Philippe Chaslin (1857–1923)

Philippe Chaslin was born in Paris. His first love was mathematics and he was only persuaded to take up medicine by his grandfather who was a celebrated physician. He became senior psychiatrist at the Bicêtre Hospital in Paris and then at the Salpêtrière. A retiring bachelor, devoted to his mother and to his profession, he was an avid collector of books and knowledgeable about avant-garde poetry.

His psychiatric writings are marked by an aversion for conventional disease categories. He wrote about the influence of the dream in the content of delirious experience and about the role of primitive thinking in confusional states. His chief work, *Elements of Semiology and Clinical Mental Conditions* (1912), from which the present extract is taken, reflects his unconventional anti-organic stance. Nevertheless, his descriptions of *'Les folies discordantes'* is remarkably similar to that of Bleuler's schizophrenia published only a year before. The extract is chosen mainly to illustrate the remarkable convergence of European psychiatric ideas in the first decade of this century, despite the dissimilar backgrounds of the clinicians.

Discordant insanity

P. Chaslin (1912)

(Chapter 13, Groupe provisoire des folies discordantes, of *Eléments de Sémiologie et Clinique Mentales*. Asselin et Houzeau: Paris)

One can distinguish three principal types of discordant insanity in the early stages, although by the time dementia has supervened these distinctions become blurred. There is also a fourth type, which I call verbal insanity. The four types are: hebephrenia (which appears to be a mixed type); paranoid insanity (delusional insanity, previously called dementia paranoides); verbal insanity; and motor insanity or catatonia.

The word 'type' has the advantage that it has no precise nosological meaning. It is uncertain whether these types, although they have in common the general symptom of discordance, are several forms of the same disorder or constitute distinct conditions.

Hebephrenia

Attenuated form of hebephrenia. This is the most frequent form of hebephrenia, the one in which the attenuation of symptoms renders the diagnosis uncertain for long periods.

Case-history:
A boy of 14, with a family history of psychiatric disorder, became apathetic, lazy and inattentive. He was unable to continue his studies, and passed his days doing nothing other than playing with his sister's dolls. His intelligence and memory were unaffected, but he showed no interest in anything except childish games. He showed one of the most characteristic features of discordant insanity: non-coherence or discordance between different mental functions. While the boy was still capable of intellectual activity, he had lost all desire, wish and initiative to achieve anything. He was like a steam-engine without power, as if it had run out of fuel. The strange fashion in which he played with the dolls can be regarded as a form of eccentricity with regression. Despite the poor prognostic signs his condition remitted and he managed to pass one of his examinations, but his subsequent fate is unknown.

Hebephrenia. The following case illustrates many of the features of this type.

Case-history:
The patient was a milliner aged 20 who was brought to the Salpêtrière by her mother. The latter reported: 'My daughter has changed a lot over the past two years. She used to be a skilled milliner, but now she does nothing. Two years ago she was sent to a new workshop and from that time she suddenly changed. No one else in our family has had anything like this. She didn't have any fits as a baby but was always very nervous; she would cry at the smallest thing, was always a little aggressive but could be kind too, and was jealous of her brother and sister. Then she became so fearful that she had to sleep with me. The first real sign of anything seriously wrong was one evening when she said: "Come and feel my stomach. It's not moving. I'm going to die. Come here, mummy and daddy. Let me kiss you." Since then, the fear of dying hasn't left her. Now, all she does all day long is fiddle about with cards, papers or ribbons, or else she just sits doing nothing . . . Every evening she pretends that she has been working all day and earning three francs a day. This is completely untrue. She even says that she is supporting *us* and calls us lazy. She detests my husband and me, says that we are making a martyr of her and treats me cruelly. She won't talk to us, thinks we're inferior to her, and if we touch her she says that we are making her dirty. In fact, she is letting herself go, neglecting herself and has terrible table manners. She throws her shoes and skirts in the fire. Despite all this she knows what is going on and there is nothing wrong with her memory. She feels she is going mad, or so she says. At one time she wanted to kill herself, to jump in the Seine, but never did anything, and after six months the idea passed off. This was about a year ago. She seems fed up with everything, to the point that she can't even be bothered to sleep. I don't know if she sleeps or not. I've heard her talking to herself at night. Her willpower and good spirits have completely left her. Sometimes she says that her hands won't work any more, or that her feet have ceased functioning . . .'

