The International Library of Psychology

PERSONALITY AND MENTAL ILLNESS

Founded by C. K. Ogden

The International Library of Psychology

PERSONALITY AND MENTAL ILLNESS

Founded by C. K. Ogden

The International Library of Psychology

ABNORMAL AND CLINICAL PSYCHOLOGY
In 19 Volumes

I	Psychotherapy with Children	*Allen*
II	Personality and Mental Illness	*Bowlby*
III	Inferiority Feelings	*Brachfeld*
IV	Abnormal Psychology	*Coriat*
V	Dimensions of Personality	*Eysenck*
VI	The Dynamics of Anxiety and Hysteria	*Eysenck*
VII	Psychology of the Normal and the Subnormal	*Goddard*
VIII	The Neurotic Personality	*Gordon*
IX	Mental Conflicts and Misconduct	*Healy*
X	The Concentric Method in the Diagnosis of Psychoneurotics	*Laignel-Lavastine*
XI	A Handbook of Psychiatry	*Lichtenstein*
XII	The Psychology of Emotion	*MacCurdy*
XIII	Psychosurgical Problems	*Mettler*
XIV	Personality and the Frontal Lobes	*Petrie*
XV	Psychotic Art	*Reitman*
XVI	Conditions of Nervous Anxiety and their Treatment	*Stekel*
XVII	Emotion and Insanity	*Thalhitzer*
XVIII	A Short History of Psychotherapy	*Walker*
XIX	Constitution-Types in Delinquency	*Willemse*

PERSONALITY AND MENTAL ILLNESS

An Essay in Psychiatric Diagnosis

JOHN BOWLBY

Prefatory Note by Edward Mapother

First published in 1940 by
Kegan Paul, Trench, Trubner & Co., Ltd.

Reprinted 1999, 2000, 2001 by
Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Transferred to Digital Printing 2006

Routledge is an imprint of the Taylor & Francis Group

British Library Cataloguing in Publication Data
A CIP catalogue record for this book
is available from the British Library

Personality and Mental Illness
ISBN 978-0415-20920-5
Abnormal and Clinical Psychology: 19 Volumes
ISBN 0415-21123-9
The International Library of Psychology: 204 Volumes
ISBN 0415-19132-7

Printed and bound by CPI Antony Rowe, Eastbourne

1st Murderer :

We are men, my liege.

Macbeth :

Ay, in the catalogue ye go for men ;
As hounds and greyhounds, mongrels, spaniels, curs,
Shoughs, water-rugs and demi-wolves, are clept
All by the name of dogs ; the valu'd file
Distinguishes the swift, the slow, the subtle,
The housekeeper, the hunter, every one
According to the gift which bounteous Nature
Hath in him closed, whereby he does receive
Particular addition, from the bill
That writes them all alike : and so of men.

(MACBETH, Act III, Scene 1)

This page intentionally left blank

CONTENTS

PREFATORY NOTE

DURING March 1940 the author wrote to Professor Edward Mapother asking him if he would write a Foreword to this book. A few days later Professor Mapother died. In these circumstances the author asked permission of Mrs Mapother to publish the private letter printed below and this she very kindly gave. The circumstances in which this letter was written explain themselves.

19 Queen Anne Street,
Cavendish Square,
W.1.

June 5th, 1939.

Maudsley Hospital,
Denmark Hill,
S.E.5.

DEAR DR BOWLBY,

There is of course no objection to the publication of your thesis on account of any information which it contains concerning cases seen at the Maudsley. However, I am very glad indeed to have had the opportunity of seeing it and should like to congratulate you. I found it intensely interesting, and as it is relevant to matters that I may deal with in the Maudsley Lecture to the R.M.P.A. which I am due to give in November next, I hope to be able to read it more slowly and carefully. Have you a copy that I could borrow, or is it likely to be printed in the near future?

Hoping you will get for your thesis the recognition which it deserves.

Yours sincerely,
EDWARD MAPOTHER.

This page intentionally left blank

PREFACE

SOME apology is required for presenting to the public a work which is so manifestly incomplete. In defence it may be said that the observations, such as they are, confirm in principle a certain theory of typology, dispose of many common beliefs and suggest a new basis for the classification of the psycho-neuroses. Moreover, few clinical as opposed to theoretical studies of the questions at issue are available. An attempt has been made to review all the clinical material published in English, to collate it and to compare it with new observations. As a clinical review of the subject it may therefore have some value.

The observations reported were begun at the Maudsley Hospital when I was a clinical assistant there in 1933 and 1934. As each patient came under my care I found myself fascinated by the questions, what sort of man was he before he became ill? In what ways, if any, was he more unstable or neurotic than others? I spent many hours discussing this with the patients themselves and with their relatives and gradually I came to recognize certain characteristic personalities who seemed specially liable to develop a functional mental illness. At this stage I re-read Kretschmer and most of the British and American literature on the subject and realized that my own observations when taken in conjunction with those of others enabled many interesting though tentative conclusions to be drawn.

The next step was clearly to undertake a systematic enquiry into the matter to check my conclusions, but since 1936 my work has been largely in child psychiatry and opportunities for continuing the work along the same lines were not available. I have nevertheless made use of the principles of classification and diagnosis described here in my work with children and have found that by diagnosing the 'neurotic' child in terms of his total personality rather than in terms of particular symptoms

more informative diagnoses and more reliable prognoses can be made.

But though I am satisfied that this classification has clinical value I should be the last to contend that my hypotheses are scientifically proven, for my observations are confined to a mere 65 patients. Yet it should be remarked that less exhaustive enquiries have been made in a far larger number of cases and the various conclusions tested in this way. These further observations are too scrappy for inclusion here but have influenced me throughout and supported me in my conclusions. Without these unrecorded observations indeed I should feel quite unjustified in proposing the various modifications of classification which I have made.

But my principal reason for publishing this work in its present incomplete state is the hope that it may stimulate others to undertake the research necessary to confirm or to modify my conclusions. Without a clearing of the ground such as that attempted here the research worker is often lost and inclined to spend time on investigations which only lead into a *cul-de-sac*. As an example of the time and energy wasted in this field may be cited the endless enquiries into extraversion-introversion and similar theories which have only the lightest of toes on the stage of clinical observation. If the work presented here provides a fruitful point of departure for a comprehensive clinical research into the problems of the classification of personality and neurosis, it will have fulfilled its object.

I should like to thank many friends for their help, especially Dr Gilbert Debenham for reading the typescript and making many valuable criticisms and Miss May Wilcox whose help in following up a number of patients enabled me to confirm various doubtful diagnoses.

My thanks are also due to Dr Edward Mapother and to Dr Bernard Hart for permitting me to publish case-histories of patients seen at the Maudsley and University College Hospitals respectively.

J.B.

May 1940.

Chapter I

INTRODUCTION: MODES OF PSYCHIATRIC CLASSIFICATION

One of the more curious features of living beings is the great diversity of form manifested within the unity of a given species. Selective breeding has extended these variations to extraordinary degrees as the vast divergences observed in the breeds of domestic animals testify, but even in nature the differences are remarkable. Compare the sweeping boughs of a beech tree growing on a Cotswold down with the crabbed and stunted bush which passes for a beech on a Scottish hillside, or the river-feeding brown trout of this country with their silver sea-feeding brothers in New Zealand. Variations as great as these are not very common, but subtle differences are universal, for practically no living creature is similar to another.

Human beings are no exception to this rule and of course the individual differences of man's physique have long been studied by anatomists, physiologists and physicians. Of recent years attention has been paid also to the variations in their mental functions. For instance much work has been done to devise tests and statistical methods for measuring intelligence and these have now reached a high degree of reliability. But there are other mental functions which have not proved so amenable to accurate testing and measurement, in particular those emotional and temperamental qualities which we sum up under the name of personality. It is obvious that these functions vary quite as widely as any physical characteristics, but, despite intensive research, great

difficulty is still encountered whenever any attempt to measure them is made.

Before going farther it may be as well to be clear what we mean by personality. The term is commonly used to describe what a person is like, how he feels, thinks and behaves in the circumstances of life, in much the same way as the term " shape " is used to describe the spatial qualities of an object. Personal characteristics are those which tell us whether a person is easy to get on with or is angular and difficult, whether he is conventional or eccentric, apathetic or ambitious. Personality is the sum of all these qualities, a synthesis of various and often contradictory trends, the unity of which these trends are but partial expressions. Clearly, then, the traits of personality are some of the most important of individual variables, for it is these, not physical or intellectual differences, which distinguish Napoleon from Nero, or Baldwin from Byron. This, of course, is not to say that physical differences may not accompany or even underlie personal differences. We may one day be able to describe the essential physical features which accompany variations of personality, but it is not yet possible and the most fruitful approach to the study of personality remains the direct observation of its manifestations.[1]

One of the first essentials of study in any field is accurate description and classification of the objects to be studied. Historically there have been very numerous attempts to classify and delimit types of personality, but none of these has proved very helpful. Of recent years the attempts have been renewed. Psychiatrists have cast their net wider and interested themselves not only in fully developed psychoses but also in the personalities which their patients showed before they fell ill and in the minor mental symptoms such as obsessions and phobias which constitute a part of the personality of

[1] Throughout this work the terms " personality " and " character " have been used interchangeably.

large numbers of people who commonly pass for "normal". These studies have cast a flood of light upon the relationship of mental disease to healthy personality and have raised the urgent problem as to whether there are hard and fast lines to be drawn between them, as Kraepelin and his followers believed. Kraepelin's theory was that the various functional psychoses were separate disease-entities each with its specific pathology and therefore qualitatively different from anything seen in healthy people. This view has been questioned and in my opinion shown to be untenable. Many workers, particularly Kretschmer on the Continent and Meyer and Hoch in America, have demonstrated convincingly that states such as mania or melancholia are not the result of specific elements added to or subtracted from healthy personality, but are similar in quality to and simply exaggerations of the mood-swings of ordinary people. Similarly, many cases of dementia praecox have been shown to have developed without a break from a seclusive personality which, though not quite normal, had not previously been regarded as sick. This theory stresses the unbroken gradation of mental states from the completely healthy to the utterly insane and recognizes no clear-cut lines of demarcation.

Whilst the gradation theory appears to have gained the day upon the Continent and in America the controversy continues heatedly in this country. There are many psychiatrists who believe for instance that a psychotic depression is something radically different from a reactive, psychogenic or psychoneurotic depression. They have often been attacked but perhaps never so completely routed as by Lewis in his exhaustive paper on melancholia. Here he has examined the criteria commonly proposed by the Kraepelinian school for distinguishing these syndromes and has shown that none of them can bear a rigorous clinical test. Lewis's views have been completely corroborated by Curran in another clinical study. Any degree of insight may be present

in psychotic patients from a complete recognition of madness to a vague appreciation that they are ill ; so-called psycho-neurotic symptoms clear up in a number of cases without active psychotherapy, contrary to Ross's assertion ; and the presence or absence of a definite psychological precipitating factor proves of no help in grouping patients.

While there has been great resistance to the idea of a continuous series from psycho-neurosis to psychosis, the notion of healthy personality grading off into psycho-neurotic or psychopathic personality seems at last to have been fully accepted. Although it met with considerable opposition when first propounded by the psycho-analytic school, it seems now to have become a commonplace. Kahn emphasizes that " it is impossible to draw boundaries between the normal and the psychopathic " ; and further, " the psychopathic . . . is differentiated not *qualitatively* but only *quantitatively* from the normal . . ". By psychopathic he means to designate " a large group of characteristics or conditions which lie in the broad zone between mental health and mental illness (psychosis) ", a group which corresponds to what is often termed neurosis or psycho-neurosis, but the emphasis is laid less on the symptom and more on the personality of which the symptom is a part. This is a particularly desirable point of view for it insists that *all mental symptoms whether major or minor, always involve the total personality.* It is obvious in a case of schizophrenia when, for example, a religious docile girl becomes obstinate, erotic and blasphemous. But the minor psychoses (or psycho-neuroses) do not affect the personality so dramatically and consequently the identity of symptom with personality has tended to be evaded. Of recent years it has been fashionable to speak of someone having a " complex " or a neurosis rather in the same way as one describes their possession of a bowler hat. But a phobia or an obsession influences feelings, thought and action in the same way as any normal component of

personality such as love or ambition, and must be regarded in the same light.

The tendency to divorce mental symptoms from personality has also been responsible for another great psychiatric evil—the use of an outstanding symptom as a diagnostic label. To diagnose a patient as homosexual or phobic is like diagnosing haemoptysis without relating it to the total thoracic condition, or hallucinations without defining the nature of the psychosis. Homosexuality and phobias are merely the symptoms of various mental states. It is obviously misleading to group two patients under the one label " phobic " when one shows elements of self-reproach and hypochondria and the other a shut-in personality with signs of thought disorder. The phobia is commonly far less important than the total mental state, a correct estimation of which will be the only reliable guide to prognosis. The psycho-neuroses are disorders of personality which do not interrupt a person's ordinary life to a degree necessitating hospital care. To call them partial or minor disorders is misleading. As Meyer long ago pointed out, some neuroses (especially certain obsessional conditions) involve the personality far more deeply than some psychoses, e.g. a depression. The fact that the latter involve temporary hospital care is the only ground for regarding them as more serious.

If this point of view is accepted, the different types of healthy personality, the psycho-neuroses and the psychoses are to be regarded simply as individual variations of personality. It is aptly summed up by Mapother, when he writes of the usual classification of mental disorder, that these " are really nothing but categories which have been invented for the grouping of cases according to symptoms where no other classification is possible, and categories into which particular cases fit with more or less accuracy and completeness. The naïve, though attractive, simplicity of the view that the number of such categories is determined by the natural

existence of a corresponding number of distinct diseases (until lately awaiting discovery by Kraepelin and others) is obsolete. Terms like demential praecox and manic-depressive insanity are at most the names of *syndromes* dependent on one fundamental psychological anomaly or on a common combination of such."

In this essay, what may conveniently be termed the "gradation theory" will be assumed throughout. No attempt will be made to discover hard and fast lines dividing healthy personalities which we meet with daily in our ordinary lives, personalities stricken with neurotic symptoms and those people whose personalities have been completely deranged, either temporarily or permanently, by psychotic changes, because it is believed that no lines exist. All such conditions will be regarded as the result of individual variations in man's personal qualities in the same way as most cases of mental deficiency and cases of genius can be regarded, not as anything specific, but simply as the upper and lower limits of the normal distribution of intelligence. Healthy personality is simply one manifestation of personality, the neuroses and functional psychoses being others. If this view is correct it is as idle to study the one without the other, as it would be to study ice or steam apart from water, or a bulb apart from the flower which springs from it.

Of course insistence upon the essential unity of these conditions is not to deny the possibility of classifying them. Although all dogs are of one species and every gradation can be found between different types, a classification of breeds is none the less convenient. Now the crux of any classification is the criteria by which differences are recognized. The most commonly accepted in the past have been the distinctions which we have just been discussing, those between a healthy personality, a person suffering from a psycho-neurosis and a person suffering from a psychosis. Each of these groups has been conceived to be essentially distinct and to show a greater unity within itself than with either of

the other two. The psycho-analytic school for instance still adheres in principle to this classification. Fenichel writes : " Schizophrenia and cyclothymic disorders seem to us to be related, at any rate in the crucial features that distinguish them, from the neuroses and from normality ", and Glover's scheme is only a slight modification of it. The neuroses and psychoses are arranged in linear order, rather reminiscent of Kahlbaum's " Einheitspsychose ", beginning with psychosexual inhibition, which is nearest normality, and proceeding via hysteria, obsessional neuroses and melancholia to dementia praecox. The variable involved is the degree of regression. Although this is a classification based upon the gradation theory it has serious faults. For instance if it were true we should expect that, when an obsessional patient became worse, he would develop a manic-depressive psychosis. This of course sometimes happens, but other obsessionals develop schizophrenia without any symptoms of an affective psychosis. Hysterias also at times become schizophrenias without any transition. Not only is the linear arrangement unsatisfactory, but there are grave objections to any grouping which emphasizes the similarity of the psychoses as a group opposed to the neuroses. It has already been pointed out that it is impossible to draw any line between the two, and that some neuroses are more severe than some psychoses. In addition, we find in many patients an alternation between a neurotic state and a psychotic. For instance, a patient may have attacks of melancholia and in the free intervals suffer from neurotic indigestion, from which his depressions relieve him. On the other hand, despite the occurrence of mixed states, the affective and the schizophrenic psychoses are commonly very different both in symptomatology and course, and transitions from one to the other are not common.

An alternative and to my mind a more fruitful method of classification is one which begins by grouping together mental conditions which can be observed in successive

phases of the life-history of single individuals. It must be remembered that personality varies enormously during the course of a lifetime. For instance, in youth a patient may be exuberant and distractable, by thirty this may have given place to careful conservative-conscientiousness accompanied by headache or indigestion. A business failure at forty perhaps precipitates a psychotic depression from which, after a short period of hypomania, he makes a good recovery, to end his days cautious and somewhat hypochondriacal. It is not a fanciful picture ; there are many people whose personalities have shown this or similar transformations. *Now if all these different states can appear in the same personality it is dangerous to separate them when constructing a classification, for they are likely to be closely related.* It was considerations such as these which led Kraepelin to reject the former habit of regarding manic and depressive states as separate diseases and to group the two together in one big group, regardless of the fact that they are superficially very different and that many patients during their lives show only the one or other reaction. With such an example in mind we are encouraged to construct a classification which assumes that, when a personality-type, a psycho-neurosis and a psychosis are found in the changing aspects of one personality, these mental states have a close internal relation to one another and spring from some common source. It will seek the underlying structure of which the various states are but partial manifestations and contrast it with other structures which may be found underlying some different series of personality states.

It is a classification of this kind which Kretschmer and Bleuler have elaborated. They have been impressed by the fact that the personalities which schizophrenics have shown before the onset of psychosis are different in many respects from those shown by manic-depressives. This led them to group so-called schizoid personalities with schizophrenics on one side, and cycloid (or syntonic)

personalities with manic-depressives on the other. This is an entirely different form of classification from that which we were first discussing. So far from grouping all the psychoses together as a unit, Kretschmer and Bleuler find their most fruitful distinction to be that subsisting between them. Kretschmer writes : " All along we have assumed, as the basis of our investigations, that the endogenous psychosis is a *pars pro toto* of a man's total psychic type. The psychic constitution of a man expresses itself not in the psychosis alone, but in the inclusive picture of his total personality at any phase of his life, of which the psychosis is only an episodic excerpt."

It will be seen then that there is a serious conflict between the two main approaches to psychiatric classification, a conflict which underlies much controversy. To demonstrate it the more clearly it may be convenient to contrast them by means of diagrams. The older type which derives from Kraepelin and which distinguishes particularly between different degrees of mental derangement may be represented thus :

HEALTHY PERSONALITY

NEUROSES	HYSTERIA
	ANXIETY STATES
	OBSESSIONAL NEUROSIS
PSYCHOSES	MANIC-DEPRESSIVE PSYCHOSIS
	SCHIZOPHRENIA

In Kraepelin's day each of these boxes was conceived of as fundamentally different from all the others. The classification in other words was completely qualitative. This same classification, however, has more recently been thought of as purely one of degree. Whichever difference is assumed, it fails to fit the facts.

The alternative basis of classification which follows Bleuler and Kretschmer is composite. Differences of degree and of kind are assumed. Variations in health and ill-health are thought of wholly as matters of degree. The qualitative distinction which is believed to be vital is that between the affective and schizophrenic psychoses. This does not mean to say that gradations between the two types are impossible, but that two factors at least are involved, the majority of people having either one or the other and only a few having both.

It is a classification closely comparable to that of infections. One person may have a tuberculous infection and another a streptococcal. Each infection has a variety of manifestations of varying degrees of seriousness —abscess, enlarged glands, septicaemia, etc. When in the same stage the two infections show much similarity and may be mistaken for one another. But the qualitative difference between them is there and is the all-important thing. One bacterium is the cause of one series of pathological changes; another behind a different, though similar, series. Moreover both diseases may be present in the one person, which finds its analogy in the mixed affective and schizophrenic conditions sometimes found.

The vertical classification to which this viewpoint gives rise can be represented thus :

CERTAIN HEALTHY PERSONALITY TYPES	Certain Healthy Personality Types
. . . . .	. . . . .
CERTAIN ABNORMAL PERSONALITY TYPES	Certain Abnormal Personality Types
. . . . .	. . . . .
CERTAIN PSYCHO-NEUROSES	Certain Psycho-neuroses
. . . . .	. . . . .
AFFECTIVE PSYCHOSES	Schizophrenias

In this diagram the qualitative distinction is represented by the vertical line, on each side of which are various

conditions which only differ among themselves in matters of degree. Although in this diagram only one vertical distinction is taken into account, there is no reason to suppose that only one exists. There is some evidence to suggest in fact that there is another series ending in epilepsy.

In this thesis it is the " vertical " classification which has been adopted, because it has seemed to fit the known facts far more closely than the " horizontal ". The latter fails to account for the fact that certain personalities only develop one kind of psychosis whilst others only develop another kind. The " vertical " classification on the other hand not only allows for transitions of a given personality from health to psychosis and back again to, perhaps, a psycho-neurosis, but also explains the limited range of possible symptoms which seem to be available for any given type of personality.

This type of classification has another great advantage over the other. Since it takes all phases of a personality into account and does not concentrate too closely on transient symptoms or syndromes it is possible to arrive at a prognosis of a given personality. Although at present our knowledge may not be very reliable, the classification if worked out would enable the type of psychoneurosis or psychosis to which someone is liable to be predicted, and also their chance of recovery. Moreover it takes account of the distinction between affective and schizophrenic psychoses which, though not absolute, has been of profound importance to modern psychiatry, especially in treatment and prognosis.

With this classificatory system in mind it has been my task to enquire what particular syndromes and personality types are related to one another. An attempt has been made to trace as far as possible the history of a number of individuals to discover to what extent personality may change in the course of time and what traits of personality and what mental symptoms are commonly associated. My own observations have been compared with those of

others and some suggestions offered, especially with regard to the proper placing of the psycho-neuroses. My purpose has been purely descriptive. No attempt is made to discuss the many theoretical problems underlying the dynamics of and distinctions between personality types and their maladies, for it is believed that accurate description and classification are essential before this can profitably be undertaken.

My procedure will be as follows :

1. To examine the work which has already been done in studying personality and relating it to neurosis and psychosis.
2. To present a schedule of personality traits which I regard as significant in distinguishing the major types of personality.
3. To tabulate these traits for 36 patients who have suffered from a psychosis.
4. To isolate 33 traits which are believed to have special significance for diagnostic purposes.
5. To describe certain personalities which are regarded as typical of certain groups of unstable personalities.
6. To tabulate the traits for another 29 patients suffering from neurotic symptoms.
7. To draw tentative conclusions as to the relationships of certain personality types to neurotic and psychotic syndromes and to suggest some revision of the present grouping of the neuroses.

CHAPTER II

PERSONALITY TYPES AND THE PSYCHOSES

WITH the foregoing background of theory stated we can proceed to a discussion of the views at present current upon the relationship of particular types of personality to types of psychotic reaction and to psycho-neurotic syndromes. As a matter of fact almost all the work at present published is concerned with the previous personality of patients who later become psychotic and comparatively little attention seems to have been paid to the position of the psycho-neuroses apart from generalized references.

The earliest detailed work on the subject was done by studying the previous personalities of patients who had developed dementia praecox. In 1909 Hoch in America published his observations and in 1913 Kraepelin produced his. They showed that a large proportion of their patients had shown definite psychic peculiarities prior to their breakdown and that usually these had existed since childhood. Berze and Medow went farther and showed that similar personalities could be found amongst the relatives of dementia praecox patients. The most frequently noted anomaly was a shyness and reserve which caused them to lead solitary and secluded lives, an observation which has often been confirmed and is now a commonplace of psychiatry. One result, however, has been that other and equally important observations have tended to be overlooked ; in particular, the early recorded fact that many female patients show an irritable, excitable and capricious temperament of an hysterical type, markedly opposed to the shy reserve

commonly emphasized. Another trait which was early remarked upon was a tendency in some patients to extreme docility and goodness—the model child—and in others the opposite disposition—to play nasty tricks, to be cruel, lazy and good-for-nothing. Many of the latter, as Willmans showed, had drifted into vagrancy, prostitution and petty crime before becoming frankly psychotic.

These observations built a bridge between psychotic and non-psychotic personality. The madman was no longer someone apart, someone who had no resemblance to common humanity ; now he was shown to be a first cousin to certain people to be met with in ordinary life. This first correlation has been of the greatest importance and all further work has centred round it. The term *schizoid* was introduced by Binswanger to describe personalities which are allied to schizophrenia but not actually psychotic, and has been widely adopted since. Bleuler, and later Kretschmer, have made its use popular.

Not long after the recognition of schizoid personality types came descriptions of another type. Reiss in 1910 had made a study of the disposition of people liable to manic-depressive insanity and had given a detailed description of the depressive personality. This was greatly elaborated by Kretschmer when he published his book *Korperbau und Charakter* in 1921. The details of his findings will be discussed later. In brief he found that patients predisposed to this psychosis were mostly sociable and genial people, in contrast therefore to the schizoids. Some were cheerful, jolly, and hasty tempered, others rather doleful, taking things to heart, but whichever pole they tended towards, whether hypomanic or depressive, they were almost always friendly and genial. " Cycloid men have 'hearts'. The word ' heart '—better, perhaps, ' good-nature '—brings one nearest to an expression of that which is common to the majority of these natures, throughout their various habitual temperamental foundations the soft, warm,

kind-hearted, philanthropic temperament, naturally capable of being moved to joy or sorrow." To describe the group Kretschmer used the term *cycloid.* His description of schizoids followed closely that of Hoch, Kraepelin and Bleuler. Kretschmer's formulation of the cycloid personality type was readily accepted. Bleuler objected only to the term " cycloid " on the ground that it includes many cases without periodical variations of emotion. Criticizing the more general term " cyclothymic " which Kretschmer used later Bleuler remarks " the majority of such cases are neither cyclic nor thymic ". He proposed " *syntonic* " as an alternative, meaning to emphasize the unity of reaction in these personalities ; " the whole personality uniformly participates in a definite and relatively vivid affect suitable for the situation of the moment. . . ." Although Kretschmer asks—what's in a name ? Bleuler's criticism was probably sensible, for the use of the terms " manic-depressive " and " cycloid " has led the unwary to think that everyone belonging to the group undergoes marked and frequent changes of mood, that this indeed is the essential characteristic of it. Such views have led to much confusion and there is no doubt that the terms " affective " psychosis and " syntonic " personality are preferable, though to these there are the obvious objections that the affects are just as involved in schizophrenia and the syntonic personality is by no means unified.

Apart from terminological disputes, however, two markedly different types of personality had been isolated, the one predisposed to an affective psychosis, the other to schizophrenia. Upon this major distinction many otherwise differing schools of psychiatry were united. Such groups of course would only include a small minority of people definitely predisposed to psychosis, despite Kretschmer's descriptions of cycloids which seemed applicable to many ordinary nice persons. The next step, however, was obvious. Was it not possible that even healthy individuals might approximate to either one or

other of these types ? Kretschmer himself, after examining a large number of " normals ", came to the conclusion that many of them did so, and this led him to describe his two great typological groups, the cyclothymes and the schizothymes, which include within them healthy as well as sick personalities. " We call the members of that large constitution class, from which the schizophrenes are recruited, '*schizothymes*', and those that correspond to the circular psychotics are called '*cyclothymes*'. One may for convenience call the transitional states between illness and health, and the pathological abortive forms, 'schizoid' and 'cycloid', as we have already done. We must, however, make it clear from the outset that the notions 'schizothyme' and 'cyclothyme' have nothing to do with the question : pathological or healthy, but that they are inclusive terms for large general biotypes, which include the great mass of healthy individuals with the few corresponding psychotics which are scattered among them." His description of these general biotypes followed closely the lines laid down in the description of the pathological forms. He attempted to define the characteristics which are common to all the members of each group rather than give a description of individuals. Cyclothymes, he thought, were essentially sociable and kindly, engrossed in their surroundings and living in the present in contrast to the schizothymes who are humourless, self-centred and shut-in. Another distinction, emphasized particularly by Bleuler, is the tendency for cyclothymes (syntones) to react to psychic stimuli with an immediate, natural and appropriate expression, whilst in the schizothyme there is an inadequate correspondence between the psychic stimulus and the motor response, which may be either explosive or indifferent or a bit of both. Kretschmer supported his theory of biotypes by two further sets of observations. Studies in heredity showed a tendency for members of one family to fall into the same class, whilst an examination of the physique of the two classes revealed marked

and typical differences. Whereas the cyclothyme is usually thick-set and well covered, the schizothyme is lean and angular with prominent features. In broad outline this work seems to have been confirmed by other workers and is only mentioned here because it is important contributory evidence in favour of the general theory.

Kretschmer, however, was not satisfied with the objective description and establishment of biotypes ; he wanted to explain the essential nature of their different reactions, and for this purpose he proposed a theory of temperament which distinguished " two scales of feeling, both of which are of fundamental importance in adjudging temperament but which are quite independent of each other ; these are the *psychaesthetic* scale which lies between the poles—' sensitive ' and ' dull ' ; and the *diathetic* scale whose terminal poles are ' cheerful ' and ' sad.' " A person's temperament, he believes, is commonly neutral in one of these scales and variable in the other ; thus the schizothymes are those who are variable on the psychaesthetic scale, the cyclothymes on the diathetic. It accounts for both hypersensitive and indifferent types of schizothymes, and amongst the cyclothymes jolly energetic temperaments and quiet depressed ones.

Though ingenious, one feels that this dualistic theory of temperament is rather *ad hoc*, unsupported by other observations and partaking of the faults of faculty psychology. Bleuler is less speculative. He simply believes that there are some fundamental biological factors corresponding to the schizoid and syntonic reactions which are present to some degree in everyone. " Every man then has one syntonic and one schizoid component. . . . Either both or only one of the reactions may be morbidly aggravated in the same individual. The extreme cases then belong to the pure manic-depressive and the pure schizophrenic diseases. Frequently, however, we find distinct mixtures. . . . Except in the rare extreme cases we now no longer have to ask, is it manic-depressive or schizophrenic ? But *to*

what extent manic-depressive and to what extent schizophrenic ? "
For the purpose of this essay, however, it is unnecessary to enter further into theoretical considerations. Our chief purpose must be to investigate the descriptive validity of the types.

A common misunderstanding of Kretschmer's position is that he holds that all personalities must and do fall into one or other of his two categories. This was never intended and he has often denied it. " It has been thought improbable that there should be only two types of human nature. But we never said there were. This work is only a preliminary canter ; by means of patient co-operation on the part of others it may perhaps be possible to divide up the types, which we have differentiated for the meantime, into sub-groups, and to discover new ones to add to them." He himself has suggested that there may be biotypes corresponding to hysteria and epilepsy, but these are not very well defined and have not been widely accepted. Nevertheless the possibility of some such existing must be borne carefully in mind.

At about the same time that Kretschmer was busy working out his concept of biotypes, another and very similar attempt to relate healthy personality to morbid reaction types was being made. In 1913, Jung wrote a paper in which, impressed by the contrast between hysteria and dementia praecox, he suggested that all people might approximate more or less to one of these extremes. " The picture presented by these contrasted illnesses is one of exaggerated emotivity in the one, and extreme apathy in the other. In their personal relations this difference is very marked." For the difference in question he proposed the terms " extraversion " and " introversion " and, like Kretschmer, applied the concepts in an effort to classify normal persons as well as those mentally ill. " The existence of two mental affections so opposite in character as hysteria and dementia praecox, in which the contrast rests on the almost exclusive supremacy of extraversion and introversion

suggests that these two psychological types may exist equally well in normal persons, who may be characterized by the relative predominance of one or other of the two mechanisms." This early suggestion was followed up in 1920 by the publication of his ambitious work *Psychological Types*, in which the tentative suggestions put forward earlier were greatly elaborated. The two main types remained, but important subdivisions and cross divisions were introduced depending upon the predominance of one or other of four modes of psychological functioning ; thinking, feeling, sensation and intuition. The resulting classification is very complicated and cannot be discussed fully.

But enough has been said to show that Jung's procedure was very different from Kretschmer's. Both started, it is true, by contrasting two morbid clinical reactions ; but whereas Kretschmer was principally concerned in discovering the differences of the *total personality* related to and involved in the two psychoses and founding typology upon these, Jung concentrated attention upon the *form of the morbid reaction* itself. This difference is best seen in their varying uses of the dementia praecox reaction. Krestschmer was concerned with the type of personality which developed this illness. He made numerous observations on this point and concluded that potential praecox patients differ from the normal in respect of sensitivity, sexuality, social relations, and other ways. These variations he contrasted with the variations from the normal shown by patients prone to an affective psychosis. Having made these detailed observations, which have since been broadly confirmed, he proceeded to construct a theory to account for them. Jung, however, was not interested in the personalities of his patients before they became psychotic. He directed attention only to the withdrawal of interest from the outside world which they showed when the psychosis was fully developed and contrasted it with the excessive interest in the outside world shown by the hysterical patient. From this

well-known fact he proceeded to generalize and produced his theory of introversion and extraversion.

Consequently, whereas Kretschmer's work is both descriptive and theoretical, Jung's is almost unrelievedly theoretical. Whatever opinion may be passed upon Kretschmer's theory of temperament it is clear that a large body of careful observation upon the transformations of personality and the correlation of different personality types and psychosis remains. There is none of this in Jung's work ; his classification is founded almost entirely upon a theory. The concepts of introversion and extraversion are theoretical abstractions intended to explain dementia praecox and hysteria and signs of them are then looked for in normal people. Consequently, Jung's work casts very little light upon the problems of prepsychotic personality, although, in so far as his clinical vision has not been blinded by the mists of his verbose theory, he has constructed a perfectly legitimate classification of personality types.

It is unnecessary to examine Jung's types further, for, as has been mentioned, except for identifying extreme introversion with dementia praecox and extreme extraversion with hysteria he does not relate his types closely to the other neuroses, nor to manic-depressive psychosis. Unfortunately, other writers have not hesitated to do so and have made some equations which have much confused the issues. It was inevitable that the terms introverted and schizoid should be identified, because of their mutual relation to dementia praecox, and Kretschmer himself described his cyclothymes as extraverted.[1] Once begun, the antithesis grew, just as, when war has broken out, the enemy grows steadily more villainous and one's own side more righteous ; and it only remained to describe the cycloid personality as frank and open in contrast to the classical schizoid shut-in type for it to be complete. Such simple contrasts

[1] See the *translation* of his textbook of Medical Psychology. I have been unable to verify the German original.

are attractive and there is no wonder that this one quickly attained widespread popularity. Henderson and Gillespie amongst others adopted it and a quotation from their textbook may be taken as representative :

> " In schizophrenia it is found that in a strikingly large percentage the personality that existed before the disease occurred or was recognized was of the so-called ' shut-in ' type. . . . This is identical with an extreme degree of introversion (Jung) and with the ' schizoid ' personality types of Kretschmer. The type of personality that is prone to manic-depressive illness is the so-called syntonic (Bleuler) or cycloid (Kretschmer) or cyclothymic personality. This type represents an extreme degree of extraversion and is characterized by its affective lability and responsiveness."

Later on they write that the " Manic-depressive disposition is one in which the affect swings from states of elation to states of depression in people who are generally recognized to have frank open personalities."

Now a moment's reflection will show the serious confusion in these passages. It is probably true that the shut-in personality is identical with what Jung means by an extreme degree of introversion, but it is certainly not the same as the " schizoid " personality types of Kretschmer. For instance, in addition to the seclusive schizoids there are the hysterical schizoids already mentioned who are the reverse of being shut-in. The concept of the schizoid personality is far more widely based than the term " shut-in " implies. Kretschmer emphasized this when he wrote : " We shall have to lay particular stress on the symptoms of psychic over-excitability, because this has been far too little appreciated as an essential ingredient of the schizoid personality." He describes as characteristics of the hyperaesthetic schizoid type, " a tenderness which easily takes on the quality of exaggeratedness, sentimentality, pathos,

enthusiasm or an elegiac colouring ; and also, again, in the sense of an unwontedly tender impressionability as regards the quiet stimuli of nature, and the world of Art and Literature", and goes on to conclude that "there is no doubt whatever that there are many 'nervous' and 'hysterical' individuals . . . who are biologically nothing other than schizoids". Consideration of the hysterical schizoid demonstrates furthermore the objection to equating schizoid with introverted ; for it will be remembered that the hysteric is precisely the type which Jung regards as pre-eminently extraverted. Whatever the similarity then of these rival classifications, it is evident that they are not identical and nothing but confusion can result from the facile equation of their terms.[1]

In addition to terminological errors, errors of description have resulted from this enthusiastic contrasting of types. Kretschmer probably drew rather too flattering a picture of his cycloids when he described them as sociable and good-natured and attributed nervous characteristics to the intervention of schizoid components ; one gets the impression that he exaggerated the differences between cycloids and schizoids, making the cycloids too much the opposite of schizoids, but he certainly never went so far as to call cycloids frank and open. In point of fact a very little investigation into the previous personality of patients suffering from affective psychosis is

[1] It is always difficult to equate personality-types described by one writer with those of another and this is not made easier by the absence in Jung's descriptions of actual clinical examples. It is my impression, however, that the following equations are justified.

Jung's extraverted "thinking", "sensation" and "intuitive" subtypes correspond to the Hyperthymic Syntonic characters described here. The extraverted "feeling" sub-type is practically identical with the Hysterical Schizoid.

