CATECHISM SERIES

MENTAL DISORDERS

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CONTENTS

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MENTAL DISORDERS

THE NATURE OF MENTAL DISORDERS

What is the nature of mental disorders?

When Henry Maudsley wrote almost a century ago "By insanity of mind is meant such derangement of the leading functions of thought, feeling and will, together or separately, as disables the person from thinking the thoughts, feeling the feelings, and doing the duties of the social body in, for and by which he lives," he gave a formulation which continues to satisfy present-day conceptions since insanity or unsoundness or unhealthiness of mind involves impairment of the patient's capacity to function as the member of a social organisation, whether he be an egocentric hypochondriac, subject to morbid fears, preoccupied with imaginations, or intellectually dull. In the mental as in the physical field it is difficult to demarcate a clear boundary between health and disease. Many mental symptoms such as fears, obsessions, depression, morbid suspicions for which patients seek advice or are brought by their relatives, in their mild forms lie within the range of common experience. When such symptoms are sufficiently disturbing or inconvenient, we refer to the individual who experiences them as one who suffers, a patient.

When anti-social conduct appears to be deliberate in a person who cannot otherwise be regarded as abnormal, it is deemed culpable or criminal and that person is punished although in certain instances after consideration of the psychological make-up and motivations of the law-breaker remedial influences and some form of psychotherapy may be applied.

What part is played by heredity in mental disorders?

Generally speaking more cases of mental abnormality and instability of various types will be found in the relatives of a group of patients under treatment for mental disorders than in those of a normal group of similar age and sex or of a group under treatment for organic disease. In most

instances however, innate tendencies and environmental factors combine in the manifestation of mental disorder. Emotional instability in children may be the reaction to the disturbing influence of a mentally affected parent rather than the result of heredity.

Transmission of inherited qualities may be *dominant* when a parent and half the children display similar qualities or *recessive* when both parents neither of whom displays the quality in question carry the special genes and an abnormality appears in the children.

Heredity is dominant in manic-depressive states, Huntington's chorea and in some cases of epilepsy and mental deficiency.

Recessive heredity predisposes to schizophrenia, when both similar twins may be affected in about 75 per cent. of cases, some paranoid states, to some forms of mental deficiency, and in all probability to a considerable number of cases of psychoneurosis and less clearly defined forms of emotional instability and inadequate and warped personality.

What part is played by physical factors?

It has been pointed out that direct heredity accounts for a small proportion only of cases of mental disorder, while the majority inherit a vulnerable constitution through recessive genes which are sporadic in incidence. In such predisposed individuals the capacity to adapt satisfactorily to psychological stresses is lowered by physical handicaps which may hardly affect the mental efficiency and stability of the average person. Nevertheless infection and injury affecting the brain directly, and morbid conditions elsewhere in the body, *e.g.*, endocrine and metabolic disorders, may be sufficiently severe to impair the efficiency of the higher centres in persons of average stability. Fatigue and exhaustion may also play a part. With an adequate history the physician should arrive at an estimate of a patient's psychological make-up and his capacity to meet stresses and strains of various kinds, and enable him to assess at their true value both physical and psychological factors in the causation of symptoms.

What part is played by psychological factors in the causation of mental illness?

Since no regular physical etiology or structural pathology can be demonstrated in the psychoneuroses and psychoses —sometimes termed functional or biogenic mental disorders —various theories have been propounded as to psychological or situational causation. Grief after bereavement, and irritability, fatigue and anxiety in the face of an apparently insuperable circumstance, come within the range of everyday experience. The Freudian and allied schools have sought to determine how it comes about that certain individuals appear unusually prone to develop symptoms to an excessive degree in the face of stresses which are neither unusual nor excessive. It is suggested that psychoneurotic symptoms represent a morbid solution of conflict between self-preserving, pleasure-seeking tendencies and the sense of obligation and duty towards the social group " in, for and by which " the patient lives. Thus the soldier who develops an hysterical paralysis for which he is treated in a hospital instead of facing danger effects at least a temporary solution to conflict between self preservation and duty. Freud taught that the seeds of psychoneurosis and psychosis are sown in disturbed emotional relationships between parents, especially the mother, and infant who develops a conflict between its feelings of love towards the one who provides protection and nourishment and on the other hand frustration, resentment and aggression because of either parent's interference with socially disapproved but to the infant pleasurable behaviour. These unsatisfactory emotional relationships established in infancy may be carried on into later years when they are manifested again in further conflicts over relationships with persons outside the family and even to morbid attitudes towards society in general.

