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On Some Varieties of Dementia Praecox[1]

Professor Sante De Sanctis

EDITOR'S NOTE:

When this translation of perhaps the first reference in the psychiatric literature to the psychotic disorders of childhood was planned and completed it was considered by the present editors to be the first complete rendition into English. However, its publication was delayed by the inevitable problems of gathering, preparing, and editing all the other manuscripts for this volume.

In this interval of several years duration a complete English translation of the contribution of Dr. De Sanctis by Maria-Livia Osborn appeared as the first paper in Chapter XXII, entitled "Three Historic Papers," in *Modern Perspectives in International Child Psychiatry*, John G. Howells, Editor, pp. 590-609, Brunner/Mazel, Inc., 1971.

In view of this last named publication the translator of the present version, Mrs. Mary Jeffress, M.S.W., agreed with the editors of this volume that its readers' interest in some historical aspects might be best served by including here only those portions of the translation relevant to the general subject of the book, namely the psychoses of childhood. Therefore, selections of the entire De Sanctis paper, here omitted, concern the author's discussion of nosological problems, not entirely solved in Kraepelin's formulation of his concept of dementia praecox. These omitted selections include those numbered in the Osborn translation as follows:

All of I, III, and introductory paragraph of V.

[1] This paper by Sante De Sanctis, "Sopra alcune varieta della demenza precoce," was published in *Rivista Sperimentale di Freniatria*, Vol. 32, 1906, pp. 141-165, and has been literally translated by Mary Jeffress, M.S.W. (A. J. Gianascol, M.D.; and Anna Mallardi Corbascio, Ph.D. collaborated in this work.)

PREMATURE DEMENTIA

Every conscientious contribution to the nosography of dementia praecox may therefore prove to be useful and is not to be despised. My study of some clinical cases in the institutes under my direction and in my private practice gives me the opportunity to make some comments.

The first problem which has particularly interested me is the relation between dementia praecox and mental deficiency.

Schule[2] speaks of "hebephrenic imbecility," grouping under this title those cases of youthful insanity which end in imbecility, as well as those cases of youthful insanity which are complicated with imbecility. He observes that true hebephrenia sometimes does not rise above a fundamental idiocy and that some hebephrenics end in imbecility (though not in dementia, to be sure!).

This acute observation of Schule would seem at first glance to generate confusion, but we may recognize its value—in spite of its lack of precision—if we call to mind an opinion of Morel's.[3] He called to our attention that *dementia in certain cases is nothing but the final outcome of a foetal evolution, the seed of which has been carried by the adolescent since birth.* It is a meaningful coincidence that it was Morel who gave the name of démence précoce to the *premature dementia* which during puberty sometimes strikes the children of alcoholics and insane persons.

Tolouse[4] revived the ingenious view of Morel when he affirmed that puberty is the boundary between congenital and acquired psychic weaknesses or insanity, so that Toulouse considered dementia praecox of puberty an idiocy of the congenitally predestined individual.

But many psychiatrists have long affirmed, and without reservation, that the weak and the imbecilic (mental deficients) at the time of puberty undergo a deterioration in their mental condition. This observation had not escaped Esquirol and those others who had described primary dementia, hereditary insanity, hebephrenia, heboidophrenia, moral insanity, and the various psychic disturbances that accompany and follow puberty.

Finzi and Vedrani[5] pointed out the "relative frequency" with which imbeciles and idiots at about the time of puberty (a little earlier, or at times later,) present symptoms of dementia praecox. Finzi himself had

[2] Schule. Clinical Psychiatry (Italian translation). "Imbecillita ebefrenica."

[3] Traité des maladies mentales, Paris, 1860.

[4] Toulouse: Classification des maladies mentales, in *Revue de Psychiatrie,* February 1900. See also S. De Sanctis: On the classification of psychopathy, *Rivista sperimentale di Freniatria,* 1902. *Atti del Congresso Freniatrico di Ancona* of 1901.

[5] Finzi and Vedrani, Contributo alla dottrina della demenza precoce, *Riv. Sper. di Freniatria,* 1902.

already noted that a demenza precocissima (very precocious dementia) could constitute a form of mental deficiency.

