. Too little attention has been paid to the real nature of the defect, for it is of a peculiar type. It cannot be explained as due entirely to defective retention of new impressions, for the amnesia tends to extend further and further back into the past, until finally the patient is living in his childhood again.

The same tendency appears when we ask senile patients their age. They tend to give much too young an age,

and this tendency is much more marked among the female patients. I have checked my impressions by a small statistical investigation, which gave the following results:

300 Male patients and 207 female patients, all over 60 years, gave answers when asked their age. Patients who did not answer were neglected. Any answer not more than three years from the correct age as given in the hospital records was counted correct.

Males: 67.7% correct.
32.3% wrong.
21.7% too low.
10.7% too high.

Females: 55% correct.
45% wrong.
39.6% too low.
5.3% too high.

Thus, there is a very pronounced tendency, especially among the female patients, to state the age as too low. I am not inclined to believe that many of the patients deliberately mis-stated their age. It appears rather as though the memory of the last decade or two had been more or less obliterated.

The common symptom of disorientation for time shows the same tendency to ignore the present. Disorientation for place also shows lack of interest in the present surroundings, and it is no doubt reinforced, as Jelgersma (11) points out, by conflict about admission to an institution.

As regards memory tests, I have not yet carried out sufficient work to come to any definite conclusions.

In testing the reproduction of anecdotes, however, there does seem to be some tendency to reproduce less satisfactorily the stories that might have an unpleasant personal reference - a tendency that was clearly demonstrated by Hartmann (12) in Korsakoff cases. There is also a very strong tendency for the patient to refer every story, whatever its content, to himself. This would seem to be a consequence of increased narcissism.

While it is certain, then, that senile dementia is primarily due to cortical atrophy, and that this produces symptoms of defect, the complete clinical picture seems to me to include also the psychological reaction and the defence mechanisms called into play; just as the clinical picture of a bodily infection depends not only on the infecting agent but also on the bodily defences. Repression seems to play a rôle of some importance in the symptoms of senile dementia itself, apart from true psychotic manifestations. The forgetting of the later portion of the patient's life and the reactivation of childhood memories present a striking parallel, moreover, to the regressive phenomena discussed in connection with the psychoses.

In short, then, I would suggest that there is probably an important functional factor in senile dementia, and that the symptoms are not all directly due to cortical atrophy.

Summary of Conclusions.

1. Psychotic manifestations play a very important part in the mental disorders of old age, and occur in more than half of all the cases examined.

2. The commonest reaction is a persecuted one, but depression and hypochondria are also common. Mixed states are typical. The idea of being killed recurs again and again.

3. Seven illustrative cases are described, and an attempt is made to evaluate the symptoms from the psycho-analytic point of view.

4. General conclusions are drawn from these cases. Evidence is adduced of defensive efforts, with narcissism, flight from reality, repression, regression, projection and introjection.

5. The hypothesis is put forward that senile psychosis represents typically a defence against the fear of death, conceived of as a deprivation.

6. The suggestion is made that somewhat similar mechanisms may be found to be operative in producing some of the symptoms of senile dementia.

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