In summary, the patient was a young woman with an abnormal childhood whose condition began suddenly with hypochondriacal ideas, paranoid ideas and non-systematised grandiose ideas. There were bizarre sensations, disorganised behaviour, fugues, suicidal tendencies, indifference alternating with hostility, fear of dying, bouts of anxiety, lying, a mocking smile and a partial awareness of her situation. The illness had been present for about two years. She had, in effect, a veritable 'salad' of symptoms which justifies the term discordant insanity. On direct mental state examination, however, there was remarkably little to find . . .

Paranoid insanity (dementia paranoides of Kraepelin)

This type of illness is not as common as hebephrenia. The following case illustrates the typical features of paranoid insanity.

Case-history:
The patient was a woman who presented with an incoherent set of delusions to which she was singularly indifferent. They were full of incredible contradictions and absurdities, and were accompanied by outbursts of excitement, laughter and gestures which bore no relationship to and often contradicted the ideas which she was expressing. The excitement was more marked at the onset of her condition and tended to occur in the presence of people whom she believed were harming her. At such times she could become violent. Some of the extravagant statements included the following:

'I am pregnant with Jesus Christ in my mind, my heart and my womb. I am the mistress of thirty Kings as well as Napoleon. My divorce was passed by all the churches. I went to the High Court and was told that I wasn't mad. I died of chickenpox and one of the Bourbon family came and got me out of the cemetery. I wanted to eat asparagus but they made me eat filth. Every night I'm buried alive; I'm cut up into pieces and Kings come and sleep with me while I'm hypnotised . . .'

In this case, the prominence of the delusions places it alongside other systematised paranoid insanity (the 'paranoia' of other authors). However, it differs from these other delusional states in that the delusions

are not only polymorphous but also incoherent and absurd, and this incoherence is not merely a function of excitement but persists even when the patient is in a cold unemotional frame of mind. Except at the onset of her illness the patient has been emotionally indifferent the whole time and all her natural feelings, such as maternal love, have disappeared. It is only her persecutory ideas which now raise any emotion. The main features of her condition are the rapid dissociation between ideas and emotion, secondary stereotypies, discordance, the preservation of memory even after five years, and an absurd, polymorphous, extravagant and incoherent set of delusions. This is characteristic of paranoid insanity, exhibited in pure form by this case, which merits the label 'schizophrenia' which certain authors have given it. Dementia paranoides, another term sometimes used, takes account of the content of the delusions but fails to convey the fact that intelligence is partially preserved . . .

Discordant verbal insanity

In addition to discordant delusional or paranoid insanity, discussed above, there is a separate type characterised by an extraordinary verbal incoherence without any true delusions. It is not entirely clear whether the paranoid and verbal types should be separated, because one could argue that the former is not really a disorder of belief but of verbal expression. Be that as it may, the following is a case of discordant verbal insanity whose features are so characteristic as to justify its separation from the other types.

Case-history:

The patient was a man aged 42 when he was admitted to the Bicêtre hospital. He had been regarded as very intelligent up to the age of 16, when he visited England to learn the language and study business methods. On his return to France he began to work as an employee in a commercial firm. He then began to stay away from work without explanation and to mislay letters which he had been asked to post. He had outbursts of excitement when he would throw things through the window. He would hit his mother without apparently recognising her. In addition, there were periods of mutism during which he would remain for hours in front of the fire, his head in his hands. His first admission to hospital had been at this period when he lost consciousness while visiting Beauvais cathedral. He was said to have been unconscious for 15 hours. He then did his military service, but spent most of it in and out of hospital with nervous complaints. After

his discharge he was admitted to a psychiatric hospital and from then on he has been completely incoherent in his speech. Whenever his mother visits him he talks fairly normally at first, asks sensible questions about his relatives, but after a few minutes he begins to ramble again.