Mention some differences between psychoneuroses and psychoses.

The main difference rests on the presence or absence of *insight* which may be defined as the acceptance by a patient

of a normal objective attitude towards his disability. The psychoneurotic, while he may not have adequate appreciation of the motivations behind his symptoms until he becomes aware of them in the course of analytic psychotherapy, in general admits that he is sick and seeks medical advice like anyone suffering from a physical disorder. The psychotic on the other hand who either denies outright that he is mentally sick (*e.g.* the manic case who " never felt better ") or by the mechanism of projection believes himself to be victimised or ascribes his symptoms to noxious gases pumped into his bedroom is said to lack insight. The ability to take a realistic attitude towards environment and towards illness of any kind depends upon the extent to which a person is intellectually and emotionally mature. In mental disorders there develop varying degrees of avoidance and retreat from reality and *regression* to more childish and primitive modes of thought and behaviour, least pronounced in the psychoneuroses and most in the psychoses. In psychoneurosis social awareness and social behaviour are far less disturbed than in the psychoses. Normality, psychoneurosis and psychosis may be said to differ in degree rather than in quality. The distinction once made that cases of " nerves " were treated outside mental hospitals while the " insane " had to be certified and put in is less close to the facts now that the majority of cases can be treated on a voluntary basis and in the earlier stages of their disorders.

NEURASTHENIA

What do you include in the term " neurasthenia "?

This is a psychoneurosis in which morbid fatigability of mind and body is the outstanding feature with an emotional state of irritability, some degree of anxiety or depression, and pre-occupation with bodily functions. The symptoms represent an emotional reaction through disappointment, frustration or inability to cope with external demands and responsibilities and they may be long standing and persistent in inadequate personalities. After physical causes for

pathological fatigability have been excluded it should also be remembered that fatigue may be an outstanding complaint by a patient in the early stages of morbid depression, schizophrenia and the various dementias. Many psychiatrists do not regard neurasthenia as a separate entity.

Head.—There is complaint of impaired concentration, loss of memory, irritability, undue sensitiveness to noise, numbness in the head, sense of pressure on the vertex, and of a tight band or fleeting pains round the temples and at the back of the head and neck, and feelings of depression. The patient experiences fatigue over certain tasks and forgets certain things; there may be found a psychological reason for this. Neurasthenics may express concern as to the possible development of " insanity " and need assurance on this point.

Chest.—Shortness of breath on slight exertion may cause the neurasthenic to seek advice about respiratory disease. Or he becomes preoccupied with unpleasant sensations in the region of the heart, especially if a relative or a friend has recently succumbed to cardiac failure. Precordial pains and a diminished capacity for effort are outstanding features of the so-called effort-syndrome or neuro-circulatory asthenia in which there is a large emotional element. High blood-pressure is another of the neurasthenic's special bogies.

Abdomen.—The patient is preoccupied with his digestion and is apt to submit himself to a detailed dietetic *régime*. He may fear serious internal disease.

Genito-urinary.—There is often worry about masturbation, nocturnal emissions, or, on the other hand, lack of sexual feeling and possible impotence. Women may focus their interests on the pelvic organs.

General Sensation.—Uncomfortable itchings, painful areas in any and every part of the body, and other somatic discomforts are often complained of.

How do you differentiate neurasthenia?

Physical causes of " tiredness " should be ruled out by clinical examination, including special tests indicated by other symptoms.