Several years ago I[6] spoke of "progressive mental deficiency." This term referred to the phenomenon, repeatedly observed by me, that mentally deficient children, cerebroplegics, as well as those without paralyses (epileptics apart), manifest, as they grow older, an increasingly accentuated mental decline (with educational arrest and regression) despite suitable medico-pedagogic treatment. Certainly this phenomenon was observed more frequently among the patients of the institutes for deficients and abnormals than among those in the elementary schools, a fact which was recently noted by Cramer.[7]

I do not feel like insisting on the term and on the concept of progressive mental deficiency. It would even appear to me idle to discuss the prejudgement of Toulouse, that is, whether a mental weakening which occurs at the time of puberty is by definition mental deficiency.[8]

In my opinion, if we wish to avoid academic discussion, one must on the one hand respect the classical concept of mental deficiency given to us by Esquirol, and one must, on the other hand, not doubt the independent existence of a psychosis which develops during the pubertal period and which today we call "dementia praecox."

However, more recently I had the occasion to observe another interesting fact, namely, that *among the mentally deficient children one could find some with a type of mentality truly insane (that is with a dementia praecox mentality).*[9] I could not, however, state at that time whether in these cases one dealt with individual psychopathic varieties or with true dementia praecox, which given the age of the patient, I called *dementia praecocissima.* The fact remained and its importance was not diminished by its implications.

[6] S. De Sanctis: Sui criteri e i metodi per la educabililtà dei deficienti, reported to the Psychiatric Congress of Ancona, 1901. In *Rivista sperimentale di Freniatria,* 1902.

[7] A. Cramer: Entwickelungsjahre und Gesetzgebung, 1902.

[8] Bourneville (C. R. de Bicetre, 1897) calls idiots also the weak mentalities that occur at the beginning of puberty at 13 or 14 years, following pathological processes in the brain. This is the accidental acquired idiocy of Esquirol. Perhaps it would be better to speak in such cases of dementias (following traumas or inflammatory processes of the meninges and of the brain, tumors, or other).

[9] S. De Sanctis: Su alcuni tipi di mentalita inferiore communication at V. International Congress of Psychology. See also *Annali della R. Clinica psichiatrica di Roma,* 1905.

EXISTENCE OF PRE-PUBERTAL DEMENTIA PRAECOX

Given these observations two distinct questions faced us: (1) If dementia praecox can occur among mental deficients, then how does it occur and when does it occur? (2) *Does a pre-pubertal dementia praecox exist, that is, a dementia which can be called praecocissima because of the time of onset?*

Another question was suggested to me by another kind of observation. The authors that follow the views of Kraepelin, and Kraepelin himself have admitted that dementia praecox is not always a pubertal or juvenile psychosis, but that, on the contrary, it can appear beyond 30 years and even to the age of 40-45 and more years, especially the paranoid form.[10]

CHILDHOOD SIGNS OF DEMENTIA PRAECOX

A last question, which we need to distinguish from the previous ones just mentioned, but which, after all, is part of them, regards the *childhood of those with dementia praecox.* It is admitted that hebephrenia, like the other forms of dementia praecox, may appear in subjects that were, up to that point, intelligent and completely normal; but *I have collected certain curious facts which raise serious doubts about the alleged normal mentality of those who become victims of dementia praecox, and which make us ask whether in the childhood of these individuals one may not frequently find signs that reveal their destiny.* This problem may bear upon the etiology of dementia praecox.

In summary, I wish to discuss these clinical-nosographical problems about dementia praecox:

1. Does a *dementia praecox subsequens or comitans* (subsequent or concomitant with mental deficiency) exist?
2. Does a *dementia praecocissima* (of childhood) exist?
3. Does a *dementia praecox retardata* exist? (Later I shall explain why I prefer the term *retardata* (delayed) to *tardiva* (late), the first term which would come to mind.)
4. Does dementia praecox in both *subsequens or comitans* and in the *retarded* form have *premonitory signs at an early age?*

In this brief prefatory note I do not pretend to have definitive answers for such questions, but I do propose to summarize concisely my clinical experiences with these ideas and so invite psychiatrists to gather the facts

[10] The case of A. Pick (Ueber primare Demenz bei Erwachsenen in *Prager medezin Wochensche,* N. 32, 1904). Even more famous is the case of Schroeder in which dementia praecox apparently began at the age of 59! (cited by Kraepelin).

required for a solution to these problems—*Dementia praecox subsequens* or *comitans.*[11]