Of the introverted types, the "thinking" sub-type corresponds to the Cautious Obsessive. The "feeling" sub-type is not easily equated but appears to lie amongst the depressive syntones, Jung himself remarking that their temperaments are melancholic and they are liable to neurasthenia. The introverted "sensation" and "intuitive" sub-types are identical with the shut-in schizoid types described by many writers.

It will thus be seen that two introverted sub-types are to be found amongst the Syntones and one extraverted sub-type amongst the Schizoids.

sufficient to dispel such a view. As we shall see they are commonly referred to as quiet, keeping themselves to themselves, shy, and so on.

The most recent work on the subject, under the direction of Bowman in America, has done much to correct the over-simplified contrasts such as we have been discussing. Working under a grant from the Laura Spelmann Foundation, a group of psychiatrists of the Boston Psychopathic Hospital made an exhaustive enquiry into these problems during the period 1925-34. Their results which had appeared in the journals during this time were published in collective form in 1935. The research covered 151 cases of schizophrenia and 79 manic-depressives, together with a few paranoiacs and psycho-neurotics, all of whom had been selected with a view to obtaining intelligent information regarding their previous personalities. 96 social science students were used as controls. They cannot be regarded as a very fair sample, however, since they were all women and all interested in social science ; moreover, they estimated their own personality traits without any check from an external source. Nevertheless even with these limitations it is probable that they provide some standard of comparison. The results are most interesting and are discussed fully in the appendices. With regard to frankness it was found that only a small minority of the manic-depressives had shown it. Whereas 27 per cent of the controls described themselves as frank and 13 per cent as close-mouthed (the rest being average) only 16 per cent of manic-depressives were regarded as frank and as many as 39 per cent as the opposite, namely reticent. Syntones therefore are far from having the "frank open personalities" commonly attributed to them. On the other hand they are not so reticent as schizoids who only showed 7 per cent as frank (a significant 7 per cent) and 66 per cent close-mouthed. The presence of undue sensitiveness was also found, contrary to the current view, to be almost as common amongst syntones as amongst schizoids

and the same was true of a model childhood which had previously been supposed to presage schizophrenia.

The origin of the misconceptions about syntonic personalities almost certainly lies in the fact that, certain peculiarities having been found commonly in the early history of schizophrenics, it was assumed that they were specific for this condition and would not appear in connection with the affective psychoses. The Boston research has dispelled several illusions of this kind, but it has not destroyed the main categories. Although a number of characteristics previously supposed to be specific to schizoid or to syntonic personalities were found to be merely the common property of persons disposed to any functional psychosis, many of the earlier ideas about these types were confirmed. Thus the classical schizoid traits of solitariness, few friends and a lack of humour, were found far more commonly in the previous personality of the schizophrenics than in either of the other groups, whilst sociable, practical and extremely sympathetic natures were seen especially amongst the syntones. But it must be remembered that these conclusions are not strictly applicable to individuals. Only some 43 per cent of schizoids were solitary and many syntones were not particularly sociable, indeed some 12 per cent were classed as solitary. They were simply statistical averages ; significant, but nothing more than averages. None the less the two basic types, schizoid and syntonic, have withstood close examination and have proved clinically useful. They are in my view safely established, far more so than the types of Jung, for not only are they strictly clinical in origin but they are founded upon the classification which above all others has proved useful in psychiatry—that into the schizophrenic and the affective psychoses. Jung's types can claim neither of these virtues.

Although widely accepted the classification into syntonic and schizoid types has not been without its critics. Schneider and Kahn in particular have challenged

the view that it is profitable to base a classification of non-psychotic personalities upon their relation to the psychoses. They believe that many morbid personality types can be discovered which are not only different from the psychoses but do not tend to develop into them. This latter point is their main argument for describing a large number of discrete personality types, including for instance depressive and hyperthymic personalities (which correspond to the main syntonic sub-types) in quite separate categories, unrelated to any other syndrome. Now it may be true that many and probably most people who have a syntonic temperament never develop an affective psychosis, but this is no argument for not grouping them together. Few people infected with tuberculosis develop phthisis, many depressive patients are never maniacal, pigmented moles are not often malignant. But in each of these instances great strides forward were made when the essential relationship of the conditions was recognized. Many of Schneider's and Kahn's types are obviously sub-types of the syntonic and schizoid groups, and although it must not be forgotten that there may be other groups besides these two, in the interests of scientific method it is important to exploit Kretschmer's hypothesis first. A multiplicity of separate types is reminiscent of the old Kraepelinian hypothesis which Mapother denounced.

Besides rejecting the hypothesis of schizoids and syntones Kahn has another objection to make. To his mind all the clinical types are too purely descriptive. They are not founded upon a theory of personality. " Direct comparison of the psychopathic personality types with the psychotic disease types must remain in many ways an important special device, but it will not suffice for the foundation of a system of psychopathies. . . . We search for the building stones for a constructive consideration of psychopathic personalities." These he finds in the concepts of " impulse ", " temperament " and " character ". All personalities are analysed

into these constituents and grouped according to the varying forms of each shown. Thus we have the strongly impulsive type, those weak in impulse and the perverts ; those whose temperaments are euphoric, depressive or changeable ; and those whose characters tend towards ego-overvaluation or undervaluation with many subtypes. This procedure he terms structural analysis. Although theories are often of the greatest value in developing classifications, the theory of evolution being a good example, they sometimes do much to confuse the issues. Kahn's building stones of personality are very arbitrarily chosen. They appear to spring more from general speculation about personality than from its careful dissection and provide very little help in understanding the ordinary reactions of individual humans which must always be the first consideration of any theory or personality. Structural analysis does little to explain why a given person thinks, feels and behaves in a particular way at a certain time.

The criticisms and modifications of Kretschmer's biotype classification do not appear to me to have much substance. The grouping of personalities into a multiplicity of distinct categories is retrogressive. It ignores important and well-established relationships and replaces them by groupings according to a theory of structural analysis which is so speculative that it is difficult to apply in practice and can have little or no prognostic value. The merit of Kretschmer's classification is that it is rooted in clinical description and, by its very mode of construction, affords a guide to prognosis. In its present state it is doubtless inadequate for the diagnoses of many personalities both healthy and diseased, but we cannot expect everything at once. The most important work to be done now is the further examination of the criteria suggested for distinguishing the two psychic types, but before attempting this it is necessary to enquire what methods of describing and measuring personality are at present available.

Chapter III

METHODS OF MEASURING AND DESCRIBING PERSONALITY

Any attempt to classify personalities must rest upon some reliable method of description. As a rule the more developed a science becomes the more remote from ordinary descriptions its accounts tend to be. For instance the ordinary description of a stone would probably be limited to its shape, size, weight and colour, whereas the physical scientist demands a knowledge of its chemical composition, electro-magnetic qualities, its geological structure, and to arrive at these more remote facts elaborate tests are often necessary. At the present time the study of personality has yet to arrive at this second stage. The simple gross characteristics of a person can be assessed and tabulated, but the inner structure of personality is still insufficiently understood for it to be possible to devise means of measuring it. It is probable that one day we shall be in a position to measure the quantity of free and bound anxiety or guilt and put the strength and direction of the super-ego in quantitative terms, but this is mere prophecy. At the moment we must confine ourselves to distinguishing the steady workers from erratic ones, the jolly from the morose and suchlike external superficial characteristics. But even these are not easy to assess with any accuracy, for personal qualities manifest themselves essentially in social situations, which are difficult to control. A stone's weight can be determined by the simple expedient of putting it upon a balance, but if we want to observe something of a person's temper we must either deliberately provoke him (which might interfere with other tests) or else rely

on the observation of chance occurrences. And not only is it difficult to evoke the required reaction in an animate being, it remains a problem to arrive at accurate and reliable measurement, without which comparisons are uncertain. But despite these great obstacles, attempts at assessing personal characteristics by *direct observation* of subjects in ordinary life have been made in America. They must be distinguished of course from the *hearsay* methods of arriving at the same results in which, instead of making our own observations, we rely upon those of the subject's friends and relatives.

The most ambitious direct observations are " those devised by Hartshorne and May at New York, in their large scale *Character Education Inquiry*. They obtained several measures of the traits honesty-dishonesty, of persistence and self-control, among large groups of children, by setting up appropriate and natural situations, when the children were given opportunities to cheat in exams., homework and parlour games, to steal and to perform generous actions for others."[1]

Another series of direct observations has been made with small children. Interesting results have been obtained by taking short samples of the child's behaviour at regular intervals during the day. " Thus, if each child is observed, say, for 10 seconds twice a day for a month, the number of periods during which he is seen to be talking to other children affords a score for talkativeness which possesses high predictive validity."[2]

Obviously such methods of assessing traits are impractical except in very special circumstances, and some alternative must be found. Now the great advantage which direct observation has is that it does not require the *co-operation* of the subject. Every other test at present available does require this vital factor, which is in itself

[1] Quoted from VERNON, P. E., in the symposium, *The Testing of Intelligence*, edited by Prof. H. R. Hamley. Vernon's survey of *Tests of Temperament and Character* is a most useful critique of the vast amount of work which has been done in this field. He provides a useful bibliography.

[2] VERNON. Op. cit.

part of what we are trying to measure and which will vary according to circumstances. For instance, it will depend upon what the subject considers the purpose of the test to be and the use to which the result might be put, and also upon his personal relations with the experimenters.

The most important of indirect observational methods are (1) Miniature Situation tests. (2) Motor tests. (3) Questionnaires. Miniature Situation tests approach the method of direct observation most closely. In these an attempt is made to produce under controlled conditions a situation which would evoke a certain temperamental trait in everyday life. For instance, going down a wrong turning in a maze instead of stopping to think is claimed to measure impulsiveness. There are very many others but their correlation is never very high. Motor tests are more abstracted from ordinary observation. Simple motor activities such as writing, cancellation, dotting, tapping, etc., are given to the subject and not only speed but fluctuations and variations in his procedure measured. Attempts are then made to correlate the results with the salient features in the personality of the subject. Most of the cruder attempts at correlation have failed so far, but Spearman and his followers proceeded rather differently. Using his well-known statistical method of factor analysis they have been able to use motor tests to isolate and measure certain general factors such as " p " and " w ". These cannot be immediately correlated with superficial personal qualities but they probably do represent some fairly fundamental factor in the make-up of personality. This work gives much promise and may well be of great importance in the future, as it appears to be measuring something more profound and constant than superficial characteristics—tending in fact towards the more exact investigations of physical science—but unfortunately it cannot yet claim to be of much value in clinical description. One of its great advantages is that it is not

necessarily apparent to the performer that it is his personal qualities which are being measured, which is usually clear in miniature situation tests and obvious in the questionnaire methods.

The Questionnaire has been employed in great variety in America. Numerous questions are listed regarding a person's emotional life, such as " Are you bothered much by blushing ? " or " Do you usually prefer to go for a walk alone ? " and the answers (various alternatives being supplied) are tabulated. The test must of course be standardized by trying it out on a number of people whose personal traits, such as nervousness or introversion, have previously been estimated by ordinary interview methods. The obvious criticism of these tests is that the subject will not answer them sincerely particularly as he may not know to what purpose they will be put. The difficulty of non-co-operation is present in all these tests, but it is clearly more likely to crop up when a person is asked, for instance, to write down answers to questions about his sexual life, than when he is merely requested to write S S S as fast as possible. Moreover, what a person will tell about himself will depend considerably upon his attitude to the person he is telling. For this reason he is likely to give very different answers to a doctor whom he trusts than to a prospective employer. It seems possible that in the hands of a sympathetic tester the questionnaire method would give valuable results, but it is very doubtful whether it is of more use than the less pretentious procedure of simply questioning the subject or his friends and relatives about his personality. In such a method direct observation is at a minimum and we simply depend upon the descriptions given us by others. Co-operation is so obviously essential that it cannot be overlooked, as it may be in the more ambitious tests.

At the present time there seems very little doubt that the *hearsay* method of learning about a person is, in the majority of cases, both simpler and more reliable than

any test yet devised. Its disadvantages are obvious, prejudice or ignorance on the part of informers for instance, but careful questioning of different sources will usually provide a reasonably accurate portrait. Sooner or later it will certainly be superseded by more reliable objective tests, probably of the motor tests variety, and until then our description can only be very rough. The *hearsay* method, however, does in fact provide much interesting material and has been the standard procedure of psychiatrists ; almost all the work on personality-types discussed in the previous section is founded upon it. The great advantage which it has over interviews and most tests is that an historical account of the personality can be obtained and a composite portrait sketched consisting of reactions noticed over a period of time.

The method consists simply in asking various questions of the patient's friends and relatives ; the patient also is usually able to give a fair account of himself, often better in certain respects than those of other informants. But obviously the information obtained will depend largely upon what questions are asked. Different workers have used different schedules, depending upon what characteristics they regard as important ; one of the commonest is that compiled by Hoch and Amsden. Human personality is so complicated that its adequate description is never easy, and a further difficulty emerges when we attempt to compare one personality with another. It is often objected that the description of a person in terms of the presence or absence of given traits is so inadequate as to be useless ; that the person is more than the sum of his traits. No doubt this is true, but so long as we concentrate on the whole, comparison is almost impossible. The great advantage of the entirely artificial method of breaking a personality up into a number of traits for descriptive purposes is that it makes comparison relatively easy. It must never be forgotten, however, that a list of traits present or absent is only a partial description, an index of personality, just as a list

of measurements is only an index of physique and will give only a meagre idea of what a person looks like.

The method of listing traits has its uses then, but, people varying in so many ways one from another, it is no easy task to select just those traits which are of significance to our purpose. Fortunately so much work has been done already on the problem of schizoid and syntonic personalities that many traits believed to be significant have already been emphasized—for instance, varying degrees of sociability. The list of traits presented here is the result of a careful consideration of the lists and results of other workers and has also been much influenced by preliminary work of my own. There is nothing final about the list. There is certainly much room for improvement.

The traits listed show great variation both in their degrees of concreteness and in their relation to health. All workers have pointed out the advantages of making questions with regard to personality as concrete as possible —to avoid such abstractions as : " Is he self-conscious ? " and to substitute : " Would he be self-conscious at a party or in a restaurant ? " Even in this latter form self-consciousness can never be as easy a trait to assess as, say, teetotalism. Whereas everyone is occasionally self-conscious and there is no clear line between moderate and morbid self-consciousness, teetotalism is not universal and when present is usually commonly known and freely admitted. Any list of traits should therefore contain as many as possible of those characteristics which can be marked as definitely present or absent, and as few as possible of those which are universally present and significant only when exaggerated.

I have made no attempt to confine the traits to those which could be regarded as normal and healthy. Apart from the difficulty of deciding what is and what is not healthy, a person can have a large number of minor mental symptoms without being regarded as neurotic and often these minor symptoms are most valuable in

distinguishing types of personality. Consequently, I have not hesitated to include many frankly pathological traits such as phobias, minor obsessional acts, tics and functional pains. As indicators of personality-types they are particularly useful, not only because they are relatively common, but because they fall into the "present or absent" group and are consequently comparatively easy to assess. Moreover, they are usually readily admitted which is not the case with all the traits which are likely to be significant. It is because of the tendency to subterfuge and also their embarrassment to some patients that I have not included many questions referring to sexual life. There are, however, a few traits which there is a likelihood of patients concealing included in the list. Drug-addiction, homosexuality and fetichism are cases in point and they are only included because if *present* I believe them to be very significant; but it must be remembered that their apparent *absence* is of little importance.

The optimum number of traits to be used is not easy to decide upon. Although I have used the large total of 105 many of these are simply the converse of each other, the actual characteristics measured being far fewer. For instance a person may react to criticism in at least four typical ways. None the less my schedule is longer than most, which needs explanation. In the first place human personality varies so much that it is not possible to describe it in terms of just a few traits. Moreover, as will be seen later, the more traits which can be discovered which are more or less specific to schizoid personalities the easier and more reliable will the diagnosis of types become, and it is for this reason that several traits which it is not always easy to get information about have been included. But perhaps the best reason for employing a large number of traits is that any one error of assessment is comparatively unimportant. Mistakes are inevitable, but the probability is that if our diagnosis of types is founded upon wide considerations one or two

errors will not seriously affect our conclusions. The only serious disadvantage of a long schedule of traits is the time taken in assessing them, but any accurate picture is bound to take time to secure.

One particular difficulty about using a list of traits as indicators of personality is the fact that some people are very changeable and traits which may be characteristic of them in one humour may be absent in another. Notes to this effect can usually be made if the changeableness is frequent and in itself characteristic, but for people who change more or less permanently from one type of character to another, say from being very overconscientious, good and kind to being morose, ill-tempered and apathetic, nothing but two separate schedules can do full justice. A further difficulty of this kind arises when a psychosis develops insidiously. It is often impossible to decide what are to be regarded as manifestations of the pre-psychotic personality and what the early psychotic symptoms. There is no really satisfactory way of dealing with the problem, the most that can be done being to ignore any features which appear suddenly during the transition period and confining ourselves so far as possible to what was previously regarded as characteristic of the personality.

The following is the schedule of traits and symptoms which I have used. It is arranged in an order which is convenient for clinical purposes, traits which are different aspects and degrees of the same characteristic being grouped together so that they can be considered and discussed with an informant at the same time. Nevertheless the groupings are very rough. Within a bracket are to be found traits some of which are complementary, others contradictory. Some subjects will therefore be positive for more than one trait in a group, whilst the fact that in most cases only extremes are listed accounts for many average healthy people possessing hardly any of the traits listed. Each heading is no more than a symbol and I have added numerous explanatory remarks

to make it clearer what I have in mind. In some cases it will be noticed that traits tend to overlap, but I think most of the distinctions drawn are just.

WORK AND INTERESTS

DISTRACTIBLE	Changes job, no perseverance, always finding "better" things to do.
STEADY	Sticks to his job, reliable.
VAGRANT	Unable to keep job, unemployable.
SLAP-DASH	Quick, careless worker.
ERRATIC	Good and careful one day, bad another.
OVER-CONSCIENTIOUS	Worries to do work right, will work over-time to finish work.
REPEATS WORK	Uncertain it is right—must go over it again and again.
OVER-AMBITIOUS	*Actually attempts* big schemes, always undertakes too much.
MOVEMENTY	Great enthusiasms, too many interests.
LEADER	Takes responsibility and leads at parties, clubs, etc., independent.
AMBITIOUS PHANTASIES	Grandiose day-dreams, *but no attempt to realize them.*
APATHETIC	No ambition or initiative, drifter.
RECKLESS	Hot-headed, imprudent, rushes into things.
OPPORTUNIST	Has an eye on the main chance—seizes opportunities.
CAUTIOUS	Careful, conservative, thrifty.

Spasmodic Energy	Works in fits and starts.
Always Busy	Makes work, on the go.
Indolent	No energy, very " lazy ".
Practical	Matter-of-fact, mundane.
Fanatic	Self-sacrifice for great abstract and metaphysical ideal.
Prophet	Feeling of a mission to save the world, etc.
Occult Interests	Spiritualism, mysticism, astrology, half-baked interest in philosophy, etc.

SOCIAL RELATIONS

Enjoys Parties	Happiest in a crowd, good mixer.
Quietly Sociable	Enjoys quiet company, dislikes either crowds or solitude.
Solitary	Prefers solitude, lonely walks.
Misanthropic	Active dislike of other people.
Many Acquaintances	and friends.
Few Good Friends	Faithful to a few old friends.
No Friends	
Closed Circle	Moves in an exclusive coterie, salons.
Can't Say No	Over-sympathetic, over-generous, always helping people.
Cold, Aloof	Withdrawn emotionally.
Unresponsive	Self-absorbed, dead to the world.
Grandiose, Loud	Grandiose style, extravagant gestures.
Precious	Affected, posing, exquisite, extremely vain.
Self-conscious	Shy, fears blushing, feels people look at him, always bothering about appearances.

JOLLY, CHEERY	Makes jokes, laughs a lot.
PRACTICAL JOKES	Comedian, buffoon.
NO HUMOUR	Lacks a warm humour. (Such people sometimes have a cold wit.)
OVER-TALKATIVE	Talks too much, eloquent, verbose.
RETICENT	Keeps self to self, prefers not to discuss private affairs.

ATTITUDE TO AUTHORITY

OVER-SENSITIVE	Feelings easily hurt, sees slights, touchy.
LAUGHS AT CRITICISM	Laughs it off.
ANGRY AT CRITICISM	Takes offence, abusive, flares up, breaks friendships.
BROODS OVER CRITICISM	Can't forget it, self-reproachful.
INDIFFERENT, SULLEN	Apparently utterly indifferent to criticism.
SHAMELESS	Defiant of opinion, justifies anti-social actions (may cover obvious sense of guilt).
OVER-ASSERTIVE	Arrogant, dictatorial, takes law into own hands.
RESENTS AUTHORITY	Insubordinate, impertinent, rebellious.
OBSTINATE	Very intractable, negativistic.
DOCILE	Extremely obedient, "good", easily led.

MOOD

OPTIMISTIC	Always hopeful.
PESSIMISTIC	Gloomy.
ANXIOUS	Openly worried and anxious, fusses, nervous ; gets upset if relations come home late ; fears an accident, etc.
SUSPICIOUS	Feels people are working against him.
BOASTFUL	Conceited, swollen-headed, over-confident.
SELF-DEPRECIATORY	" Inferiority complex ", apologetic, lacks confidence, feels guilty.
EXCITABLE	Becomes over-excited at parties.
SCENES	Emotional outbursts, screaming fits, hysterical laughter or tears.
UP AND DOWN	*Rapid* changes of mood.
DEPRESSIONS	Gets very depressed at times.
PHOBIAS	Of dogs, horses, etc. Fear of burglars at night, terrified of thunderstorms (gets under bedclothes), claustrophobia (fear of going in tubes).
FEARS BEING ALONE	Must have companion.
UPSET BY ACCIDENTS	e.g. In street, alarmed by blood.
SELF-RIGHTEOUS	Proud, never admits to be in wrong, deceives self.
SELF-PITY	Martyr, " nobody loves me ", feels thwarted.
DISSATISFIED	Grumbles, criticizes and blames others for everything.

TEMPER

VIOLENT TEMPER	Loses temper and becomes *violent* (distinguish from mere bad temper). Attacks people.
IRRITABLE, SULKY	Bad-tempered, morose.
SAINT-LIKE	Perfect saint-like equanimity, turns other cheek, *no signs whatever of hostility.*

FEUDS	Relentless insistence on "rights", gets what he wants by making a row.
DISDAINFUL	Sarcastic, biting, superior, contemptuous (often especially of parents).
AVOIDS ROWS	Dislikes squabbles, always gives in, anything for peace.

DESTRUCTIVE	Destroys property, arson.
CRUEL	Spiteful, mean, nasty tricks; cold-blooded, brutal, sadistic, bully.
HATES KILLING	Can't kill a fly (often vegetarian and anti-blood sport).

ATTITUDE TO FAMILY

OVER-ATTACHED TO FAMILY	Very devoted to one or more of *parents* or *siblings*, can't leave home. (Exclude spouse.)
WORRY OVER RELATIONS' HEALTH	Upset and fussing if *any* relation is ill.
HATES MEMBER OF FAMILY	Openly and constantly hostile to one or more *parents* or *siblings.* (Exclude spouse.)

SEX

PROMISCUOUS	Numerous affairs, includes being a prostitute.
NO SEX	No apparent interest in opposite or same sex. (Such people sometimes masturbate.)
PASSIONATE ATTACHMENTS	Very violent affairs, each one assumes tremendous proportions, often very changeable and fickle. Uneven sexual demands.
JEALOUS	Acute jealousies.
IMPOTENCE OR FRIGIDITY	Partial or complete, ejaculatio praecox.
HOMOSEXUALITY	Manifest homosexual feelings *after 18 years of age* (with or without physical expression).
FETICHISM	

HABITS AND OBSESSIONS

DRUGS	Drug-addiction.
ALCOHOLIC	
TEETOTAL	
EXTRAVAGANT	Spendthrift.
ASCETIC	Regards pleasure as bad, very frugal.
OVER-CLEAN	Always washing, upset if even ordinary clothes get dirty, fusses.
OVER-TIDY	Can't bear disarray, " everything has a place ", always putting things straight, etc.
VERY UNTIDY	Leaves things all over the place.

REPEATS PRECAUTIONS	Goes back to see if gas or electricity is turned off, door is bolted, cigarette extinguished, etc.
VERY SUPERSTITIOUS	Really upset if 13 at table, or spills salt, always on look-out for ill omens.
RITUAL	Apparently meaningless rituals, ceremonial touching, etc. (Excluding repetition of ordinary actions, e.g. precautions.)
NUMBERS	Attaches significance to numbers, always counting things, obsessional ideas about them.

HEALTH, ETC.

WORRY OVER BOWELS	Upset if motion is missed, takes frequent laxatives, diets, etc.
PATENT MEDICINES	Persistent addiction to medicines, excluding laxatives.
MIRROR	Gazing at self in mirror for long periods, laughing or grimacing at self, exaggerated care of body.
INVALIDISM	Always looking after self because of supposed ill-health, wanting attention from relatives and doctors.
PAINS	Functional pains, headache, indigestion, " neuritis ", etc.
TIC, SPASMS, ETC.	Functional movements of all kinds, hysterical vomiting.

ACCIDENT PRONE — Always getting involved in accidents, either major or minor.

For purposes of tabulation and comparison I have used a different sequence. It is clearly convenient to group traits in such a way that common constellations stand out and so point the way to classification. It was my original intention to group traits into those which are typical of syntonic personalities and those which are typical for schizoids, since most previous work had led me to expect that it would be possible to do this by finding traits which never appeared in the previous history of affectives but were common in that of schizophrenes and vice versa. But this was soon found to be impossible. Although certain traits did appear to be peculiar to schizoids, no trait could be found which was common amongst affectives and rare to schizophrenics. In other words, *not a single trait could be found which was in any sense characteristic or specific of syntones.* Bowman's observations that syntones are apt to be sociable, practical and extremely sympathetic were largely confirmed, but schizoids show these traits sufficiently frequently to make it clear that syntones have no monopoly of them. My conclusion therefore has been that *whereas any syntonic trait may appear in schizoids, the reverse does not happen,* a conclusion exactly parallel to Bleuler's views regarding the symptomatology of the psychoses themselves : " All manic-depressive symptoms may appear in schizophrenia, but not the specific schizophrenic symptoms in the former disease."

A different system of grouping traits to that usually adopted is therefore necessary. I have first selected a list of some 33 traits which appear frequently in schizoids and only very occasionally in syntones. This leaves 72 traits which have no specificity. Each of these big groups can then be sub-divided in an attempt to picture common types either of schizoid or syntone. Thus the

non-specific group of traits can be divided into those characteristic of the depressive personality and those which indicate a hyperthymic type. The grouping of schizoid traits is more difficult and will be commented upon in Chapter VI where different personality types are discussed.

Although I am satisfied that the main outline of the grouping is useful and correct there are many traits whose position is very doubtful, especially those about which accurate information is difficult to obtain as for instance drug-addiction and fetichism. The resulting grouping is bound therefore to be extremely tentative, but it should not be difficult to check its validity by more thorough observation on a larger number of patients.

Chapter IV

SOME TRAITS DISTINCTIVE OF SCHIZOID PERSONALITIES

The total number of patients upon which this study is based is 65. Of these 36 were undoubtedly psychotic, the remaining 29 being regarded as psycho-neurotic or psychopathic personalities. The only basis of selection has been the possibility of obtaining reliable information about their personalities and mental state. The psychotics are made up as follows :

	Male	Female	Total
Affective Psychosis ..	20	3	23
Schizophrenia ..	10	3	13

It will be seen that only 6 are females. This is the result of particular circumstances, but, since personality differs somewhat between the sexes, it must be taken into account when conclusions are drawn.

For conclusions to be reliable, the information should satisfy at least three criteria.

1. The diagnosis must be correct.
2. The description of traits must be reasonably accurate.
3. Information must be complete.

Unfortunately my material fails to a greater or less degree under each of these headings.

1. *Diagnosis.* It is particularly important that this should be reliable, because it is upon this that our chief conclusions with regard to the specificity of schizoid traits will be drawn. 32 of them (including 12 schizophrenics) were seen at the Maudsley Hospital ; most of

them came before a ward clinic and the diagnoses can be regarded as well attested, except in Nos. 4, 22 and 29, about which there was doubt.[1] The remaining four patients (Nos. 1, 11, 12 and 32) were seen in the Department of Psychological Medicine at University College Hospital. All of them subsequently went to mental hospitals and the diagnosis originally made on them confirmed.

2. *Accuracy of Information.* For accurate information, it is obvious that the more informants who can be interviewed the better. Time and opportunity, however, necessarily restrict our work and in most cases it is not possible to discuss the patient's personality with more than one or two relatives and the patient himself. The patient's own information is often valuable, especially on obsessional traits and other things about which he is not anxious for his relatives to know. On the other hand, a relative's information is usually essential regarding traits usually regarded as undesirable, for instance quarrelsomeness and apathy. Information can never be regarded as satisfactory unless we have both the patient's own and at least one relative's account. There are only one or two psychotic patients whose relatives have not been available, but in about half the psychoneurotics I have had to rely solely upon the patient's own description of himself. In all of the cases where no relative has been interviewed I have drawn some conclusions from direct observation of their behaviour

[1] These three patients have been followed up.

No. 4, diagnosed depressive has had two further attacks since first seen. In each he has been depressed and paranoid and later made a good recovery.

No. 22, diagnosed manic, has had no further attack. He has been able to remain at work since and takes an active part in sport and social life. He is, however, very introspective, full of speculation about the value of life and shows much self-criticism. The diagnosis of the original psychosis remains in doubt, but we are probably dealing with a mixed psychosis.

No. 29, originally diagnosed schizophrenic has had one further breakdown, with symptoms of unreality, depression and threats of suicide. There was nothing schizophrenic about this attack and the original diagnosis should probably be revised to one of depressive state.

to me and I believe the total assessment to have fair validity.

Discrepancies sometimes appear between the relative's account and the patient's own account of himself. A mother will sometimes say that her daughter is not the least self-conscious, and the daughter inform you that self-consciousness makes her life unbearable. Similar discrepancies often occur over traits such as sensitiveness or jealousy. In these circumstances it is necessary to decide which seems the most likely story, and there is usually plenty of internal evidence supporting one view as against the other. When in doubt, however, it is probably safer to accept the patient's own account except when the trait is clearly something which he is wishing to disown. Again and again one finds that the patient can give a clear and consistent account of himself when the relative's picture is vague and uncertain. In the present research I am deeply indebted to these patients for telling me so much about themselves.

3. *Completeness of Information.* It will be seen that in many cases my tables are sadly incomplete. This is largely due to my enquiry growing wider as time went on and the list of traits which seemed significant increasing. Many of the earlier patients were consequently quite insufficiently investigated according to my later standard. I have included them in my results, however, because I think even incomplete records are of some use.

These shortcomings, together with the very small number of patients of each class examined, make it impossible to draw any but very tentative conclusions from my observations. Nevertheless they have seemed to me sufficiently suggestive to warrant their presentation and it is to be hoped that it may later be possible to check them by more reliable and comprehensive research.

Tabulation. The following tables show the presence or absence of each trait in the personality of the 36 psychotic patients. Where there is no information the

space is left blank. If the trait is believed definitely absent, this is indicated by a minus sign (—). The presence of a trait is indicated by one, two or three plus signs (+). These different grades of positiveness are only very rough, and should not be taken too seriously. If the trait is present but not conspicuously so, it is given a single plus. If it is conspicuous it has a double plus, and only if it is regarded as one of the salient features of a personality and complained of either by the patient or relatives is it given a triple plus. Sometimes a trait may be variable, present at times and not at others, and this I have indicated by ±. Occasionally when definite information is lacking, but where much indirect evidence has led me to suspect the presence of a trait, I have indicated it by ?+.

A glance at these tables will show in what way schizoids differ from syntones more vividly than any statistics can describe. The schizoid traits in Table A (Affectives) are few and far between. There are only two double plus and the total positive traits present only amount to 27 for 23 patients. In Table B (Schizophrenics), on the other hand, they are dense. Double plus are numerous and there are 2 triple plus. Positive traits present number 87 for only 13 patients. No such obvious differences appear, however, when the non-specific traits of the two groups are compared. Depressive and anxious traits are very common in both tables. Hyperthymic traits are less frequent amongst schizoids but not very noticeably so.