The most important condition to exclude is *morbid depression*, in which the patient complains of having to make extra effort in initiating physical or mental activity. The neurasthenic becomes exhausted after effort. Depression is associated with restricted interest, inability to take pleasure in anything, and in more severe cases feelings of guilt, hopelessness and *suicidal inclinations*. The neurasthenic feels more fatigued as the day progresses, whereas the depressive is at his worst in the morning.

Schizophrenia.—The neurasthenic type of onset is common but increasing withdrawal, emotional incongruity and indifference and the development of odd fantastic ideas indicate the real nature of the process.

Dementia.—In the various cerebral degenerative states : arteriosclerotic, neurosyphilitic, neoplastic, and presenile and senile dementias—mental fatigability gives place to progressive defect of memory and of other intellectual functions.

What is the treatment of neurasthenia?

The first step in the treatment of the condition is a detailed inquiry into the symptoms. The patient should be encouraged to unburden his mind of all his worries and to enumerate all his feelings of mental and bodily discomfort. The physician will then be able to compare the symptoms with the physical examination and to appraise their significance. Tonics and hypnotics are often of value. Amphetamine may afford relief but should not be prescribed if there has been any considerable loss of appetite and weight. More detailed attention may now be paid to the psychological situation, and an attempt should be made to trace out the symptoms to their origin. It will often be found that the symptoms are a reaction to an unpleasant situation, *e.g.* an uncongenial task renders the worker unduly fatigued, or the symptoms may result from a sense of grievance or injustice. The chain of causation should be made as complete as possible and emotional reactions should be noted. As soon as the physician feels that he understands the patient's personality and his mode of reaction to his difficulties, he may enter upon the con-

structive side of the treatment. The patient should be given an explanation of the mechanism of development of the symptoms and also direction as to resumption of normal activities. A holiday may be all that is needed for persons of good personality who have developed neurasthenic symptoms after unusual and prolonged stresses provided that the physician is quite sure that his patient is not suffering from a depressive state.

Traumatic neurasthenia.

This, more appropriately termed traumatic anxiety or hysteria, is a psychoneurosis in which symptoms following an accident are out of all proportion to any physical injury. In some cases there is an element of malingering, while others are the victims of suggestion on the part of family and friends. Worry over legal proceedings, loss of confidence, fear of the loss of earning capacity, or domestic worries unrelated to the accident or to conditions of employment may contribute towards the development of an anxiety state. In some instances improvement follows a financial settlement.

ANXIETY PSYCHONEUROSIS

Give an account of the symptoms and signs of the anxiety psychoneurosis.

A mental state of morbid concern, fear and apprehensiveness may be accompanied by disordered bodily functions, such as occur in a normal reaction of fear.

The mental state includes the sense of inward tension irrational fears of certain objects and situations (phobias) on to which by a process of repression and disguise the affect has become focussed by displacement from the real source of anxiety. When the morbid anxiety is sufficiently intense to interfere with concentration and to cause lapses of memory the patient is apt to develop secondary fears of insanity and mental dissolution. From time to time he

may suffer anxiety attacks when mental and physical symptoms are temporarily intensified.

The physical symptoms are based on a disturbance of the mechanisms concerned with offence and defence in which are involved the endocrines, especially the thyroid, pituitary and adrenal glands, the various parts of the autonomic system and the balance between the activity of the cerebral cortex and subcortical structures. The emotional disturbance leads to loss of appetite and weight and disturbed sleep.

Cases of anxiety psychoneurosis have an unstable autonomic-endocrine mechanism which is activated by stimuli which are not strong enough to affect the average individual. According to Freudian theory morbid anxiety arises from sexual frustration, but the obstruction to any strong instinctive trend such as self-preservation and the urge to self-expression is liable to release emotional instability. " Stage " and " examination " fright are anxiety states, and the psychoneurosis in the form of an exacerbation of a long-standing tendency comes under notice in members of the fighting services.

What are the physical signs and mental symptoms of anxiety psychoneurosis?