Thus I provisionally describe the precocious dementia which appears in mentally defective individuals, the so-called mentally deficient (idiots, imbeciles, the slow, deficients). Perhaps not all the psychiatrists are convinced, as I am, of the great frequency of this type; but nevertheless, this type is so easily observed that it would not deserve such attention if various psychiatrists did not persist in confusing the dementia praecox of mental deficients with those periods of agitation that are characteristic of idiots and imbeciles, or with the psychopathologic states, the episodes of delirium, melancholia, etc., of the so-called degenerates. It is in the name of that clarity which clinical forms must attain that I insist on provisionally describing such cases as cases of *dementia praecox subsequens* or *comitans.* In reality, this variety is very frequent; in a few months and in a restricted field of observation (that is, outside of a mental hospital), six cases have come to me, each of which I have studied closely over a long period. I am now convinced that *in the prognosis of mentally deficient educable children, dementia praecox must be considered as a serious possibility.*

PROGNOSIS OF DEMENTIA PRAECOX IN MENTALLY DEFICIENT CHILDREN

Here is what I conclude from my personal experience with this clinical variety:

a) Dementia praecox *subsequens* or *comitans* is a fairly common variety which occurs more in the female than in the male. Of my last six cases, four were of the female sex.

b) In my six cases, it appeared between the twelfth and the twentieth year.

c) The immediate apparent causes were, in one case, a febrile sickness; in another, exhaustion (surmenage) (?); in two, more or less intense emotions (fear, terror); in the remaining two cases, any precipitating cause escaped completely.

d) In only one of the six cases was the antecedent mental deficiency serious; in the remaining four cases, the degree of deficiency was moderate. One of the female patients learned without special pedagogical methods to read and write well, and even to acquire the elements of a foreign language (see reported case). The other five cases completed the

[11] Professor Tamburini would suggest calling this form *dementia praecox phrenasthenica.* See discussion in my paper at the *E. Accademia di Roma,* January 28, 1906.

first three elementary grades. In all cases, however, a deficient mentality had been noted by the family and by the physician from the time of early childhood. *However, based on my experience, I can affirm that patients with serious mental deficiency are less disposed than the others to dementia praecox.*

e) All six cases exhibited forms of mental deficiency without paralysis; but among cases observed by me on a different occasion there were two in which the original mental defect was accompanied by epileptic attacks.

f) The symptoms with which the dementia praecox announced itself in my six cases were, in order of frequency, the following: strangeness of character and capriciousness; apathy; depressed mood; scruples; negativism; hallucinations; and agitations. In only one of the six cases was there marked catatonia.

AGE OF BEGINNING DETERIORATION

In general in the mental deficients who develop dementia praecox, the intellectual deterioration begins in the eleventh or twelfth year or sometimes later and proceeds at least for some months or even years progressively, to the extent that it becomes necessary to suspend any pedagogical treatment. The most serious cases—those which in general fall under the observation of the psychiatrist—have the characteristics of the hebephrenic or paranoid form; but many cases have the characteristics of simple dementia and for this reason pass unobserved. In some of these cases the intellectual decline was so placid I was led, in 1901, to the concept of "educational regression."[12] Rereading what Kahlbaum had written on heboidi forms and some other cases I found in the literature (Diem, Cramer, Monod) called simple dementia or frusta, I found a complete resemblance between these and some of my cases of educational regression.[13]

It seems unnecessary to report all the six cases more recently observed by me. I shall report only one of them as a sample illustrative of the clinical variety that I am describing.

Typical Case—S.A., Age 17

Although the family history is not entirely free of neurosis, six sisters and two brothers of the patient enjoy good physical and mental health.

[12] See my report to the Psychiatric Congress of Ancona already cited, 1901.

[13] I say some; and above I said that the term educational regression was suggested to me in part by the cases of which I speak, just because the *educationally regressed* can be determined not only by the *decline*, now placid, now tumultuous, of *intelligence, coinciding with the time of puberty*, but also by epileptic forms, by the environmental influence, by precocious intoxication, and by other causes unknown to us.

The patient had no incidence of disease in early or late childhood, but both her family and teachers had recognized her intellectual deficiency in her early years. She was inactive, had little capacity for attention, had a weak memory, and despite her perfect physical development was regarded by everyone as defective. Her character was normal; she studied willingly, so much so that with much effort she succeeded in completing all the elementary courses and finished two grades beyond that, and she was also able to learn a little of the French language.

We should note, however, that she completed all her studies in private religious schools[14] and several times repeated the same classes. Her first Communion marked the beginning of her scruples and sadness, although she maintained a correct demeanor until she was sixteen. Then, as her scruples became aggravated, A. began to show marked changes of character, diminution of affection towards her parents, a spirit of contradiction, indocility, extravagant ideas, and, as expressed by her mother, "strange ideas."