It is from these observations that I have concluded that certain traits are virtually exclusive to schizoid personalities, whereas syntones are possessed of no such specific traits. In Appendix A the specificity of the 33 schizoid traits is examined in detail, my own observations being compared with those of other workers, particularly Kraepelin, Hoch, Kretschmer, Bowman, Amsden, MacCurdy, Smalldon and Lewis. In Appendix B a similar examination of the non-specific traits has

A. Affectives

Schizoid Traits	Depressives								
	M. 1	M. 2	M. 3	M. 4	M. 5	M. 6	M. 7	M. 8	M. 9
1. Solitary	—	—	—	±	—	—	—	—	—
2. No friends	+	—	+	+	—	?+	—	—	—
3. No sex	—	—	—	—	—	—	—	—	—
4. No humour	—	—		?+	—		—	—	—
5. Cold, aloof	—	—	—	?+	—	—	—	—	—
6. Docile	—	+	—	?+	—	—	—	—	—
7. Saint-like	—	—	—	—	—	—	—	—	—
8. Fanatic	—	—	—	—	—	—	—	—	—
9. Prophet	—	—	—	—	—	—	—	—	—
10. Occult interests	—	—	—	—	—	—	—	—	—
11. Ambitious phantasies	—	—	—	—	—	—	—	—	—
12. Closed circle	—	—	—	—	—	—	—	—	—
13. Precious	—	—	—	—	—	—	—	—	—
14. Disdainful	—	—	—	—	—	—	—	—	—
15. Ritual	—	—	—						
16. Homosexual	—	—	—	—	—	—	—	—	—
17. Fetichist									
18. Passionate attachments	—	—	—	—	—	—	—	—	—
19. Scenes	—	—	—	—	—	—	—	—	—
20. Violent temper	—	—	—	—	—	—	—	—	—
21. Hates family	—	—	—	—		—			—
22. Mirror	—		—						
23. Superstitious	—		—	—					
24. Numbers	—		—	—					
25. Apathetic	—	—	—	—	—	—	—	—	—
26. Indolent	—	—	—	—	—	—	—	—	—
27. Vagrant	—	—	—	—	—	—	—	—	—
28. Indifferent	—	—	—	—	—	—	—	—	—
29. Unresponsive	—	—	—	?+	—	—	—	—	—
30. Shameless	—	—	—	—	—	—	—	—	—
31. Misanthropic	—	—	—	—	—	—	—	—	—
32. Destructive	—	—	—	—	—	—	—	—	—
33. Cruel, spiteful	—	—	—	—	—	—	—	—	—
Total number of Schizoid traits	1	1	1	6	0	1	0	0	0

A. Affectives

Depressives										Manics			
F.	F.	M.	M.	M.	M.	M.	M.	F.	M.	M.	M.	M.	M.
10	11	12	13	14	15	16	17	18	19	20	21	22	23
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	++	—	—	—	—	—	—	—	—	—	+	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	±	—
?+	?+	—	—	—	—	—	—	—	—	—	+	—	
	—	—	—	—	—	—	—	—	—	—		—	—
—	—	—	—	—	—	—	—	—	—	—		—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
	—	—	—	—	—	—	—	—	—	—	+	?+	±
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	?+
—	—	—	—	—	—	—	—	—	—	—	—		
—	—				—				+	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	++
					—				—				
—	—	—	—	—	—	—	—	—	—	+	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	
—	—	—	—	—	—	—	—	—	—	—	—	—	—
	—	+				—			—	?+			
	—	—	—		—	—			—	—	—	—	—
	—		—	+	—	±	—		—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
1	2	1	0	1	0	1	0	0	1	2	3	2	3

A. Affectives (*continued*)

Non-Specific Traits (Depressive)	Depressives								
	M. 1	M. 2	M. 3	M. 4	M. 5	M. 6	M. 7	M. 8	M. 9
1. Steady worker	++	++	+	—	++	+	+	++	+
2. Practical	+	+	+	+	+	+		+	+
3. Few good friends	—	+	—	—	+	—	+	++	++
4. Quietly sociable	—	+	+	—	+	—	+	+	—
5. Avoids rows	—	?+	—	+	?+	+	+	+++	++
6. Cautious	?+	?+		+	?+	++	++	+	+
7. Can't say no			+			+	+	++	++
8. Over-conscientious	++	+	+	+	+	?+	++	+	+++
9. Always busy						+		+	++
10. Over-tidy	++	++	++	+++	++	++		+	+
11. Over-clean	++		++	+		+		+	
12. Repeats work	++	—			—	?+			?+
13. Repeats precautions	+++	—	+	—	—	++		—	—
14. Reticent	++	+	++	++	+	++	+	++	+
15. Ascetic		—		—		+			
16. Teetotal	—	—			—			—	—
17. Hates killing	—	—	—	+	+++	+		++	++
18. Over-attached to family	—	+		+			—		
19. Worry over relations' health	++	++		++			—	++	
20. Pessimistic	+	+			—		?+	?+	—
21. Obstinate	+								
22. Suspicious	—		—	++					—
23. Over-sensitive	++		++	+	++	++		+++	+++
24. Broods	+		—	+	+	+		+	+
25. Depressions	+		—	++	+	—	—	—	—
26. Self-depreciatory			+					?++	+
27. Self-conscious	+	++	++	+			+	++	+
28. Patent Medicines	—	—	—	—	—	—	—	—	—
29. Worry over bowels	+		—			—	?+		+
30. Pains	+	—	—			—			
31. Tic, spasms	—	—	—	—	—	—	—	—	—
32. Impotence or frigidity	—	—	—		—	—	—	—	—
33. Invalidism	—	—	—	—	—	—	—	—	—
34. Accident-prone	—				—	—	—	—	—
35. Anxious	+							+	
36. Phobias	—		—	—					
37. Fears accidents				++					
38. Fears loneliness									
39. Erratic	—	—	—	—	—	—	—	—	—
40. Spasmodic energy	—	—	—	—	—	—	—	—	—
41. Very untidy	—	—	—	—		—		—	—
42. Up and down	+	—	—	—	—	—	—	—	—
43. Irritable, sulky	+		—	—	?+	—	—	—	—
44. Self-pity		++							
45. Jealous	—		+						

A. Affectives (*continued*)

Depressives										Manics			
F. 10	F. 11	M. 12	M. 13	M. 14	M. 15	M. 16	M. 17	F. 18	M. 19	M. 20	M. 21	M. 22	M. 23
+	+	++	+	++	++	++	++	−	±	++	−	++	−
+	+	+	+	+	++	+	+	+	++	+		+	−
	+	+	−	+	+	+	++	+	+	+	+	+	+
+	++	+	−	±	+	−	+	−	−	−	+	+	+
++	+	++	+	+	++	+		++	−	−		−	
+	++	++		+	+		+	+	−	−		−	
++	+	±	++	++		+		++	++	+	?+		
-++	++	++	+++	++	++	++	+	++	++	−	++	−	−
	+	+			++			+++	+			+	−
++	++	++	+		++	++	++	−	±	?+	++	−	+
-++	++	+++	++	++	+	+	++	−	+++	−	++	−	+++
+		+	?+	−	−		−		+	−	−	−	−
++		++	?+	−	−	++	−		−	±	−	−	−
++	++	++	++	++	+			−	+	−			++
+		−		−	−	−		+	−	−	−	−	
-++	++	−		−	−			−	−	−	+	−	
++	++	+							−	−			
+	++	++	?+	−		?+		?+	−	?+	?+		
++	++	+	++		−	++	+	+++	−	+++	++		
−	+	+	−			−	−	+	−	−	+	−	
−	−	+		?+	?+				++				
−	−	−	?+	−		+	−	+	++	−			
+	−	+	++	++	+	−	−	+++	++				++
	−	++	+	?+	+	−	−	++	+	−	+	?+	
++	−	−	+	?+	+++	+	+	+	++	−	−	+	
++	+	+	+		+	−		+	−	−		−	
++	−	+	++	++	+++	++	++	++	+	+++	++	−	++
−	−	++	+	−	−	+	−	−	−	−	+	−	+
?+	−	+		−	−	−	−	?+	−	−	−	−	
++	−	+		−	+	−		+	−	−	−	−	
−	−	−	−	−	+	−	−	−	−	−	−	−	
	−	−		−	+	+	−	+	−	−		−	
	−	−	−	−	+	−	−	+	−	−	−	−	
++	+	+		+	+	?+			−	+		−	
−	−	−	−			++	−	++	−	±	−	−	−
	−	+							−	+			
	−	−						+				−	
−	−	−	−	−	−	−	−	++	−	−	+		+
−	−	−	−	−	−	−	−	++	++				+
−	−	−	−	−	−	−	−	+	±				−
?+	−	−	++	+	?+	++	+	+++	+++	−	−	+	+
−	−	−	−			−	−	−	−	−	−		
−	−	−		−	−	−		++	+	−		−	
−	−	−		−	−	+	−	+++	++			−	−

A. Affectives (*continued*)

Non-Specific Traits (Hyperthymic)	Depressives								
	M. 1	M. 2	M. 3	M. 4	M. 5	M. 6	M. 7	M. 8	M. 9
46. Many friends	—	—	—	—	?+	—	—	—	—
47. Enjoys parties	—	—	—	—	—	—	—	—	—
48. Jolly, cheery	—	—	—	—	—	—	—	—	—
49. Jokes	—	—	—	—	—	—	—	—	—
50. Optimistic	—	—	—	—	+	—	—	—	±
51. Leader	—		—	—	—	—	—	—	+
52. Opportunist	—		—	—	—	—	—	—	—
53. Over-ambitious	—	—	—	—	—	—	—	—	+
54. Movementy	—	—	—	—	—	—	—	—	—
55. Distractable	—	—	—	—	—	—	—	—	—
56. Over-talkative	—	—	—	—	—	—	—	—	—
57. Laughs at criticism	—	—	—	—	—	—	—	—	—
58. Excitable	±	—	—	—	—	—	—	—	—
59. Slap-dash	—	—	—	—	—	—	—	—	—
60. Reckless	—	—	—	—	—	—	—	—	—
61. Boastful	—	—		—	—	—	—	—	—
62. Extravagant	—	—	—	—	—	—	—	—	—
63. Theatrical	—	—	—	—	—	—	—	—	—
64. Promiscuous	—		—	—	—	—	—	—	—
65. Drugs	—	—	—	—	—	—	—	—	—
66. Alcohol	—		—		?+	—		—	—
67. Over-assertive	—	—	—	—	—	—	—	—	—
68. Resents authority	—	—		—	—	—	—	—	—
69. Feuds	—	—		—	—	—		—	—
70. Self-righteous				—	—	—		—	—
71. Angry if criticised	—		++	—	+	+		—	—
72. Dissatisfied	—	—		—		—		—	—

A. Affectives (*continued*)

Depressives										Manics			
F.	F.	M.	M.	M.	M.	M.	M.	F.	M.	M.	M.	M.	M.
10	11	12	13	14	15	16	17	18	19	20	21	22	23
—	—	—	+	—	—	+	+	+	—	+ +	—	+ +	—
—	—	—	+	+			+	+ +	+	+ +	—	+ +	
—	?+	±	+	+	—	+ +	+ +	+ +	+ + +	+ +			
—	—	—	+	?—	—	+	+	—	+ + +	+ +	+	+	
—	—	—		+	—	?+	+	—	+ +	+	—	+	
—	—	—	+	+ +	+	+	±	+ +	+ +	+ +	—	+ +	—
—	—	—	—	—	—		—	—	+			?+	
—	—	—	—	+	+ +	+	—	—	+ +	—	—	—	?+
—	—	—	—	—	+		—	—	—	—	—	—	
—	—	—	—	—	—	+	—	+	—	—	—		
—	—	—	—	—	—	—	?+	+	+	+	—	+	?+
—	—	—	—	—	—		—	—	+	±	—	—	—
?+	—	—	?+	—	—	+	?+	+ +	+ + +	+ +		+	+
—	—	—	—	—	—	—	—	—	—		—		
—	—	—	—	—	—	—	—	—		+ +	—		
—	—	—	—	—	—	—	—	—	+	?+	—	?+ +	
—	—	—	—	—	—	+	—	+	+	—	—		
—	—	—	—	—	—	+	—	?+	+	—	—	—	—
—	—	—	±	+	±	+	—	—	+	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	
—	—	—	±	—	—	—	—	—	—	±	—	—	
—	—	—	—	—	—	—	—	—	+	—	—	?+	
—	—	—	—	—	+	—	—	—	+ +	—	—	+	
—	—	—	—	—	—	—	—	—	+ +	—	—		
—	—	—	—	—	—	—	—	+	+	—	—		
—	—	—	—	—	—	—	—	+ +	—	±	—	—	—
—	—	—	—	—	—	—	—			—	—	—	

B. Schizophrenics

Schizoid Traits	M. 24	M. 25	M. 26	M. 27	M. 28	F. 29	F. 30	M. 31	M. 32	F. 33	M. 34	M. 35	M. 36
1. Solitary	++	++	++	+	+	++	—	++	—	++	+	++	—
2. No friends	++	+	±	+	+	—	—	—	±	+	—	++	—
3. No sex	++		++	+	+	—	—	—	—	—	—	—	—
4. No humour	+	?+	—	+	+	—	—	—	—		—	+	++
5. Cold, aloof	+	+	+	++	+	±	—		—	—	—	+	+
6. Docile	±	—	++	—		—		+	—	—	—	—	—
7. Saint-like	—	—	++			—		—	—	—	—	—	—
8. Fanatic	—	—	+	+	—	—	—	—	—	—	—	++	—
9. Prophet	—	—	—	—	—	—	—	—	—	—	—	+	—
10. Occult interests	—	++	+	+	—	—	++	—	—	—	—	+	++
11. Ambitious phantasies	—	—	—	—	—	—	—	—	—	—	—	++	—
12. Closed circle	—	—	—	—	—	—	—	—	—	—	—	—	—
13. Precious	—	—	—	—	—	—	—	—	—	—	—	—	—
14. Disdainful	—	—	—	?+	—	—	—	—	—		—	—	?+
15. Ritual	—	—	—		—	—	—	+	+	—	—		
16. Homosexual	—	—	—		—	—	?+	—	+	—	—	—	—
17. Fetichist	—	—	—		—	—	—			—	—		
18. Passionate attachments	—	—	—	—	—	—	—	—	—	++	+	++	—
19. Scenes	—	—	—	—	—	—	—	—	—	++	—		—
20. Violent temper	—	—	—	—	—	+	—	—	—	?+	±	+++	—
21. Hates family	++	+	—	—	+	++	—	+			—		—
22. Mirror		+		—			—	+	++		—	—	—
23. Superstitious		—		—	—		—	+	—				
24. Numbers		—		—	—		—	—	—				
25. Apathetic	—	—	—	—	—	+	—		—	—	±±	—	—
26. Indolent	—	—	—	—	—	—	—		—	—	±±	—	—
27. Vagrant	—	—	—	—	—	—	—	—	—	—	—	—	—
28. Indifferent	+	±	—	+	—	±	—	—	—	—	?±	—	—
29. Unresponsive	+		—	+	—	++	—		—	—	?+	—	—
30. Shameless	—	—	—	—	—	—	—	—	—	—	—	—	—
31. Misanthropic	—	—	—	—	—	—	—	—	—	—	—	—	—
32. Destructive	—	—	—	—	—	—	—	—	—	—	—	—	—
33. Cruel, spiteful	—	—	—	—	—	—	—	—	—	—	—	?+	—
Total number of Schizoid traits	9	8	8	10	6	7	2	6	4	5	7	11	4

B. SCHIZOPHRENICS (*continued*)

NON-SPECIFIC TRAITS (Depressive)	M. 24	M. 25	M. 26	M. 27	M. 28	F. 29	F. 30	M. 31	M. 32	F. 33	M. 34	M. 35	M. 36
1. Steady worker	+	++	++	+	+	±	++	−	+	−	−	−	+
2. Practical	−		−	−	−	+		−			+	−	+
3. Few good friends	−	−	−	?−	−	−	+	−	−	−	−	−	
4. Quietly sociable	−	−	−	+	−	−	+	−	−	−	−	−	+
5. Avoids rows	−	−	+	+	++	−	+	±	?+	−	+	−	
6. Cautious	+					−		−		−	−	−	
7. Can't say no		−	++	−	++	−	?++	+	+		+	−	
8. Over-conscientious	+	++	?++	++	++		?+	++	−	+	++	−	+
9. Always busy	−	−	−	−	?+	−	?+	−	−	++	−		++
10. Over-tidy		−		+	−		−	−	±	+	−	−	−
11. Over-clean		−		−			−	++	++	++	−	−	
12. Repeats work		−		?+			−	++	++	?+	+		
13. Repeats precautions		−	−	−	+		−	+	++	++	−	−	−
14. Reticent	+	+	+++	++	+	++		+	++	+	+		−
15. Ascetic			+	+		−				−	−		−
16. Teetotal	+		+	+									−
17. Hates killing				+							?+		
18. Over-attached to family	+		+			−	+		−	?+	−		−
19. Worry over relations' health				+			+				+		
20. Pessimistic	−				−		−						−
21. Obstinate	++	+	−	?++		+	−						
22. Suspicious		+	−	?+			−	++	++	+++	+	+++	
23. Over-sensitive	−	±	++		++		?	++	++		+	?++	−
24. Broods					+		−	+	+		+		+
25. Depressions	?+	+	−	−	−	+	−	+	++		++	+	+
26. Self-depreciatory						++		++					−
27. Self-conscious	++	++		+++	+++		+	++	+++	++	++		−
28. Patent Medicines	−	+		−	−		−	+	++	++	−	−	
29. Worry over bowels	−	+	−		−			+		++			−
30. Pains	−	−	−		−			−	−		−		−
31. Tic, spasms	−	−	−	−	−	−	−	−	−	−	−	−	+
32. Impotence or Frigidity											−	−	+
33. Invalidism	−	−	−		−	−	−	−	−	−	−	−	−
34. Accident-prone	−	−	−				−	−		−	−	−	
35. Anxious		−	−	−		−	−		+	++			−
36. Phobias		−	−	−	−		−	+	++	++	+		
37. Fears accidents											++		
38. Fears loneliness	−		−	−						+			

B. SCHIZOPHRENICS (*continued*)

NON-SPECIFIC TRAITS—(*Contd.*) (Depressive)	M 24	M. 25	M. 26	M. 27	M. 28	F. 29	F. 30	M. 31	M. 32	F. 33	M. 34	M. 35	M. 36
39. Erratic	—	—	—	—	—	—	—	++	±	++	++	++	—
40. Spasmodic energy	—	—	—	—	—	—	—	—	+	+	+	++	—
41. Very untidy		+	—	—			—	+	—	—	+		—
42. Up and down	—	—	—	—		—	—		+	+	+	+	—
43. Irritable, sulky		—	—	—	—	—	—			—	+	—	—
44. Self-pity	—		—	—	—		—	—	—				—
45. Jealous			—	—	—		—	—			+	—	
(Hyperthymic)													
46. Many friends	—	—	—	—	—	—	+	—	—	—	—	—	+
47. Enjoys parties	—	—	—	—	—	—	—	—	—	—	?+	—	+
48. Jolly, cheery	—	—	—	—	—	±	?+	—	—	—	—	—	—
49. Jokes	—	—	—	—	—	±		—	—	—	—	—	—
50. Optimistic	—	—	—	—	—	—		—	—	—	—	—	—
51. Leader	—	—	—	—	+	—	—	—	—	—	—	—	+
52. Opportunist	—	—	—	—	—	—	—	—	—	—	+	—	+
53. Over-ambitious	—	—	—	—	++	—	—	—	—	—	—	+	+
54. Movementy	—	—	—	—	—	—	?+	—	—	—	—		—
55. Distractable	—	—	—	—	—	—	—	—	—	—	—	—	—
56. Over-talkative	—	—	—	—	±	—	—	—	—	—	—	—	—
57. Laughs at criticism	—	—	—	—	—	—	—	—	—	—	—	—	—
58. Excitable	—	—	—	—	?+	±	—	—	+	—	?+	?+	—
59. Slap-dash	—	—	—	—	—	—	—	—	—	—	—	—	—
60. Reckless	—	—	—	—	—	—	—	—	—	—	++	—	—
61. Boastful	—	—	—	—	—	—	—	—	—	—	—	?+	?+
62. Extravagant	—	—	—	—	—	—	—	—	—	—	±	—	—
63. Theatrical	—	—	—	—	—	—	—	—	—	—	—	—	—
64. Promiscuous	—	—	—	—	—	—	—	—	—	—	+	±	—
65. Drugs	—	—	—	—	—	—	—	—	—	—	—	—	—
66. Alcohol	—	—	—	—	—	—	—	—	—	—	++	—	—
67. Over-assertive	—	—	—	—	—	—	—	—	—	—	—	?+	—
68. Resents authority	+	?+	—	—	—	+	—	—	—	—	++	+	?+
69. Feuds	—	—	—	—	—	—	—	—	—	++	—	—	—
70. Self-righteous	—	—	—	—	—	—	—	—	—	—	—	?+	—
71. Angry if criticized	—	++	—	—	—	—	—	—	—	++	—	?+	—
72. Dissatisfied	—	?+	—	—	—	+	—	—	—	+	—	+	—

been undertaken and the same comparisons made. The final classification and inclusion of traits was only settled after this detailed work had been completed.

In these comparisons many common observations have been confirmed. Hardly one of the schizoid traits for instance has not been remarked upon by some other worker and many of them are mentioned by almost everyone. On the other hand there are frequent divergences over what I have called the non-specific traits. Almost all other workers have held certain traits to be specific for syntones. A review of the literature and my own observations have convinced me that these conclusions are wrong and born of the theory that there *ought* to be traits specific to syntones. Only after a long search for these specifically syntonic traits was I led to the conclusion that they did not exist.

Even the schizoid traits are not absolutely specific.

An examination of the credentials of the 33 listed as specific reveals in fact that almost any of them may appear in a syntone. Indeed it is probably not going too far to say that it is impossible to find a single trait which may not sometimes turn up in a person who, when looked at as a whole, is typically syntonic. None the less it seems probable that most of these traits are far commoner in schizoids and could be arranged in an order of comparative specificity. Perhaps the most specific would turn out to be, " solitary ", " no humour ", " cold ", " saint-like ", " occult interests ", " ambitious phantasies ", " apathetic ", " indolent ", etc. On the other hand " no friends ", " no sex ", and " docility " would probably be found to be less specific. It is not difficult to envisage methods of weighting the traits to provide a more reliable index of the schizoid component than that which can be obtained by simply counting the number of schizoid traits presented by a given individual. Yet even this simple additive method appears to give significant results.

If these 33 traits are regarded as a group or battery of

tests, it will be found that the scores[1] made by the 13 schizophrenes (see Table p. 54) differ markedly from those of the 23 affectives (see Table pp. 48-49). The latter had, on an average, about one of these traits each, whilst the schizophrenes averaged about 6½ each. The number of traits shown by individual patients is given in the following table.

No. of Schizoid Traits Present	Affectives	Schizophrenics
0	8	
1	9	
2	3	1
3	2	
4		2
5		1
6	1	2
7		2
8		2
9		1
10		1
11		1
	23	13

From this it will be seen that whereas all except one of the affectives had three or less of these traits, the bulk having 0 or 1, all except one of the schizophrenics had four or more, the greatest being 11. This difference I believe to have significance and upon it many of my conclusions depend.

The patients with atypical traits are rather interesting. The one affective patient with more than three schizoid traits, No. 4, was a single man of 27 who was admitted in a depressed and apathetic state, having had ideas that

[1] The entries ?+ and ± are both counted as indicating the presence of the trait.

people were talking about him. The apathy and lack of feeling led one psychiatrist to suspect schizophrenia, but no hallucinations or thought disorder were elicited and he improved fairly rapidly. It is unfortunate that I was unable to obtain more definite information with regard to his schizoid traits (four out of six are ?+), but I have felt sufficiently confident that they were present to include them.

There are some similarities between this patient and No. 33. This was a married woman of 28 admitted in a depressed condition following childbirth and complaining that her husband was trying to poison her. She had had a similar attack nine years previously after the birth of her first child. Except for a few aural hallucinations before admission there was nothing to lead one to suspect schizophrenia and at a ward clinic it was agreed that the diagnosis should be depressive state and the prognosis regarded as good. After a few weeks, however, thought disorder and very florid hallucinations developed and the state was obviously schizophrenic. Now this patient had 5 schizoid traits in her prepsychotic personality[1] several of them being very marked ; for instance she refused to have anything to do with people because she thought they were being nasty to her and was constantly making scenes (different aspects of a strong paranoid disposition). Although it is always easy to be wise after the event, it seems to me that, had these characteristics been taken into account, it would have been possible to diagnose her condition as *potentially* schizophrenic before schizophrenic symptoms had supervened, and quite apart from the mental state on admission.

The development of schizophrenia in patients who have previously shown typical symptoms of an affective psychosis is a constant difficulty in psychiatric prognosis and at present no criteria are available for detecting those who are likely to develop the more serious illness.

[1] Actually her personality between the two breakdowns.

If the conclusions to be drawn from this work are confirmed, a detailed study of the pre-psychotic personality of patients would be of considerable help in selecting patients who, although at the moment showing symptoms more or less typical of an affective psychosis, must nevertheless be regarded as potential schizophrenics and given a more guarded prognosis. With this in mind I have been inclined to regard the exceptional depressive (No. 4) as a potential schizophrene and to predict that future psychotic attacks will show a preponderance of schizophrenic symptoms.[1]

Amongst the schizophrenes, there was only one patient who showed less than five schizoid traits—No. 30. She was a single girl of 23 who developed an acute catatonic illness following a love affair in which she felt that the man had no real affection for her and only wanted her physically. The informant, an aunt, was particularly anxious to make her out normal and from other information it was possible that she should have been classed as " docile " or even " saint-like ". But even this would only give her four schizoid traits.

Even with qualifications it is clear that this patient is an exception to the general rule, especially as there were few neurotic traits on the non-schizoid schedule. In other words here was a young woman who had passed for normal, having been a reliable secretary for six years, who suddenly falls ill of an acute schizophrenia. Exceptions of this kind, of course, are well known to occur and are discussed further in Chapter VI.

In view of these facts it is evident that we must be cautious in concluding that because a patient has *not* got many schizoid traits he is not a potential schizophrene. On the other hand the figures in this research, together with a more superficial examination of numerous other patients and coupled with the observations of many other

[1] When followed up four years later this prediction proved wrong. He had had two further attacks, but in neither does he appear to have had symptoms of schizophrenia.

workers, all go to suggest that *if a number of these traits are present it can be taken as an indication that the personality is schizoid.*[1]

It is a crude criterion, but, so far as I know, it is the best at present available. When only 3 or 4 traits are present, the diagnosis is uncertain, but when more than 5 appear in a personality and especially when some of them are striking instances the likelihood of that person being schizoid I believe to be enormous. This criterion, which, let us hope, will soon be superseded by some simpler and more objective test, will later be applied to the 29 psycho-neurotic and psychopathic patients in an endeavour to classify them characterologically instead of symptomatically. With neurotic and psychopathic patients I believe it to give fairly reliable results. Healthy personalities, on the other hand, may show so few traits that diagnosis is difficult. For instance, I have gained the impression that many fairly normal people who score low on the schizoid schedule none the less have a strong schizoid component.

Since one of the chief values of this research is believed to be its isolation of specifically schizoid traits it may be worth making some general observations about these traits.

In the first place it is to be observed that traits denoting opposite extremes appear in the list. For instance, both "docility" and "destructiveness", "no sex" and "homosexuality", "saint-like" and "hates family",

[1] This was written before it was discovered that No. 29, who had 7 schizoid traits, was probably not schizophrenic. This patient was exceptional in one important respect however. Her mother died when she was two and she was thenceforward looked after by foster-parents. Working in a child guidance clinic I have come across a large number of children with this history who have developed personalities similar to this patient. They tend to be solitary, distant and difficult to get any contact with, completely indifferent to criticism and emotionally unresponsive. On this showing they should be classed as schizoid, but it has been my impression that this conclusion is false. The criteria proposed in this essay therefore hold only for children who have had a conventional home life and are likely to give false results when applied to characters who have had breaks in their relation with their mothers before the age of 5 years. The commonest causes of such breaks are illegitimacy and foster placements, death or illness of mother and prolonged hospitalization of child. For details see BOWLBY (79).

appear as schizoid traits. It may be asked how, if one of these pairs of traits is specifically schizoid, the other can be also? The answer is that schizoids are of many different types. A schizoid of one type may be docile, saint-like and show no interest in sex. A schizoid of another type may be the opposite of this in all respects : he may be violent, bigoted, and lead a turbulent sexual life. This is a point of importance and will be treated at length in Chapter VI. It must always be borne in mind, therefore, that because one extreme of a trait may be almost specific to the schizoid character, it does not follow that the opposite extreme never occurs in schizoids. The reverse is usually the case.

Another point which will be noticed is that I have not included the traits " shut-in " or " seclusive " in my list. They have seemed to me rather ambiguous and I have preferred to split them up into a number of traits under the headings, " solitariness ", " no friends ", " no sex ", " cold and aloof ". Kasanin and Rosen (using Bowman's material) have pointed out that seclusiveness can be of at least five different types, ranging from a completely passive and withdrawn seclusion to a seclusion which is self-imposed to prevent the person making enemies which his intolerant and aggressive nature inevitably leads him to do when he mixes with people. A term which covers such a variety of behaviour and feeling is obviously inconvenient, hence my rejection of it. But even solitariness is of more than one type and since only one kind seems to be specifically schizoid it is necessary to amplify. There are some people who apparently prefer to be alone, either because they hate their fellow men or simply because they prefer solitude to company, whilst there are others who hate solitude and who long for company but are too shy to make friends or perhaps feel so ill after meeting people that it is not worth their while to do so. The main difference between these two types is that the one is indifferent or averse to company of any kind, whereas

the other enjoys it and wants it but finds it difficult to obtain or upsetting to their nerves.

It has seemed to me that this distinction, although not absolute, is important. Some depressive patients are solitary, but in almost every case I have found that it is because of shyness and that they *dislike* being alone. The schizoid patients don't dislike it and many of them prefer it. Kretschmer makes a point of this and characterizes schizoids as "seeking loneliness". This is the sense in which the trait is included in the schizoid schedule.

The great frequency of the shut-in personality in schizoids has been confirmed by almost every worker, since Hoch first noted it in dementia praecox patients. Not only is there complete unanimity of opinion on its schizoid specificity, but the frequency figures of different workers including my own show a remarkable constancy. This figure is about 50 per cent. This raises an issue in which I have been particularly interested. If 50 per cent of schizoids are shut-in, what are the other 50 per cent like? Are they partially shut-in? The answer to this is given fully in Chapter VI, but we may forestall it by remarking at once that the majority of this other 50 per cent are not shut-in at all and that many of them are the reverse—hysterical individuals with large circles of acquaintances, given to passionate quarrels and histrionic reconciliations.

This leads us to a comparison of the sexual lives of the two groups. Here again no simple contrasts can be made, because schizoids alone can show many extremes of sexual behaviour.

Kretschmer, however, has drawn attention to the fact that "the sexual lives of circulars and schizophrenes show certain remarkable differences, not so much in individual cases as on an average". Whereas the syntone lives a comparatively normal sexual life, schizoids deviate in at least three directions.

(1) Many of them seem to have *no desire for sexual*

relations with either the opposite or their own sex and are content either with nothing or else only masturbation. Although some of them masturbate excessively (Nos. 31 and 35 were examples) I do not think that excessive masturbation is confined to schizoids. Excessive (compulsive) masturbation is also found amongst syntones, for instance Nos. 8 and 9 both said they masturbated a great deal when they were boys, though subsequently both had married and given it up. The difference between schizoids and syntones seems to be that whereas the schizoid is often quite satisfied with masturbation and does not seek a sexual relation with another person, the syntones regard it simply as a *pis aller* to be replaced by more interesting sexual relations as soon as possible.

Another feature of schizoids noted by Kretschmer which is related to this lack of a practical interest in sex is " an abnormally lasting deprivation from sexual knowledge, and persistence in prudish ignorance and a system of infantile phantasy ". They deliberately evade getting sexual knowledge, and if told anything deny its truth.

(2) But not all schizoids have this negative sexual life. Kretschmer remarks that in others the *sexual impulse is over-strong and variable*, swinging " abruptly backwards and forwards between the alternatives of excessive heat and excessive coldness", and suffering from an unevenness of regulation. This perhaps is what Hoch meant when he described his schizoids as having a poorly balanced sexual instinct. Nos. 33 and 35 of my series are good examples of this variability.[1]

Such a sexual disposition is not unnaturally apt to lead to promiscuity and in women to prostitution. Kraepelin found that of 386 women patients 3 per cent had been prostitutes and he mentions debauches as common amongst the men. But although an uneven, unstable sexual life is probably fairly specific for schizoids

[1] See Appendix A. schizoid trait No. 18.

promiscuity is not so. Many people of a cheerful hypomanic temperament are promiscuous. Although it is probable that there is a difference in the form of promiscuity in schizoids and syntones it is not easily defined.

(3) Homosexuality is mentioned by several writers as being a schizoid trait. " We find among them (schizophrenes) and among their relations frequent tendencies to homosexuality, and, further, cases without strong sexual impulses, of contrary-sexual types of affectivity—masculine women and feminine men " (Kretschmer). Even Kahn admits that homosexuality is associated with schizophrenia and recent researches have tended to confirm this view.[1]

The marked tendency for the sexual life of schizophrenes to be abnormal in one of these three directions can be taken as established, but what of the affectives? Kretschmer holds that " deviations from the normal direction of the sexual impulse are seldom found among circulars " and with certain qualifications this conclusion seems to me just. The only patient in my series who was homosexual (No. 23) was only 20 years of age and an undergraduate, when homosexuality is less abnormal than in later years. But it is striking that only 10 out of the 23 had married, especially as 16 were over thirty years old. After reviewing the sexual lives of these patients one is forced to the conclusion that, although Kretschmer is correct in saying that the sexual impulse in syntones is normal in direction or in quality, it is very often markedly inhibited or alternatively over-developed. There follows a brief description of the sexual lives of the twenty-three affectives.

The seven under thirty were all unmarried. Of the two girls, No. 11, aged 21, had had no interest in boys ; No. 10, aged 26, had walked out with a boy from the age of 16 for 6 years. She was very conscientious and had been worried what she should do about it. Finally

[1] See Appendix A., schizoid trait No. 16.

she brought things to a head and broke off the liaison which she subsequently regretted as she was anxious to get married and have children. Recently she had been seeing another young man. Of the men No. 16, although 27 years old, had never had a best girl. He said he had had heaps of opportunities for intercourse but had always been terrified of contracting venereal disease. He had attempted intercourse twice and each time suffered from ejaculatio praecox. Of the others No. 20, age 21, had always been very shy with girls, but had been with a prostitute once. No. 4 (age 27) the shut-in depressive, had walked out with an epileptic girl for a short time, but broke this off, whilst No. 21 (age 17) had no interest in girls and said that they stared at him and made him feel embarrassed. No. 23 was homosexual.

Of these seven patients only one, No. 10, can be said to have had an even tolerably satisfactory relationship.

The six unmarried patients over 30 were all men. No. 13 (aged 31) said that sex had always caused him great difficulty. He had been brought up very strictly and said that as a result he had never masturbated nor had sexual intercourse. He had had various affairs with girls who were his social inferiors, but had broken things off whenever he had felt they wanted intercourse or marriage. No. 22, also aged 31, said he had never had any serious affairs; he had "fooled around with other people's wives", but had never had intercourse. No. 2, aged 32, had gone with prostitutes since he was 17. He had been engaged for the past 7 years and was hoping to save sufficient money whilst he was abroad to get married, but he fell ill on his return to England. No. 14 (aged 45) had had numerous guilty affairs with servant girls and prostitutes and had contracted gonorrhœa, which had been cured. An affair with a girl who was described as very well suited to him had become extremely protracted. Despite her desire to marry him, he had remained very undecided for fear that there might not

be sufficient love between them and that he might still be infective. These difficulties seem to have precipitated his breakdown which took the form of obsessive precautions against infection. Nos. 7 and 15 were both old bachelors of 57. No. 7 was an elderly man who for many years had been part of a *ménage à trois*. He had been the lodger and later became the lover of the wife, a managing woman, with an obedient little husband. It was suggested that several of her children were his. He contributed materially to the household and was treated by the wife rather like a second husband, but despite all this the husband was alleged to remain ignorant of the wife's infidelity. It was interesting that the patient had no desire to marry the woman. No. 15 had been engaged in his youth, but this had been broken off by the girl. Later on he had wanted to marry but felt he could not afford it ; of recent years he had become intimate with a married woman whose husband had deserted her. He often found himself impotent with her and usually felt rather miserable after being with her.

Summing up these half dozen patients we may say that they all showed considerable interest in the opposite sex, but were to a greater or less extent frightened of sexual relations and the responsibilities of marriage.

The ten who were married were all between 34 and 54 years of age ; only one was a woman. Of the nine men no fewer than six were described by their wives as admirable husbands—they would not want a better—and their marriages as exceptionally happy. They were careful, thoughtful of their wives and took matrimonial responsibilities extremely seriously ; often they had been anxious lest they should be unable to look after their families properly. Most of them had a few children to whom they were devoted.

Nos. 1 and 3 were exceptions to this general rule. Both men were extremely quiet and this irritated their wives. No. 3 had got on well with his wife at first, but later she

complained that he would not go out enough. He had been so shy that she had done all the courting.

No. 19, the only hyperthymic temperament amongst the married men, had never got on very well with his wife whom he found too cold and jealous, but he seems to have been a conventionally good husband and devoted father.

No. 18, the only married woman, was a faithful, if difficult, wife. For several years before marriage she had known her husband. During this time there had been constant quarrels and reconciliations. She was exceedingly jealous and once broke off the engagement for trifling reasons. She had always been frigid in sexual relations.

Except for the hyperthymic patient, No. 19, the men did not make strong sexual demands on their wives. No. 4 for instance was satisfied with intercourse about every 6 weeks.

From this short survey we may conclude that the syntone's sexual life is more variable in quantity than peculiar in quality. It would be a mistake to think that it was wholly normal—the tendency to impotence or frigidity and a fear of undertaking the responsibilities of marriage amongst the depressives, or the tendency to promiscuity in the hyperthymics are sufficient deviations to show that various anxieties interfere with it. On the other hand syntones rarely take refuge either in perversions or complete asceticism, and their affairs remain gross and mundane in comparison with the idyllic and explosive loves of some schizoids.

It is on these grounds that the " perverse " traits—" no sex ", " homosexuality ", " fetichism ", and " passionate attachments "—are included in the schizoid schedule, whilst the quantitative traits—" promiscuity " and " impotence " are regarded as non-specific.

Chapter V

TYPES OF SYNTONIC PERSONALITY

So much for the dry bones of personality traits ; at their best they only provide a convenient, if clumsy, method of comparing individuals and discovering what is typical and what incidental in a personality ; they can never replace full descriptions of real people. For a person is in no sense the sum of his traits. It is the combination of traits in a given individual which is often so characteristic, for instance great ambition combined with inactivity in the schizoid or a sharp tongue together with anxious solicitude for others' safety in the anxious depressive. There are many combinations of traits which seem strikingly common and in this chapter it is proposed to describe certain individuals who show syndromes which the previous examination of the incidence of traits suggests are typical of those people who are liable to fall ill of an affective psychosis.

The great variations and incompatibility of many of the traits listed as specifically schizoid will have suggested that the variations *within* one of the two groups (syntone or schizoid) are likely to be as great as if not greater than those subsisting between members of *different* groups ; for instance both brutal violence and saint-like passivity are listed as schizoid traits, punctilious care and wild recklessness as typical of different syntones. This expectation is fulfilled and we find that the most unobservant person can distinguish a cautious obsessive syntone from the cheerful hypomanic, whilst on the other hand the similarity between a depressive syntone and a " shut-in " schizoid may be so close that even a thorough investigation along the lines suggested may still leave a doubt about the true

classification.[1] In this chapter only the divergences between different syntonic personalities are described. If the similarities and divergencies between certain syntonic types and certain schizoid types are to be appreciated the syntonic personality should be compared with its schizoid counterpart described in the following chapter.

Though it must be remembered that no hard and fast lines can be drawn between any groupings of personality, it is none the less convenient to isolate types to which individuals approximate more or less closely. At least three types of syntone have been commonly recognized, the hyperthymic (or hypomanic), the depressive and the circular, a division which is based upon whether a person is active, sociable and optimistic ; the reverse of this ; or a mixture of the two. The variable involved corresponds to Kretschmer's diathetic scale, to Jung's introversion-extraversion scale, and has recently been termed surgency by Cattell, who has isolated the factor by statistical methods. The hypomanic personality has much surgency, whilst the depressive is desurgent. But in addition to this, syntonic personalities vary very markedly in their temper. Some desurgents are invariably good-natured and kind, others irritable and unpleasant. The same is true of hypomanics, some of whom are always cheerful and good-tempered whilst others, like the proverbial colonel, aggressive and choleric. Kretschmer has a tendency to gloss over the bad-tempered syntones in an effort to make them all warm and friendly, but there is no doubt of their existence.

Two different factors are therefore present, surgency and temper, and, since they can be combined in any way, four sub-groups are formed. Thus we may have a desurgent, good-tempered personality. This I have called the Cautious Obsessive character. The desurgent and bad-tempered personality I have named the Anxious

[1] " Above all we shall have to attempt to characterize the temperamental depression which bears a close relation to the circular group, more or less in contradistinction to that which points rather more in the schizophrene direction."—KRETSCHMER, *Physique and Character*, p. 123.

Depressive. It is true that these two depressive subtypes differ as much in the degree of manifest anxiety as in temper. I think, however, that there is an association between bad temper and overt anxiety, good temper and obsessive traits, and that this division corresponds roughly to the division of surgent personalities into good- and bad-tempered. The good-tempered surgent I have termed the Cheerful Hyperthymic and the bad-tempered surgent the Quarrelsome Hyperthymic. This classification can be tabularized thus :

	Desurgent	Surgent
Good-tempered	CAUTIOUS OBSESSIVE	CHEERFUL HYPERTHYMIC
Bad-tempered	ANXIOUS DEPRESSIVE	QUARRELSOME HYPERTHYMIC

This, however, leaves out of account the circular personalities. The most striking thing about them is their variable surgency, but they also vary in temper. Indeed, they can be made up of almost any combination of surgent and desurgent characters, but it would be too complicated to divide them into a number of groups.