On examination he always presents the same picture. Grey-haired, small, active and perpetually moving about, he is generally to be seen talking to himself, even at night, and does not appear demented. He has an intelligent-looking face and always addresses an interlocutor politely. He looks after himself and is well adjusted to asylum life. He keeps himself clean, exhibits good table manners, but rarely talks to his neighbours. As for his relationship with the nurses, they have to put up with his constant demands for tobacco. He is indifferent to visits from outsiders, although he always receives his mother kindly. He has nothing to occupy his time; he plays no games and does not join in with the other patients, spending the whole day walking about.

At interview, he is usually co-operative and gives the impression of being interested in the exchange. His eyes light up, he smiles and makes gestures underlining some of the strange phrases which he emits. Here is a sample of conversation:

Patient:	*Psychiatrist:*
'Hallo, how are you?	How are you?
Have you come to fetch me?	I just want to talk for a while
He won't give me any tobacco	Who won't?
The Government	What's your complaint?
Every month, a packet worth six sous arrives. It's not enough, so I wonder if you could give me some	What do you smoke?
Cigarettes. I keep them in my pocket. Why don't you give me some?	I haven't got any. How long have you been here?
For centuries. How long is it?	I'm asking you
I don't know how many years. They pass so quickly	Do you know today's date?
I don't bother with dates. We must be in the year 1908 or 1909	1908. What month?
I don't know, I live like a mole	I understand you speak English well?
Yes, but English, I can't say a word. It is as if you changed climate. Someone's changing	

me. *Boalabese*, it is a lake of *azene*. I see myself in the sea, it is the sea, it is made of cotton and wool.

It's the sea in any case

No

Yes. We will see that later. I'm going to get a job as a veteran "aide de camp"

It's your business. It's the sea in *simée* looking at itself in a sea, if I bother about your affairs. Aide de camp, it is the sea *simée*; the azene, you send it for a walk, always running, even it lives somewhere, if you make clay run it will live in the *azene*'

Are we talking of your travels!

Have you been to South America?

In Alaska then?

What is that?

Discordant motor insanity, catatonia

Motor phenomena can so dominate the clinical picture in some patients that a particular form of insanity is thereby established. Borrowing Kahlbaum's term I shall designate this type as catatonia. The following patient illustrates the condition.

Case history:

The patient was a man of 32 when admitted to the Bicêtre. Father was rheumatic and syphilitic and his mother intelligent and active, but the victim of unfortunate circumstances. The patient completed his secondary education but left school without passing examinations and followed no career. He was a bank employee for a few months and married at the age of 29. He was subject to frequent falls and after reading books about hypnosis began to believe, at the age of 31, that his uncle was making him fall by the power of suggestion. At the same time he developed ideas of grandeur, believing that his wife was of noble birth . . . From his admission in 1903 until the end of 1906 the only data recorded were brief comments on his mental state and a weight chart. One of these comments stated that the patient 'is affected by manic excitement, disordered ideas and behaviour, rambling speech; ideas of persecution, of poisoning, of grandeur and of mysticism; a feeling that he must redeem the sins of mankind; and a tendency to sing, shouting, whistling, violent outbursts, insomnia, and refusal of food . . .'.

In February 1907 he was adopting cataleptic attitudes. He would maintain his arms for a long time in any position that they were placed. He would stay for an entire half-day with his arms outstretched, the palm of his hand turned upwards and his head and eyes facing the wall . . .

In September 1908 he would recite litanies in a singsong and declamatory fashion: 'Monsieur Vincent – five years; *embaude* – five years; enfer (Hell) – ten years; *emmarmet* – ten years; *emmar* – ten years; *emcatholique* – ten years . . .'.