On some days the patient refused even to eat, giving the reason that she wanted to mortify her senses. The spring and summer of 1905 passed fairly well, but in August of that year A. became very restless, strange, and contradictory to excess. In September when I saw her for the first time, I was unaware of her history, and I diagnosed her as a common case of dementia praecox. On the 3rd of October she was admitted to my hospital, and on the 26th of the same month she was transferred to a sanatorium because she had become agitated, strange, at every moment changeable in mood and wishes, and obstinately refusing to eat or to leave her room.

Here in brief are the patient's most obvious symptoms observed in my hospital and in the sanatorium between the 10th of October and the 20th of November:

Subject well-developed, brunette-type, well-proportioned, 162 centimeters in height, her weight 51 kg., her thyroid gland under-developed[15]; presenting a sharp, facial assymetry, both anatomical and functional (the right side of her face moves more than the left); physiological functions regular, except on some days she has had bad breath, constipation, and sleepless nights. No

[14] Translator's note: In Italy children in religious schools are tutored if they are having learning difficulties.

[15] One should note this detail. In another case of hebephrenia which I have mentioned elsewhere, one had an enlarged thyroid and had symptoms of hyperthyroidism. However, any further significance escapes us. In the case which I here describe, the use of thyroid tablets had no effect.

alteration of muscle strength with active or passive movements, nor of reflexes or sensation.

From the mental point of view her silly behavior, her movements, her affective instability and nonsense were particularly surprising. Periodically, she is very agitated, she breaks things and threatens to commit suicide, wants to run away, and does not stop smiling and grimacing. In periods of calm, she either laughs or cries, or keeps an obstinate silence, or expresses absurd ideas, or speaks words without sense, or assumes statuesque postures and grotesque affected poses. At certain times her negativism becomes extreme. For many days she refuses food, becomes mute, and even refuses to urinate, so that several times she was catheterized.

In the patient's speech I noted frequent associations of assonance, rhyme, foulness of speech, neologisms, echolalia, verbigerations, confusion of words without sense (Wortsalat)—symptoms that have their counterparts in her writings. Here is an example of her speech:

> "And I am sure that all the Saints in Heaven will assist me and will make me in the end a novice of the Sacrament, and there should not be locomotives, or carriages, or horses. But everybody must walk with their legs. By day or night one must never rest, but I would not want anyone drunk or badly behaved, lazy, vagabond, but that all shall work with the sweat of his brow, and the vines must be all thrown in the fire, in short all burned and the grain not even, etc. . . in short, they should all be controlled or they should all eat equally as in an institution."

On other occasions the patient, with much laughing, said:

> "Sel . . . selleri . . . Buoni i selleri. I shall do it, you shall do it, they shall do it. Beautiful French . . . ne pa, papa, Napoleon, tiger, ferocious beasts . . . No, no, no . . . "

In this passage the superficial associations of assonance are abundant. And even more characteristic are her writings. Here is one of her letters:

> "My dear D. M.
> "Do me the pleasure of sending me a half onion, because instead of being called Assunta, I am called Addolorata (Our Lady in Sorrow); therefore, do me the kindness of sending me also the tears of the Madonna."

And in another letter written in very bad French to her relatives, she adds as postscript these words: "But only say to the Archpriest of Santa Maria to change his name to Lucifer, or rather they should call him in another manner, which frightens me."

The patient expresses the most absurd ideas imaginable. Her condition is plainly one of dementia. All told during the three months I had her under observation I found in her all the mental symptoms of a dementia praecox.

DEMENTIA PRAECOCISSIMA

Those that have written about *hebephrenia, heboidophrenia, simple dementia* or *primary dementia,* etc., have not considered the possibility that such illnesses could occur many years before the period of puberty. Stecker did not consider it, nor did Kahlbaum, Fink, Clouston, Bevan-Lewis, Ball, Mairet, Spitzka, and Marro. Seppilli[16] claimed that the psychoses of puberty were rare even between the twelfth and fourteenth years. We should remember, however, *that the so-called moral insanity* (acquired after a trauma, or an illness, or an emotional condition) has also been observed in children. The statistics of Bertschinger also provide cases of *dementia praecox at ten years,* although no one can say that *dementia praecocissima* has a literature. Kraepelin limits himself to the observation that *certain* conditions of psychic weakness in early childhood must be regarded as manifestations of *hebephrenia.* He compares certain catatonic disorders of idiots to those which appear in the final stages of dementia praecox and recalls apropos of this, the opinion of Masoin. Weygandt warns that the occurrence of dementia praecox before puberty is still open to question.