(*a*) The physical signs are those which usually accompany the state of fear and apprehension. Often they resemble those of mild hyperthyroidism. Loss of weight is common.

Respiratory.—Breathlessness, sense of suffocation. It may be noted that asthmatic attacks are often accompanied or precipitated by anxiety.

Alimentary.—Loss of appetite, dry mouth and throat, difficulty in swallowing, nausea, gastric fullness, flatulence, air-swallowing, vomiting, diarrhœa.

Cardio-vascular.—Throbbings and palpitations, attacks of precordial distress simulating angina, faints, general vaso-motor instability.

Genito-urinary.—Frequency and polyuria. Disturbances of the sexual functions. Dysmenorrhœa and pelvic symptoms.

Skin.—Flushing and pallor in the face are normal expressions of intense emotion. Erythemata, pruritus, some forms of dermatitis, alopecia and lichen planus are some of the conditions which may be aggravated if not initiated by emotional tension.

Central nervous system.—Tremors, cramps ; twitchings, numerous uncomfortable sensations.

(*b*) *Mental symptoms.*—The patient suffers from fear and apprehension, either constantly or in attacks. There are usually restlessness, irritability, intolerance of noise, and the prevailing mood is one of depression. Sleep is impaired and is disturbed by nightmares, in which the patient dreams of falling over precipices, of being chased by wild animals, etc., and wakes up bathed in perspiration. Sometimes the content of the dream is frankly sexual. Fears may be prominent, but in contrast to the phobias of the obsessional neurosis, the fear is " free-floating," and is liable to become attached to each new experience ; every event and expectation in the patient's life is met with fear and apprehension. Often there is fear of insanity or of sudden death. A sense of mental confusion is often mentioned as one of the more distressing symptoms. In giving a prognosis, history and personality should be taken into account, also the degree of stress to which the patient has been subjected. The constitutional factor is unduly large in anxiety neurosis, and although many cases react well to treatment, especially those who have been subjected to physical and mental stress, others tend to remain chronically anxious and worried. Exacerbation may occur in the involutional period.

Outline the treatment of anxiety states.

As in neurasthenia treatment should begin with a frank discussion of symptoms, and after appropriate physical examination explanation to the patient concerning the emotional basis of symptoms. In more severe cases and when considerable weight has been lost a period of rest in bed and injection of 5 to 10 units of insulin before breakfast and the mid-day meal may prove most beneficial. Sedatives such as one of the barbiturates or the newer " tranquillisers "

may be given in moderate doses several times a day. A dose of 1 to 3½ grains of amytal often helps a patient over a situation in which he is apt to feel especially tense and disturbed. The patient will usually need to attend on several occasions, spaced as his condition requires, when further psychotherapy can be given, and sedation reduced to a minimum, or better still discontinued. Leucotomy should be considered for persistent, severe anxiety states which have not responded to other methods.

HYSTERIA

What are the important aspects of hysteria?

It occurs in emotionally immature individuals who retain a large measure of childish suggestibility. It has been aptly termed " the great simulator " since the symptoms and signs are copies of physical disabilities or of more serious mental disorders such as psychoses. In ordinary civilian practice hysterical manifestations are more commonly seen in young women, but under special stress such as combat and after accidents men appear equally liable. Just as suggestibility appears to play an important part in the production of symptoms so it may effectively be used in treatment.

What is the psychopathology of hysteria?

The symptoms provide a means of escape from a difficult or unpleasant situation. In the Freudian view the psychosexual development of the hysteric has remained fixed at an infantile level so that he is unable to face problems and difficulties in a fully adult manner. Conflict, sometimes of a sexual nature is resolved unconsciously by *conversion* into an assumed or imitated disability. Further, when the hysteric appears unconcerned over his disability (*belle indifference*) and behaves as if unaware of a limb (functional anaesthesia or paresis) or of certain past events (hysterical amnesia) he is said to be in a state of mental *dissociation*. A narrow sexual etiology hardly accounts for cases occurring

in combat where conflict between self-preservation and sense of duty to others is the precipitating factor. In civilian life threats to economic security to social prestige may be productive of symptoms.