In summary, his childhood and adolescence were abnormal and marked by extreme laziness. The onset of his condition was heralded by neurasthenic symptoms, followed by delusions of persecution and grandeur. There was intermittent agitation and, in the early period of his admission, he seemed to have preserved his intelligence. Later he engaged in declamatory litanies, showed catatonic stupor and developed secondary disabilities from his abnormal postures. At this stage, too, he had become indifferent to his surroundings, and he would alternate between negativism and suggestibility; stereotypies and neologisms became more frequent.

Discussion

Discordance and discordant insanity. Is each of the types described under the general title of discordant insanity a separate form of insanity or only a particular form of the same illness? Is the link between these types – the discordance – sufficient to categorise them as one form of insanity? Clinical observations do not provide an answer at present and I do not intend to construct a nosological system. The term 'clinical type' is intended to be non-committal.

Whatever the situation may be, clinically there seems to be a link between the various types. It appears as if there are transitions between them, and that one can identify approximately three phases – the onset, the established state, and the terminal stage.

It was Kraepelin who joined together the hebephrenia of Hecker and Kahlbaum, the catatonia of Kahlbaum and dementia paranoides under the rubric of 'dementia praecox'. There is also the question of systematised hallucinatory insanity, which I believe is distinct from these and which I shall keep separate.

Dementia in discordant insanity. The term 'dementia praecox' chosen by Kraepelin is unfortunate because, as we have seen, dementia only supervenes after many years. Bleuler used the word 'schizophrenia' to characterise this type of insanity whereas I prefer the term 'discordant insanity', which reflects the intrapsychic ataxia noted by Stransky and the intrapsychic dysharmony observed by Urstein. Dementia, even if it occurs, does not appear to be very pronounced; it is more like the end stage of the systematised insanities where, more often than not, it does not occur at all or is very mild. Patients suffering from 'dementia praecox' are always less demented than they appear. If the term 'dementia praecox' is taken to mean an early onset to the condition, this is also inappropriate because many patients develop their illness in later life, in middle age or even old age, and one finds such paradoxical terms as 'late onset dementia praecox' or 'late onset catatonia' in the literature . . .

Conclusions

Discordant insanity has as its main characteristic a discordance or dysharmony between symptoms, which therefore appear as if they had no connection with one another. Klippel found organic changes in the nervous system in some of these cases. If this is true of all cases of all types then we will be able to regard discordant insanity as having a known cause. At the present time, however, this is not certain.

Generally, there is a family history of psychiatric disorder and, often, the patient demonstrated abnormal features in childhood.

There are four principal types of discordant insanity: hebephrenia and attenuated hebephrenia; paranoid insanity; verbal insanity; and catatonia. Epileptic fits can occur in any of these types. The development of the condition may be intermittent particularly in hebephrenia and catatonia. The outcome is grave, as it is doubtful whether full remission ever occurs, although there may be some improvement.

There is no effective treatment.

Hebephrenia. The *onset* is between 8 and 25 years of age, or at the very latest 30; some authors place the upper limit as even later. The disorder can commence slowly, quickly or insidiously.

The *first symptoms* are laziness, indifference, slowness at work, conflicts with others, outbursts of anger and periods of sadness; in short, there is a change in personality. Sometimes there are periods of unexplained excitement, fugues, tics, outbursts of laughter, grimacing,

bizarre attitudes, infantile behaviour, vague delusional ideas and inexplicable nocturnal or day-time fears. Excessive masturbation may occur. Complaints about the state of health are common. Hysterical seizures, migraine, neuralgia, anorexia, constipation, insomnia and nightmares may be prominent at this time. It is usually the school teacher who is the first to pick up a change in attitude, work performance or general appearance. These are first attributed to laziness and disobedience on the part of the pupil, whereas they are the first signs of the developing illness.