CURABILITY OF DEMENTIA PRAECOX

In my work about "Some Types of Inferior Mentality," quoted later, I said: "I am certain that in childhood mental insufficiency (mental deficiency) is frequently characterized by the mental symptomatology of heboido and hebephrenia . . . I doubt that this is a different clinical entity, or variety of mental deficiency." I reaffirm these words, but I must add something. It appeared probably to me then, as I have stated, that the insane type constitutes simply one type of mentality in mental deficiency. One must admit with much caution that in infancy and in childhood there are other causes of true intellectual deficit apart from those which determine mental deficiency. My opinion was strengthened by the fact that children of the insane type could at times derive improvement from medical-pedagogical treatment as do mentally deficient children, whose deficiency was of a different mental sort. But today I ask myself, no one could indeed rule out that mental defectives (of the insane type) have (true) dementia

[16] Seppilli: Delle psicosi della puberta. Of the psychoses of puberty. *Atti del V. Congresso della Societa Freniatrica Italiana* in Siena, 1886.

praecox because of the single fact that they can improve. Using this unique fact of the curability-educability (therapeutic criteria), I begged the question. I used to believe that all forms and varieties of dementia praecox were incurable. Now I believe that some children regarded as mentally deficient, who present clearly insane mentality, not only have improved but can be cured. *This suggests that these are not cases of mental deficiency with insanity (psychosis), but true cases of dementia praecox,* because, apart from symptomatology, *it is more reasonable to believe in recovery from an attack of dementia praecox than to believe in recovery from mental deficiency,* which if you want to be precise, should not be thought of as an active disease process but rather as a final result of a process.

OTHER PHYCHOSES IN CHILDREN

Thus, I certainly do not claim that all mental defectives with insanity have dementia praecox. Moreover, I would like to add that *one must not confuse with dementia praecox other psychoses which are not very rare in children from five to eight years of age and which usually recover.* (These other psychoses) which I have observed include hysterical dream-like states, certain forms of strange deliria, which resemble paranoia in miniature, the hallucinatory psychoses. Thus one can observe in children, for example, the epileptic dementia, which is not at all rare.

DEMENTIA PRAECOCISSIMA

I only use the diagnoses of *dementia praecocissima* when (the children) exhibit the classical symptomatology of dementia praecox. I exclude it (using only a diagnosis of insanity) when the child since early infancy showed symptoms of dementia praecox along with concomitant somatic phenomena *(paresis, spasms, defective development, etc.)* which makes one think of a pre- or post-natal cerebroplegia (brain damage). I cannot exclude, however *hereditary syphilis from the diagnosis of dementia praecocissima.* It is curious that many of my cases of dementia praecocissima were born to syphilitic parents and had the so-called *ocular syphilitic stigmata.* But I do not intend now to enter into details. It is enough for me to establish the *fact* that there is in childhood a *form of dementia praecox* that I called *dementia praecocissima,* in which the prognosis is not always so grave as that of dementia praecox in young people and in adults, but which, like certain forms of *heboidophrenia of Kahlbaum,* may be at times curable.

A few months ago I explained my views to a German colleague, and I learned that he too had *observed dementia praecox in children who later were cured,* and that a very interesting case of a similar kind had occurred to Professor Binzwanger of Jena.

CASE ILLUSTRATIONS

Typical Case—D. Flavio, Aged 10 (observed in 1899)

Father choleric, impulsive but healthy. Paternal uncles irritable and of little regular conduct; mother chronic cough, maternal grandfather alcoholic and brutal, maternal great-aunt insane.

Flavio was born at term with spontaneous birth, had the eruption of teeth early; the first tooth appeared at four months and dentition was complete during the first year of age. He began to walk at three years. He was delayed in the development of articulate speech. He began to pronounce words well only at five years. Ever since childhood, he has been of irritable character, but he went to school and profited from it. Now he has finished the second elementary class. His father notes, however, that for the past two years Flavio's character has become increasingly strange, so that now he has changed so much they are no longer able to keep him disciplined. He refused everything, and for that reason they brought him to me.