Name some of the more important manifestations of hysteria.

Hysterics in general invite sympathy and attention and their behaviour is designed to attract notice in much the same way as the child who feels neglected may " play up ". *Physical manifestations* include paralyses, sensory disturbances such as " glove " and " stocking " anaesthesia, amaurosis and deafness, tremors, convulsions, and a variety of abnormal gaits, postures and contractures. " Phantom " tumours may be produced by local muscle contraction and pregnancy simulated by abdominal distension. Vomiting may lead to emaciation though more often weight is preserved by surreptitious eating.

Mental symptoms.—All hysterical phenomena are, of course, manifestations of an abnormal mental attitude. In so far as motivation appears to be unconscious the hysteric's mind can be described as being in a state of *dissociation*. For example, ideas concerned with movement of an arm become shut off from the rest of the mind and paresis occurs. Major forms of dissociation include amnesias automatic behaviour, somnambulisms, trances, fugues (prolonged trances with wandering) and narcoleptic and cataleptic attacks. There may also be episodes in which a confusional state is simulated. Close observation in these conditions will reveal that the patient is by no means indifferent to the environment.

How do you distinguish between epileptic and hysterical fits?

The hysterical fit tends to occur in association with some emotional disturbance, the onset is rarely sudden, and is accompanied by tremblings and emotional display, usually in the presence of some other person. The onset of the epileptic fit is sudden and may be preceded by an aura. The hysteric cries and screams throughout, throws himself about without injury, does not bite his tongue and seldom

loses control over the bladder. The movements are often purposive, dramatic and even frankly erotic. The crisis may continue for several minutes. The epileptic convulsion begins with a cry and after going through tonic and clonic stages ends in coma and sleep. In hysteria the corneal reflex may be abolished but never the pupillary reactions to light, and the plantar responses remain flexor. In epilepsy the pupils are inactive during the phase of unconsciousness and the plantar response may be extensor during and just after the convulsion. The hysteric may be exhausted by his efforts while the epileptic often falls asleep after a fit or remains confused for a while. The hysterical paroxysm may be controlled by suggestion or by the application of cold water or of painful stimuli.

It is important to remember, however, that epilepsy and hysteria may co-exist and that hysterical manifestations may precede or follow the epileptic convulsion. In some cases careful observation of the paroxysms may be necessary before a diagnosis can be made. The electroencephalogram may be helpful. Convulsive movements may be an hysterical overlay in cerebral tumour and arteriosclerosis, neurosyphilis, and other organic cerebral disease.

How do you distinguish between paralysis of functional (hysterical) and organic origin?

1. In hysteria the affected muscles are functional groups involved in some movement. In organic paralysis the distribution is determined by nerve supply, cord segment or higher anatomical centres.

2. In hysteria tendon reflexes are retained though they may be difficult to elicit due to resistance by the patient. In organic paralysis there may be clonus and an extensor response.

3. In hysteria the electrical reaction of degeneration is absent even when the muscles are flaccid and wasted from disuse.

4. The hysteric may be unable to stand but moves the legs quite well against resistance when lying down (astasia-abasia).

5. The aphonic hysteric can still cough.

What are the special features of hysterical anaesthesia?

1. The affected area is determined by the patient's ideas, not by anatomical nerve supply. Hence " glove " and " stocking " areas, with a sharp line of demarcation.
2. If there is dissociation of sensation it fails to correspond to organic types.
3. Protective reflexes, including the blinking reflex to a loud sound in hysterical deafness are retained.

Give an account of anorexia nervosa.