In the *established phase* there is an accentuation of all these phenomena, with each case presenting a slightly different pattern. In some patients depression and sadness may be prominent: there may be delusional ideas with a vague persecutory content, suicidal tendencies, anxiety, impotence, or difficulties in movement, thinking or acting. Excitement and pressure of speech may stand out along with agitation, pseudomania, anger, motiveless outbursts of laughter, infantile behaviour, silly jokes, tics, stereotyped and extravagant movements, disorganised and bizarre writing, idiosyncratic use of language, fugues and anti-social incidents. Other patients may show mainly persecutory ideas, with or without hallucinations. Others may have grandiose ideas. All these phenomena usually have a strange and disorganised appearance. More remarkable is the fact that they are quite superficial in the position they hold in the patient's mind. Underneath there is usually a complete indifference or apathy which is only interrupted by occasional bouts of catatonia with excitement, stupor or negativism. At the same time intelligence, memory, judgement and sometimes attention are preserved to a surprising degree. In short, intelligence remains intact, at least for lengthy periods, but the patient no longer makes use of it, as he does not work and does virtually nothing other than engage in infantile or automatic acts. The patient's attitude sometimes makes one think that he is simulating insanity, making fun of the interviewer or acting a part. His strange movements, his often contradictory facial expression, his ironic smiles and laughter, his grimacing and his flights of fancy all contribute to this impression . . .

In the *demented phase* there is intellectual impairment of varying degrees. The symptoms of the earlier phases lose their distinctness and become stereotyped. The patient remains standing, lying or sprawled out in a corner, dirty and slovenly. Activity is restricted to gobbling up food. Life seems purely vegetative and automatic, although one is sometimes surprised to find sparks of intelligence beneath this

envelope of dementia. Another curious feature of the condition is the preservation, in some cases, of an intelligent facial expression. At this stage the patient is fit only for simple tasks; only a few ever regain their former activity or return to society, and even these rare cases are not cured, only improved.

Attenuated hebephrenia resembles neurasthenia in some ways, but the extreme indifference and pathological laziness should make one suspect the former. Bizarre gestures, idiosyncratic and fleeting interest in things, tics, grimaces, outbursts of laughter and infantile preoccupations all occur, but in a more sketchy fashion than in fully developed hebephrenia.

The *differential diagnosis* includes neurasthenia (rare in childhood and often concealed); obsessional neurosis – which may precede hebephrenia, but there is no indifference, no personality change and no loss of insight; tics and chorea, distinguished by the characteristic movements; tuberculous meningitis, where there are signs of meningitis; epileptic dementia, predominantly a loss of intelligence with slowness and emotional outbursts; general paralysis of the insane and cerebral syphilis, identified by physical signs and lumbar puncture; epileptic confusional states, with a history of fits; and psychopathic states which may precede hebephrenia but without movement disorder or delusions. Other conditions which may be mistaken for hebephrenia include: acute organic psychosis, with transient disturbance of intellectual functions; epileptic psychosis, usually short-lived and with a history of fits; mania, where there is a more widespread involvement of mental functions and never as a cause of stereotypes or mannerisms; depression, rare in late childhood and distinguished by the genuine emotional pain that one witnesses; chronic systematised insanity [paranoia – Tr.], identified by the systematised delusions, the coherence of all the phenomena, suspiciousness and the lack of indifference – indeed one usually finds the opposite, an intense preoccupation with the symptoms; acute insanity, characterised by a polymorphous but incoherent pattern to the delusions; and hysteria, where there is marked suggestibility, convulsive attacks of a special type and altered consciousness.

Paranoid insanity. This usually begins in early adulthood rather than childhood, and sometimes begins in middle age.

Its *onset* is usually abrupt, with several different types of delusional ideas with or without hallucinations. The ideas may concern persecution, grandeur, hypochondria, nihilistic notions, bodily change or

inventive topics. They may be accompanied by depression, anxiety, agitation or rapture. Intelligence appears intact at this stage.