Boy well-developed, a little pale, a brachycephalic head, wide face, with nose a little flattened. Weight 26.500 kg.; height 126 cm., with some degenerative signs. State of general nutrition poor. Respiratory function weak. Flavio was subject to frequent bronchitis, he has a healthy heart, but suffers from palpitation of the heart, especially at night. He has very little appetite. He sweats in an extraordinary manner at night, in winter as well as in summer. He habitually sleeps soundly but has frequent night terrors. He tosses much in his sleep. Trophic condition of muscles regular. Reflexes superficially lively; knee jerks normal. Passive and active movements regular. The small movements of the fingers, upon request, are all possible, but one needs time and patience to get the patient to perform; for the most part, he is distracted or likes to joke. Muscular strength regular. Sight A.D.V.=1/3, A.S.V.=1/2, distinguishes well by name the colors green, red, and yellow. Hyperesthesia of the retina with tearing reflex. Traucoma localized at the conjunctive tarsae. Skin sensation normal; strong tolerance to pain provoked with mechanical stimulus. Easily satiated little appetite.

His attention is prompt and of sufficient duration, except when he is occupied in play. Often he becomes fixed in contemplating objects and asks many questions in regard to them. Memory fair, musical memory is

very good; his father says that "he has a good ear." He can add and subtract numbers up to 1000; he finds multiplication very difficult. He reads fairly well but writes very badly. He is afraid of darkness but does not seem afraid of other things. His emotions of anger are frequent and quick, erotic emotions do not appear. No sense of pity; Flavio is cruel to animals, shows emotion (physically) rather strongly and cries and laughs with extreme facility; but sensibility is very obtuse. He does not feel affection for anyone. His spasmodic laugh is peculiar, bursts out occasionally with the greatest facility, provoked by one word or one rather strong impression. Asked with insistency why he laughs so loudly and endlessly, he either does not answer or says "Who knows?" His mood is habitually gay, but above all, variable. His behavior is silly, without motive, postures are grotesque; he grimaces, has affectations in walking and in greeting. Childish curiosity. Tends toward solitude and to drink alcoholic beverages. He doesn't like to play games with other children, flees from company, and prefers to remain in idleness and make grimaces alone. His sense of imitation is much developed, he imitates the physiognomy and gestures of others. He does not like cleanliness, is disorderly, unstable. In school he behaves as one who does not understand the reason for things; however, he shows good memory, and when it seems that he has not understood anything the teacher has explained, it is surprising to hear him repeat what the teacher has said or read. From time to time he has an inane expression; he laughs, repeats endless times a gesture or any movement, he moves, he contorts, makes faces with his mouth and with his eyes; and all this without the least reason in the world. His father adds that often in the house he repeats for many minutes the same word; and sometimes this repetition of the same word is accompanied by stereotyped head and hand movements (stereotypes with verbigerations).

On certain days he displays a very sharp spirit of contradiction and even refuses to eat.

Recently I was able to gather from this patient, whom I have not seen since 1899, some news of great interest. Flavio in these last six years has changed much. He continued for about two years to show himself as described above, and his father was desolate over this; but then, his father said, "He became more serious." He has put him to work and finally, now that he is fifteen years old, he earns 5 lire per week.

IMPROVEMENTS OF PATIENTS

The improvement of the patient is neither due to pedagogy nor to medicine of any kind. It came about little by little during the period of

pre-puberty, after the condition of deficiency and insanity as his father had described had lasted about six years. I cannot at all ascertain that recovery may follow this improvement. It is probably that Flavio may retain a certain amount of intellectual deficit.

DIAGNOSIS OF DEMENTIA PRAECOCISSIMA

The *diagnosis of dementia praecocissima* does not seem to be doubtful in the case described above. The reasons are as follows: (1) The condition did not manifest itself in early or late infancy, when mental deficiency usually appears, but only in childhood; (2) The condition appeared without apparent causes and without concomitant symptoms involving sensory or motor behavior; (3) The condition presented the common symptoms of *dementia praecox;* (4) The condition had a well-defined course as true disease processes have and which mental deficiency does not usually have. In summary, I have observed at least five of these cases that I believe I could distinguish from cases of mental deficiency with insanity only. I was unable to observe in all five the decline of the dementia syndrome in puberty that I have described in the above patient.

I now want to refer to one of the cases in which one is *uncertain whether one deals with dementia praecocissima or only with mental deficiency with insanity.*

Doubtful Case: G. M., 6 years old (observed in 1899).