The classification suggested with the number of patients of my series belonging to each type is therefore as follows :

		Patients
A.	DEPRESSIVE	
	(1) Cautious Obsessive	13
	(2) Anxious Depressive	2
B.	HYPERTHYMIC	
	(1) Cheerful Hyperthymic	2
	(2) Quarrelsome Hyperthymic ..	—
C.	CIRCULAR	6
		23

For each of these first four types there are certain groups of non-specific traits specially characteristic. These are as follows :—

Cautious Obsessive ..	1–19	and 20–31
Anxious Depressive ..	32–45	
Cheerful Hyperthymic ..	46–57	and 58–64
Quarrelsome Hyperthymic	65–72	

The frequency of these traits in syntones is discussed at length in Appendix B, where I have compared my own findings with those of other workers. In contrast to my general agreement with others over the incidence of certain specific traits in schizoids, my observations on syntonic traits are often at variance. Many traits which have usually been thought to be absent in syntones, e.g. sensitivity, I have found with monotonous regularity. Consequently my portraits of typical syntones, especially the depressive personalities, differ appreciably from those drawn by others. The only normal or neurotic traits which I have found to be genuinely rare in syntones are the 33 traits regarded as specifically schizoid.

A. Depressive Personalities

(1) *Cautious Obsessive*

The traits characteristic of this type are the first thirty-one non-specific ones, which include all the obsessive and depressive traits. The former are especially characteristic, and are contrasted with the symptoms of manifest anxiety and euphoria, which characterize the anxious depressive and hyperthymic groups respectively. Although most of these obsessive personalities are rather gloomy by no means all of them are, some making a point of wearing a smile come what may. Indeed there are many quiet humorists amongst them.

The features of the obsessive character have often been described before. The group here depicted corresponds

by and large with those termed by Schneider "anancastic", by Kretschmer "sensitive", by Jung "introverted thinking", and by Abraham "anal-erotic", although all these headings are apt to include amongst them certain obsessive schizoids who are, of course, specifically excluded from my group of obsessive syntones. For obsessive characters can unquestionably belong to either of the main categories. Here we are concerned only with obsessive syntones, but in Chapter VII a patient (No. 58) is described, who, whilst being markedly obsessive in personality, had also a large number of shut-in schizoid traits, and is regarded as an obsessive schizoid.

No. 12 is a good example of the Cautious Obsessive. He was the elder of two children. Although his father was healthy, his mother had always been "nervy" and had had numerous minor ailments, but otherwise there was said to be no nervous or mental disease in the family. The house was comfortable and the children well cared for. The patient went to elementary and secondary schools where he worked hard, did quite well and made a few friends. After leaving school he was apprenticed and later became a gas-fitter with a large and reputable company.

At the time of his illness he had been with the company twenty-three years, was regarded as an excellent, reliable workman and was always extremely punctual at his job. He had worried a good deal about his work and apparently had never had much self-confidence for he commonly felt unequal to a job which in fact he could do excellently and was apt to go back over the work again to make sure it was satisfactory; though he never did it so often that he got behind at his work, which frequently happens with these people.

In society he was very quiet. His wife would have preferred him to have a little more "go" about him, but he felt awkward and self-conscious in a crowd and preferred the company of a few close friends. He was

said to be well liked and respected and could be quite an amusing companion in congenial surroundings, but amongst strangers he shut up like a clam and he particularly disliked visiting friends' houses or going into a public restaurant. He had never been known to become overexcited, on the contrary his mind was even, varying little from day to day, except occasionally when he was specially quiet.

He married when he was 30 having known his wife for a couple of years. Previous to this he had walked out for a short time with another girl, but had decided they were not suited and had broken it off. He had never had sexual intercourse before marriage. His wife described him as an extremely good husband. Devoted to her, he never went out without her and held strong views on fidelity. On one occasion when his wife was jealous of his talking to another woman, he had reproved her strongly for entertaining such feelings about him. But there was one bone of contention between them. Before his marriage he had been closely attached to his home and family, especially his mother, and even after he was married he still felt it his duty to continue living at home so that he could look after his parents. His wife tolerated it for eight years but finally insisted on their having a separate establishment. Even so he went over to visit his parents every day of the year except during his fortnight's annual holiday.

In the house he was a model husband. Very clean and neat, he would willingly help his wife with her housework and spent much of his spare time improving their house, doing odd carpentry jobs, painting and distempering. He looked after his clothes with great care and when he came home from work spent quite three-quarters of an hour washing himself before he had a bite of food. In some respects he was a bit of an old woman, but he certainly created no trouble in the home. Unfortunately they had no children. They had had intercourse fairly regularly every fortnight and his wife twice became

pregnant, but miscarried. This was a source of great unhappiness to him as he liked children and wanted them, and he was also upset to see his wife ill, as he had always been very tender-hearted. He had brooded over these miscarriages, the last of which had been two years before his breakdown and said himself that he had never felt really well since they had happened.

Although he would try to grin at trouble, his wife felt that he was very sensitive and brooded underneath. He would often have periods when he was unnaturally quiet and although he would say nothing to her, she realized that he was depressed and worried. Exceedingly cautious, he had refused a better job on one occasion because he felt that it might not turn out satisfactorily. His wife was disappointed, but he had said he was quite happy where he was and stayed there. He was very polite and kept clear of controversies and conflicts; he preferred not to interfere for fear he might upset one or other party, and that made him unsociable. Regarding money he was careful, but he had his little pleasures and was not disapproving of the extravagances of others.

His wife had always felt that he was far more nervous than he showed. Apparently he kept a firm hand on it and admitted it neither to himself nor others. Ever since she had known him, however, he had gone round the house at night at least a second time to make certain that the gas was out and the door locked and on occasion he had got out of bed again to have another look. But he explained this to his wife as only reasonable precaution and that it was much better to make sure than regret accidents afterwards. He was not particularly superstitious, only objecting strongly to opening an umbrella in the house. In addition to these worries he was distinctly nervous over his health as appeared from the numerous patent medicines which he took. These were mostly for his bowels, which were rather constipated, but he had also dieted at one time for

" stomach trouble ", and had suffered from dragging pains in the side and colitis at different periods ; but he was not inclined to complain and his wife had often found it difficult to discover what his symptoms were. His breakdown came on all of a sudden when he was 41. He had been working overtime for 8 to 9 months and had felt he was not doing the job properly. Suddenly he lost all interest in the work, wanted to be quiet and alone and felt hopeless. Then he felt people were against him, perhaps because he smelt. When I saw him he was retarded and depressed and said he felt he had fallen to pieces. He admitted having suicidal impulses and said that " spasms came over him " because they had no children. He wondered why they had not and obviously blamed himself in some way for it. No hallucinations or thought-disorder were elicited and his condition was typical of an affective depression.

Here then is a man who has been a reliable worker and a model husband, who may have been looked upon as a little neurotic in his perfectivism, in his excessive care about precautions and in his worry over his health, but who otherwise passes for normal. None the less at the age of 41 he has a psychotic breakdown.

Twelve other patients (Nos. 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 15 and 21) were very similar to this man, although most of them were more inclined to be gloomy and pessimistic, and Nos. 1, 3 and 5 were sometimes irritable and sulky, unlike the quiet good-nature of No. 12. No. 4 was similar in many respects, but as previously mentioned, he had several schizoid traits.

It will be seen then that half of my series of affectives was of this type, and that all but one (No. 21) became melancholic. Although the total numbers are small it is my impression that this proportion is representative.

Many of these characters are of course ' model children ' grown up. Bowman found that a quarter of all syntones had been model children, so it appears that this type is readily recognizable from an early age.

Their tendency to overwork should also be noticed. It is of course an integral part of their nature and, when excessive, a symptom (not a cause) of impending breakdown. These characteristics are some of the mechanisms by which nervousness and anxiety are hidden. In the thoroughness with which they achieve their end they are to be distinguished from the next type, who, by contrast, are as a ragged darn to invisible mending.

(2) *Anxious Depressive*

This group has much in common with the last, but they are less 'repressed', more obviously anxious and usually rather sharp-tongued. The non-specific traits, Nos. 23 to 45, are typically found together with some of the cautious obsessive traits and a few paranoid ones (e.g. non-specific 68-72). Unlike the Cautious Obsessive they are anxious and flustered about everything they do, irritable and snappy when things go wrong and vary in mood from one moment to the next, dependent upon trifling incidents.

It has been my impression that women tend more frequently to this make-up whilst men are more likely to be Cautious Obsessives. This would account for the fact that only two of my patients were of the anxious type (both women) as against 12 obsessive, who were nearly all men.

No. 18 was an example. Like No. 12 she fell ill at the age of 41, but her illness was a severe agitated melancholia following thyroidectomy.

She was one of a large family of girls, the daughters of a prosperous but highly excitable business man and a nervous mother who suffered from Graves' disease. One of her sisters also suffered from Graves' disease with the usual nervous symptoms. The patient herself had done quite well at school and had lived a social life at home after leaving, being particularly attached to her father. She had always been very fond of parties and was said to be the life and soul of them ; she enjoyed

tennis and bridge and, although very self-conscious, played the piano and the violin quite well. (It seems to be quite characteristic of these anxious personalities to play some instrument or sing, although their nervousness hampers them.) During the war she did some nursing and it was at this time that an exophthalmic goitre developed, which was treated in a conservative way for some 15 years.

She was married soon after the war to a man whom she had known well in 1912 and who had wanted to marry her then. But at that time she had been extremely undecided about what to do and eventually they had drifted apart. During the long courtship she had been very difficult, especially during the engagement when she was intensely jealous without any provocation, and her husband was constantly expecting her to break it off. On one occasion she did so because he took a cousin out for the evening, but they patched it up again later. Finally she did bring herself to marry him, but the marriage was not particularly successful because of frequent petty quarrels. For instance, they quarrelled over the boy ; her husband thought she molly-coddled him whilst she thought he was unkindly harsh. Another source of friction was her frigidity and dislike of intercourse. She was very puritanical, despite being brought up to be an atheist, and was disgusted by many ordinary modern novels, such as *Grand Hotel*.

In contrast to this unsatisfactory relation with her husband, she enjoyed looking after a house. She took great pains to have it tastefully decorated and furnished and enjoyed entertaining. But she was a very inefficient housekeeper, for she spent endless time and energy fussing over household arrangements at the end of which everything was in an indescribable muddle and she utterly exhausted. When they entertained, which they did on a small scale, she was rather extravagant in the food and wine and also in her own clothes, for she hated not being well-dressed. These parties were a source of

irritation between husband and wife. Neighbours and friends were always a worry to her since she was for ever feeling that they were criticizing her, and after a party she was obsessed by anxiety lest she or her husband should have offended them in any way. She would go so far as to call upon them next morning to make apologies, usually for some trifling act or remark of her husband's which the visitor may never even have noticed. Her husband, not unnaturally, resented the implied criticism.

She herself was frightfully sensitive to criticism and brooded long over small things. Unlike the previous patient (the Cautious Obsessive) she was apt to be very critical herself and her husband frequently suffered from her sharp tongue—though she would be very repentant afterwards. Her spirits were variable as quick-silver and would change in a moment, in contrast to the slow heavy moods of No. 12. One moment she would be down and miserable, but a few visitors coming in would banish her depression and make her as lively as ever.

A constant source of worry was health, her own, her husband's and her son's. There always seemed to be something wrong with her, either a headache or indigestion or perhaps just fatigue. Her only son, aged 10, was the subject of her greatest solicitude ; every meal, every motion, every cold was scrutinized and fussed over, and when her husband came home late she had always imagined some dreadful calamity. A constant fear was that perhaps one day he might fall really ill.

Her anxieties indeed went quite unhidden. Thunderstorms terrified her ; and she was the kind of woman who would scream if she saw a mouse or a street accident.

It is obvious that such symptoms were associated with her goitre. Since it had been getting slowly worse, and symptoms of breathlessness had developed early in 1933, a thyroidectomy was performed by an eminent surgeon at the end of May. She made a good recovery, though during convalescence she was occasionally more nervous than usual. In August she began feeling that

her maid and her sister were working against her and she was afraid she might go mad. Fits of depression and weeping began to alternate with excitement until finally in October, when on a visit, she became obviously psychotic, making wild accusations against members of her family and reproaching herself for running away from her husband. When admitted to the Maudsley she was acutely agitated and self-reproachful and was diagnosed as an agitated melancholic.[1]

This patient was very much more obviously neurotic than No. 12 and a psychotic breakdown is perhaps less surprising. One other patient, No. 10, had also been of an acutely anxious temperament, but she had more obsessive traits and was less flustered and bad-tempered than No. 18, and might be regarded as transitional between the depressive sub-types, Cautious Obsessive and Anxious Depressive.

B. Hyperthymic Personalities

(1) *Cheerful Hyperthymic*

The Cheerful Hyperthymic is characterized by the non-specific traits, Nos. 46-64. He has often been described. In appearance at least he takes life lightly, is hail-fellow-well-met, boisterous and daring. The timidity and decorum of the Cautious Obsessive is like a red rag to a bull to this cheerful type, who will commonly tease and make fun of the pious prig. The Cautious Obsessive in his turn is shocked by the thoughtlessness, recklessness and lack of sensibility shown by these overbearing, boastful people. But although the two types often hate one another, sometimes they admire the qualities in the other which they lack themselves and form fast friendships. Rapid decision and never-failing

[1] The fact that when patients suffering from Graves' disease become psychotic their symptoms are usually those of melancholia supports the view that there is an association between anxious personalities and melancholia, a point which will be discussed again.

cheerfulness appeals to the indecisive and gloomy, whilst the rash hyperthymic values forethought and reliability.[1]

No. 20 was an example of the Cheerful Hyperthymic. A single youth of 21, he was admitted in a manic state after returning from a few weeks' holiday.

The family history was not good. His father was a nervous man and his paternal grandfather had become violent for six weeks following an attack of bronchitis. One of the father's brothers had committed suicide after business difficulties and one of his sisters had been paralysed following a fit at 14 years. The patient's mother was very nervous and hypochrondriacal, whilst her father was described as eccentric and mean. Her brother was excitable, and had been in prison for stealing. One of the patient's younger sisters had died of convulsions, aged 2.

The patient was the second in a family of five, of which two girls, both younger than he, had died in infancy. The home seems to have been a comparatively happy one, the parents' marriage being successful and the family united. The patient himself got on well with the others and was especially devoted to his mother.

Since he was only 21, much of the description of his personality applied to adolescence. From the details furnished by his father and himself one gets the picture of exaggerated jollity superimposed upon a very sensitive and self-conscious nature. On the one hand is his father's description of him as a " dare-devil sort of boy " who was always up to pranks and was exceedingly popular at school. The proudest moment of his school life was said to be when he had to line up for the stick. He was in constant high spirits and was known at home as the " joke of the family ". He had plenty of friends, was a good entertainer, played the piano, sang and did some work in dance-bands. When anything went wrong he joked over it and made the best of it. But

[1] Most of Jung's extraverted types appear to be variations of the hyperthymic. The only exception is the " feeling " extravert.

there was another side to him. Despite his *bonhomie* and apparent care-free manner he felt extremely self-conscious with strangers and if he wore a new suit felt people were looking at him. When as a choir boy he was promoted to be soloist, he disliked being so conspicuous and left the choir. Moreover, he had one or two phobias such as a fear of electricity and dislike of going on top of trams for fear they would fall over, and until the age of 15 he had been terrified of the dark. Until a year or two previously any criticism would make him lose his temper, but recently he had taken less notice.

Although he does not appear to have brooded about himself, he did worry a great deal over his parents' ailments and also over the death of his little sisters. Both his father and mother were invalids, his father suffering from chronic indigestion, and his mother from the after-effects of a stroke which she had had ten months before the patient's breakdown. His father thought that the boy had worried over her illness but had bottled up his feelings about it. In this connection it is worth noting that he could never bear to see a cripple, a trait sufficiently marked for his father to remark upon it spontaneously.

The patient was 14 when his little sister, Sheila, died of convulsions at the age of two. Her death was a severe shock to the whole family as she was the only remaining girl and was much younger than the other children ; in fact her father was quite overcome with emotion when mentioning it seven years later. There seems no doubt that it was also a severe blow for the patient. He described how he went for long solitary bicycle rides between the age of 16 and 18 thinking about Sheila, and his manic delusions were largely concerned with his possible responsibility for her death and the actuality of her reincarnation. It was a secret sorrow, however, for he never mentioned it to anyone and had evidently hidden it effectively under his jolly manner. Regarding work he had been in the

same job for five years and had given satisfaction. He had had a secondary school education but did not reach the matriculation standard because his conduct was too bad. Moreover, he was very nervous about examinations and was probably quite glad to have evaded it. Since leaving school at the age of 16 years he had been working as a clerk, had done well and enjoyed it. In this respect he was steadier than many hyperthymic personalities, but he had no obsessive traits and was not specially conscientious. He tended to be untidy at home but he was exceedingly particular about clothes and spent a long time dressing, preening himself in front of the mirror, and said that he had had to " fight vainness ".

There was nothing unusual about his sexual life. Between the ages of 13 and 19 he had masturbated, but later felt he had conquered it. When he was 19 he had walked out with a girl, who was a family friend, but after some 16 months she had broken it off as she was in love with someone else. Very characteristically he had reacted by saying he did not mind—in fact that it was a good thing as he would be better off with the boys. Since then he had not had a best girl, but he had been with a prostitute on one occasion, whilst on holiday.

Although very fond of games he had been " unlucky " in getting numerous minor injuries and finally twisting his knee playing football when 18 ; this had led to synovitis, which had kept him inactive for some time. Smoking and drinking were inclined to be excessive. As a rule he only had an occasional glass of beer, but when on holiday he had been apt to go on the spree and get drunk.

It was whilst on holiday at the seaside that the manic attack began. He fell in love with a girl called Celia, whom he identified with his dead sister Sheila. His over-activity, drinking and jokes amused his holiday companions very much and he was not seen medically until his return home. He made a good recovery in hospital, and returned to work after six months.

One other patient, No. 22, was fairly similar, but lacked the warmth of feeling characteristic of the type and so was rather atypical. It is obviously not possible to generalize from these few cases, but it is my impression that most hyperthymic personalities who are liable to psychosis are markedly self-conscious and sensitive underneath their show of care-free jollity.

(2) *Quarrelsome Hyperthymic*

The cheerful hyperthymic who meets difficulties with optimism and humour and laughs at criticism is far more popular as a rule than this type who is often difficult and unpleasant. He becomes angry and abusive when criticized, bears grudges and makes enemies. He is always finding fault in others and often becomes quite paranoid about them. The non-specific traits, Nos. 66-72, are specially characteristic though he has many of the other hyperthymic traits also.

No patient in my series was of this type, so that an example is not possible. Kretschmer, unfortunately, gives no full case on the grounds that so many have been previously reported. They seem to be less common than the cheerful form, however, and I have been unable to find a good example in the literature.

Henderson and Gillespie give a short description of one. P.S., 50 years old; a professional man. "He has been ill more or less continuously since 1911, with alternating attacks of depression and excitement. One sister was stated to have been in a mental hospital, and another was described as a "nervous wreck". The patient himself had been an extraordinarily capable man, who had taken a high place in examinations, and had reached a position of great distinction. He was always of an aggressive type, very much a leader, described by some as too independent, by others as an agitator, and, by his son, as one who could not brook opposition." MacCurdy also describes a fairly typical onset of manic excitement in one such patient. "Lawrence P., aged 24,

single. . . . The attack in question commenced six weeks before admission, when the patient became much incensed over a certain article in a newspaper, the contents of which is unfortunately not mentioned. The excitement began with a threat to horse-whip the editor, and his consequent acts all seem to indicate a tendency to dominate those in authority. He demanded that the newspaper should no longer appear at a well-known club of which he was a member, and, when this order was not obeyed, he wrote an insulting letter to the president of the club."

These cases serve as examples of the character and behaviour exhibited by this type of hyperthymic personality. There are naturally many people who vary between cheerfulness and quarrelsomeness and are intermediate between the two hyperthymic types. There are others who lie midway between this type and the Anxious Depressive.

C. Circular Personalities

Although most syntonic personalities approximate to one of the four types of patient already described, no sharp dividing line can be drawn between the groups. Various mixtures occur, and when the mixture includes both melancholic and hypomanic features in fairly equal proportions, a circular personality results. Unlike the foregoing types who remain preponderantly either euphoric or depressed, these people are changeable, their moods varying either from day to day or more commonly over a longer period.

It is this type which is so often described as typical of the syntonic personality and which such terms as " manic-depressive disposition ", " cycloid " and " cyclothymic " personality immediately suggest to the mind. The mistake of regarding lability of mood as typical of, or even common in, syntones has been stressed in Appendix B, and it may here be repeated that *probably not more than a*

third of all syntones show marked variations of mood. Moreover, many who do so are more conveniently classed as Anxious personalities, since, although variable in spirits, they never show the boastful self-confidence and infectious gaiety which denotes a genuinely hyperthymic component. The group of Circular personalities consequently is not a very large one.

Of the six patients of this series who varied perpetually between a cheerful and a depressed mood, No. 19 is the best example. A married man of 43, he was admitted in a depressed state, very self-reproachful, and with paranoid symptoms, which soon cleared up. There was no retardation, rather the contrary.

He was one of a pair of twins, who were the youngest in a family of six. There was no history of mental disease on either side of the family, but both his mother and an elder sister were said to have been temperamental and fussy. His twin was a retired naval officer who tended to be depressed and unsettled. He had become a ne'er-do-well, got into trouble over the accounts of a club of which he was secretary, and constantly borrowed money off the patient.

After leaving public school the patient entered a colonial service and went abroad. He never liked the work much and felt dreadfully lonely and miserable on the long periods of absence from civilization. He had always had a bit of a temper and when in authority was intolerant of any disobedience or trivial misdemeanour and so soon got into the habit of striking the natives. This proved effective in strengthening his authority but it was frowned upon by his seniors. The Government dropped on him and supervised him specially for three years and he did not get the promotion which would otherwise have been due to him. Finally when, after the war, various reforms were introduced into the service he resigned, because he felt out of sympathy with the new liberal policy. A further factor was that the natives were becoming more antagonistic to government

of any kind and the one thing he could not stand was criticism and unpopularity. The period before his retirement was specially trying for him and sometimes he became so depressed that he would shut himself up in his bungalow for days together and give the whole thing up as hopeless.

After returning home on a small pension he took to breeding a type of dog which was particularly popular at the time. His kennels grew rapidly and since prices were very good during the boom period he made a considerable profit. Always an optimist when things were going well, he took to keeping other breeds. This period was one of great happiness. He was no longer subordinate to disapproving superiors, but independent and making a great success of his venture. When things went well he worked hard, for he hated being idle and was a stickler for perfection—" I can't enjoy anything in which there is any blemish." If a job was not done just right he would do it over and over again until it was. But he had not the solid conscientiousness of the typical obsessive personality, who never gives in until he has a severe breakdown. If things went wrong he lost interest and gave up.

Unfortunately his great success at dog breeding was short-lived. First the economic depression which upset prices, then the failure of his animals to breed, and perhaps most bitter of all the reproaches of his friends to whom he had sold animals with a view to their taking up breeding too. He had recommended his wares in sanguine terms during the boom and, when the bottom fell out of the market and the animals failed to breed as well as advertised, his friends felt swindled and lodged complaints. As failure began to show itself, his enthusiasm waned : his accounts were in a muddle, the income tax authorities worried him and he began to feel that " vital information " about his animals was being given to rivals by his secretary. Finally he took in a partner to help with the business. The partner seems to have

done his best to pull the business together by supervising the accounts, but the patient had always hated supervision and criticism and when it came from a newcomer and was directed against his own private venture which he had spent so many years building up, it was unbearable. He became deeply depressed, was unable to work and felt that the partner was trying to oust him from the business.

An acute sense of inferiority is apparent throughout this story, a feeling to which he reacts either by finding faults in others or in exaggerated optimism. His sexual life shows a similar disposition, though in this the feeling of inferiority is more obviously a sense of guilt. Brought up religiously both at home and at school, the laxity of morals which he found obtaining in the colony shocked and perturbed him. Throughout his residence he was in perpetual conflict whether to persist in the moral scruples which he had always had or to fall to custom and keep a native mistress. During his early days, when he was seriously tempted to become a missionary, he remained continent and sometimes took religious services, but later, during his lonely periods up country, he had a housekeeper who became his mistress. He was strongly sexed and, despite intense feelings of guilt, continued to have native mistresses until he left the country.

When he was 30, after being out about ten years, he married an Englishwoman whom he had known for a year or so. Though they had not separated, the marriage had never been a happy one. It is difficult to apportion blame, but there can be no doubt that the patient must have been exceedingly trying to live with. His wife was rather a cold managing woman who, he felt, criticized him and gave him too little affection. Sexually she was rather frigid which upset the patient and led to friction. But the patient himself was exceedingly apt to find fault and criticize. She was rather untidy and his fear that the three children would contract

this fault led to his being very insistent on tidiness, which annoyed her. Moreover, he was exceedingly jealous, though his wife seems to have given him few grounds for it compared to himself. For instance, he had once found his brother holding her hand and had expelled him from the house because of it. On the other hand, after his marriage he had continued having native mistresses whenever he went up country alone and, after his return to England, occasionally went with prostitutes. These things he was deeply guilty about, which showed particularly in his elaborate defence of his pleasure in the company of young women—he found their company " uplifting " and helpful, whilst inveighing against the loose morals of other men.

To his three children he was devoted, especially to the youngest who was a girl and he always liked having her with him round the kennels. But the treatment of the children was often a source of disagreement between him and his wife and he felt, moreover, that she gave them more affection than she gave him or, to put it in his own words, that she "was emphasizing the maternal very greatly to the partial exclusion of the attitude of the mate ".

Whilst in hospital he commonly talked in this grandiloquent language—trying pathetically to impress and at the same time avoiding calling a spade a spade. His manners were usually exaggeratedly polite and he was constantly assuring one of his gratitude for any little help given. Humour had been one of his great standbyes in life and he did his utmost to keep his spirits up in hospital despite the fact that he was often in tears. On one occasion he described to me how he was feeling in very " good form " and had " been able to keep up a vein of humour ever since he came," that he was " irrepressible " and that he had been " extraordinarily grateful for the experience "—referring to his psychosis. Throughout his life he seems to have been like this—often feeling utterly miserable, but able to laugh it off until it got too

intense. Amongst acquaintances he could be the life of the party and on several occasions felt he had rather outdone his strength through sheer excitement. His spirits had always varied from great heights to great depths, seldom striking a happy mean.

His joy in life had taken slightly theatrical forms on occasion such as wearing purple shorts, but this was done out of exuberance, not affectation. But this exaggerated cheerfulness had not won him any friends, and since he depended greatly on company he often felt rather lonely. Criticism, however slight, was deeply resented. Moreover, he commonly felt that men were trying to dominate him, and perhaps partly for these reasons he got on better with women. Although he had a few obsessional traits, such as a horror of dirtiness and a tendency to avoid cracks in the pavement, he did not repeat precautions and he was neither superstitious nor hypochondriacal. Moral questions, however, had always bothered him and he had been inclined to read a great deal of religious controversy, a thing his wife disapproved of. He also read a good deal about politics and held strong views on the importance of "Service to humanity"; but his interests remained comparatively simple and never took an occult turn. Indeed, there was nothing bizarre or unexpected about his character and he had no schizoid traits.

This is a man who all his life had been markedly unstable, the instability taking a classically cyclothymic form, with the hypomanic traits most pronounced. The other five circular patients (Nos. 13, 14, 16, 17, 23) were much less manic, Nos. 13, 14 and 17 being cautious obsessives, with a hyperthymic tendency.

These case-histories give a fair picture of the types of personality found amongst people who later suffer from an affective psychosis. They follow closely types described by Kraepelin and Kretschmer, but lay considerably more emphasis on the importance of obsessional traits, especially amongst depressives. Considering the

frequency of the Cautious Obsessive type in my material, it has surprised me that it has not received more attention. Although several of Kretschmer's case-histories contain references to obsessional traits[1] and his description of the Silent-Good-tempered Man amongst his average cyclothymes corresponds exactly to my Cautious Obsessive type, he lays comparatively little emphasis either upon these features or upon other depressive traits. He remarks at one point that "It is important to notice that one does not find constitutional depressives, i.e. people in whom the sadly toned disposition comes to the fore with marked continuity, nearly so often in the region of manic depressive madness. One could collect together a superb series of typically hypomanic temperaments out of our circular material, far more easily than a correspondingly large group of constitutional depressives." One wonders whether differences of race account for this, since it is strongly my impression that in this country depressive personalities are more frequent than hypomanics.

It is unnecessary to go further into these five types of syntone since their correspondence to types described by others is obvious, but two subsidiary enquiries are interesting; first to examine the relation between the type of syntonic personality and the form of the psychosis developed and secondly to see in what conditions a person may change from one of these sub-types to another.

Relation of Personality-type to Form of Psychosis

Most investigators have found that there is a considerable correlation between the hyperthymic personality and the manic reaction, the depressive personality and

[1] *Physique and Character*, 1st English edition, 1925. On page 137 a Cheery Hyperthymic is described as washing and ironing his tie and handkerchief every morning with the help of a small handkerchief iron. On page 140 a Quiet Contented type is described as putting his room straight, doing everything himself, all the cleaning and scouring, and hating to be idle.

the melancholic reaction, the circular personality and the alternating manic and depressive reactions. Indeed, until Bowman's research failed to demonstrate this connection it had almost been taken as established.

Amongst the earlier workers Reiss found that very few depressive personalities had developed manic attacks without depression, whilst two-thirds had never had a manic attack. A high proportion of the manic personalities on the other hand had developed depressions, only 23 per cent escaping. The irritable and cyclothymic personalities also developed depressions more frequently than manias. His results expressed as the percentage of each temperament group are as follows :[1]

	Form of Psychosis			
Temperament	Depressive	Combined	Manic	
Depressive ..	64	28	8	100
Irritable ..	46	30	24	100
Cyclothymic ..	35	53	12	100
Manic ..	36	41	23	100

MacCurdy's figures are unfortunately expressed in a different way (as percentages of each psychotic group) and are therefore not easily compared. The rarity of manic attacks developing in a depressive personality is confirmed, however, since not one patient whose psychosis was either wholly manic or circular with manic attacks predominating had a depressive temperament. The tendency of hyperthymic patients to develop depressions

[1] The table is taken from Kraepelin's textbook. The total number of patients examined is not stated.

as well as excitements is also confirmed, since nearly one-third of 76 cases of depression had been cheerful or hyperthymic. Figures are as follows :

The Depressive Personality appeared in :

0%	of	patients	suffering from	MANIC attacks.
0%	,,	,,	,,	CIRCULAR (mostly manic).
17%	,,	,,	,,	CIRCULAR (equal).
26%	,,	,,	,,	CIRCULAR (mostly depressed).
46%	,,	,,	,,	DEPRESSIVE attacks.
47%	,,	,,	,,	INVOLUTION MELANCHOLIA.

Of the 76 patients suffering from depression :

46%	had had	Depressive Temperaments.
18%	,,	Quiet Temperaments.
7%	,,	Normal Temperaments.
29%	,,	Cheerful or Hypomanic Temperaments.

The third investigation available, that of Smalldon on 75 patients, points in the same direction. His results are not easily quoted since he does not divide his patients clearly into those who showed hypomanic, circular or depressive personalities. It appears, however, that of the depressed patients only about 20 per cent had had circular personalities, the remainder being equally divided between manic and depressive personalities, whereas amongst the manic patients there were about 70 per cent of hypomanic personalities, nearly double that amongst depressed patients. Nearly half of the circulars had been subject to changeable moods, this being more than double the proportion found in manic or depressive patients. These figures have much in common with MacCurdy's, the chief difference being that whereas MacCurdy found no depressive personalities suffering only from manic attacks, Smalldon found about 20 per cent.

The series of seven patients suffering from chronic mania reported by Wertham suggests the same correlation. Of seven patients, four had had pronouncedly hypomanic personalities, one had alternated between a manic and an obsessive character and only one had been irritable and depressive. (The other patient, No. 2, had certain manic features, but the history suggests a strong schizoid component as well.)

My own series of cases contains so few manics and circulars as to make generalization impossible, but they go to confirm the general view. Amongst 19 depressives, none had had a hypomanic temperament, five had been circular, and the majority (14) typically depressive. On the other hand of the four manics, two (Nos. 20 and 22) were markedly hypomanic in personality, one (No. 23) probably circular, and only one (No. 21) depressive. From others' experiences one would have expected a few hypomanic characters amongst the depressives but in other ways these findings are similar to McCurdy's.

It is curious to find that Kretschmer has nothing to say on this question, but in various places one gets the impression that he found similar correlations.

With all this cumulative evidence it comes as a great surprise to find that Bowman discovered no significant differences in the personalities of patients who suffered from manic attacks and those who suffered from depressions. Were it not that Bowman's work was so careful and based on an examination of 79 manic depressive patients one would be tempted to ignore his results, but as it is they must be recorded as conflicting with conclusions which would otherwise appear to be well based. These are :

(1) Over 50 per cent of patients with a depressive personality who develop a psychosis have only depressive attacks, about one-third have manic and depressive attacks and only a very small percentage have only manic attacks.

(2) Although about 25 per cent of hypomanic personalities who develop a psychosis have only manic attacks, probably more than this proportion (about 33 per cent) have only depressions, whilst the remainder have alternating attacks.

(3) Circular personalities show a high proportion of circular psychoses, though about one-third have only depressions and a small percentage only manic attacks.

Looked at from the point of view of the psychotic groups, this means that extremely few manics have previously had a depressive temperament, but that a large number of depressives (about one-third) have had a hypomanic temperament. In other words far more hypomanic personalities develop a depression than depressive personalities develop manic attacks.

Changes of Syntonic Personality from One Type to Another

Except for the mellowing of age, people change little during the course of their lives. The Cautious Obsessive may become even more careful, the Quarrelsome Hyperthymic perhaps gives up the fight against wrong-doers, and the Cheerful Hyperthymic may show more signs of the feelings of sensitiveness and anxiety which he covered up in youth under the guise of happiness. But the leopard does not change his spots. So comparatively stable is a person's temperament, indeed, that it is commonly asserted that the gloomy or sanguine temperaments are constitutional and unalterable. This view may be correct but there are certain facts which conflict with it.

In addition to circular personalities whose spirits vary from day to day or week to week, there are people who seem to have two different personalities. In one phase they are clear examples of the depressive disposition, with obsessive and anxious features, in the other equally clear examples of the hyperthymic type. In this respect they differ from the circulars, who are never

clear-cut examples of either, but *combine* the traits in a characteristic way. Bleuler for instance mentions three cases of a change of temperament, which he thinks is likely to occur especially around the time of puberty. He quotes the case of David Hess who was depressive as a boy and then said to himself: "Now I am no longer melancholic", and remained until death in a manic mood. He also mentions a woman who "up to about her twentieth year, seemed noticeably cheerful, lively in the pleasant sense, then for a time mildly depressive". After the age of forty she had two attacks of melancholia.

An interesting case is described by Wertham. It is of a single woman who, after several manic attacks each lasting a few months, developed a chronic mania on the first anniversary of her father's death, her mother having died meanwhile. Describing her previous years Wertham writes: "Her life was very uneventful. She lived at home with her parents who were Christian Scientists and to whom she was very much devoted. The patient and her mother were inseparable. The patient had many friends and was popular. It was recognized that she had "two dispositions". Each persisted for a matter of weeks. For a time she would be a meticulously neat housekeeper, rather morose, disinclined to go out visiting or receive friends; at other times she was very cheerful, read omnivorously, slept poorly, was a sloppy slap-dash housekeeper and was extremely sociable. She was very set in her ways—"pig-headed"—but very cheerful and good-hearted. She took correction poorly although always good-natured."

The description is short but clear. One of her two dispositions corresponds exactly with the Cautious Obsessive type, whilst the other is typical of the Cheerful Hyperthymic. A better illustration of their affinity could hardly be imagined.

Although, so far as I am aware, none of my series of cases demonstrated this change of temperament, a

schoolboy of my acquaintance showed it clearly. At home he was the family buffoon, cheerful, always up to pranks and jokes, demonstrative in his affections and generally popular. But at school all this changed. Gone was the apparently care-free child with the impudent humour. Instead, there appeared a serious-minded over-conscientious quiet boy who worked hard, made a great point of keeping the school rules and was consequently thoroughly unpopular with the other boys who called him " pi ". Each time he returned home for the holidays the hypomanic cheerfulness was reborn, whilst during term-time butter would not melt in his mouth. The probability is that there is a much greater plasticity of temperament in youth and it may well depend upon circumstances which becomes predominant. But cases of double personality suggest the possibility that even in adults the opposite temperament may be present in latent form.

The famous case of Sally Beauchamp, reported by Morton Prince, is of great interest from this point of view, since her two chief personalities are beautiful examples, the one of the depressive and the other of the hypomanic personality. They are described in the following excerpts.