This should be distinguished from the loss of appetite, nervous anorexia, which occurs in anxiety and depressive states. The condition is seen in young women and appears to be prompted by a sense of frustration or as a protest against parental demands. The patient refuses to eat and vomits food which is forced on her. Considerable emaciation and dehydration may follow, but the patient presents an attitude of complacency or lack of concern and continues to be active. Treatment is by isolation, resolution of the conflict, and carefully supervised diet, assisted by small doses of insulin. The condition must be distinguished from other causes of loss of appetite, and cachectic states due to systemic diseases such as diabetes, tuberculosis, neoplasms and pituitary disorders.

What is the treatment of hysteria?

Resolution of difficulties between patient and family or other persons will often prepare the ground for removal of symptoms. While the patient should be understood, sympathy is usually misplaced and unwise. Suggestion applied directly or under hypnosis plays a leading part in treatment. Faradism may assist the removal of anaesthesias and pareses and abnormal postures. More intensive psychotherapy involving some form of analysis may be needed. Repressed memories may be brought into consciousness by hypnosis or narco-analysis. The family will often need advice for the wiser handling of an hysterical member.

The Weir Mitchell *regimen* of repose-seclusion with a milk diet can be carried out quite well in a medical ward and often leads to an early renunciation of gross hysterical manifestations such as paralyses, retention of urine, refusal to eat, or vomiting.

OBSESSIONAL STATES

Give a general account of the obsessional psychoneurosis.

This is a condition in which the patient is troubled with ideas, emotions, or impulses which force themselves into his mind in an imperative manner. Normal individuals in fatigue are liable to experience mild obsessions, *e.g.* a tune "running in the head," or a doubt as to whether a tap has been turned off. In the neurosis these phenomena assume much greater prominence, and may cause serious interference with normal activities.

Obsessional ideas take the form of states of doubt and indecision, questions of a religious or philosophical nature, and preoccupation with abstract topics without finality. Sometimes religious and sexual ideas are associated.

Obsessional fears (*phobias*).—These are fears of specific objects or situations, such as metals, glass, animals, open or closed spaces, heights, etc. These fears occur in attacks in which the patient is thrown into a state of acute anxiety, with trembling, palpitations and perspiration. At the same time there is full realisation of the unreasonable nature of the thoughts.

Obsessive acts and impulses, or morbid desires, sometimes termed *manias* (not to be confused with the psychosis "mania"), are compulsions to steal, count, perform meaningless repetitive movements, etc. There is an increasing sense of tension and discomfort until relief is finally obtained after a struggle by compliance with the impulse. Alcoholic indulgence sometimes occurs as a result of morbid impulse (dipsomania).

This psychoneurosis often proves resistive to treatment including intensive psychotherapy. As in certain anxiety states, obsessions may be accompanied by a considerable

degree of depression and such cases may benefit from electroplexy. Patients with persistent severe nervous tension and anxiety and obsessional symptoms may also be relieved by the operation of prefrontal leucotomy.

What is meant by psychosomatic medicine?

This includes the recognition of psychological influences over bodily functions and the treatment of somatic symptoms by psychotherapy. Mind and body interact and just as adequate mental activity depends on a healthy state of the body especially the brain so mental impressions which have a more or less intense emotional accompaniment may have a marked influence on functions innervated by the autonomic system such as vasomotor, and gastro-intestinal. Symptoms in the anxiety neurosis may be predominantly somatic, such as dizziness, gastric discomfort, or feeling of air-hunger rather than mental such as unreasonable fears and dreads. While it may be granted that instability of one or more visceral systems is constitutional in many instances, *e.g.* asthma, peptic ulcer, allergies, aggravating psychological factors are often present.

What is covered by the term "psychopathic personality"?

The term is applied to a variety of individuals including drug addicts, sexual perverts, pathologically irritable and aggressive, and inadequate, shiftless and dependent types, who are more or less constantly in difficulties with society, including conflict with the law. They are egocentric and selfish, and gratify their desires with little regard to consequences, including obligations to their fellow men. Since they lack any genuine desire to be different, they fail to co-operate in remedial measures. They thus appear to be fundamentally lacking in moral sense—they are a-moral rather than immoral. Since the majority are of at least average, if not of superior intelligence, they cannot be