The paternal grandfather killed himself for love at age 55. Father immoral; liar, dissembler, very sensual, of very irregular conduct; has never loved his son Giuseppe. A paternal great-aunt died in a mental hospital, a paternal great-uncle was considered half insane. His paternal uncles had irregular conduct and were all erotic. The mother is deficient, vain, very fond of festivities and pleasures, jealous of her husband. A sister is well developed physically and rather beautiful; therefore she is loved by her parents. G. was delivered with forceps (at term). He suffered much during suckling; also later on he often lacked necessary nutrition. Maltreated as a baby, he had many traumas. He always wet the bed, and his aunt states that this habit is due to the fact that the mother never trained him as she should have. There is a suspicion of congenital syphilis. He always showed himself incapable of learning and therefore was dismissed from all the schools to which he had been admitted. In the winter of 1899 he was received in my school for poor, deficient children. He is a child normally developed physically, a brunette, weight 17.600 kgs., height 107 centimeters. Hands stumpy, fingers short, nails small; low forehead, straight black hair with abnormal vortex of

the scalp; small eyeballs, iris dark, face slightly asymmetrical, teeth with anomalies of form and position.

The state of G.'s general nutrition is very poor; respiration was regular, his heart was healthy. Nocturnal enuresis. Sleeps habitually soundly. G. presented stenosis of the left nostril because of a deviated nasal septum; cartilaginous crest of the same nostril, nasal catarrh.

Superficial reflexes sluggish, deep reflexes normal, pupillary reflexes normal, trophic conditions of muscles normal. Slight hypotonia of the lower limbs. Alternating strabismus is noted. The movements of the face, tongue, neck, trunk, upper limbs (at request) were impossible to examine on account of the mental state of the child; it does not seem, however, that there were important anomalies. His motor ability is little developed. G. always needs the help of someone in everything. The muscular strength of his hands seems normal. G. has habits among which is the sucking of his fingers. Sight and hearing normal. Sensitivity of touch normally developed. Sensitivity to pain (skin and mucous membranes) with mechanical stimuli is dull. Voracity in eating.

His attention is little developed. There is torpor and mobility. Memory is weak. He has no capacity to calculate. The capacity for emotion is very slight; no demonstration of affection towards his parents; no liking for companions. Mood habitually hostile or effusive, always very changeable, countenance silly. An extraordinary tendency to contradiction. Suggestibility paradoxical. G. has attacks of absolute mutism that last many days. Many times he has refused to urinate and to take food. Many times also he has been discovered eating some piece of bread which he kept in his pockets when he thought he was not observed. Here are the fundamental traits of his character: Indocility, negativism, and when he is in school, he keeps himself mute, solitary. Occasionally with the slightest stimulation he becomes very impulsive. He has a stereotyped smile that stays with him even when he is overcome by impulsive behavior.

To a superficial eye these would look like idiotic stigmata, but they are not so, because returning home in the evening G. comes out of his mutism, tells what he has seen and heard in school. Therefore, it is easy to rule out that the behavior of G. may be the product of pathological timidity. G. is not timid; rather, he is insensitive and impulsive.

After three months during which his condition remained unchanged, he was dismissed from the school, and I have not been able to hear any further news from him.

In this case the *diagnosis is doubtful* because the control of the course of the illness escaped us and we do not know anything concerning the beginning of the illness. The presence then of alternating strabismus and

slight paraplegia makes us suspect one of the many simulated forms of cerebroplegia. Certainly in G. M. one finds at least a type of insane mentality.

And finally a question (which is based upon what I have said about dementia retardata): *Has dementia praecox, in general, premonitory signs in the early years of life?*

According to my experience I should reply: very often.

I have had at my disposition only a small amount of material, but nevertheless I have become convinced that the history of patients with dementia praecox is never or hardly ever negative. Not only their heredity is tainted most of the time (it is admitted that 75% and even more have obvious hereditary predisposition), but these patients attracted attention for changes of character, or intellectual deficiency, or episodes of excitement, or of depression, etc. Whenever a case is presented to me of a youth that may exhibit hallucinations, confusion, excitement, and whose syndrome does not offer any other means for excluding dementia proecox, I believe it is valid to exclude it if he has a perfectly negative personal and family history.

I had already reached these convictions from my personal clinical observations when I reread the chapter on dementia praecox in the seventh edition of Kraepelin. I was surprised to discover that Kraepelin acknowledged certain psychopathological phenomena as antecedents of dementia praecox: timidity, strangeness, bigotism, affected behavior, irritability, and intellectual weakness; and he reports also observations analogous to those made by Schroeder.

THOSE DESTINED TO DEMENTIA PRAECOX

Furthermore, when we leaf through the literature of dementia praecox, we are struck by the need for distinguishing between two forms of this psychosis. There is the sort made up of individuals, completely normal and intelligent, who become acutely ill with dementia praecox at an age that varies between the 20th and 45th years. There is the second sort made up of predestined individuals who already in adolescence and in the dawn of youth are struck by melancholy, by hallucinations, and by psychomotor excitement. In the grip of these tumultuous symptoms (dementia simplex) these patients run their course heading toward precocious intellectual decline, as if nature had endowed them with a cerebral organization and structure devoid of resistance.