" When Miss Beauchamp first came under my professional care, in 1898, she was, as has been said, a student in one of our New England colleges ; she was 23 years of age and a ' neurasthenic ' of an extreme type. The most salient features of her physical condition were headaches, insomnia, bodily pains, persistent fatigue, and poor nutrition. All this unfitted her for any work, mental or physical, and even for the amount of exercise that ordinary rules of hygiene required ; but in spite of her disability nothing could dissuade her from diligent and, in fact, excessive study which she thought it her duty to persist in. My notes taken at this time, before it was known that there was any division of personalities, thus describe her general condition :

" ' Is a pronounced neurasthenic of extreme type ; has never been able to pursue steadily any occupation in consequence. Tried three times to do professional nursing and broke down. Is now studying at ——— College ; ambitious, good student ; does good work, but always ill ; always suffering. Over-conscientious and mentally and morally stubborn. Is very nervous, and different parts of body in constant motion. General appearance of an hysteric ; cannot sit still, cannot fix her eyes to properly test field of vision ; probably slight visual limitation, but this is difficult to determine. *No objective anæsthesia*, or other physical stigmata.' "[1]

In addition to these symptoms she suffered from phobias. She " has a nervous antipathy to spiders, snakes and toads ; she abhors them to a degree that contact with them throws her into a condition of terror."[2] He continues :

" Miss Beauchamp . . . is extremely reticent and dislikes intensely any discussion of herself or her circumstances. She is even reticent in reference to her physical ailments, so much so that it is never easy to discover any temporary indisposition from which she may be suffering. . . . The constant answer to my frequent remonstrance about her reticence is, ' I have never been in the habit of talking about my private affairs '. All this is carried to the verge of morbidness, or to what more exactly might be termed ' fixed ideas.' "[3] Nevertheless this had not prevented her making friends for we read that " she had established during the course of a number of years strong bonds of association with her friends ".

" Besides the reticence in matters pertaining to herself, already mentioned, she is possessed of a conscientiousness which at times has proved embarrassing to her friends. It, too, is carried sometimes to a degree

[1] MORTON PRINCE, *The Dissociation of a Personality*, p. 14.
[2] Op. cit., p. 161.
[3] Op. cit., p. 9.

that may be characterized as morbid. For instance, while in college she was the recipient of a scholarship ; consequently she considered it her duty, in return for this benefit, so diligently to apply herself to her studies that it was impossible for teacher or physician to enforce sufficient recreation, or even the rest and hygienic measures which were absolutely necessary to keep what little health she had.

" Equally embarrassing from a therapeutic point of view is a morbid pride which makes her unwilling to be the recipient of favours or attention which she may not be able to repay."[1]

" Miss Beauchamp has already been described as a very reserved person. She never drops into familiarity of speech, nor does she invite it. Her personality is one that cannot be provoked into rudeness ; rather her tendency is to bear in silence what others might resent. If anyone has done ill to her she bears it in resignation without idea of retaliation by word or deed. Personal dignity, a predominant characteristic, never lets her descend into the vulgarisms which ordinary, though refined, people may be pardoned for falling into under the stress of petty annoyances. This I mention here, that the differing characteristics of the separate personalities, as the latter are developed, may be appreciated. With me and with those who know her trouble, she has a depressed, rather weary, expression and manner. Her voice, too, is strongly indicative of this frame of mind ; but I am told that with strangers who know nothing of her infirmity she is more buoyant and light-hearted."[2]

This description, it will be seen, refers again and again to traits which I have concluded are characteristic of the depressive temperament. Extreme reticence, but not such as to lead to loneliness, over-conscientiousness running to overwork, sensitiveness, self-depreciation, phobias, a tendency to aches and pains, an avoidance of

[1] Op. cit., pp. 9-10.
[2] Op. cit., pp. 23-4.

retaliation, all these are consistent with a syntonic depressive character, and since there is nothing in the description to suggest schizoid components, we can conclude that she was a depressive syntone.[1] But during the process of hypnotic treatment another personality was revealed which referred to the depressive personality in the third person as "she" or "Miss Beauchamp" and who called herself "Sally". Now Sally was none of the things which Miss Beauchamp was, but "a mischievous imp", full of fun, quite irresponsible and up to every kind of prank. The relation of this personality to the depressive one and their alternation in consciousness need not be entered into here, but Prince comments that "she looked at everything from a child's point of view. Her general attitude of mind and her actions were those of a very young girl, as were some of her ideas of fun, and particularly her love of mischief."

A few examples will demonstrate Sally's hyperthymic temperament.

"One of Miss Beauchamp's prominent characteristics is a sense of responsibility and duty. Amusement plays no part in her conception of life, owing to certain circumstances of her environment. However much one might, from a moral point of view admire this characteristic, there was a delightful attractiveness in Sally's[2] absolute disregard of responsibility; she was a child of nature. Though it was not until much later in her career that she had an opportunity to put her own ideas into practice, and to please her own tastes (which she did with a vengeance) she early let her sentiments be known."[3]

[1] The terms "neurasthenic" and "hysteric", it is true, are commonly used to describe these personalities. In my view they only confuse the issue. The description "depressive syntone" has the overwhelming advantage of relating the character to melancholia. This view is discussed further in Chapter VII.

[2] In the earlier days Prince called the hypomanic personality Chris, but later she called herself Sally. To avoid confusion I have used the name Sally throughout the quotation.

[3] Op. cit., p. 53.

" Most of Sally's peculiarities of conduct came from her thoroughly childlike character. Her point of view and knowledge of the world being those of a very young girl, she loved to be thought wicked, though her ideas of wickedness were youthful. She pretended to like French novels, though she could not read French and knew nothing about the literature."[1]

Later she insisted on carrying on an affair with a man, made arrangements to go with him to Europe and wrote him letters in a style which would (and did) shock Miss Beauchamp.

(Sally to Jones.) " Won't you please come and take me away right at once? Someone—I cannot tell you who—is going to hypnotize me and make me so awfully good that I won't ever be allowed to see you again. And I want you *not to let it be done. Please take me away.* I do truly want to go, and I'm not making a fool of you this time. I'm going to be awfully reasonable, and I won't forget any of the notes I write or the things I say, and I *will* love you a great deal,—if only you please won't be so very much in earnest. I don't like it, you know. Come to ——— about five-thirty tomorrow, and we will do our planning all over again. It will be such fun, won't it? And we will leave all this dreary unhappy life behind us, and never be sorry any more. But you must not let me be hypnotized again—that is true really—it spoils everything. Don't ask me any more about it, for there is a very special reason why I cannot tell you. *Only* we must stop it. Isn't this a *very* nice note? Until tomorrow then."[2]

There is much more of this type of behaviour described. It gives a vivid picture of a hyperthymic personality. Her fun, practical jokes, irresponsibility and desire to be thought wicked are all characteristic of the hypomanic reaction and once again there is nothing remotely savouring of the schizoid. The personality

[1] Op. cit., p. 54.
[2] Op. cit., pp. 111-12.

of Sally appears typical of the Cheerful Hyperthymic syntone.

Some of the letters she wrote might have been written by a patient in a manic attack.

" Know all men by these presents that I, Sally, being of sound mind and in full possession of all my senses, do hereby most solemnly promise to love, honour and obey Morton Prince, M.D., situate in the city of Boston, State of Massachusetts, from this time forth, *toujours*. Amen, amen, amen.

" *Toujours* is French, you know."[1]

Throughout these descriptions it needs an effort of imagination to remember that the mischievous Sally and the prim Miss Beauchamp are one and the same person. It is even more difficult when Sally deliberately torments her other self with practical jokes, such as tearing up her school work, presenting herself with a box of spiders (because she knew it would frighten Miss B.), or writing letters to friends telling exaggerated or invented stories about Miss B's private affairs.

Enough has been quoted to demonstrate that the two personalities which co-existed in this patient belonged to well-established types of syntonic personality. The fact that Miss Beauchamp suffered from intense agitation and depression and on one occasion tried to gas herself is consistent with the view that this patient belonged to the manic-depressive group. I do not know whether such an hypothesis would account for other cases of double personality, but it seems to me to cast much light on this patient. If it turns out to be well-established, careful study of cases of this kind might in future add considerably to our knowledge of the psychology of the affective psychoses.

One further phenomenon of this type might be mentioned. During religious conversion a change of personality is often effected. For instance Oliver Cromwell spent a wild and drunken youth at Cambridge

[1] Op. cit., p. 138.

when he seems to have been a cheerful hyperthymic ; later he suffered from a mild melancholia, during which time he used to waken up in the night fearing death. Finally he underwent a religious conversion. From that time forward he developed the ascetic and ruthless puritan character by which he is known in history (and which incidentally does not fit very neatly into the classification suggested here). St. Francis of Assisi had a similar beginning to his life, although his end was very different from Cromwell's. In both cases, however, the hyperthymic mode of living gives way to a more sober and perhaps more obsessional outlook on life and is strongly suggestive that processes comparable to the change in Miss Beauchamp are at work. However this may be, these few instances suggest that an examination of religious conversion from the point of view of typology might prove fruitful.

Chapter VI

TYPES OF SCHIZOID PERSONALITY

The error of supposing that all schizoids are seclusive has already been laboured. Types of schizoid personality are as varied and numerous as syntonic, but their classification is more open to controversy. Kretschmer has divided them according to what he calls a psychæsthetic scale, separating those who are predominantly sensitive (hyperæsthetic) from the apathetic and indifferent (anæsthetic), leaving an intermediate group who have some characteristics of each. The psychæsthetic scale is really a measure of the sensitivity of a person to others' opinions. Thus the hyperæsthetic person is like a delicate scientific instrument which measures the thoughts and feelings which surrounding people have towards him, though an instrument so sensitive that storms either of anger or affection may dislocate it. The anæsthetic on the other hand is as sensitive as a stone to the boot which kicks it, appearing utterly indifferent to feeling in others, behaving as though no one else existed. It should be noted, however, that Kretschmer includes amongst his anæsthetics characters who seem to act *in defiance* of others' opinions. These are not strictly anæsthetic ; they are sensitive, only in reverse gear.

Despite this, the psychæsthetic scale is undoubtedly valuable, although by itself it is not sufficient to account for all the variations amongst schizoids. For instance, Kretschmer includes amongst his anæsthetic group both actively antisocial hysterical characters and also apathetic vagrants, types quite as different to meet as a Cheerful Hyperthymic and a Cautious Obsessive. For these reasons it is necessary to look round for another factor,

and surgency immediately occurs to the mind. It is this factor which has been used to describe the variations in activity and sociability found in syntones, and it is reasonable to suppose that it would also apply to schizoids. It is true that the majority of schizoids are desurgent, but it has already been emphasized (Chapter IV) that a certain minority of schizoids, often forgotten, are active and sociable and therefore surgent. Indeed, it seems to me that this factor of surgency, roughly comparable to extraversion-introversion, is quite as important in the classification of schizoids as it undoubtedly is in that of syntones.

With these two factors four groups are formed. A fifth which I have termed the Cold Solitary, is desurgent and falls midway upon the psychæsthetic scale. It contains rather a heterogeneous group of patients. who should be more carefully studied with a view to further sub-division. The five groups may be represented thus :

	Desurgent	Surgent
Social (hyperæsthetic)	Saint-like	Hysterical
	Cold Solitary	
Asocial or Antisocial (anæsthetic)	Apathetic Asocial	Shameless Antisocial

It is possible that all schizoids approximate to one of these five types, but it must not be forgotten that some have appeared so normal before their illness that their relation to these types is by no means obvious. Consequently it has seemed advisable to include a sixth type, the 'Normal', until it has been possible to investigate such personalities more fully. The classification

suggested is therefore as follows, together with the number of patients of this series belonging to each type.

	Patients	Characteristic Schizoid Traits
A. "Normal"	2	—
B. Saint-Like	1	Nos. 1-13
C. Cold Solitary ..	9	Nos. 1-5, 21-24
D. Apathetic Asocial ..	1	Nos. 1-5 and 25-30
E. Hysterical	—	Nos. 11-24
F. Shameless Antisocial	—	Nos. 8-21 and 30-33
Total	13	

In the second column are the numbers of the schizoid traits which are characteristic of each type. It should be remembered of course that the non-specific traits are also very frequent in these schizoid personalities. It would not be difficult to divide these non-specific traits also into groups characteristic of each schizoid type.

A. 'Normal'

It will be remembered that one schizophrene patient of my series showed comparatively few either of schizoid or non-specific 'neurotic' traits. Such exceptions are well known to occur. Mapother for instance points out that such traits may be conspicuous by their absence, the subject being entirely stable and reasonable. Faver found no striking trait present in 29 out of 154 schizophrenes, 12 of them having been good mixers and the life of the party. Henderson and Gillespie believe that these comparatively normal personalities are associated with an illness showing catatonic features, which was the case with No. 30 of my series. It is my impression that roughly 10 per cent of schizophrenes are of this apparently healthy personality and that in most cases the onset of illness is acute.

The main features of No. 30, one of the two patients of this series who were comparatively " normal ", have already been noted (p. 60) but it may be worth giving some details of another, No. 36, who although showing four schizoid traits, also seems to fall into this " normal " group.

He was a single man of 27, of Russian Jewish stock. He was admitted complaining that his business partner was attacking him "psychically", that an experiment was being tried on him to get him to have intercourse with a girl friend and other similar plots. On examination he was co-operative but over-talkative, describing the various plots in very great detail. He complained the nurses in the ward were trying to seduce him by various magical processes. Information regarding him was obtained from his father and brother who were co-operative and seemed reliable.

The family history was not good. His mother had been in a mental hospital for three years, when she was excited and accusatory. These accusations, principally against her husband, had continued since her return home when the patient was seven. It was believed that other members of her family were also mentally ill.

Owing to his mother's condition family life was always unhappy but the boy was said to have been normal except for unilateral St. Vitus Dance which came on for six months after a shock when he was aged 10. This was presumably an hysterical symptom. He went to a secondary school where he did well and ended top boy. He did not play games ; there was no evidence of his being bullied.

After trying one or two odd jobs his father bought him machinery for embroidery and he taught himself the trade. He was very successful at this and made enough money to buy several machines and employed four boys in a workshop of his own. This business made good profits for a time, but later the fashion changed. He lost money and after a year or two had to close down. From the

age of 23 to 25 he became an employee in another embroidery workshop. Trade was bad, however, and during the two years previous to his admission he had had various jobs, sometimes on his own, sometimes as a traveller for others.

His father described him as a good steady worker and thought that he would have continued successfully in his business had not the fashion changed. His failure had come as a great blow to him. He led an active social life with numerous friends and he enjoyed dancing. He not only belonged to several clubs, but he was on the committees of two and was regarded as a useful member. His brother described him as having always been a committee man. It seems, however, that he wore rather a heavy air of responsibility and tended to be over-conscientious. His brother felt also that he was too serious-minded and he had no sense of humour, but he appeared to enjoy life and was not given to depressions. He read a great deal especially "deep" books on psychology and astrology, but was not religious.

His sexual life had not been especially unusual. There had been masturbation as a boy, but no homosexuality. At 22 he had been with a prostitute once when he found himself impotent. Apart from this he had had a number of short affairs with girls, but these had come to an end, usually though the girl breaking it off. These disappointments he appears to have taken "philosophically". During the months prior to his breakdown he had been carrying on with a girl, whom he had met in a hiking club. Many of his symptoms were connected with this girl, who he felt was trying to seduce him. Finally he had intercourse with her in the belief that it would solve a great many of his problems.

Although there is much further information about this man which one would like before deciding that he was reasonably 'normal', the picture obtained in the routine enquiry was of an energetic, capable, sociable young man who did well both in his work and also in his

social relations. Apart from his earnestness, his lack of humour and his interest in the occult, there was little in his personality to suggest that he was a potential schizophrene. Yet at the age of 27 he developed a florid psychosis.

B. SAINT-LIKE

This type has been frequently described. Kretschmer presents an example amongst his hyperæsthetic group (sensitive, cold, aristocratic type);[1] "her external behaviour manifested a satisfied, almost ecstatic stillness which made her seem very serious". Kraepelin also mentions schizoids characterized by docility, good-nature and anxious conscientiousness, the very patterns of goodness. But he fails to distinguish them sufficiently from the Cautious Obsessive syntone. This comparison is important since many of the traits shown by the Saint-like schizoid are identical with those characterizing the depressive syntone, the difference lying in the presence in the former only of several of the first thirteen schizoid traits. Farrar also fails to make the distinction adequately, describing the type as precocious, bookish, serious and prudish, the model child. Mapother recognizes them, describing them as dependent, unduly submissive and given to maudlin affection.

In biography the portrait of Nijinsky drawn by his wife provides an admirable if pathetic example. The most striking schizoid traits presented are his aloofness from the world, his forgiveness of enemies, his charity and his absolute concentration upon his dancing for hours together. Homosexuality, a chosen circle of friends and the development of peculiar religious interests are others.

Only one patient of my series, No. 26, exhibited this character, but it was so well developed that it affords ample illustration.

A youth of 21, he was admitted in a catatonic state

[1] *Physique and Character*, p. 133.

so that most of the information about him had to come from relatives, his father and uncle. The family history was not bad, although one sister, who seems to have been rather like the patient, had recently suffered from a nervous breakdown in which depression was a chief feature.

The patient himself was a model child. He went to a co-educational school, where he worked hard, took no interest in the girls and made a hobby of archæology and astronomy, which were encouraged. He disliked games and preferred long walks. After leaving school he became a medical student and had been studying for his second year examinations when he fell ill. He was described as being "utterly absorbed in his work" and appears to have been working about ten hours a day at that time.

Socially he was very quiet, uncommunicative and difficult of access, but he was said to have two or three good friends. Whilst a student he had taken many of his holidays alone, going for long tramps with a rucksack. He never went to parties and only very rarely to cinemas or theatres, but in a small family group he could be quite merry and witty.

One of the chief features of his personality was an extraordinary docility and peacefulness which his relatives constantly emphasized. Always even tempered and utterly unselfish, his mother called him, not without admiration, a "Saint". He had been brought up to Quaker beliefs and had become devoted to them. Indeed he used to take an active part at Quaker meetings, unusual for a boy of his age, and was also active in the Student Christian Movement.

His sexual life was in keeping with the rest of his personality. His uncle remarked that "Sex had not entered into his life", but this was not strictly true since he had masturbated, very guiltily, a few years previously. Nevertheless except for a childhood passion for a girl a little younger than himself he had never fallen in love nor taken any interest in girls.

Although manifestly over-conscientious he does not seem to have had many other obsessional traits (though these were not examined fully), nor was he hypochondriacal. His mood was apparently remarkable for its evenness (one is tempted to say absence) and he seems never to have suffered from depression, excitement or anxiety.

The illness developed insidiously without any obvious precipitating event, except that he had been working very hard and was living a secluded life. A lecturer who had made fun of the law relating to sweepstakes had upset him and he had written to the dean about it. Later he had fits of giggling without reason, complained of feeling tired and began to take a long time over routine things and to be forgetful. His natural reticence increased, he became apathetic and began to have sudden unexpected tempers when he was destructive, assaultive and incontinent. He became annoyed by trifles and had to be humoured. Finally catatonic symptoms developed.

Although the Cold Solitary is perhaps rather more the classic schizoid, this Saint-like type is also markedly shut-in and introverted. It has much in common with the Cautious Obsessive syntone, with which descriptions sometimes confuse it, although the contrast is really marked enough in most cases. For these schizoid-characters lack the feeling and humour and responsiveness which, even in the most obsessional, are usually present in syntones.

C. Cold Solitary

This, perhaps, is the best known of all schizoid types, being characterized, as the name implies, by an aloofness and affective deadness which has earned the name shut-in. The schizoid traits most commonly found are Nos. 1-5 and 21-24 inclusive. It is unnecessary to quote the literature on the type, since every author has commented upon it. It should be noted, however, that such personalities vary considerably, some being simply dull, backward and colourless and thus bordering upon

the fourth group—Apathetic Asocial—whilst others are more alert and active, sometimes even domineering and aggressive. Both sub-types are shy and solitary and may be stubborn and suspicious as well.

No. 24 was an example of the dull backward sort. He was only eighteen and a half when admitted suffering from a simple form of schizophrenia with some bizarre behaviour and hallucinations. He was the youngest of a family of four, the others being healthy. His father, however, was erratic, violent and dominating, and was cordially disliked by the rest of the family.

The patient himself had been to an elementary school where he had always been a nobody, drifting on in school life without making any friends whatever or taking any part in social activities. He was rather backward and had failed to reach the top standard when he left at fourteen. For the next four years he worked at an art school, studying commercial art, for which he had no special ability, but which he was better at than anything else. Although he worked all day and seems to have thought of little else, he had taken no interest whatever in art exhibitions and had never heard of the better known painters of the day. Shortly before he fell ill his father had insisted on his leaving the school and earning money and he had been collecting together drawings to show to publishers in the hope of getting commissions for illustrating.

His life at the art school had been similar to that at school. He was very self-conscious and hardly mixed at all with the other students. He seems to have enjoyed his married sister's little parties, however, though he always remained in the background. He was said to be shy and bashful with girls and denied taking any interest in them ; certainly he had never had a best girl and he said he had never masturbated. Games and sports had no attraction for him and he very rarely went out except to travel to and fro from school. Occasionally he played a little ping-pong at his sister's.

Although colourless with apparently no vitality, he was by no means easy to manage. Criticism usually left him completely untouched, but if abused he became immovably resistant and obstinate. This may have been partly the result of brutal treatment from his father, who had often lost his temper and beaten the boy. However, quiet coaxing seems usually to have worked and this was one reason why his sister could get on with him better than the others. The boy, not unnaturally, disliked his father (hate would be almost too strong a word to use to describe such dead feelings) but he was fond of his mother and very dependent upon his sister.

It looked as though leaving the art school and being forced to earn a living contributed something to the schizophrenic reaction. His sister thought it had upset him considerably ; at any rate he immediately began sleeping and eating badly and became dreamy. After a few weeks he collected a number of his sister's possessions and took them in a suitcase to the school. Other symptoms developed and he was hospitalized. It was noticeable that he looked some years younger than his age and his emotions were shallow and apathetic.

Although there is much information, especially regarding obsessional traits, missing from this description, there is sufficient to draw a quite typical picture of the dull backward type of Cold Solitary schizoid. The aloofness and solitariness are similar to those of the saint, but sweet docility is replaced by mulish obstinacy and acute sensitiveness by dull indifference. In these traits he has much in common with the Apathetic Asocial type. Indeed, it seems possible that in rather different social circumstances this patient might have become completely indifferent and apathetic.

No less than eight other schizophrenics were of this type (Nos. 25, 27, 28, 29, 31, 32, 33 and 35). None of them were as dull and feeble as the patient described, and at least one, No. 35, so far from being quietly obstinate was active and intense, flying into senseless

rages, sometimes with provocation and sometimes without it. In these features he had something in common with the fifth group, the Hysterical schizoid.

D. Apathetic Asocial

Since Wilmans first drew attention to the frequency of dementia praecox amongst prostitutes and vagrants, this type has been well known. Although in many ways similar to the last described type, the Apathetic Asocial has given up trying, he has ceased to be sensitive either to others' opinion or to his own conscience and has lapsed into a lazy indifference to his fate. Often there are traces of more sensitive feelings, but they are so painful that he prefers to ignore them. This is the prototype of Kretschmer's anæsthetic group, a term which must not be allowed to obscure the fact that there is intense sensitivity beneath the impassive exterior. The group is characterized by traits Nos. 1-5 and 25-30 in the schizoid list.

There was only one patient of this series who approximated to the type, No. 34. He was not typical, however, for he had been able to recover from this state for some years before becoming frankly psychotic. I will therefore rely on one of Kretschmer's descriptions.

" Karl Hanner . . . was from childhood upwards very gifted and very naughty. From the time when he was a student he was regarded as being no longer quite normal mentally. First he went through a complete theological course, was for a short time in an office, then went over to philology ; for this he used up the last savings of his poverty-stricken family. Before the state examination he was seized with examination-fright, suddenly ran away and disappeared to America.

" There he sank lower and lower down the social ladder, and finished up in a hopeless position. He was so clumsy that he could only have taken employment in a factory with machines at the risk of his life. An attempt to recommend him as a tutor was shattered by his complete

nonchalance, his untended, dirty hands, and bad manners. So he was for a long time out of work, and lounged about by himself; what he lived on, no one knows to this day. All day long he read old books in a public library, and by night he slept in the open air on benches. And yet he needed nothing, he lived like an ascetic, drank nothing, smoked nothing, stole nothing, and did nothing he ought not to have done.

" In this condition he was discovered after some time by a young nephew who had emigrated; lean as a skeleton, with no appetite, and his clothes hanging down about his body. He would inquire unconstrainedly of his nephew how he was getting on, he was always drily amused, swung his stick, sang student songs, interspersed with Greek and Latin quotations. A complete philosopher and stoic. He was incredibly well-read. He was at home in all philosophical systems. He was not of an opinion that it went ill with him.

" His nephew bought him a ticket, gave him some travelling money and a good overcoat, and put him on a steamer in New York. By Bremen he had already sold the coat; what became of the money no one knows. Thus he appeared one day, on foot, looking like a wandering labourer, in a tattered suit of clothes, before the door of his old parents' house.

" The further history of his life offers nothing new. Long-suffering friends of his youth occasionally got him into some small post. He was of the greatest use in systematic office work. And yet he came and went when he pleased, had shocking manners, would not answer, made cutting remarks, and picked a quarrel with everyone he met. His freedom he valued more highly than anything, and he hardly needed anything to live on. Gold or any good thing never remained long in his hands, he gave away or exchanged everything. Sometimes he would appear uninvited, after years of absence, at the homes of old acquaintances and relatives; he would run into the room, walk up and down with

great strides, his hands behind his back, and say not a word. If he did say anything, it was a sarcastic *bon mot.* He had an old sister with as sharp a tongue as his own. When he came in sight of her, the grimmest quarrels took place. He threatened her with a stick, abused her coarsely, and finally called her a ' parson's daughter '. That was the most insulting thing he could say."

E. HYSTERICAL

Although widely described in the literature, this type still seems inadequately known. The emphasis on the shut-in schizoid and the identification of the schizoid personality with the introvert have done much to distract attention from the Hysterical schizoid who is of course markedly extraverted ; indeed it was the original pattern from which Jung derived the concept of extravert. Almost any schizoid traits may appear in these characters, Nos. 11-24 being the most common, and " precious ", " passionate attachments " and " scenes " the most typical.

Schultze[1] seems to have been one of the first investigators to draw attention to an unstable and capricious character preceding dementia praecox. He noted it especially in the female sex, an observation repeated by Kraepelin who described these girls as inclined to " irritability, sensitiveness, excitability, nervousness, and along with these self-will and a tendency to bigotry ". Farrar describes them as neurotic, selfish, deceitful and given to temper tantrums and minor ailments such as headaches. The traits which seem to me especially typical of this group in contrast to other schizoid types are caprice, excitability, selfishness and temper tantrums. Mapother dwells particularly on these traits, mentioning marked vanity, a craving for notice, hypersensitiveness to criticism and extravagant poses to attract attention.

It is generally agreed that these personalities form only a small proportion of all schizoids and are usually

[1] Quoted by Kraepelin.

female. For these two reasons it is not surprising that none of my schizophrenic patients were of the type, although in Chapter VII there are recorded two female patients (Nos. 61 and 62) who were markedly hysterical and also showed very numerous symptoms suggestive of schizophrenia. For purposes of illustration I have included a case described by Strecker and Willey where schizophrenic symptoms were indubitable, although recovery occurred after about fifteen months.

" Elizabeth M. was a single girl of nineteen, pupil nurse by occupation and born in America of native parentage. The family tree is unsound—root and branch. The paternal grandfather was a notorious " jail-bird "; the father an epileptic and ne'er-do-well. The mother, maternal uncle and an older sister are in a State Hospital with dementia praecox. A younger sister is a psychopath, immoral and a drug habitué. Another sister is in an orphanage.

" If personality is to be regarded as the end-result of the reaction between individual and environment, then it is important to appreciate the setting in which this patient developed. During her early childhood the father deserted the family several times. The patient never saw him after she had reached her ninth year. Soon after, the mother was committed to the Trenton State Hospital and the remnants of the family were separated and scattered. The particular unit in whom we are interested became a public charge and had eight placements in as many private homes during a period of six years. Always she complained there was not sufficient opportunity to obtain an education. At sixteen she ran away to New York and finally was arrested for vagrancy. A Girls' Aid Society became interested and secured an excellent home for the patient with a woman physician. Here she did well and completed the first year of High School. Finally, against the advice of the foster-mother, the patient entered a training school for nurses and for the ten

months preceding the beginning of the psychosis she acquitted herself in a creditable manner. Among the character marks were many traits which pointed to a consistent attempt to escape from the sordidness of her early surroundings. She was bright, clever, ambitious and although described as seclusive there was likewise a craving for affection and a passionate attachment to anyone who stood in relation of superiority, such as her school teachers. There was a tendency to be dramatic, to gain attention and to be affected. She tried to read 'lofty' books and held herself 'above' her family. There was a lack of persistency but it is unlikely that the patient was either immoral or positively delinquent. She was self-willed and had a violent temper which she succeeded in partially correcting.

" Her previous physical health has not been recorded.

" No one incident in the patient's career stands out clearly enough to be regarded as definitely precipitating the psychosis. Certainly the ancestral deficiencies were not without effect and, as will appear from the psychotic content, deleterious environmental thrusts also had considerable influence.

" The onset was abrupt. She became forgetful, had ideas of reference and felt that the other pupil nurses were discussing her family without particular emotional reaction, she frequently asserted that she was becoming insane. At this time it was remarked that the symptoms closely mimicked those which both the mother and the sister had displayed in the early stages of their attacks."

These Hysterical schizoids have to be distinguished from Hyperthymic syntones and also from Anxious Depressives. Their tendency to boastfulness and vanity together with excitability suggest the hyperthymic, but their total mood is commonly quite different. For instance both may be promiscuous in their sexual lives, but where the hyperthymic is gay-hearted and simple in his affairs the hysteric's is a tangle of passionate attachments, broken hearts and scenes. Both may be

generous, but whilst the hyperthymic seems to do it from sheer exuberance and kind-heartedness, there is usually something artificial about the hysteric—it seems to be done for show or to make an impression. The same is true of their temper tantrums which contrast with the simple honest abuse which comes from the quarrelsome syntone. Both characters enjoy being the centre of the stage, but whilst the hyperthymic is usually quite happy when he is not, the hysterical schizoid is consumed with jealousy and will probably make a scene or leave the party in pique.

Exhibitionism, vanity and artificiality commonly lead them to the stage, where it appears many of them do well. It is in this respect that there are often similarities with the Anxious Depressive who also enjoys performing. The Anxious Depressive, however, seems to remain herself when performing and is consequently self-conscious. The schizoid on the contrary has the ability to transform herself into the character which she is impersonating, a gift which every good actress must have to some degree and with which Nijinsky was lavishly endowed.

In other words the schizoid may do the same things as a syntone but there is a different feeling about the way they do them. Such differences are not easily assessed and it is useful to have more concrete differences. Homosexuality, a hatred of a parent and a tendency to disown humble origins are often such noticeable and unequivocal indicators.

E. Shameless Antisocial (Psychopathic Personality)

Some hysterical characters, if their craving for attention and finery is not satisfied, resort to dishonest tricks such as lying and petty theft. Dishonesty may become such a habit with them that they attempt to justify it either by accusing others or by saying they don't care what they do, doing whatever they feel to be most shocking in order to prove it does not matter. It

is to these people that the term ' psychopath ' is applied and some people have been tempted to call them ' morally defective ' implying that the moral faculties are absent. This theory flourished so long as it was attempted to get them to admit that what they had done was wrong. Like guilty children they will protest that there is nothing wrong in it, that they don't care if there is, and so on. But a sympathetic talk immediately reveals acute feelings of guilt which they are for ever battling against and trying to push from their minds. The term ' morally defective ' then is only permissible if it implies a *faulty development of the moral sense*, for it certainly is not absent.

Almost any schizoid trait may be present, Nos. 20 and 21 and 30-33 being most typical. It seems unlikely that many schizophrenes have been of this type prior to their illness. No writer describes them in any detail except Kretschmer, although Farrar mentions that hysterical schizoids may be deceitful. None of my schizophrene patients had been of this type, although in Chapter VII are discussed two psychopathic personalities (Nos. 64 and 65) who showed very numerous traits which I have shown reason to regard as specifically schizoid. The following case quoted from Kretschmer[1] is an excellent example of a psychopathic personality who became psychotic.

" Ernest Katt, a 23-year-old student, persecutes his parents with a fanatic hatred, and the most brutal insults ; he calls his father a ' dishonourable lout ' and his mother a whore, threatens to beat them with a riding-whip, and steals and forces money from them whenever he can. Their whole life is made a continual martyrdom, during which they are never, for one moment, free from the danger of bodily harm. His mother has her purse lying before her on the table ; with a nonchalant air, a cigarette in the corner of his mouth, he reaches for the

[1] *Physique and Character*, p. 194. " Predominantly cold and insensitive temperaments. Cold despotic type (moral idiot)."

purse, takes out all the house-keeping money, sticks the notes quietly into his pocket, and gives the purse back to her. His father refuses to pay his debts. He takes up a pair of silver spoons, has a careful look at their hall mark, and puts them in his pocket. He pawns all the movable objects of value in the house, until his request is acceded to. When he is threatened with the police he just shrugs his shoulders ; he knows that his father won't make a fuss. He misbehaves himself promiscuously with waitresses and well-educated young ladies, whom he smuggles by night into his room in his parents' house. If anyone is indignant about his morals he merely gives a cold laugh. It is only when he is required to do some work that he becomes quivering with rage ; after such an episode he leaves the room bathed in perspiration.

" His studies have gone completely astray without having any end in view ; he has already made several starts in all the faculties, idled, and then done nothing in the end—philosophy, psychology, æsthetics, all muddled up with one another. He usually sleeps the whole morning away. Eventually he came to the conclusion : I am an exceptional man, the usual mode of life is not suitable for me. Now he wants to be an actor.

" Outside his own home he is quite different. He is completely under control, behaves in the most charming manner, passes as a young man of good breeding and social ability, is a great favourite among his comrades wherever he goes, and in good society he plays a certain part as *maître de plaisir.* He is rather fascinating with young ladies, and with many he enters into tender relations. He always wears a monocle, has a surprising weakness for the nobility, and tries to give the impression in his own person of noble descent. ' I cannot move in the circle in which my parents live.' His political views are ultraconservative, harsh and arrogant. Sometimes the sudden whim takes him to play the part of the proletarian, who would have a good mind to ' shoot off ' the whole bourgeoisie.

" One day Ernest came to us alone. He had a thin nervous frame. His face was very long and pale, cold, still, and, as it were, petrified—hardly a gesture. His movements were rather nonchalant, pendulous, aristocratic. He spoke lifelessly, and in an undertone, with no alteration of accent. Occasionally there came out something stiff, or affected in his speech, or else a strange, disconcerting expression. If he speaks for any length of time, the thought processes become quite confused. One has the feeling that his thoughts are luring him away, while he is forming the sentence. He cannot be tied down to concrete questions and he always escapes into general abstractions; idealistic speeches about personality, views about life, psychology, art, race through his mind, leading nowhere, almost chaotically involved one with another, now abruptly joined on to one another, now leaping by in unfinished sentences. ' I have given up the struggle.' ' I stand fixed upon a spiritual basis.' ' Spiritually, I am completely conscious.'

" There is a coldness of feeling, and blaséness about his behaviour that cannot be surpassed. And yet, between-whiles, one catches glimpses of a psychic wilderness, and confusions, with echoes of despair and misery. ' Inner hopelessness and conflict,' as he says. He has a leaning towards ' sport, theatres and psychology ' : only nothing that savours of a livelihood, nothing that ' anyone can do as well '. His parents are always getting in the way of the unfolding of his personality. They have only to give him the means which he needs to live in ' his sphere ' which means to satisfy his artistic craving, to live in a pampered aristocratic milieu. He never gets anywhere. He can never feel himself. It would be far better if he could only creep away. He has ' an impulse to express himself, a desire for beauty, for contact with human beings '. He writes a great many letters. But all his feeling has died in him. He leads a ' purely artistic life '—' in order to squeeze myself forcibly into the social machine, in order to

experience myself, in order to gain self-expression'. He bursts into a convulsive fit of weeping. 'I want humanity, I want society.'

"He has never had any sense of humour; he feels that himself, and he has never been able to get over the difficulty of managing his own personality. 'The world is a stage to me, on which I only play myself.' He has never had any friends, and he cannot away with youth. He has never been seriously in love with a woman. He has had a great deal of sexual intercourse but has always been emotionally cold. 'For me it is only a convulsive attempt to get away from myself.' Everything else in life is 'Technique', 'Push', forces working coldly upon him, theatrically improbable. He still has left a strong æsthetic feeling, especially for the drama and music. Beautiful music is 'great fun'.

"He plays the mask of the interesting, bewitched spirit of beauty, which hovers over life. Sometimes he will say suddenly: 'I am a sausage.'

"Earlier in life Ernest Katt was quite different; a weak, silent, spoilt child. His father spoke of him as follows: 'He was always among the best of the schoolboys.' There was in his character, side by side with a pronounced conscientiousness, a seriousness beyond his years, an abnormal solidity, and an extraordinary energy for work. His laconic, joyless, reserved temperament was often the cause of trouble.

"For the rest he was a good-natured, tractable, and lovable young man, and especially gentle to his mother. The entrance into puberty was delayed; for a long time he took not the slightest interest in girls. At this period, while he was in the top forms at the gymnasium, a remarkable gradual change of his nature set in. He became shy, very nervous, and remarkably hypochondriacal. There was a noticeable decrease in his capacity for perseverance and his general mentality. Superficial reading took the place of concentrated study, and he

went in for vaguely defined philosophising and unsatisfactory attempts at poetry. Faustian moodiness set in. His appearance suffered on that account; he had to be forced to wash himself and do his hair. He sat about for hours broody and stupid. The result of the standard leaving examination was a bitter disappointment of the hopes to which his earlier efforts had given rise.