In the *next phase* emotional reactions disappear and the delusions become extravagant, absurd, changeable, diffuse and contradictory. There is usually indifference or euphoria, an ironic facial expression, incoherent speech, preserved memory and intelligence, and catatonic signs . . .

Finally, dementia of varying severity supervenes after several months or years.

The differential diagnosis includes all those conditions which give rise to incoherent delusions: delirium tremens, infectious delirium, epileptic psychosis, general paralysis, hallucinatory delusional states (where the hallucinations dominate the picture), chronic systematised insanity, and acute insanity.

Discordant verbal insanity. This is rare. In pure forms, after an initial phase which is similar in all respects to the early stages of the other types, the clinical picture changes and becomes dominated by completely incoherent language. Neologisms are frequent and, although words are expressed with normal intonation and appropriate smiles or gestures, their meaning is completely incomprehensible. Patients indulge in dialogues and monologues, uttered with normal facial expression but accompanied by total indifference. It seems as if intelligence is less affected than language itself, and that the thought disorder may stem from this disorder of language.

The differential diagnosis lies between all these conditions which cause incoherent language. Most of them, however, are immediately eliminated because they do not produce such an abundance of neologisms. The main problem is to distinguish discordant verbal insanity from cases of chronic systematised insanity where there is a secret, symbolic language.

Catatonia. The onset may be similar to that of the other types or the final episode itself may be a catatonic attack . . . During a period of stupor the patient usually retains normal attention and memory, but appears unable to use them to engage in any intellectual task, because of indifference and apathy. Once he has started a task, however, there appears to be no difficulty, even in carrying out certain movements. The slowing down of ideas does not come about through inhibition. The slowness is apparent even before a response or action and stems from a mechanism which we can call 'association by contrast'. It was

this mechanism which Kraepelin called *Sperrung* (blocking) as opposed to *Hemmung* (inhibition).

There are often physical signs to be seen: unequal pupils, dilated pupils, exaggerated reflexes, excessive salivation . . .

The condition may last a considerable time until dementia supervenes.

The differential diagnosis includes other conditions which produce catatonic features, although in these cases the catatonic signs are transient and incomplete: infectious delirium and dementia, traumatic and epileptic psychoses, general paralysis, cerebral tumour, idiocy, depression and hysteria.

Ernest Dupré (1862–1921)

Ernest Dupré was born in Marseilles but spent most of his life in Paris. His father became a teacher of rhetoric in a Parisian grammar school. After qualifying as a physician he studied general medicine for several years and then chose to specialise in psychiatry. He became the director of a hospital for the criminally insane and most of his publications reflect his interest in forensic psychiatry.

During the First World War he campaigned for more adequate psychiatric services for the French soldiers and described the frequent occurrence of a neurotic reaction among combatants, which one of his pupils termed 'Dupré's disease'. Dupré was a cultured man who tried, in his writings, to accommodate the 19th century views of Morel and Magnan on 'degenerates' with more enlightened and psychological notions of how disturbed imagination and emotional disorder could lead to antisocial behaviour.

Dupré is celebrated for inventing the term 'mythomania' – a tendency in some people to fabricate the events of their life. The article selected here, which he wrote with Logre, is an attempt to explain how this mythomanic tendency could lead to the development of a psychosis.

Jean Logre (1883–1963)

Jean Logre was born in Lisieux in Normandy. He studied medicine in Paris and then turned to psychiatry, first as a pupil and then as a collaborator with Dupré. He was appointed director of the hospital for the criminally insane in Paris on the death of de Clérambault.

Logre was a cultured man, an expert on Latin verse, who was respected by the French psychoanalytical school. He wrote a comprehensive textbook of psychiatry. The article translated here illustrates his interest in forensic and nosological issues.

Confabulatory delusional states

E. Dupré and J. Logre (1911)
(Les délires d'imagination, *Encéphale* **6a**, 209–32)

Introduction

In 1910 we introduced the term 'confabulatory delusional states' to designate those psychiatric conditions where there was a selective