In this second category we find those individuals, *the mental deficients*, who are destined to *dementia praecox.*

Is this clinical distinction logical? Let us look at the pathogenic hypotheses that have been advanced for dementia praecox. To tell the truth there are not many plausible ones, but the hypothesis of Kraepelin (auto-intoxication from abnormal internal secretions of the sexual glands)[17] does not seem to be without evidence.

Kraepelin, indeed, intends a hypothetical relation between dementia praecox and the sexual function, in a very broad way, because he believes that auto-intoxication would be capable of provoking the cerebral process of dementia praecox whenever the genital glands enter into activity—puberty, menstruation, pregnancy, climacteric. Under these various circumstances the glandular activities are not so different. Thus it would be hard to understand how a brain, having withstood the physiological storm of puberty without deleterious consequences, would be affected deleteriously by pregnancy or the climacteric when cerebral development is complete and has occurred normally (sound brains).

In any case, the question is why such auto-intoxication should affect normal individuals as well as originally defective individuals. Is the generally acknowledged fact of the high frequency of infirmities among the dementia praecox patients a mere coincidence?

PREDISPOSITION OF BRAIN STRUCTURE TO DEMENTIA PRAECOX

But let us turn to pathological anatomy. In the various forms of dementia praecox, besides easily detectable alterations found in the brains of the amentias or of the melancholy (Kiernan, 1877, and all the recent authors: Nissl, Deny, Voisin, Ballet, Hoch, Meyer, et al.), besides unspecific chemical alteration of blood (Deny, Lhermitte and Camus, W. Prout, et al.), morphological and structural modifications of the cerebral cortex have been found of more value, like hypoplasia, atrophy, deviations of development, specifically localized in the deeper cortical layers, especially in the associative areas, or cellular atrophy and degeneration (Dunton, Alzheimer, Lugaro, Klippel and Lhermitte). It seems, therefore, difficult to explain certain structural alterations and certain specific localizations without *postulating a definite predisposition* in the brain structure of *patients with dementia praecox.*

It is more logical to consider dementia praecox a psychosis with a single pathogenesis and a single etiology that strikes in various degrees and with differing rapidity the developing organism.

[17] I have observed a typical case of dementia praecox in which from time to time the thyroid gland visibly swelled, and I have observed three cases also of classical dementia praecox, in which the development of the thyroid gland was very slight.

PREMONITORY SIGNS OF DEMENTIA PRAECOX IN CHILDHOOD

Individuals with dementia praecox may become ill even late, to pay, as it were, at a later date their constitutional debt, but they do not cease to be predestined, and the signs of their destiny may be found upon careful inquiry even in their childhood. How many times the epileptic attack due to congenital cerebral illness appears late in individuals who are destined to epilepsy; in epileptics in which the attacks began only at 25 or 30 years of age there were found at autopsy traces of prenatal encephalitis or porencephaly and microgyria. But in these cases before the attack would fully occur the *congenital illness* was revealed by other signs: slight motor phenomena, abnormalities of character, defective mentality, etc.

It is not conceivable that true dementia praecox may erupt in the constitutionally healthy organism completely developed and integrated. Psychiatric nosography would profit by a re-examination of those reports of dementia praecox described in the fourth or fifth decade of life in patients previously mentally balanced and robust, as well as those patients reported to have regained all their lost intellectual strength.

Kraepelin himself cannot explain how a psychic organism which had developed regularly and vigorously until adult life suddenly could without apparent cause stop in its development and often disintegrate. He adds that not even the most grave hereditary disposition could explain this extraordinary fact to us. And then? . . . We are dealing with nosography; the syndrome is not enough to determine a classification. Why not consider that in such cases one is dealing with a psychosis other than dementia praecox?

I think that the introduction of the term dementia praecox in psychiatry has been of incalculable utility, but only if by dementia praecox one means a psychosis linked to constitutional predisposition and to states of mental development which from their beginning and from their nature are truly demented, and therefore of invariably serious prognosis. Mental weakening must be real and therefore lasting, not only apparent, as is that of amentia, or of the hallucinatory form, or of nervous exhaustion. [18]

[18] Naturally the characteristics of the variety which I have here called "very precocious dementia" could be, in part, different from those of the common dementia praecox.