"At the same time his whole character changed. The good-natured quiet boy became unsatisfied, morose, stubborn, and incalculable. He hated his father. He still remained very affectionate and gentle to his mother, and also to his sister until the latter married and died shortly afterwards of tuberculosis. He then set himself against his brother-in-law, actuated by obsessional jealousy and got it into his head that his parents were guilty of her death, and he began to persecute his mother with almost fanatical hatred. At intervals traces of the old gentleness come to the surface, and they come back even now in a spasmodic way. 'His love for his mother was the last prop he had.'"

This type is not easily confused with others. It is discussed further in Chapter VII in which the group of psychopathic personalities is examined.

The various types of schizoid personality having now been described it is worth making enquiries similar to those made at the end of the last chapter, firstly whether there is any correlation between types of personality and forms of schizophrenic psychosis and secondly in what circumstances a person may change from one type to another. It will be found, however, that there is far less information available on these questions in the case of schizoids than there was in that of syntones.

Schizoid Types and Form of Psychosis

Very little systematic work has been done on this question, one difficulty being that of classifying satisfactorily the forms of the psychosis itself. Amsden, however, published a research upon 182 cases and came

to the following conclusions. The simple form of dementia praecox he found had developed in markedly shut-in personalities who corresponded either to the Cold Solitary (especially the dull backward) or the Apathetic Asocial types described here. This would correspond to No. 24 of my series. Hebephrenia had usually been preceded by a more romantic, kind and cheerful disposition, which seems to be related to my Saint-like characters. Paranoid patients could be divided into two groups ; the first were good and often over-conscientious workers but inclined to arrogance and extreme stubbornness, suspiciousness and disobedience. Some of these had little imagination and were solitary, whilst others were less solitary and more visionary. The second group were less suspicious and more bashful and retiring. The catatonics were either similar to the paranoids or else nervous and easily frightened.

It is not always easy to compare Amsden's types with those described here. His work, however, suggests that there is some correlation between types of personality and the form of the psychosis though less obvious than in the case of syntones. The best established correlation is that between an apathetic and dull personality and simple dementia praecox.

Changes from one Type to Another

It is well known that schizophrenes who recover usually show a changed personality from that preceding the psychosis and this change is often in the direction of greater irritability and pre-occupation with ' psychic ' subjects. On the other hand few cases of schizoids who have changed in personality without a manifest psychosis seem to be recorded. Kretschmer's case of psychopathic personality which has been quoted is consequently interesting. This boy seems to have begun life as a model child with the schizoid characteristics of joylessness and no interest in the opposite sex. Up to that time

he seems to have belonged either to the group of Cold Solitaries or possibly to that of Saint-like characters. During adolescence his conscientiousness gave way and he suffered from a breakdown which probably bordered on the psychotic. After this, instead of being over-conscientious, he apparently became shameless in his behaviour, and a lack of sexual interest changed to promiscuity. It might be argued that this psychopathic personality was post-psychotic. Kretschmer regarded the breakdown as the " biological equivalent to a schizophrenic process ".

But it seems certain that these changes can occur without an obvious psychosis. For instance in my patient, No. 34, a double change occurred. At school he had been hard-working and over-conscientious, although solitary. After leaving he went to seed for about five years loafing about with neither interests nor ambition. He went in for drinking bouts and smoked heavily but he was not obviously psychotic. This phase ultimately passed. He became deeply interested in motor bicycles, took part in road tests and became quite famous. Later he got work as an electrical engineer. During this last period he was again a hard, in fact over-conscientious, worker with a tendency to obsessional repetitions. Moreover, he became lively and sociable although he had always to fight self-consciousness.

The external picture changed in this case from a conscientious worker to that of an idle loafer and finally back to a conscientious worker, before the psychosis finally developed. No doubt many similar changes could be noted in the prepsychotic personalities of schizophrenics. But as in the syntone the scope of possible change is limited. A schizoid will always remain a schizoid and only vary from one sub-type to another. Like the mountain hare who changes from brown to white in winter and returns to brown in the spring the external form of the personality may change but the internal structure remains constant.

Chapter VII

THE PSYCHO-NEUROSES

A. Introduction

In this country two schools of thought still dispute the relation of the psycho-neuroses to the psychoses. Those who, like Ross and Gillespie, hold that the psycho-neuroses are radically different from the psychoses often base their distinction upon the degree to which the patient is influenced by the environment. In his latest book Ross, writing of the psycho-neuroses, says : " Here recovery followed at once when the illness was no longer useful, when the circumstances were better for him. There was nothing spontaneous about this recovery when one examined closely what had happened. In the manic-depressive it is of no avail to change anything. In the typical cases the patient gets better when the attack comes to an end."

Lewis attacks " this false antithesis ". After an admirable survey of the literature he concludes :

" The discussions referred to above indicate that the distinction is regarded by many British psychiatrists as fundamental with a decisive bearing on treatment.

" There can be little doubt that this view is false. Every illness is the product of two factors,—of environment working on the organism ; whether the constitutional factor is the predominant and determining influence, or the environmental one, is never a question of kind, never a question to be dealt with as an ' either/or ' problem ; there will be a great number of possible combinations according to the individual inherited endowment and training, and the particular constellation of environmental forces. To set up a sharp distinction

'in the interests of academic accuracy' when the distinction is not found in nature and is no help to thought or action, when it is accurate only so long as it remains rigidly academic, but elsewhere inaccurate and misleading—this is not the current conception of the purpose of psychiatric classification, which essays to delimit only types of reaction, with every possibility of intermingling, and no certain independence. Biological and genetic studies have not confirmed the existence of separate and independent types of reaction or even diseases, but have indicated the great complexity of the constitutional factors and predispositions. 'Pure' syndromes and reaction-types are less and less often found as more careful examination of the patient and his illness is made. No one has declared this more emphatically than Adolf Meyer. In his paper on the interrelations of the domain of neuro-psychiatry he made it clear that no sharp line could be drawn between the psychoses and the neuroses; many neuroses represented a more far-reaching disturbance in the general adjustive equilibrium of the individual than some psychoses. If the occurrence of compulsive, anxiety, and other 'psycho-neurotic' symptoms be considered, as enumerated in the preceding sections of this study, the inapplicability of any other view, except on pragmatic grounds of didactic value, etc., is clear."

With this view I find myself in complete agreement. Not only is it impossible in practice to find any reliable criteria of difference between the neuroses and psychoses, but the similarities are most striking. The incidence of neurotic symptoms in psychotics, the tendency of neurotics to become psychotic,[1] the incidence of similar psychological

[1] Ross quotes six cases of psycho-neurosis who became delusional immediately after the removal by treatment of hysterical symptoms and three others who had been diagnosed "neurosis" and later developed a psychosis. He concludes: "It is no doubt from stories like these that the view has arisen that there is little difference, save that of degree, between neurosis and psychosis. There is, however, good ground for thinking such histories uncommon," and he proceeds to quote statistics of 1,186 patients diagnosed psycho-neurotic who had been discharged from hospital during

precipitating factors in the two conditions, all these point to a close relationship. In this study, however, I am not chiefly concerned to prove that the psycho-neuroses and psychoses are indivisible but to demonstrate the relations of particular types of neurosis to particular psychoses. The psychotic patients already examined throw much light on the problem, and a further 29 patients diagnosed as suffering from some form of neurosis are also valuable, since it has been possible to determine to which of the various syntonic and schizoid personality types each approximates.

It is consequently proposed to accept the view that neuroses and psychoses are closely related and that patients pass easily, though not often, from one condition to the other, and to enquire whether it is possible to predict which type of psychosis a given neurotic patient might develop. Mapother is at once pessimistic. " There is not a single type of neurosis ", he writes, " which may not precede or alternate with any type of psychosis," and further, " there is practically no early case, whatever its present form, that may not develop eventually the form and customary course of the schizophrenic-paranoid group. This can never be excluded by the mere absence of anything or by the mere presence of signs indicating another reaction type ". The preceding personality studies are already an attempt to controvert such diagnostic and prognostic nihilism and in the two appendices further evidence will be adduced to show that in the absence of certain traits and symptoms the onset of a schizophrenic condition is, at the least, most unlikely.

---

the preceding 13 years. It was not possible to keep in touch with all of these patients, but it is certain that 33 had had psychotic attacks and a further 16 were voluntary patients in mental hospitals. Some of these may not have been psychotic but this is offset by the probability that a few untraced patients had become so. It could be estimated, therefore, that some 50 out of 1,186 (4-5 per cent) psycho-neurotic patients had become psychotic after an interval averaging 6½ years. Ross regards these figures as supporting his view that " such histories are uncommon ". The conclusion seems to me to be just the opposite.

Examples of psycho-neurotics becoming psychotic will be found later in this chapter.

Bleuler, developing his "two-factor" theory of personality, is less pessimistic. He expects to be able to isolate schizoid and syntonic factors in the various neuroses, a diagnostic task which I believe to be both possible and desirable. On purely theoretical grounds, however, he puts forward the astonishing view that the "essential factor in all *neuroses* rests on schizophrenic mechanisms", and mentions "the splitting off, the pinching off, the arraignment of one impulse by the other, the inability to adjust to certain situations" as examples of a schizoid mechanism, although the syntonic element is admitted to enter in as well, providing the labile affectivity in some neuroses. This is not the place to enter into a discussion of the nature of the schizoid and syntonic factors, but Bleuler's view I believe to be quite false. Melancholic patients, in whom there is no ground for supposing a schizoid element to be present, show an "arraignment of one impulse against another" in marked degree. The view that syntones have no mental conflicts or complexes is as absurd as to hold that such conflicts as they have are due to schizoid factors. It is therefore quite unnecessary to assume with Bleuler that repression, dissociation and other neurotic mechanisms are by nature schizoid.

Actual clinical studies are of very much more importance than abstract theoretical discussions. Since it is my view that one method of detecting a schizoid factor and the possibility of a schizophrenia developing is by a thorough study of the prepsychotic personality, this has been done in the case of 29 patients diagnosed as suffering from a psycho-neurosis. Their symptomatology was of course also carefully scrutinized. Here again the question of diagnosis is important. All of them were seen by other psychiatrists and no case was regarded as definitely psychotic, although in some there was doubt whether they should be regarded as depressives or not. Several were suicidal for short periods and much depressed but this either did not go on for long enough or else

was not sufficiently severe for them to be diagnosed psychotic. All 11 patients whose chief symptoms were physical had been rigorously examined by competent physicians to exclude organic disease.

Whatever the difficulties may be of deciding whether a patient is psychotic or only psycho-neurotic, it is nothing to the difficulty of knowing into which of the traditional psycho-neurotic categories we should place him. Thus No. 54 not only suffered from very severe obsessions for many years, but was of a markedly hysterical character. No. 62, on the other hand, was referred for her hysterical behaviour, although investigation elicited numerous obsessional symptoms. In fact, these two patients were very similar, but the different emphasis in symptoms would quite legitimately lead to one being classed as obsessional neurosis, the other as hysterical personality. Nos. 55, 56, and 57 all complained of obsessions and are included as obsessional neurotics. Many psychiatrists, however, would have diagnosed them as anxiety states.

In the following table the 29 patients have been divided according to conventional practice and diagnosed with orthodox labels. It is unlikely that everyone would accept my diagnoses, but I am satisfied that they are a fair representation of current practice. Their inadequacy will appear more clearly in subsequent discussion.

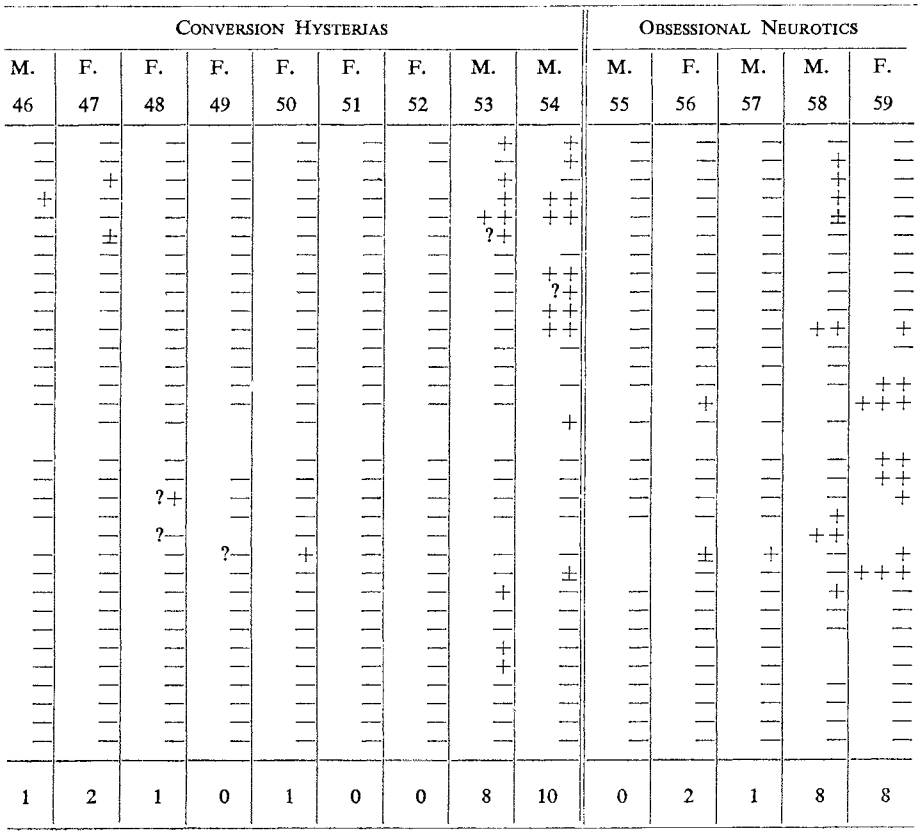
	Male	Female	Total
Anxiety States and Neurasthenia	3	4	7
Conversion Hysteria ..	4	7	11
Obsessional Neurosis ..	3	2	5
Hysterical Personality ..	—	3	3
Psychopathic Personality ..	1	2	3
Total	11	18	29

The following charts give details of their personalities.

C. Psycho-neurotics

Schizoid Traits	Anxiety States								
	M. 37	M. 38	F. 39	F. 40	F. 41	M. 42	F. 43	F. 44	M. 45
1. Solitary	—	—	—	—	—	—	+	—	+
2. No friends	+	—	—	+	—	—	—	—	—
3. No sex	—	—	—	+	—	+	—	—	—
4. No humour	—	—	—		—	—	+	—	—
5. Cold, aloof	—	—	—	—	—	—	+ +	—	—
6. Docile	—	—	—	—	—	—	—	—	
7. Saint-like	—	—	—	—	—	—	—	—	—
8. Fanatic	—	—	—	—	—	—	—	—	—
9. Prophet	—	—	—	—	—	—	—	—	—
10. Occult interests	—	—	—	—	—	—	—	—	—
11. Ambitious phantasies	—	—	—	—	—	—	—	—	—
12. Closed circle	—	—	—	—	—	—	—	—	—
13. Precious	—	—	—	—	—	—	—	—	—
14. Disdainful	—	—	—	—	—	—	+	—	—
15. Ritual	—		—	—	—	—	—	—	—
16. Homosexual	—	—	—	—	—	—	—	—	—
17. Fetichism				—			—		
18. Passionate attachments	—	—	—	—	—	—	—	—	—
19. Scenes	—	—	—	—	—	—	—	—	—
20. Violent	—	—	—	—	—	—	—	—	—
21. Hates family	—	—	—	—	—	—	—	—	—
22. Mirror			—				—		—
23. Superstitious	—	—	—	—	+	—	—	—	—
24. Numbers	—	—	—	—	—	—	—	—	—
25. Apathetic	—	—	—	—	—	—	—	—	—
26. Indolent	—	—	—	—	—	—	—	—	—
27. Vagrant	—	—	—	—	—	—	—	—	—
28. Indifferent	—	—	—	—	—	—	+	—	—
29. Unresponsive	—	—	—	—	—	—	+	—	—
30. Shameless	—	—	—	—	—	—	—	—	—
31. Misanthropic	—	—	—	—	—	—	—	—	—
32. Destructive	—	—	—	—	—	—	—	—	—
33. Cruel, spiteful	—	—	—	—	—	—	—	—	—
Total number of Schizoid traits	1	0	0	2	1	1	6	0	1

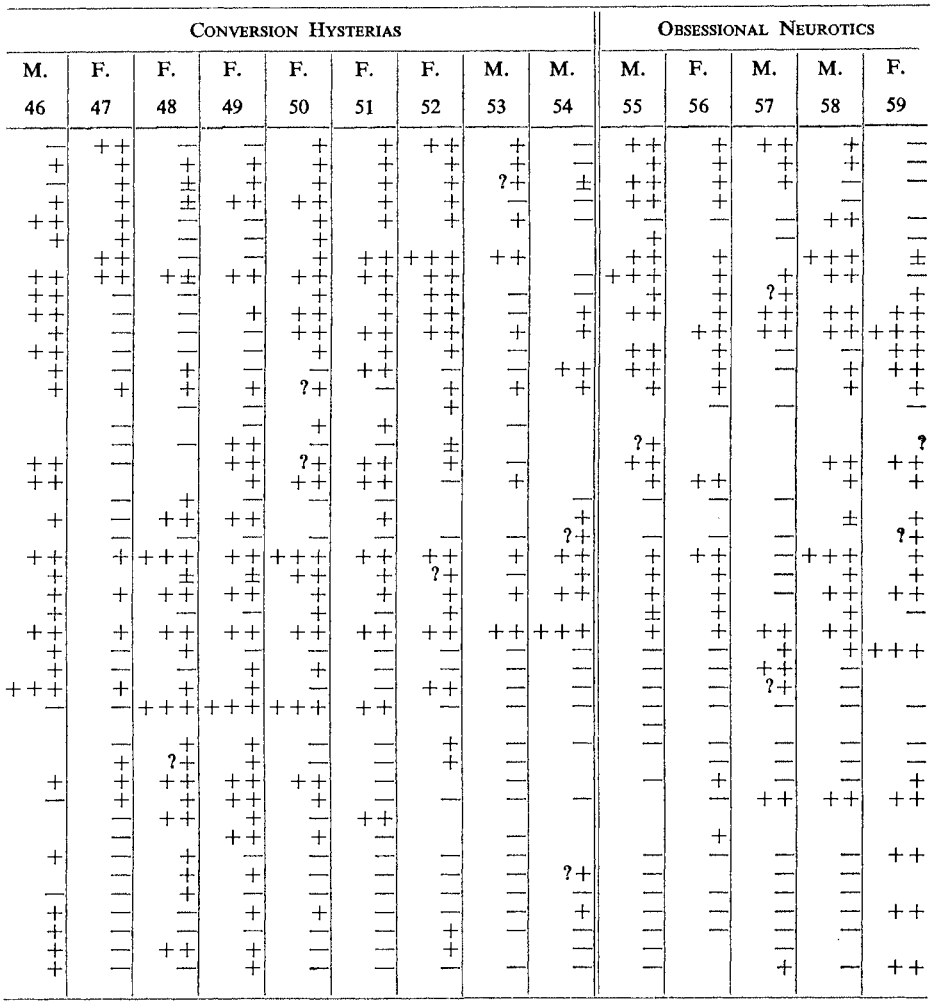
C. Psycho-neurotics



C. Psycho-neurotics (*continued*)

Non-Specific Traits (Depressives)	Anxiety States								
	M. 37	M. 38	F. 39	F. 40	F. 41	M. 42	F. 43	F. 44	M. 45
1. Steady worker	++	++	+	++	±±	+	—	++	++
2. Practical	+	+	+	+	+	+	—	+	+
3. Few good friends	—	+	+	—	?—	++	+	+	+
4. Quietly sociable	+		+	—		+	+	+	
5. Avoids rows	+	—	—		±	+	++	+	+
6. Cautious	+++		—		—	+	+	+	++
7. Can't say no	+		+	+	+	+	—		—
8. Over-conscientious	++	+++	++	+	+	++	—	+	++
9. Always busy	+	+	+		++		—	+	
10. Over-tidy	+++	+++	?+	—	++	+	—	+	++
11. Over-clean	++	+	?+	—	++	—	—	+	++
12. Repeats work	—	—		++	—	+	—	+	—
13. Repeats precautions	+	+		+	—	+	—	—	—
14. Reticent	++		++	+	—		+	++	+
15. Ascetic			—		—		—		—
16. Teetotal	—		—			+	—		—
17. Hates killing							+		—
18. Over-attached to family	—		++	?+	+++	+	—		+++
19. Worry over relations' health	++		++	++	+	+	—	?+	+
20. Pessimistic	+	—	+	+	+		—		++
21. Obstinate					—		+		—
22. Suspicious	—	—	—	—	—	—	—		—
23. Over-sensitive	++	+	++	—	++	++	+±	++	+++
24. Broods	+		+		—	++	++	+	++
25. Depressions	+	—	+	++	+++	+	++	—	++
26. Self-depreciatory			—	?+	++		—		++
27. Self-conscious	+	±	+	++	++	++		++	+++
28. Patent Medicines	—	—	—	—	—	—	—	—	+
29. Worry over bowels	+		—	++	?+	—	—	—	±
30. Pains	+		+	—	+	+	—	++	+++
31. Tic, spasms	—	—	—	—	—	+	—	—	—
32. Impotence or Frigidity	—	—			+		—		
33. Invalidism	±	—	—	—	+	—	—		—
34. Accident-prone	—	—	+		—		—	—	—
35. Anxious			—	++	+++	++	—	+	++
36. Phobias	—	±	—	++	+++	+	—	—	—
37. Fears accidents	+		?+		+		—		—
38. Fears loneliness	—		?+		+++		—		—
39. Erratic	—	—	—	—	+±	—	—	—	—
40. Spasmodic energy	—	—	—		++		—	—	—
41. Very untidy	—	—	—	?+	—	—	—	—	—
42. Up and down	—	—	—		++	++	+	—	—
43. Irritable, sulky	+	—	—	?+	+	—	—	?+	+
44. Self-pity	+		—	?+	?+		—		—
45. Jealous	—		—	—	++	—	+	—	—

C. PSYCHO-NEUROTICS (*continued*)



C. PSYCHO-NEUROTICS (*continued*)

NON-SPECIFIC TRAITS (Hyperthymic)	ANXIETY STATES								
	M. 37	M. 38	F. 39	F. 40	F. 41	M. 42	F. 43	F. 44	M. 45
46. Many friends	—	—	—	—	—	—	—	+	—
47. Enjoys parties	—	+	—	—	—	—	—	++	—
48. Jolly, cheery	—	+	—	—	?±	—	—	+	—
49. Jokes	—	+	+	—	—	—	—	—	—
50. Optimist	—	+	—	—	—	—	—		—
51. Leader	—	—	—	—		—	—	—	—
52. Opportunist	—	—	—	—		—	—		—
53. Over-ambitious	—	—	—	—	—	—	—	—	—
54. Movementy	—	—	—	—	—	—	—		—
55. Distractable	—	—	—	—	?+	—	—	—	—
56. Over-talkative	—	—	±	—	?+	—	—	+	—
57. Laughs at Criticism	—		—	—	—	—	—	—	—
58. Excitable	—	—	—	—	+	—	—	—	—
59. Slap-dash	—	—	—	—	—	—	+	—	—
60. Reckless	—	—	—	—	—	—	—	—	—
61. Boastful	—	—	—	—	—	—	—	—	—
62. Extravagant	—	—	—	—		—	—		—
63. Theatrical	—	—	—	—	—	—	—	—	—
64. Promiscuous	—	—	—		—	—	—	—	—
65. Drugs	—		—		—	—	—	—	—
66. Alchohol	—	—	—		—	—	—	—	—
67. Over-assertive	—	—	—	—	—	—	—	—	—
68. Resents authority	—	—	—		—		+	—	—
69. Feuds	—	—	+		—	—	—	—	—
70. Self-righteous	—	—	—		—	—	—	—	—
71. Angry if criticized	—	—	—	?+	+	—	+	—	±
72. Dissatisfied	—	—	+	?+	++		+		—

C. PSYCHO-NEUROTICS (*continued*)

CONVERSION HYSTERIAS									OBSESSIONAL NEUROTICS				
M.	F.	F.	F.	F.	F.	F.	M.	M.	M.	F.	M.	M.	F.
46	47	48	49	50	51	52	53	54	55	56	57	58	59
—	—	—	+	—	—	—	—	—	+	—	+	—	+
—	—	—	++	+	—	—	—	—				—	++
—	—	—	+	+	—	—	—	—	+	—	++	—	±
—	—	—	—	+	—	+	—	—	—	—	—	—	±
—	—	—	+	—	+	—	—	+	?+	—	+	—	
±	—	—	—	—	—	—	—	—	?+	—	—	—	++
—	—	—	—	—	—	—	—	—	—	—	—	—	
+	—	—	—	—	—	—	—	—	—	—	—	—	++
—	—	—	—	—	—	—	—	++	—	—	—	—	
	—	—	—	—	—	—	—	—	—	—	—	—	
	—	—	+	—	—	—	—	—	—	—	—	?+	+
—	—	—	—	—	—	—	—	—	—	—	—	—	—
±	—	?+	—	+	—	—	—	+	—	—	—	—	+
+	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	
	—	—	—	—	—	—	—	—	—	—	—	—	
	—	—	—	—	—	—	—	—	—	—	—	—	
	—	—	—	—	—	—	—	—	—	—	—	—	+
—	—	—	—	—	—	—	—	—	—	—	—	—	++
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—
	—	—	+	—	—	—	—	—	—	—	—	—	+
+	—	+	+	—	±	—	—	—	—	—	—	—	++
—	—	—	+	—	—	—	—	—	—	—	—	—	+
?+	—	+	±	—	—	—	—	—	—	—	—	—	+
+	—	++	?++	—	—	—	—	—	—	—	—	—	+
+	—	++	++	—	—	—	—	—	—	—	—	—	+

D. Hysterical and Psychopathic Personalities

(N.B.—60-62 Hysterical, 63-65 Psychopathic)

Schizoid Traits	F. 60	F. 61	F. 62	F. 63	F. 64	M. 65
1. Solitary	—	—	—	—	—	—
2. No friends	—	—	—	—	—	—
3. No sex	—	—	—	—	—	—
4. No humour	—	—	—	—	—	—
5. Cold, aloof	+	±	—	—	±	—
6. Docile	—	—	—	—	—	—
7. Saint-like	—	—	—	—	—	—
8. Fanatic	—	++	—	—	—	+
9. Prophet	—	—	—	—	—	—
10. Occult interests	—	—	—	—	++	—
11. Ambitious phantasies	—	++	—	—	—	±
12. Closed circle	—	—	—	—	—	—
13. Precious	—	++	+	—	—	+
14. Disdainful	?+	—	+	—	+	+
15. Ritual	—		?+	—		++
16. Homosexual	—	+	—	—	++	++
17. Fetichist	—	+				—
18. Passionate Attachments	+	—	+++	—	++	++
19. Scenes	++	++	+++	—	++	++
20. Violent	+	+	++	—	+	++
21. Hates Family	++	—	++	—	—	+
22. Mirror		++		±		+
23. Superstitious	—	—	+	—	+	++
24. Numbers	—	—		+	—	?+
25. Apathetic	—	—	—	—	—	—
26. Indolent	—	—	—	—	+	±
27. Vagrant	—	—	—	—	—	—
28. Indifferent	—	—	—	—	—	—
29. Unresponsive	—	—	—	—	—	—
30. Shameless	—	—	+	—	±±	±
31. Misanthropic	—	—	—	—	—	—
32. Destructive	—	±	+	—		—
33. Cruel, spiteful	—	—		—	++	—
Total number of Schizoid traits	6	10	10	2	11	15

D. Hysterical and Psychopathic Personalities

(continued)

Non-specific Traits (Depressive)	F. 60	F. 61	F. 62	F. 63	F. 64	M. 65
1. Steady worker	+	—	—	—	—	—
2. Practical		+	—	+	—	—
3. Few good friends	+	+	—	+	+	—
4. Quietly sociable	+	—	—	±	—	—
5. Avoids rows	—	—	—	—	—	—
6. Cautious	—	—	—	—	—	—
7. Can't say no		±	+	—	±	+
8. Over-conscientious		±	—	+	—	±
9. Always busy	—	±		—		—
10. Over-tidy	?+	—	++	?+		—
11. Over-clean	?+	—	++	?+		+
12. Repeats work			++	—		—
13. Repeats precautions		—	++	—		+
14. Reticent	+	—		++	—	—
15. Ascetic	—	—	—	—	—	—
16. Teetotal	—	—	—	—	—	—
17. Hates killing	++	—		—	—	
18. Over-attached to family	—	—	—	—	—	—
19. Worry over relations' health		+		—		
20. Pessimistic	—	±		—	—	—
21. Obstinate		—	++	++	+	++
22. Suspicious	—	—		—	+	++
23. Over-sensitive	—	+++	+	+++	?+	+
24. Broods		++	+	—		+
25. Depressions	++	++	++	+	+	++
26. Self-depreciatory	—	+		—	—	±
27. Self-conscious	+++	+++	+++	—		±
28. Patent Medicines	+	+	++	—		++
29. Worry over bowels	+	—		—		+
30. Pains	+	+		—		—
31. Tic, spasms	—	—	—	—	—	—
32. Impotence or Frigidity		—			+	—
33. Invalidism	—	±	—	—	—	±
34. Accident-prone	—	—		—		—
35. Anxious	—	—	+	—	—	—
36. Phobias	+	—	+	++		+
37. Fears accidents	+			—		
38. Fears loneliness	+	?+	+	—	++	
39. Erratic	—	++	+	+	++	++
40. Spasmodic energy	—	++	+	—	+	++
41. Very untidy	—	—		—		
42. Up and down	+	++	++	—	+	++
43. Irritable, sulky	+	—	—	—	—	—
44. Self-pity	+	+	+	—	+	
45. Jealous	+	+	++	—	++	++

D. Hysterical and Psychopathic Personalities

(continued)

Non-specific Traits (Hyperthymic)	F. 60	F. 61	F. 62	F. 63	F. 64	M. 65
46. Many friends	+	+	++	+		++
47. Enjoys parties	±	++	++	+	+	+++
48. Jolly, cheery	±	±	+	++	+	+
49. Jokes	—	+	—	++		—
50. Optimistic	—	—		+	+	+
51. Leader	—	—	+	++	+	+++
52. Opportunist	—	—			++	+
53. Over-ambitious	—	±	—	—	—	+
54. Movementy	—	—	—	—	?+	+
55. Distractable	—	—		—	?+	++
56. Over-talkative	—	—		+	+	++
57. Laughs at criticism	—	—		—	?+	—
58. Excitable	?+	+	++	+	++	++
59. Slap-dash	—	—		—		—
60. Reckless	—	—		—	++	—
61. Boastful	—	—		++	+	
62. Extravagant	—	++	?+	+	+	++
63. Theatrical	—	++	++	+	++	++
64. Promiscuous	±	—	+	—	+	+
65. Drugs	—	—		—		—
66. Alcohol	—	—	?+	—	+	—
67. Over-assertive	—	—		++	++	+
68. Resents authority	—	—	++	+	++	+
69. Feuds	—	—	++	—	++	+
70. Self-righteous	—	±	+	+	++	++
71. Angry if criticized	+	±	++	++	++	++
72. Dissatisfied	++	++	++	—	++	+

From these charts it will be seen that only a minority of psycho-neurotics score many schizoid traits. Though it must be remembered that a small proportion of schizophrenes score only a few schizoid traits, it is safe to conclude that the majority of these patients are syntones. On the other hand a few score a very large number which, it has been advanced, is strong evidence in favour of a schizoid factor. It is important to note that the patients showing schizoid traits are scattered amongst the different categories more or less indiscriminately. One neurasthenic, two conversion hysterics, all three hysterical personalities, two of the five obsessionals and two out of three psychopaths have a large number of schizoid traits. The significance of this finding will be discussed category by category.

B. Anxiety States and Neurasthenia

Although recognized by older psychiatrists, the great emphasis which is laid upon anxiety by modern psychopathology is very largely due to Freud. It was he who first drew attention to the connection of anxiety with the patient's sexual life and who attempted to isolate two syndromes, Anxiety Neurosis and Anxiety Hysteria. Whilst accepting much of Freud's work, many psychiatrists and psycho-analysts have not been able to confirm the clinical distinction between these syndromes. Clinical work has led me to the view that such a distinction is quite unjustified, but it is still sufficiently widely held for a few comments to be in place.

It was in 1894 that Freud published his paper on the Anxiety Neurosis, in which he attempted not only to separate out a clinical entity, but also to investigate its nature and propose a theory of its causation. Clinically it was characterized by general irritability, anxious expectation and a variety of physical manifestations equivalent to an anxiety attack. Further investigation led to the discovery that almost all these patients were leading an abnormal sexual life, the commonest abnormality

being conditions in which sexual passions were aroused without being properly satisfied, such as coitus interruptus. Exceptions to this rule were patients who fell ill whilst nursing sick relatives. Passing by this exception Freud formulated a theory to account for the condition. It was that sexual excitation of a *somatic* origin, instead of passing up to the mind and being felt as sexual desire and discharged psychically, was accumulated subcortically and felt as anxiety. His next important paper on anxiety was that published in 1909 on " Little Hans ". The anxiety in this small patient of five years took a phobic form. Now on investigation Freud saw many similarities between the pathology of this condition and that of a case of hysteria, the origin of which he believed to be purely psychic. He consequently coined the term Anxiety Hysteria for the phobic condition and postulated a purely psychic pathology to account for it. Two syndromes were thus described, Anxiety Neurosis with an organic pathology, Anxiety Hysteria with a psychic pathology. The one is termed an *actual* neurosis, the other a *psycho* neurosis.

Many clinicians deny the existence of Anxiety Neurosis with its toxic pathology. They point out that its symptomatology differs not at all from that of Anxiety Hysteria, and that practices such as coitus interruptus are widespread and accompany normality, psychoneurosis and often psychosis, showing no discrimination. Nevertheless the diagnosis remains in current use especially in psycho-analytic writings, which is all the more surprising in view of the fact that psycho-analysis is concerned principally with psychic and not organic factors. Fenichel, for instance, has elaborated the toxic theory, making it more fashionable by introducing the notion of "sexual hormonal substances" and regarding the actual neuroses and neurasthenias as the " organic, toxic results of the fact that sexual hormonal substances through external—or perhaps more frequently internal psychogenic —factors failed to find a proper outlet (abortive orgasm) ".

It is a pity that when the psychogenesis and psychopathology of phobias came to be understood, the concept of the Anxiety Neurosis with its organic pathology was not carefully examined and investigated afresh. Had this been done it would probably soon have been realized that there were no symptoms and signs which could distinguish the two conditions. The symptomatology as presented in Freud's first paper falls under three heads, (1) General Irritability, (2) Anxious expectation and numerous phobias, (3) Anxiety attacks or their equivalents. Freud does not regard the General Irritability as specific ; it is Anxious Expectation which in his view forms the " nuclear symptom of this neurosis ". It is worth quoting his description of this in full.[1]

" *Anxious Expectation*

" I cannot better describe the condition I have in mind than by this name and by appending a few examples. A woman who suffers from this anxious expectation will imagine every time her husband coughs, when he has a cold, that he is going to have influenzal pneumonia, and will at once see his funeral in her mind's eye. If when she is coming towards the house she sees two people standing by her front door, she cannot avoid the thought that one of her children has fallen out of the window ; if the bell rings, then someone is bringing news of a death, and so on ; whereas on all these occasions there is no particular ground for exaggerating a mere possibility.

" Anxious Expectation of course fades off imperceptibly into normal anxiousness. It comprises all that is covered by the word ' nervousness '—apprehensiveness, the tendency to look on the dark side of things ; but at every opportunity it exceeds the limits of this plausible form of nervousness and is frequently recognized by the patient himself as a kind of compulsion. For one form of anxious expectation—that relating to one's own health—we may reserve the old term *hypochondria*. Hypochondria does

[1] Freud : *Collected Papers I*, pp. 79-80 and 83.

not always coincide with a high degree of anxious expectation ; in general it requires as a preliminary condition the presence of paraesthesias and disagreeable bodily sensations, and therefore hypochondria is the form favoured by true neurasthenics when they fall victims to anxiety-neurosis, as they often do.

" The tendency to *pangs of conscience*, scrupulousness, and pedantry may be a further expression of anxious expectation, a tendency which is especially frequent among morally sensitive people and likewise ranges from the normal to an exaggeration known as *folie du doute.*

" Anxious Expectation is the nuclear symptom of this neurosis ; it clearly reveals, too, something of the theory of it. We may perhaps say that there is here *a quantum of anxiety in a free-floating condition,* which in any state of expectation controls the selection of ideas, and is ever ready to attach itself to any suitable ideational content. . . .

" On the basis of chronic apprehensiveness (anxious expectation) on the one hand, and a tendency to attacks of vertigo with anxiety on the other, two groups of typical phobias develop, the first relating to common physiological dangers, the other to locomotion. To the first group belongs the fear of snakes, thunderstorms, darkness, vermin, and so on, as well as the typical moral over-sensitiveness, and the forms of *folie du doute* ; the available anxiety here is used simply to exaggerate the aversions which are implanted instinctively in everyone. Usually, however, a phobia with obsessive strength arises only when, added to such an instinctive aversion, a reminiscence of an experience in which the anxiety could come to expression supervenes—for example, after the patient has actually experienced a thunderstorm in the open air. To attempt to explain such cases as mere continuations of strong impressions would be incorrect ; what makes these experiences significant and their retention in memory of long duration is indeed simply the anxiety which both originally and subsequently thus found a means of expression. In other words, such

impressions remain potent only in cases where ' anxious expectation ' is present.

" The other group includes *agoraphobia* with all its accessory forms, collectively characterized by their relation to movement."

In addition to anxious expectation and phobias it is interesting to note that he includes hallucinations as sometimes occurring.

Now it will be seen that this is an excellent description of the state of mind which is common in obsessive and anxious depressives, and is reminiscent in every detail of No. 18 of my series.[1] It could of course be argued that this patient was suffering from anxiety neurosis before falling ill of melancholia, but that would involve us in a double diagnosis. The alternative theory is that the symptoms of anxiety from which she suffered were the prodromal symptoms of melancholia. It is true that a double diagnosis does not disturb Fenichel[2]; in fact most of the defenders of the concept of " actual " neuroses, when taxed, admit that they rarely occur without hysterical symptoms as well—again a double diagnosis. Of course, patients sometimes do suffer from two diseases at once, but the history of medicine and ordinary clinical experience have demonstrated again and again the danger of this procedure. Once we begin to ascribe one symptom to one pathology and another symptom to another pathology we have left the world of scientific method for a world of anarchy.

Even if the clinical picture of anxiety neurosis is identical with other and psychogenic anxiety states, it may still be argued that the pathology is different, that the *conditions under which it arises*—sexual excitement with frustration—are specific. So far as I am aware

[1] Described in full in Chapter V as a typical Anxious Depressive.

[2] Speaking of hypochondria, which he also regards as an " actual " neurosis, Fenichel says " in reality hypochondria very rarely appears alone, as an isolated neurosis ; it appears more frequently as a factor complicating the picture of some other psychopathological condition ; it is to a mild degree a complicating factor in the compulsion neurosis and other neuroses and, as is well known, it is an important complication in all psychoses ".

no systematic examination has been made of this association and consequently no certain refutation is possible. There is much good evidence, however, against such a view. It has already been mentioned that psychotic patients have often been impotent or frigid long before their psychosis, symptoms which are probably the result and not the cause of the psychic condition. In other words the so-called specific conditions occur elsewhere as well. Even more important, however, is the fact that some of the patients diagnosed by Freud as Anxiety Neurotics fell ill whilst nursing a sick relative. Now investigation has shown that the illness or death of a near relative is an exceedingly common precipitating factor in both psycho-neuroses and functional psychoses. If it is also found to precipitate the anxiety neurosis, there is a *prima facie* argument in favour of the view that this neurosis has a pathology of a nature similar to that of the psycho-neurosis. The identity of the conditions is further supported by the fact that some other of the alleged predisposing causes of Anxiety Neurosis, such as marriage and the climacteric, are also common precipitating factors in the purely functional illnesses.

My conclusions, therefore, are that clinically it is impossible to distinguish the syndrome Anxiety Neurosis from Anxiety Hysteria by any specific symptoms or group of symptoms and that the predisposing conditions alleged to cause it, when they are not merely symptoms of the neurosis, are identical with the precipitating factors of the psycho-neuroses and functional psychoses. Since the distinction between Anxiety Neurosis and Anxiety Hysteria is not admitted, the problem as to which condition the following patients belong to does not arise.[1]

The term 'neurasthenia' needs less introduction. Supplanted in her office by Anxiety Neurosis, Neurasthenia is a psychiatric maid-of-all-work who has gone out of business. The diagnosis is still sometimes used, however, in connection with states of depression and

[1] I am told that Freud himself in conversation dismissed the concept of Anxiety Neurosis as mistaken.

exhaustion without delusions, since the term Anxiety State (or Neurosis) is more appropriate to cases where anxiety and agitation are prominent. Of the following seven patients, Nos. 37 and 38 might be diagnosed Neurasthenia, Nos. 39, 41 and 42 Anxiety State, with Nos. 40 and 43 doubtful.

No. 37. Married man of 43, clerk, case of exhaustion, worry, depression. He felt down and out, that he could not manage the work and that he had been doing it wrong. This followed three months after a reduction of staff and the doubling of his work. During the war he had had shell-shock.

Course. Gradual improvement and partial recovery after six months.

Personality. Syntone. Typical Cautious Obsessive (quiet type).

No. 38. Married man of 43, clerk, case of insomnia, work on his mind, small things seemed big, unable to work, afraid perhaps that others were trying to get his job. These symptoms followed an office reorganization and his transfer to another department when, instead of being independent, he was under a bullying supervisor. He was very depressed.

Course. Gradual improvement and recovery after a few months.

Personality. Syntone. Cautious Obsessive (with some cheerful hyperthymic features).

No. 39. Single woman of 30, living at home, case of severe insomnia unrelieved by drugs, restlessness, nervousness, depression, hypochondriacal fear of cancer. The symptoms came on three years previously after a younger brother's death from cancer.

Course. Persistent and unchanged for three years; recovery after eighteen months' psycho-analysis.

Personality. Syntone. Cautious Obsessive (a few quarrelsome features).

No. 40. Single woman of 35, clerk, case of claustrophobia in tubes, much depression and some suicidal

thoughts. Hypochondriacal fear of heart trouble. A chronic condition, exacerbated by mother's and sister's illnesses.

Course. Chronic and getting worse over a period of several years. (Refused treatment.)

Personality. Syntone. Obsessive and Anxious Depressive.

No. 41. Married woman of 33, housewife, case of acute anxiety and agitation, depression, mild self-reproach, thoughts of suicide, hypochondriacal fear of cancer. Symptoms followed immediately after mother's " brain-storm ", in which she was violent and abusive.

Course. Gradual improvement with tendency to relapses.

Personality. Syntone. Typical Anxious Depressive. (Gay type like No. 18.)

No. 42. Single man of 20, clerk, case of headaches, tremblings, irritability, exhaustion, stammering. Great anxiety over unemployment, vague paranoid feelings and self-reproach, frequent thoughts of suicide. Followed loss of work.

Course. Gradual improvement and partial recovery after nine months. Later became unemployable owing to nervousness, stammering and tics.

Personality. Syntone. Obsessive and Anxious Depressive.

No. 43. Married woman of 23, housewife, case of fits of depression and crying, inability to work, constant need for attention and sympathy, mild suicidal threats. Onset soon after marriage.

Course. Gradual recovery during two years' psycho-analysis.

Personality. Probably schizoid (six schizoid traits). Cold Solitary type.

From these details it will be seen that, with the exception of the last, all these patients had much in common with patients suffering from a psychotic depression. The similarities can be discussed under four heads.

1. *Symptomatology.* All the features of an affective psychosis from insomnia, loss of appetite and weight to depression, self-reproach and vague paranoid feelings are present to some degree in the symptomatology of these anxiety states (or neurasthenias). It is true that self-reproach and paranoid ideas never reached the stages of full-blown delusion (for which reason the patients were not diagnosed psychotic) but although this is important clinically there is no reason to suppose that pathologically there is any radical difference between the varying degrees of such feelings. Mild self-reproach, which is often present in so-called Anxiety States, is particularly difficult to assess. There is every degree of it from remorse at not having done more to help a sick relative to the delusion of being responsible for their death and it is never easy to say where normal remorse ends and delusion begins.

The frequency of mild self-reproach and depression in anxiety states is balanced by the incidence of anxiety in melancholia. After quoting the views of Bleuler, Mapother, Delmas and Laye, Lewis concludes that " anxiety is a common and probably integral part of the depressive reaction ". It was prominent in many of the 19 patients of this series, particularly Nos. 8, 10, 13, 14, 15, and 18.

2. *Course of Illness.* A further similarity was the course of illness in these patients. All except two (Nos. 39 and 40) had had a comparatively sudden onset, got increasingly worse for a few weeks and then began to recover spontaneously without much treatment except rest from work and hypnotics. One, No. 39, had remained chronic for three years and recovered during intensive psycho-analysis (this may have been a spontaneous recovery and only accidentally associated with treatment) and one, No. 40, continued chronic.

3. *Precipitating Factor.* Although it is sometimes held that an anxiety state or psychogenic depression can be distinguished from a true cyclothymia by the

presence or absence of an external precipitating factor, much work goes to show this view to be untenable. It is not possible to discuss the question here, but it may be stated that the frequency and nature of the precipitating factors in the anxiety states were similar to those found in the psychotic group. The view that no true manic-depressive attacks have external precipitating factors only needs to be investigated to be shown untenable.

4. *Personality.* It is not only the mental states, course of illness and precipitating factors of these six patients which are reminiscent of an affective psychosis. Their personalities before breakdown showed both an absence of schizoid traits and a great number of those obsessive and anxiety traits which were found to be typical of the prepsychotic melancholic. They belonged quite characteristically to one of the two depressive syntonic types. Three were Cautious Obsessives (one with a few cheerful features and another a little quarrelsome), one Anxious Depressive and two transitional.

The similarities of these patients to mild affective depressives having been described, it only remains for us to recall the frequency with which phobias and more generalized anxiety precede a full-blown psychotic depression. In my own series 8 out of 23 had shown it; Kraepelin quotes the remark: " I was born in anxiety ", made by one of his patients, as typical and MacCurdy found it in at least 5 out of 22 patients. Craig and Beaton regard anxiety states and acute agitated melancholia as a continuous series. They point out that the latter condition is " usually the sequel to a morbid anxiety state " although it occasionally occurs in individuals who give no history of acute anxiety.

With these observations before us it is difficult to avoid the conclusion that many cases of Anxiety State or Neurasthenia are no more or less than attacks of cyclothymia which have not progressed to a delusional stage.

The Anxiety States approximate to Agitated Melancholia whilst the Neurasthenias are more like Retarded Depressions. (Of course there is often an interchange between these groups, an agitated patient becoming retarded and vice versa.) But this conclusion must not be allowed to blind us to the fact that " anxiety is not the prerogative or the characteristic feature of any psychosis or neurosis " (Lewis). The same of course is true both of depression and excitement. We shall, therefore, hardly expect states of anxiety or depression to be confined to syntones. In certain circumstances schizoids also become depressed or anxious. No. 43 is a case in point. Although the symptoms were not markedly different from those in the other patients, this girl showed several schizoid traits. It is true that they were neither numerous nor marked, but they are sufficient to make me give a more guarded prognosis.

In Appendix B it is pointed out that schizophrenes often suffer from depressions and anxiety before becoming psychotic (Nos. 32 and 33 had strong phobias for example). Such symptoms are also common and intense in the early stages of the psychosis itself, a fact too well known to illustrate. The question therefore arises whether there are any patients with such symptoms who do not approximate more or less closely to one or other of the functional psychoses. A final answer would need much research, but it is my impression that the great majority do so approximate and that it is of clinical importance that this should be recognized, and an attempt made to discover to which group any given patient belongs. It is my contention that every patient suffering from an Anxiety State or Neurasthenia, or for that matter from any other neurosis, should be examined, not only to exclude psychotic symptoms, but also with a view to determining whether he is syntonic or schizoid in make-up. If this is done prognosis would become more reliable, treatment more intelligent and psychopathology more scientific.

C. Conversion Hysteria

The term 'hysteria', never very carefully used, has now come to be applied in a great variety of ways. Originally it was confined to somatic symptoms without organic lesions, but since their study by psychiatrists, the 'hysterical personality', and the syndrome 'anxiety hysteria' (phobias) have been christened; the first because it was supposed to be the necessary personality accompaniment of hysterical symptoms, the soil in which they grew, and the second because a similar psychopathology was discovered, the manifest symptoms, pains, paralyses, phobias, etc., being the different end-products of essentially similar processes. Hence the use of the same name. It has already been argued that anxiety hysteria is not to be differentiated from anxiety neurosis and that the condition is, if not always at least in the majority of cases, allied either to psychotic depression or to schizophrenia. Hysterical personalities will be dealt with in the following section. In this it is proposed to examine the 11 patients whose chief symptoms were somatic (conversion symptoms) and who did not show prominent signs of an hysterical personality.

It must be confessed that they are a mixed bag and that enuresis and hair-rubbing, for instance, would not be included as 'conversion' symptoms by everyone. However, it is convenient to include them here. In every case thorough physical examination had failed to demonstrate any organic lesion (except for the possibility of inflammation around the nerve in Nos. 46 and 47).

No. 44. A single girl of 19, typist, case of constant splitting headache. Sudden onset following tonsillectomy. Whilst in hospital another and garrulous patient had continually likened the patient to her dead daughter, which upset the patient very much. Also much depression, crying fits, irritability and a feeling of unreality.

Course. Gradual improvement and recovery after twelve months.

Personality. Syntone—Circular (Cautious Obsessive with cheerful features).

No. 45. Single man, aged 26, cook, case of severe pain over right eye for five years. Pain never leaves him, sometimes worse at week-ends. Pain getting worse and the patient increasingly sensitive, silent and depressed. Self-reproach about his work and contributions to his home ; talking about suicide, crying fits.

Course. After being severely depressed for about three weeks (retarded but no obvious delusions), he made a quick recovery and returned to work after three months.

Personality. Syntone. Cautious Obsessive (very quiet and sensitive).

No. 46. Single man of 31, shop assistant, case of severe trigeminal neuralgia for three and a half years—attack every other day. First attack on a Good Friday, which was also the third anniversary of father's death. (Father had died suddenly in patient's presence ; great shock to patient, he felt dazed, thought he would be the next and felt he must " atone ".)

Course. Chronic (refused psychotherapy).

Personality. Syntone. Circular (obsessive and quarrelsome traits).

No. 47. Single girl of 23, musician, case of pains in right arm—neuritis—prevented her from working ; depressed, crying fits. Came on after troubles at home.

Course. Gradual improvement and recovery at convalescent home.

Personality. Syntone. Typical Cautious Obsessive.

No. 48. Single woman of 31, case of persistent vomiting. First attack had been four months after falling astride a chair, which caused minor local injury. Immediately afterwards she had pain in her side, worried much about possibility of internal damage and irregularity of periods. Severe vomiting supervened. Improved rapidly in hospital but relapsed on return to work.

Course. Very chronic. Recurrent vomiting attacks. Also severe depression with thoughts of suicide, much

self-reproach about masturbation which she could not control.[1]

Personality. Syntone. Anxious Depressive (with quarrelsome features).

No. 49. Single woman of 23, factory worker, case of spasmodic attacks in which her right arm contracts, a feeling like pins and needles spreads all over body like an electric shock, whole body taut for a minute, then relaxes. Remains conscious, lies down before attack develops, passed water on two occasions only. Also very severe anxiety and depression—agoraphobia, terrified of attacks, etc. Severe condition followed trip in aeroplane when she had impulse to throw herself out.

Course. Chronic for three years, with periods when she was worse. In hospital total of twelve months, terrified to get out of bed, crying fits when spoken to. Unable to go out alone. Considerable improvement after three years' intensive psychotherapy.

Personality. Syntone. Circular (Anxious and Quarrelsome Depressive + cheerfulness).

No. 50. Single woman of 24, shop assistant, case of choreiform movements of arms and legs. Onset sudden, ten days before marriage which was thereby postponed. Lasted seven weeks and accompanied by anxiety and much depression (crying fits), self-depreciation and reproach about her ignorance of housekeeping, etc. (Known young man four years—suitable marriage.)

Course. Choreiform movements stopped after seven weeks, anxiety and depression cleared up after eight more. Keen to proceed with marriage.

Personality. Syntone. Cautious Obsessive (fairly cheerful).

No. 51. Schoolgirl of 16. Mother complained she rubbed her hair out, severe nail-biting. Has persisted during four years. Mother thinks it began during worry over homework.

[1] Since writing this, this patient has had a psychotic attack from which she recovered after 8 months. The psychiatrist who saw her regarded it as a typical melancholia.

Course. Persistent—worries a lot over work—rather depressed.

Personality. Syntone. Cautious Obsessive (Model Child).

No. 52. Schoolgirl of 15, case of severe headaches of migrainous type since the age of 11. Bilateral headaches came on two or three times a week, caused vomiting and passed off after a few hours. This patient also suffered from occasional periods lasting some hours when she completely "forgot herself" and for which she was subsequently amnesic. During these times she remembered only the past, not recent events. Does school work, but later cannot recall doing it, puzzled by her exercise books. Said to stare during these turns. She was always having minor accidents.

Course. Much improved by superficial psychotherapy.

Personality. Syntone. Cautious Obsessive (Model Child).

No. 53. Single boy of 18, shop assistant, case of persistent nocturnal enuresis ever since a child. Some depression, constant feeling that people are talking about him behind his back, tendency to senseless laughter.

Course. Unknown.

Personality. Schizoid. (8 schizoid traits.) Cold Solitary (dull backward).

No. 54. Unmarried man of 21, unpaid eclectic-political work, case of headaches, tight band round head, shooting pains in arms, recurrence of sleep-walking which he had as a child, bad dreams, depressed. After losing temper took five medinal tablets gr. v, but recovered. Always very self-conscious. Worried about being homosexual. Once, in a dizzy confused state, undressed in his father's sitting-room. Insidious onset with no known precipitant factor.

Course. Persistent condition.

Personality. Schizoid. (About 10 schizoid traits.) Cold Solitary or Apathetic Asocial.

Summary of Personalities

Syntones—Cautious Obsessive	.. .. ..	5
Anxious Depressive	.. .. ..	1
Circular	.. ..	3
Schizoids—Cold Solitary	.. .. ..	2
		11

Of these 11 patients, 9 had syntonic personalities whilst 2 were markedly schizoid. As in the case of the Anxiety States, the illness from which the 9 syntones suffered bore strong resemblances to the depressive phase of the affective psychosis. The resemblances can be discussed under five headings.

1. *Symptomatology.* Psychiatrists are agreed that hysterical patients showing *belle indifférence* are a rarity nowadays whatever they may have been last century. Ross's extensive experience is interesting. " I have not attempted to differentiate the results between hysteria and the anxiety state. For years we have returned patients under these two heads, but the distinction between them seems a little unreal. There is hysterical paralysis on the one hand and there are patients on the other with, say, a phobia and nothing else, but the categories do on the whole run into one another. I think that in fact we seldom saw the classical hysterical paralytic with the so-called *belle indifférence.* Our patients with paralysis seemed mostly to be very anxious nervous people." This was the case with my patients. At least 5 of the 9 syntones were severely depressed and one suffered from acute anxiety for some years. If they had had no conversion symptoms, their other neurotic symptoms would have been quite sufficient for a diagnosis of anxiety state or neurasthenia to have been made.

But the similarities of symptomatology are not confined to the conversion hysteric suffering from anxiety and depression. Contrariwise patients with psychotic depression often complain of conversion symptoms.

For instance No. 2 of my series complained bitterly of shooting and gnawing pains all over him. Lewis has specially emphasized the incidence of such symptoms in melancholia. Of his 61 patients, 7 or 8 had pains of various kinds such as headache or indigestion, 2 had vomited persistently at the beginning of their illness, 1 stuttered (cf. No. 42 of this series) and 1 was given to fainting.

2. *Transitions from Neurosis to Psychosis.* Further evidence of the close relation of functional somatic symptoms to the manic-depressive psychosis is the fact that a certain proportion of patients subject to these symptoms actually develop the psychosis later in life. Kraepelin was one of the first to draw attention to this. He mentions twitching, attacks of migraine and nervous dyspepsia, as common symptoms preceding a depression. Five depressives of my series had suffered from severe pains—indigestion, neuritis, headache—prior to their psychotic breakdown and one had been afflicted by twitching movements of the right arm.[1] It was interesting that in the case of No. 15, the indigestion, constipation and attacks of neuritis from which he suffered all vanished whenever he had an attack of depression, of which he had had four.

Ross, an opponent of the view that there is no difference except in degree between psycho-neurosis and psychosis, none the less quotes six patients in whom psychosis followed immediately the removal by persuasion or hypnosis of hysterical symptoms. Unfortunately, he does not tell us the nature of the psychoses. Paranoid, depressive and hypochondriacal symptoms seem to have predominated and there is no suggestion of schizophrenia. It is probably safe to conclude that the psychoses were of the affective type.[2]

[1] For details see Appendix B. non-specific traits Nos. 30, 31.

[2] The tendency of these patients to become psychotic is beautifully illustrated also by No. 48 of this series. The text had already been completed when I heard that this woman had developed a typical melancholia. She is therefore listed as a Conversion Hysteric of Syntone Personality, although a few months later she would have been included among the Melancholics.

3. *Course of Illness.* Although in not such a large proportion as in the Anxiety States, in four of the syntonic Conversion Hysterics (Nos. 44, 45, 47 and 50) the illness had come on suddenly and had cleared up more or less spontaneously after a few months. Four (Nos. 46, 48, 51 and 52) had remained chronic over a period, whilst No. 49 after a prolonged attack made a good recovery during a course of psychotherapy. The tendency shown by four patients to spontaneous cure is obviously reminiscent of the affective psychoses. Bleuler comments on it, calling attention to the recurrent nature of many of these functional somatic symptoms. " Probably everything designated as periodic neurasthenia, recurrent dyspepsia, etc., also belongs entirely to manic-depressive insanity ; also attacks of hypochondria. . . ."

4. *Precipitating Factor.* This cannot be dealt with at length here. The remarks made under the same heading in reference to Anxiety States (p. 149) hold good also for conversion symptoms.

5. *Personality.* Every one of the nine patients, who, it is argued, were suffering from a mild form of the affective psychosis, had a type of personality which has been shown characteristically to precede that illness. Only one had as many as 2 schizoid traits and 4 had none. On the other hand, they all had, in a marked degree, the obsessive, anxious and quarrelsome traits, which are so common prior to an affective psychosis. Indeed the previous personalities of the Affectives and the Conversion Hysterics are quite indistinguishable.

In this connection it is interesting to find that amongst patients suffering from migraine, which is often suspected of being akin to conversion hysteria, are also found typical depressive personalities, usually, so far as can be judged, of the syntonic variety.

An examination of 50 patients carried out by Touraine and Draper revealed the following features as particularly frequent :

Finds decisions difficult.

Exaggerated sense of insecurity.

Difficulty in making social contacts, with a tendency to force themselves to do so.

Detailed perfectionist.

Urge to check and re-check work.

Extremely sensitive response to criticism.

Unnecessary burdens and responsibilities assumed.

Anxious, anticipates disaster.

Deep emotions, but frustrated expression.

Self-pity.

All these of course are typical non-specific depressive traits. The addition of such descriptions as :

Slightly dulled responsiveness,

Partial absorption,

Turning backward into themselves,

Warmth of personality lacking,

is suggestive of a schizoid factor but, as has previously been remarked, some Cautious Obsessives especially when ill and depressed can be markedly withdrawn and self-centred, a tendency which leads to difficulty in diagnosis.

Confirmatory work on migraine is published by Knopf. Of 30 patients examined, 20 had been very obedient as children (" I was always held up as an example to the other children "), 25 were especially sensitive and about half were shy, had difficulty in making friends, were inclined to worry and be jealous and resentful. Summarizing their personalities she says : " It has been found that a certain type of personality prevails in a group of 30 cases of migraine. The patients are, on the whole, of the goody-goody type, very ambitious, reserved, repressed and ' dignified ', sensitive, domineering and possess very little sense of humour."

The authors of these papers are in striking agreement over the personalities of migrainous patients. All the traits characteristic of an obsessive and depressive make-up are found with comparatively few schizoid traits. It is difficult to assess the lack of humour noted by one

observer and the tendency to be emotionally withdrawn mentioned by the others, but from reading the case histories it seemed to me unlikely that many of them were of schizoids. However that may be, it is certain that few were hysterical personalities. Need for attention, caprice, labile emotions, passionate attachments, none of these are specially mentioned, which corresponds with my own experience. Of the 10 patients presented here only 2 (Nos. 48 and 49) behaved in any way hysterically. The theory that hysterical symptoms only occur, or occur most frequently, in hysterical personalities is almost certainly false.

In addition to the similarity in personality to depressive syntones displayed by migrainous patients, a fair proportion actually suffer from mental symptoms such as anxiety, depression and hypochondria. Touraine and Draper found that " contemplation of suicide in migrainous patients is frequent " ; one had made an attempt whilst three others had persistent ideas of it. Of Knopf's 30 patients 5 had previously suffered from mental illness, diagnosed 1 anxiety neurosis, 1 manic-depressive psychosis, 1 climacteric depression, 2 hypochondria. When examined by her, 2 were in a state of depression, 1 hysteria and 1 psychoneurosis.

Observations on patients suffering from Anorexia Nervosa have much in common with those regarding migraine. Ryle mentions that such a patient " may be over-devoted to her mother and yet frequently ' at loggerheads ' with her. She is often excessively conscientious ". Five out of 51 patients either were or became psychotic but unfortunately no details as to what the type of psychosis was are available.

With all this wealth of evidence it seems to me impossible to persist in the theory that a hard and fast line can be drawn between certain of the patients suffering from conversion hysteria and others suffering from psychotic depression. But just as it was seen that not all anxiety states were allied to melancholia, so it must

not be forgotten that some patients who have conversion symptoms are of a schizoid make-up. No. 53 who had chronic enuresis and No. 54 with headaches and somnambulism are cases in point. (In addition to numerous schizoid traits No. 53 said that he was sometimes inclined to senseless giggling.) Another is No. 60, an hysterical girl with several schizoid traits who is described under Hysterical Personality. She had very numerous functional symptoms, but unlike the patients described in this section, they rarely lasted more than a few days. One day it would be a severe abdominal pain, the next a persistent spasmodic cough, then difficulty in breathing and so on.

But not only are Conversion Hysterics sometimes of schizoid make-up ; such symptoms often precede an actual schizophrenia. No. 36 was the only patient of this series known to have had them. At the age of 10, during the air raids, he developed St.Vitus dance. The fact that it was unilateral and cleared up suddenly after 6 to 9 months is strongly in favour of its being functional in origin.

Therefore, just as in the case of Anxiety States, we are driven to the conclusion that symptoms of so-called Conversion Hysteria are to be found in radically different types of personality, and in conjunction with mental symptoms of differing orders of severity. On the one hand is a large group of patients whose personality is depressive syntone and whose mental symptoms include anxiety, depression, hypochondria, etc., symptoms which, as Ross admits, make them indistinguishable from certain anxiety states and also, which he denies, indistinguishable from mild depressions. On the other hand are patients who not only have many schizoid traits, but who also show symptoms suggestive of an incipient schizophrenia. In the 11 cases here presented 9 are syntones and 2 schizoid. It is my opinion that for prognostic purposes this distinction is of far more value than any attempt to differentiate anxiety states from conversion hysteria, or,

as will be seen in the next section, from obsessional neurosis.

D. Obsessional Neurosis

There is still much individual idiosyncrasy in all psychiatric diagnosis, but perhaps no diagnosis is subject to more personal interpretation than that of obsessional neurosis. We may agree with Ross and many others that the diagnosis should be confined to those patients who have few symptoms other than obsessions, but this, unfortunately, is not universal practice. To draw attention to the way in which the diagnosis is sometimes made, I have included here three patients (Nos. 55, 56 and 57) who, whilst indubitably suffering from severe obsessions, would be labelled Anxiety State or Neurasthenia by most psychiatrists.

No. 55. Married man, aged 30, factory worker, case of inability to convince himself that he had done his work properly. Felt forced to inspect his work several times to make sure it is correct—makes him too slow. Transitory fits of depression and weeping. Fear of losing job and being unable to look after young wife. Had always had obsessional traits ; symptoms followed the dismissal from work of several other employees.

Course. Rapid improvement and recovery in hospital.

Personality. Syntone Circular. (Cautious Obsessive with cheerful features.)

No. 56. Married woman, aged 38, housewife, case of anxiety that her children might have an accident when she was at work and necessity to repeat the extinction of gas and electric many times. Onset after sister's death from T.B. Patient had nursed her but had been tormented by fear that she would hurt her if she touched her. Much depression and self-reproach (not delusional) after death. Ideas of suicide and feelings of unreality.

Course. Rapid improvement and recovery at convalescent home. (Patient had had previous attack from which she also had recovered.)

Personality. Syntone. Typical Cautious Obsessive (with a few anxious features).

No. 57. Unmarried man of 20, packer, case of impulses to attack his girl friend with a knife. Acute anxiety over what he might do to her—describes himself as an enemy to himself. First experienced these impulses when in a tube train returning from visiting his girl—preceded by attack of claustrophobia. Very depressed, crying, self-reproach about getting breakdown, feared he might commit suicide. Sleeps badly.

Course. Occasional attacks had preceded acute attack during previous 2 years. Acute attack cleared up after 4-5 months' rest at home and hypnotics.

Personality. Syntone. Probably Circular with Cautious Obsessive features predominating.

No. 58. Unmarried man of 18, clerk, case of feeling that devil might put thoughts into his mind to hurt people. Perpetual ruminations, e.g. how God put us on the earth ; compulsive thoughts to think pretty things ugly with subsequent feeling that they are so. Mother complained of his increasing apathy at work and unhappiness. Patient had feeling that he had to laugh at serious things and that sometimes "all my thoughts seem to go".

Course. Chronic with changing content since puberty, getting worse ; some improvement during 9 months' psychotherapy.

Personality. Schizoid (8 schizoid traits). Cold Solitary, with marked Obsessive features.

No. 59. Unmarried woman of 32, typist, case of complicated obsession about the number 5. Nothing must be done five times, therefore did everything six times, e.g. biting food. Unable to use words of five letters or touch things with five fingers. Great wealth of similar symptoms. Terror of committing suicide, much depression and crying. Acute feelings of unreality. Self-reproach about sexual incidents. Hypochondriacal. Evidence of incipient thought disorder—feeling that thoughts are put into her mind—are not her own, etc.

Course. First attack when 14, second at 23 and chronic on and off since. No improvement in hospital—getting worse.

Personality. Schizoid (8 schizoid traits, many very marked). Hysterical type (bright but variable, acts well, writes poetry, very contemptuous of mother, must be in limelight, etc.).

Of these 5 patients it will be seen that 3 are typical syntones of the Cautious Obsessive type who, whilst always suffering from slight obsessional traits, developed, in one case after an obvious precipitating event, a more acute illness with all the features of a mild depression or anxiety state. In all essentials these patients were identical with Nos. 37-42 who are included as Anxiety States, and with several patients included as Conversion Hysterias. The total personalities were identical, the symptoms of anxiety, depression with inability to work, fatigue, sleeplessness, etc., were all found in both groups, whilst in the majority there was a sudden onset and recovery after a few months. In all three obsessional syntones, symptoms, both obsessional and depressive, cleared up after a few months' convalescence and without any psychotherapy.

Now the symptomatology and course of illness in these three patients differed radically from those in the other two, Nos. 58 and 59. In these the obsessions, instead of being of a simple kind, were more bizarre and obscure, the illness was more chronic and improvement not considerable. Moreover, unlike the syntonic cases, evidence suggestive of incipient schizophrenia was present. The fact that in neither case did these symptoms of inappropriate mood and thought disorder progress is immaterial. In the syntonic cases they were not present at all, in the latter two they were unmistakable, though not serious.

But not only was the symptomatology and course of illness different in the two groups: they had totally different characters also. The syntones were all comparatively simple, friendly people. Two were happily

married, whilst a third had a long-standing attachment. Both the men had had steady jobs and were highly esteemed by their employers, whilst No. 56 was a conscientious and efficient housewife. Each had numerous neurotic traits, mostly of a depressive kind, and not one had more than two schizoid traits (0, 2 and 1 respectively). Nos. 58 and 59 provide a striking contrast. One was so shy that he had never had any sexual affair whatever, whilst the other had been the victim of various sexual incidents, each of which had upset her but come to nothing. The boy had had a regular job, but was in danger of losing it owing to apathy, whilst the woman quarrelled so with her employers that she had had fifteen jobs in ten years. Their neurotic traits were not confined to the depressive type. Each had eight schizoid traits, several being textbook examples.

No doubt every obsessional neurotic would not fall so neatly into one or other of the main categories, syntone and schizoid. The five presented here do so, however, and tentative conclusions are permissible. In the one category are three patients who have syntonic personalities and simple obsessions which develop in association with symptoms typical of mild depression and run a recurrent course ; in the other category two patients of markedly schizoid personality with complicated obsessions running a chronic course in association with symptoms suggestive of schizophrenia. One is tempted, therefore, to propose a division of the diagnostic group obsessional neurosis into two, the one allied to affective psychosis, the other to schizophrenia. There is much other evidence to support such a view. Hitherto there has been a tendency for psychiatrists to emphasize either the one relationship or the other ; " on the one hand are Bonhoeffer, Stocker, Reiss, and others, who insist on the close connection between the manic-depressive psychosis and obsessions ; on the other hand Bleuler, Schneider and Jahrreiss who point out transitions to schizophrenia " (Lewis). It is my belief that both

parties are right, but it may be wise to examine their findings before coming to a conclusion.

Obsessional Traits prior to an Affective Psychosis

Abraham was one of the first to draw attention to the prevalence of obsessional traits in patients who later developed a depressive psychosis. (This obsessional character was termed anal-erotic and is substantially similar to what I have called the Cautious Obsessive.) His observations have since been amply confirmed. Lewis, for instance, found obsessional traits, such as excessive cleanliness, tidiness, over-conscientiousness, repetitiveness, etc., in as many as one-third of his 61 melancholics whilst their incidence in the manic-depressives of my series[1] was so frequent, and their form so characteristic that they clearly indicated a special type of syntonic personality (the Cautious Obsessive). No less than 13 depressives belonged to it, whilst another 3 combined obsessional traits with hyperthymic in a circular personality. The association of an *obsessional character* with an affective psychosis can therefore be taken as established.

Obsessional Symptoms as part of an Affective Psychosis

In view of the frequency of obsessional traits in the prepsychotic personality of affectives, it is not surprising to find obsessional symptoms common in the psychosis itself. Numerous continental psychiatrists have written on this topic and Lewis has discussed the problem at length in his monograph on melancholia, so that it need not be laboured here. Their high incidence is now beyond doubt. Lewis, for instance, found that no less than 13 (20 per cent) of his melancholics showed compulsive features (washing manias, obscene thoughts, compulsive scratchings, etc.) during their illness.

By way of further illustration two depressive patients of my own series, in whom such symptoms were most marked and caused much distress, may be described.

[1] See Chapter V and Appendix B.

In one, No. 14, they took the form of obsessional washing in an attempt to disinfect himself from gonorrhœa which was in fact already cured. The other, No. 15, had obsessional impulses to hurt people. At one time there would be an impulse to kick other people, then this would go and an impulse to tear up photographic portraits would take its place or alternatively an impulse to hurt either himself or others with his hands. He had had several previous attacks, and it was interesting that on each occasion the obsessional impulses had developed in conjunction with depression and had receded with the depression after a period of some months. Both these patients had numerous obsessional character traits when well.

With so much unequivocal evidence it comes as a shock to find such eminent psychiatrists as Kretschmer remarking that " the average poverty of obsessional ideas in circulars is well known", Gillespie regarding the view that obsessions are common in melancholics as a recent and novel observation, and Ross apparently surprised to find a patient in whom obsessional symptoms recurred from time to time in attacks.

Obsessional Neurosis and Schizophrenia

Whilst admitting that " compulsive syndromes occur in the most varied dispositions and diseases, especially neurasthenia, manic-depressive insanity, and dementia praecox ", Bleuler comments that the typical cases, " which seem to have originated independently on a psychopathic basis . . . have so much about them that is schizophrenic in appearance and heredity, that one cannot suppress the suspicion that they are actual schizophrenics, whose symptomatology exhausts itself in compulsive syndrome ". The two cases outlined above, Nos. 58 and 59, provide support for this thesis. Unlike the first three who would be diagnosed anxiety state, neurasthenia or mild depression by many psychiatrists, these two patients were absolutely typical

obsessional neurotics, and they each showed not only numerous schizoid traits, but actual symptoms differing only in degree from those of a full-blown schizophrenia. It might consequently be expected that both these patients in time would develop schizophrenia, but curiously few of such patients apparently do. As Lewis aptly remarks, " the surprising thing here is not that some obsessionals become obviously schizophrenic but that only a few do so ". That a few do so, however, is indubitable. Not only are there many cases on record where schizophrenia has been preceded by or developed with obsessions,[1] but cases have been collected in which patients with long-standing obsessional neuroses have gradually developed the psychosis.

Perhaps the best examples of the latter are those presented by Gordon. In one, a girl ever since childhood had had great anxiety that she had done everything wrong. From puberty, in addition to a phobia of horses, she had continually to repeat her actions owing to doubts about them. When at 18 she became a kindergarten teacher, her doubts continued. Despite exhaustion and bad headaches, she was fairly successful at her work, until the obsession of having taught the children the opposite of what she should supervened. She became terrified of disgrace and later developed delusions and hallucinations in which she thought her pupils were reproaching her and their parents threatening her. Finally at the age of 24 she committed suicide by jumping from a window.

A still clearer case and one which has numerous striking similarities to my own patient, No. 59, deserves fuller quotation :

" M.L., female, 35 years old, school teacher, was

[1] Amongst the schizophrenes of my series at least three, Nos. 31, 32 and 33, had had obsessional traits such as excessive cleanliness and a compulsion to repeat both work and precautions. Jahrreiss has collected 16 patients in whom obsessions were important in the early stages of schizophrenia, whilst Brill mentions two typical cases of obsessional neurosis who became manifestly schizophrenic after two months and one year of analysis respectively.

always considered a refined person. In early childhood she developed a liking for painting, the father being an artist of note. Circumstances, however, prevented her from taking up art as a vocation. She attended primary and secondary school and finally a Normal school. She always had to work hard, because of an inherent difficulty of memorizing. As a child and as an adult she was unusually sensitive and apparently tender. She would cry when a friend would accidentally sustain the slightest injury. She would become easily attached to her schoolmates, but not for a long time. She would drop them and get other friends. Her attachment would be exceptionally strong for the time it lasted, but she would become promptly reconciled in giving up her friendly relationship. In all matters she was capricious, changeable. Extreme obstinacy was an outstanding feature. She was very pedantic in her relations to her people, and to strangers, in her daily work and in her personal appearance. She was not responsive to affection exhibited towards her by her parents and her brother.

" In spite of her apparent tenderness towards others she could not tolerate tender attention shown her by others. She was totally frigid. At times she showed cruelty towards the dog in the house, at others extreme affection. All these personality-characteristics were ignored by her parents, who were more interested in her school progress than in her emotional life. At the age of ten, for the first time, an obsessional phenomenon made its appearance ; she feared handling buttons. When accidentally her hands would come in contact with a button, she would be seized with terror, tremble and scream (*délire de toucher*). Her fear was based on the possibility of swallowing a button. This condition lasted a whole year and finally disappeared. In high school another obsessional phenomenon developed. The proximity of a girl friend who had made a complete recovery from influenza disturbed our patient considerably. She figured out that she herself might be attacked

by the same disease if she sat close to her friend. She feared to touch the friend's hand or clothes. This condition lasted four months. Her school work was satisfactory and she kept on making progress in spite of her obsession. In the Normal school she developed ideas of inferiority. Although her work was not below the average, nevertheless she kept on complaining that she would never be able to accomplish anything, that the principal of the school would eventually force her to leave. This inferiority idea spread to other features of her life. She would spend considerable time at her toilet, constantly fearing that she would never be able to look and act like others. She would talk on this subject wherever she found herself, at school and at home. Finally she graduated. Soon she succeeded in obtaining a position as a teacher in one of the schools. She was very attentive, prompt and conscientious. At the end of the first year of teaching, she began to show a desire for isolation. She would lock herself in her room and neither her father nor mother could induce her to partake of food during an entire afternoon or evening. She was heard several times talking to herself. She did not speak voluntarily, but when questioned, she would either not answer at all or give very brief replies. At times she would appear morose and then all at once her facial expression would show an interest in others, but the latter was shallow and very brief. Soon it was observed that she was accumulating buttons, she would buy them in large quantities, pick them up on the street or on the floor of her home and cut them off her father's clothes. Sometimes she spent hours in assorting them, moistening her index finger and touching each of them, and laughing aloud. When spoken to about it, she said that she loved buttons, that they spoke to her, and indeed she was often found addressing endearing terms to them. Her former schoolmates called on her frequently, but she would sometimes dismiss them and at other times she would have them sit close to her, saying that their proximity

would keep her from contracting diseases. More and more she would concentrate all her actions around her own personality and she withdrew progressively from all contact with her own people and friends. Hallucinatory images appeared to her more and more frequently. A complete and final schizophrenic state became established. It is now the twelfth year and there is no evidence of the slightest return to reality. Commitment to an institution was never entertained by the parents. She is confined to a suite of two rooms in charge of an attendant. The deterioration is becoming deeper and deeper."

This patient's half-brother also became schizophrenic.

Here is a schizoid personality who, having had severe obsessional symptoms in attacks since the age of 10 years, developed a characteristic schizophrenia when about 25 with progressive deterioration over the following 12 years. Like Nos. 58 and 59, and in contrast to the syntones, her obsessions were often "meaningless"; for instance, the terror of buttons and subsequent collection of them, like the obsessions over the number 5, are not readily comprehensible. The presence of "meaningless" obsessions in schizophrenic or schizoid patients and their absence in obsessive syntones is my evidence for regarding them as specifically schizoid and including them in the list of schizoid traits (cf. Appendix A.).

Gordon's patient is incidentally an excellent example of the hysterical type of schizoid[1] and with No. 59 described here serves to emphasize the fact that *by no means all patients suffering from obsessional symptoms are of an obsessional character make-up*. In this connection it may be mentioned that another patient of grossly hysterical personality, No. 62, also suffered from numerous obsessional symptoms. The frequency with which patients of obsessive character develop symptoms of conversion

[1] Schizoid traits which are specifically mentioned are No. 15, Ritual—bizarre obsessions; No. 18, Passionate Attachments—fickle friendships; No. 22, Mirror; No. 29, Unresponsive; No. 33, Cruel. It is more than likely there were many others.

hysteria has already been discussed. It now appears that hysterical personalities often develop severe obsessions. The association of obsessive character with obessional symptoms and hysterical character with hysterical symptoms, which is often held to be important, is thus seen to be by no means invariable. Indeed, it is probable that the symptoms which may be developed by each of these personality types are just as likely to be of the one kind as the other.

If No. 59 is a typical hysterical schizoid, No. 58 is a typical shut-in schizoid of obsessive personality. For a shut-in schizoid personality is just as good soil for the development of obsessive traits as is a cautious syntone, and in this case such traits as over-conscientiousness, fussiness over things being clean and tidy and a tendency to repeat precautions were pronounced.

Much evidence has now been presented to demonstrate the affinity of obsessional symptoms to the psychoses. It is true that every patient with obsessions does not develop a manifest psychosis, but it is also true that many patients with syphilis fail to develop G.P.I. and not every sailor becomes an admiral. The point is that transitions from the one to the other are so gradual that there are no legitimate grounds for drawing hard and fast lines anywhere. Moreover, the personalities who develop obsessions are characteristically those who are candidates for a psychosis.

But recognition of the intimate relation of obsessional symptoms and personalities to affective and schizophrenic psychoses is not enough. What has not been sufficiently appreciated is that *obsessional neurotics are not all of one kind*; that the patients who may develop an affective psychosis are of an altogether different make-up to those who might develop schizophrenia. By a careful examination of the personality it is possible in the majority of cases, I believe, to distinguish quite easily those who are related to the one psychosis and those who are related to the other. There may of course be

transitional syndromes, and the method of diagnosis proposed here is far from perfect, but none the less the two chief types stand out quite clearly from each other. What is true of obsessional neurotics is probably also true of obsessive personalities.

Just as was suggested in the cases of Anxiety States and Conversion Hysteria, therefore, two clinical types can be carved out of the heterogeneous group of obsessional neurosis—the syntonic obsessional and the schizoid obsessional. They can be distinguished in a number of ways. First, and I believe most important, is their total personality make-up. Secondly, there is the presence or absence of transitory schizophrenic symptoms such as thought disorder and inappropriate moods. Thirdly is the course of the illness, in one type developing as attacks in association with marked symptoms of anxiety and depression, in the other running a more chronic course with less affect and occasional exacerbations. Fourthly, and perhaps least important, is the difference in content. Mapother believes that the obsessions associated with the affective psychoses are mainly of the readily intelligible type, which is also my opinion, whereas those in the typical obsessional neurosis, which runs a chronic course, are apt to be bizarre and curious. It is these which usually have other schizoid features, and which occasionally develop schizophrenia.

Now if these two sorts of obsessional neurosis are distinguishable it may be asked, What are the relations subsisting between them? Are they more intimately related to each other than either is with, say, conversion hysteria, or are they different conditions each more closely allied to other syndromes than to the other? It is my belief that, though having symptoms in common, the conditions are radically different, as different in fact as a classical recurrent case of manic-depressive psychosis is from dementia praecox. The fact that there are symptoms in common is partly accidental, no more significant than that any infection gives rise to a fever,

or that anxiety may appear in any neurosis or psychosis. The rightness or wrongness of this hypothesis is vital both for clinical prognosis and also for psychopathology. For if it is correct it is futile to expect to find vital psychopathological differences between obsessional neurosis and the psychoses. The differences which matter will be those between the two obsessional illnesses which at present go by the same name—differences which will be similar to, and must be related to, the differences between the affective and the schizophrenic psychoses themselves.

E. Hysterical Personality

The term " hysterical personality " was originally used to describe the type of patient in whom hysterical somatic symptoms were believed commonly to arise. The section on Conversion Hysteria will have demonstrated that many patients in whom such symptoms occur are on the contrary quiet and hate prominence, thus being as poles apart from the hysteriac. Bleuler recognizes this distinction, when he says " notwithstanding all transitions *Two Groups of Hysteria* can be distinguished quite sharply ". In one the most important element is the *disposition*, and the personal need for self-expression ; this is found most commonly in women. In the other the *affective event* which precipitates a certain symptom is the important factor. It was seen particularly in the war neuroses, and is the type which has already been discussed under Conversion Hysteria. In this section " hysterical disposition " will be examined.

To some extent it has already been done. Amongst the types of schizoid, there has been recognized one which is pronouncedly hysterical in the sense that it is capricious, precious, enjoys showing off, hates lack of attention and so on. It will not be surprising therefore that the three patients which I am including in this group all have numerous schizoid traits.

No. 60. Unmarried girl of 19, shop assistant, case of fits of depression and crying lasting 2-3 days. Loses

appetite. Sometimes becomes " hysterical ", screams ; terrified of dying. Erythrophobia, transient " conversion " symptoms, suicidal impulses. Feeling that thoughts are outside her head, are not her own, etc., during attacks. Gradual onset during adolescence. Becoming worse.

Course. Recovery after 4 years' psycho-analysis.

Personality. Probably Schizoid (6 schizoid traits). Hysterical type.

No. 61. Married woman of 23, actress, case of fits of depression and crying, obsessional impulses to suicide with occasional partial attempts. Inability to work despite great ambitions. Creates a scene if not in limelight. Chronic, but worse after first child.

Course. Partial recovery during 4 years' psycho-analysis.

Personality. Schizoid (9 schizoid traits—many very marked). Typical Hysterical type.

No. 62. Unmarried woman of 29, dancer, case of great anxiety, terror of going mad, much depression and crying, constant suicidal ideas and several partial attempts (e.g. cutting wrists), obsessional thoughts about male genitals—sees them everywhere. Furious tempers, hit mother over head with chair, threatened to kill her. Very histrionic. Depersonalization. Feels doctors are hypnotizing her and attributes obscene thoughts to others. " Something else thinks the bad thoughts—I don't think them." Onset $3\frac{1}{2}$ years previously after being left by lover.

Course. Chronic and variable. Schizophrenic features have not developed further during past 2 years.

Personality. Schizoid (10 schizoid traits—many very marked). Typical Hysterical type.

Now these patients are extremely reminiscent of several other patients already described. Some of the symptoms of No. 62, the most obviously hysterical of the three, are suggestive of an actual schizophrenic illness and bring to mind the patient described by Strecker and

Willey (quoted in Chapter VI as an Hysterical Schizoid). Both No. 61 and 62, moreover, had serious obsessional symptoms which recall Gordon's patient (quoted in the section on Obsessional Neurosis) and also No. 59 of this series, who, because of the overwhelming importance of the obsessions, was grouped with the obsessional neurotics. Despite individual differences there seem to be no adequate grounds for regarding these patients as suffering from different illnesses. Indeed their separation into three categories, although common practice, appears highly artificial and misleading. The personalities of all of them are identical, down to the point that Nos. 59, 61 and 62 were all happiest when acting. In all of them (except possibly Strecker and Willey's patient) hysterical *and* obsessional symptoms are important and it is absurd to emphasize either the one or the other in the interests of an imposed classification. In fact they form a well-defined personality group, that of the Hysterical Schizoid, whose *symptoms* may be phobic, obsessional, hysterical, manic, depressive or schizophrenic or any combination of these.[1] The points of unity are (1) the type of personality, (2) the bizarre nature of many of the symptoms, (3) the chronic course and (4) the tendency to deteriorate into an actual schizophrenia. They are very resistant to treatment and are probably the type of patient whom Adolf Meyer had in mind when he wrote that many neuroses are more far-reaching in their disturbance than some psychoses. For even when their symptoms fall short of psychotic such patients are infinitely more difficult to treat and have a far worse ultimate prognosis than a syntone suffering from psychosis. The syntone will probably recover, return to normal life and may never have another

[1] Kahn agrees with the observations, but seems unable to accept the obvious conclusion that it is purely artificial to divide the patients into separate groups. ". . . *hysterics* like many other psychopaths, sometimes have compulsive manifestations, so it may happen that in an individual case it is impossible to decide with certainty whether we are dealing with an anancastic with hysterical traits (need for prestige) or with an hysterical psychopath with compulsive phenomena."

psychotic attack, whereas the hysterical schizoid pursues her stormy existence, finding everyone she meets as impossible as they find her, tortured by her thoughts and emotions, furiously but vainly seeking some haven of peace. At any moment she may develop a malignant psychosis. It often takes an excited form,[1] but there may be no recovery.

It would be a mistake, however, to conclude that all patients to whose personalities the term 'hysterical' can be applied are schizoid. Amongst the syntones already described the melancholic No. 18, the anxiety state No. 41, and the conversion hysterics Nos. 48 and 49 all had a tendency to be histrionic, or to be dependent upon attention and sympathy. Of Lewis's patients at least 10 were hysterical in this sense (e.g. " D.N.—was melodramatic in the expression of her sufferings, and intimate and appealing in her manner ; her letters read like novelettes ").

Another syntone who has been described as hysterical is Sally Beauchamp—Morton Prince's case of double personality. This person has been discussed at length in Chapter V and the conclusion reached that she was an Anxiety Depressive with an alternating manic character. This conclusion may cause some surprise since, it will be said, she is so obviously a *split* personality, therefore schizoid. But the point is that whichever personality was uppermost at a given moment was self-consistent, thoughts and feelings are either wholly euphoric or wholly depressive. Some confirmation is brought to this view, moreover, by the discovery of dream-states in No. 52 of this series who was an extremely typical syntone. Splits of this kind do not necessarily point to a schizoid factor.

Once again then it is suggested that one term has been

[1] ". . . manic attacks in people who at the same time have a hysteroid disposition run a course with vivid visual hallucinations which remind one of hysteria, but what is otherwise so designated and especially what was so called daily are schizophrenics according to my experience." (BLEULER.)

used to describe personalities whose prognosis is radically different. On the one hand is the important group of hysterical schizoids who it has been noted may suffer from a great variety of symptoms including severe obsessions, on the other the less distinct group of hysterical syntones, who are usually far less exaggerated and eccentric characters and who approximate to the category of Anxious Depressives. It is my belief that in the majority of cases a close study of the personalities and symptoms will indicate to which category any particular patient belongs.

F. Psychopathic Personality (Sociopath)

The term 'psychopathic personality' has been used very diversely by psychiatrists. Apart from minor variations, there are two chief uses which ought never to be confused.

(1) Schneider and Kahn use it to describe almost any unstable or unbalanced personality. As such it is almost equivalent to the term 'neurotic' and is applicable to each and all of the prepsychotic types described in Chapters V and VI.

(2) Others, for instance Gillespie and Partridge, have confined its use to the description of a special type of personality which is characterized by an apparent lack of moral and social sense, an inability to learn from experience and a capacity for being a nuisance to others.

Since the latter is the meaning attached to the term here it may be an advantage to quote Gillespie's definition. "Persons suffering from an early age from mental instability, not amounting to certifiable mental disease or deficiency, but characterized by emotional dullness or instability, together with a lack of perseverance, persistent failure to profit by experience and persistent lack of ordinary prudence, and resulting in occupational instability, marital instability, economic insufficiency, extravagance, sexual excesses, alcoholism, drug addiction or delinquency."

For many reasons it seems doubtful whether the term should continue to be employed at all. Its diverse use and its vague and very general meaning are against its application to a special group of patients, whilst the atmosphere of moral condemnation surrounding it is most undesirable. As an alternative Partridge has proposed ' sociopath ', on the grounds that it emphasizes the antisocial form of the illness.

Only three patients of this series are included under this heading, but the obsessional No. 59 and the hysteric No. 62 both fall well within Gillespie's definition.

No. 63. Unmarried woman of 20, nursemaid, unable to keep job, employers complain of stealing clothes, etc., untruthfulness, insolence. Runs up bills, tells grandiose stories about herself and position. Does well under supervision, but always thinks her work better than it is. Genuinely penitent and anxious to go straight. An illegitimate child whose parents subsequently married. Numerous foster placings, etc. Child always bone of contention between parents who thrashed her. Complaints of stealing since 8 or 9 years old.

Course. Much improved during 2 years' psychotherapy. No further stealing; insolence much diminished.

Personality. Syntone. Quarrelsome Hyperthymic.

No. 64. Unmarried woman of 25, living on friend's money, referred for stealing clothes, letters, etc., giving worthless cheques. Denies any regret, except for getting caught, would do it again, etc. Complains bitterly of injustices. Masculine type of Lesbian. Delinquencies followed extravagance and temporary lack of money.

Course. Variable. Un-coöperative at first, but later considerable improvement during prolonged psychotherapy.

Personality. Schizoid (11 schizoid traits). Shameless Antisocial.

No. 65. Unmarried man of 25, varied work, actively homosexual, pesters men, referred by Court. Always

changing work—clerk, reading for holy orders, stage, etc. Untruthful and unscrupulous when worried, opens father's letters, gets money from father by false pretences, hysterical outbursts if thwarted. Likes to give impression of wealth and position. Very plausible. Always having good intentions to go straight, but fails to implement them. Always the same since childhood.

Course. Variable. Co-operated for some months in psycho-analysis, but later un-coöperative and failed to attend.

Personality. Schizoid (15 schizoid traits). Shameless Antisocial with Hysterical Features.

Now these three patients, although having much in common, especially repeated delinquencies, probably belonged to different categories. No. 63 had only two schizoid traits neither of which seemed very important. Moreover, unlike the other two, there was a certain solidity of character, an acute consciousness of having done wrong and a real effort to go straight. It would be absurd to suggest that this girl was without moral sense. Nos. 64 and 65 were very different. Not only had they very numerous schizoid traits but they were always wholly unreliable and did seem to lack moral sense, inasmuch as they denied any regret for being the cause of much suffering to others. These differences have one important practical result. Whereas No. 63 benefited from psychotherapy and gave hopes of permanent improvement, No. 65, though given longer and more intensive treatment, constantly relapsed whenever treatment was interrupted. No. 64 refused to undertake serious treatment for a long time, although later her attitude changed. Using the criteria proposed in Chapter IV, No. 63 is a syntone and Nos. 64 and 65 are schizoids.

Kretschmer regards "shamelessness" as specifically schizoid and these two patients, who each have numerous other schizoid traits, do seem to confirm his view. Actually both of them had a most powerful feeling of

guilt over their delinquencies, but they did not admit it to themselves nor was it allowed to prevent their repeating the offences.

Another trait which I was at one time inclined to think might be specifically schizoid was persistent untruthfulness and pseudologia phantastica. Various considerations, however, make it seem likely that it is also shown by hyperthymic personalities, such as No. 63. Its more extravagant and bizarre forms like the 'meaningless', as opposed to comprehensible, obsessions are probably schizoid.

Whatever the truth about individual traits, Schneider and Kahn regard the whole attempt to relate types of psychopathic personality to the psychoses as quite unjustifiable, since they deny that there is any evidence for such a procedure. Schneider, for instance, declares that in his clinical experience he has been unable to find any transitional forms between psychopathic personalities and functional psychoses. From this he draws the conclusion that psychopathic personalities never become psychotic and are therefore quite unrelated to the psychoses. He is of course speaking of unstable characters as a whole and not only of sociopaths, so that all the conclusions reached in this book he would call in question, and not merely those of this section. It seems to me that the evidence is against him throughout, although that regarding sociopaths is not as conclusive as it is regarding obsessional neurotics. But plenty of cases are on record where a psychosis has developed in a sociopathic personality. Kretschmer's patient David Katt (quoted in full in Chapter VI) is a case in point and proves that such people sometimes become schizophrenic. The similarity in personality and behaviour of this patient to Nos. 64 and 65 is extraordinary and strengthens my opinion that both of them are schizoid. Furthermore, Nos. 59 and 62 of this series are transitional types. Both are sociopaths and both show symptoms suggestive of a schizophrenic process, such as thought

disorder and feeling of being controlled. Sullivan has stated that "A remarkable number of them become schizophrenic. Psychopathic personality is a common ground for schizophrenic development" (he uses the term in its narrow sense of sociopathic), whilst Amsden notes the similarities which certain pre-schizophrenic personalities have shown to the sociopath. Whatever Schneider's experience, then, others' has been different.

But the issue is really one for painstaking and accurate research, not for opinions and single cases. It is consequently most unfortunate that, so far as I know, none is available. The work of Partridge, who has published numerous studies, is marred by diagnoses which seem seriously inaccurate. For instance, in his study of 100 cases of psychotics who had previously shown a sociopathic personality 34 are said to be manic-depressive, 18 schizophrenic and 7 mixed. Several of the 34 manic-depressives, however, would certainly be called schizophrenes by most psychiatrists, so that any conclusions drawn from the figures would be grossly misleading. An unpublished investigation of Healy, Clarke and Kasanin in 1930 is also disappointing, since, although 1 out of 106 cases of psychopathic personality became psychotic, no indication is given either of its mode of onset or the type of psychosis.

Kretschmer's case, the opinions of Sullivan and Amsden, the appearance of transitional types and the high incidence of specifically schizoid traits in some sociopaths are my reasons then for controverting Schneider and Kahn and concluding that a large though unknown proportion of sociopaths are schizoid and potentially schizophrenic. It would be rash, however, to assume that all sociopaths are schizoid. For instance, there are no grounds for so regarding No. 63, although she comes within Gillespie's definition of psychopathic. Inasmuch as she suffered from emotional instability from an early age and showed failure to profit by experience, both of which resulted

in occupational instability, extravagance and delinquency, she was like the other two patients. Yet her genuine perseverance and absence of traits such as hysterical scenes, homosexuality, passionate affairs, cruelty, indolence and shamelessness made her appear quite normal in comparison, and far easier to deal with. The differences therefore are quite as important as the similarities, and point to her being syntonic and not schizoid.

Actually she bore all the hall-marks of the Quarrelsome Hyperthymic. She was very sensitive and apt to be impertinent and quarrelsome, boastful about herself and extravagant far beyond her means. It seems likely that most of the sociopaths who are not schizoid are of this type. Some are feckless, extravagant, and easily tempted to alcoholism and prostitution, others difficult, suspicious, quarrelsome and perhaps litigious. Quite a variety of antisocial behaviour can be expressed by hyperthymics and is consistent with a syntonic temperament.

Once again and at the risk of being wearyingly monotonous we can conclude that people of so-called sociopathic personality can be divided into two groups, those having an affinity to the affective psychosis and those related to schizophrenia. The discussion of each and every category of neurosis and unstable personality has revealed the same state of affairs, namely the common practice of diagnosing patients with the same illness in different categories and with different illnesses in the same category. Psychopathic personality is no exception. Of the three patients examined one is hyperthymic and allied to patients such as the depressive No. 19 and the woman with hysterical vomiting No. 48, whilst the other two are schizoid and obviously related to hysterics like No. 62 and obsessionals like No. 59. Once again it is believed that it is of far more importance to know whether a patient is schizoid or syntone than to argue whether he is hysterical, obsessional or psychopathic.

The latter type of diagnosis is largely concerned with particular symptoms and usually fails completely to take the whole personality into account. A diagnosis based on total personality and temperament is often easier to make and provides a far more reliable guide to prognosis and treatment. Indeed, it is maintained here that without it prognosis either relies solely on an individual psychiatrist's experience or is pure guesswork.

SUMMARY

It may be convenient to summarize the conclusions:

(1) The distinction drawn between Anxiety Neurosis and Anxiety Hysteria is believed to be false.

(2) Anxiety States and Neurasthenias are believed usually to be mild forms of the Affective Psychosis. At other times they are allied to Schizophrenia.

(3) Both Conversion Symptoms and Obsessional Symptoms may appear in either syntone or schizoid personality. For a proper understanding and prognosis of the case, it is believed that the type of personality, rather than the symptom, is of chief importance.

(4) Hysterical and Psychopathic Personalities are usually schizoid, but may also be syntonic. This distinction is regarded as of more importance than any particular symptom which either may show.

(5) Sexual disorders were discussed in Chapter IV. Whereas impotence was believed to be common in both syntonic and schizoid personality, manifest homosexuality and fetichism were believed to be far more frequently functions of a schizoid personality.

(6) In all cases of sexual, neurotic or personality disorders, it is believed that it is of far more value to diagnose to which main type and sub-type of personality the patient belongs than to try to settle the diagnosis between the traditional groups—anxiety state, hysteria, obsessional neurosis, psychopathic personality, etc.

Chapter VIII

THE BASIS OF PSYCHIATRIC DIAGNOSIS

If the observations which I have made and the conclusions which I have drawn from them are correct, it follows that the present classifications of the psychoneuroses and character types, apart from Kretschmer's, are quite inadequate. Current classifications depend almost entirely on the most striking trait or symptom—introvert or extravert, obsession or phobia—and ignore subordinate symptoms and above all the total personality structure. Throughout it has been maintained that introversion or extraversion in a syntone are quite different to what they are in a schizoid, that the presence of an obsession or a phobia is profoundly unimportant compared to the presence or absence of specific schizoid traits.

The time factor is another element which is frequently neglected in current classifications. Instances have been quoted of patients who, though at one time typical cases of conversion hysteria or obsessional neurosis, at a later period were equally typical examples of a psychotic depression or a schizophrenia. The existence of such transitions is one of many arguments against a rigid separation of the psycho-neuroses from the psychoses.

Of recent years these transitions have been studied more carefully. At least one classification, the psychoanalytic, emphasizes similarities between "normal" character types and psychoses and provides a theoretical explanation for transitions. The onset of a mental illness is conceived of as a process of regression from later fixations to earlier and earlier ones. With some slight modification by Glover, the neuroses and psychoses are

arranged in a linear order with schizophrenia as the most regressive, and melancholia as more regressive than obsessional neurosis. This implies that it is largely a matter of the degree of regression as to whether a given obsessional becomes melancholic or schizophrenic.

Now it seems to me that any theory which suggests that all the neuroses and psychoses are simply different degrees of each other is false. Schizoid and syntonic individuals, be they healthy, neurotic or psychotic, are fundamentally different from each other. In each there is much evidence of primitive impulses and anxieties (in the schizoid it is usually more obvious) but the psychic mechanisms employed to deal with them are profoundly different. A healthy schizoid uses mechanisms, such as divorcing feeling from ideation, which are not found even in psychotic syntones.

Although differences of degree undoubtedly exist, my contention is that qualitative differences exist also. But whereas the qualitative difference is often thought to lie between the neurotic on the one hand and the psychotic on the other, the qualitative difference which I recognize is that between a syntone, whether normal, neurotic or psychotic, and a schizoid, normal, neurotic or psychotic. It is this latter question, normal, neurotic or psychotic, which in my view is the matter of degree.

It is therefore contended here that it is as erroneous to regard the differences subsisting between these clinical conditions as matters only of degree as it is to separate them off into little boxes as Ross attempts to do. These issues were mentioned in Chapter I but their importance justifies a fuller discussion here. We will deal first with the Scylla of separation and then consider the Charybdis of a theory of *Einheitspsychose*.

The schools which hold that there is an abyss separating psycho-neurosis from psychosis or one psycho-neurosis from another fail wholly to take the time element into consideration. So long as this was ignored mania and melancholia were regarded as different diseases and

classified separately. The same blindness to the time factor has led certain anxiety and obsessional states to be classified separately from affective depression. These clinicians simply ignore the fact that either before or after a psychosis a patient can show all the signs and symptoms typical of a psycho-neurosis. Few people remain the same throughout their lives whilst many show at successive periods an unstable personality, symptoms of psycho-neurosis and of psychosis. It is therefore absurd to conceive of a patient in terms of any one condition. He must be thought of as *an individual of certain potentialities, a unity of which the particular traits and symptoms shown at any one moment are but fleeting expressions.* He must be thought of in the same way as we think of a butterfly as having a history, the phases of which may be very dissimilar but yet, because the life cycle runs a characteristic course, as having a specific individuality.

The opposite school seems to be so impressed by the tendency for caterpillars to turn into chrysalises and later into butterflies, that it assumes that *any* caterpillar can turn into *any* butterfly, that any personality can develop any psychosis. This is the antithesis of Ross and to my belief equally wrong. This point of view is equivalent to a pathologist becoming so excited over the discovery that rheumatic fever and syphilis can both cause endocarditis and inflammation of the central nervous system that he concludes that they are therefore the same disease and that a child suffering from rheumatic mitral disease is in danger of developing G.P.I.

A mild anxiety state in a syntonic personality may have something in common with certain early forms of schizophrenia. There may be anxiety, depression and obsessions in both but this is no reason to suppose them any more closely related than rheumatic fever is to syphilis, or the purple emperor caterpillar to the swallow-tail caterpillar.

The theory which my observations have led me to and which has been advanced in this thesis follows Kretschmer,

who has propounded the view that most individuals can be recognized as belonging to one of two groups, the cyclothymic and the schizothymic (syntonic and schizoid). The division between the two is believed to be fundamental, in spite of the fact that mixed states may occur. It has the great advantage of deriving from a distinction which has proved of the utmost value in clinical psychiatry, that between schizophrenia and the affective psychosis, and resting upon much other well-attested evidence regarding prepsychotic personality. The examination of 36 psychotic patients has provided fresh evidence, which, though meagre, confirms the belief that persons liable to an affective psychosis differ in personality make-up from those who later become schizophrenic.

These observations together with those of others have provided the basis for an attempt at tabulating this difference in such a way that a means of diagnosing to which type both healthy and neurotic personalities belong may be available. Although by no means infallible, a certain measure of reliability is claimed for the method. When applied to 29 psycho-neurotic patients, it revealed that each of the classical groups of neurosis was composed of both syntones and schizoids. It was therefore impossible to say that obsessional neurosis is allied to the affective psychosis whilst hysteriacs were predominantly schizoid since the line of demarcation cut right across such groupings. Some obsessionals were schizoid, others syntone and the same with the other neurotics. In the majority of cases it was quite clear to which group a personality belonged.

For this investigation to be complete it would be necessary to examine large numbers of healthy personalities in addition to psychotics and psycho-neurotics, to see whether they too can be divided into syntone and schizoid, as Kretschmer contends. This has not been done but from casual observations of a number of my acquaintances it has appeared to me that the majority of them do in fact approximate quite closely to one or

other of the types described in Chapters V and VI. It must be remembered, however, that the illustrations given there were of highly unstable personalities. Their normal counterparts are far less pronounced and show few of the high tones characteristic of the prepsychotic. Thus the normal counterpart of the Cautious Obsessive is far less cautious and far less obsessive ; the normal counterpart of the hysterical schizoid is less extreme in her moods, less dramatic, less trouble both to herself and to others. Yet the relationship is often obvious, the differences being merely of degree.[1]

But in spite of the majority of normal people approximating more or less closely to the pathological types, there is a minority who are puzzling. The question whether these are simply masked forms of the recognized types or belong to some different type or types hitherto undescribed is a matter for further research. For it is to be emphasized with Kretschmer that the theory of syntonic and schizoid character types in no way precludes the possibility of any number of similar and equally important types being discovered. For instance, genetic evidence suggests that there may be an epileptic type.

In brief, then, Kretschmer's fundamental theory of cyclothymes and schizothymes is accepted as corresponding to the facts. Mixtures of course occur, but although there are various studies of the mixed psychoses, there is little available relating to mixed personality types. It is therefore impossible to discuss them in detail. Some comment, however, is desirable upon Bleuler's theory, mentioned in Chapter II, that, except in extreme cases, all personalities are mixtures. " Except in the rare extreme cases we now no longer have to ask, is it manic-depressive or schizophrenic ? but *to what extent*

[1] It is probable, however, that the criteria proposed here for distinguishing the different types become less and less reliable and informative as the person becomes more stable for the reason that the majority of the traits listed denote abnormality. For instance, many healthy schizoids would show only a low score on the schizoid schedule. If it is to be adapted to test the normal, therefore, a much greater sensitivity in the scale will be required.

manic-depressive and to what extent schizophrenic?" It may have been observed that throughout this work the question has not been posed in this way and an explanation is necessary. My reason is simply that I do not agree with Bleuler that mixed states are the rule and pure states the exception. Certain of the affectives described here, it is true, showed some schizoid trends. A case could be made out for the existence of a schizoid tendency in Nos. 1, 4, 10, 16, 18, 20, 22 and 23. But even with this very liberal interpretation they remain a minority. The remainder seemed to me as purely syntonic in personality as they were affective in illness. The probability is that Bleuler's view of mixture developed as a result of taking the terms syntone and schizoid too literally. Of course, if we put down all splitting of personality, all repression, all active unconscious impulses as well as splits between idea and feeling to a schizoid component, then all men are schizoid to some degree. But this conclusion is absurd and makes nonsense of the classification. The truth is that whatever else it may be, the psychic mechanism which distinguishes the schizoid from the syntone is not simply a splitting of the mind. It is my belief that it is *a particular form of splitting which is distinctive.* The syntone commonly represses both feeling and idea along with impulse. The schizoid, on the other hand, not only makes this split, but also divorces feelings from ideas as is seen in the classical obsessionals as well as in schizophrenes. It is in the psychic mechanisms available for dealing with the psychic pain arising from anxiety and guilt that I expect to find the critical differences underlying the types under discussion. It is possible also that differences will be found in their respective endowments of impulse, for the schizoids appear to have a greater wealth of perverse and infantile sexual impulse and phantasy than syntones.

But it is not my intention to enter further into the psychopathology underlying our types. To investigate it is naturally of great importance but accurate description

and classification necessarily come first and, though psychiatry has long been engaged in this task, it is still a long way from completing it. It may properly be asked, however, how these types are conceived as originating—are they hereditary or do they arise from early infantile experiences? At present this question is impossible to answer with any certainty but various considerations make it probable that they are hereditary.

Research into the inheritance of mental disease is as yet only in its infancy but two principles seem already established. First, that a tendency to mental illness is inherited, and secondly that the major functional psychoses breed true.

As upon all problems of human genetics, much prejudice has confused the issues; the old antithesis of nature and nurture dies hard. With the smoke clearing from the battlefield, however, it now appears indubitable that some people are born more liable than others to mental instability. The incidence of psychosis shows that certain families are far more liable to insanity than would be expected on chance or even allowing for the effect upon children of unstable parents. But of course this tendency may never result in actual mental illness. The environment may be so congenial that a perfectly stable personality results. The tendency, however, is there and moderately bad surroundings (probably especially in early life) will bring it out. On the other hand it seems probable that there are other people in whom the tendency is minimal. But this does not necessarily mean that an insanity is out of the question. A very prolonged deleterious environment might be effective.

But not only is there an inherited tendency towards insanity. There is an inherited tendency towards a specific insanity. In one family a large number of affective psychoses will appear, in another schizophrenia will be common. There seems no tendency whatever to produce either or both indiscriminately, indeed there is some evidence which suggests that the association is

negative, that a manic-depressive family is *less* likely to produce schizophrenias than the average.[1] All the evidence points against a " neuropathic taint ", which may give rise to any variety of mental illness, being inherited, and points instead towards the inheritance of specific reaction tendencies.

" The evidence for the genotypical distinctness of the various forms, affective psychosis, schizophrenia, epilepsy, etc., is now considerable. Unless we are prepared to ignore this evidence and to say that there is only one unitary psychosis, with the most diverse forms, we must accept the principle of the separate transmission of the main types of reaction from generation to generation. To go on talking without further qualification about ' bad family history ', ' a hereditary neuropathic taint ' is to recall outworn beliefs." (Lewis.)

The genetic evidence regarding the psychoses therefore strongly supports the general theory presented here, namely that there is a fundamental difference between schizoids and syntones. Moreover, what little genetic work there is on the neuroses fails to contradict it. There is no evidence for instance that anxiety states, hysteria and obsessional neurosis breed true. McInnes has shown that neurosis and psychosis are rather commoner amongst the relatives of neurotics than amongst a control group, but evidence of specificity is entirely lacking.

Further evidence in support of the genetic origin of the main types is contributed by Kretschmer. An investigation into the personalities of the relatives of psychotics revealed that the relations of schizophrenes are commonly schizoid in make-up, whilst those of affectives are usually syntonic. Again his examination of physique in relation to mental make-up yielded material which is most easily explained genetically. His own and subsequent researches have shown that there is a

[1] Slater's work confirms the true breeding of manic-depressive states, but suggests that schizophrenics are not less, but rather more common in manic-depressive families than in normal ones.

correlation between thick-set (pycnic) physique and affective psychosis, lean and angular (asthenic) physique and schizophrenia. It is possible of course that the physique is determined by the developing mental make-up but it seems more probable that it is inherited.

The genetic evidence, then, points to every person being born into one of the main character-types. To paraphrase Gilbert one might say :

> " Every boy and every girl
> Who's born into this world alive
> Is either a little schizothyme
> Or else a little affective."

Now if we accept the genetic evidence we cannot retain the view that early infantile experience determines the *specificity* of psychosis. The psycho-analytic school has postulated earlier fixation points for schizophrenics than for affective psychosis and has sometimes suggested that infantile experience is responsible for the fixation points. Actually it seems to me very doubtful whether earlier infantile material does appear in the one psychosis more than in the other, but even assuming it does, it now seems probable that the tendency to specific fixations is the result rather of inheritance than of experience.

But the main character-type is only one of many factors deciding a man's destiny. A second factor is the *degree of stability or instability* which he inherits. Some babies even in the best psychological surroundings are difficult and easily upset, others are placid and genial in the worst conditions ; whilst the incidence of mental disease strongly suggests that in some families, even after allowing for the deleterious effects of unstable parents, children are born with a serious propensity to frank insanity. It seems therefore that babies are born with a greater or less vulnerability to the slings and arrows of fortune.

But even if the main character-type and a tendency to a certain degree of stability or instability are the result

of genetic factors, the final outcome is greatly influenced by a third and non-genetic factor. *Early surroundings* are probably of great importance in all children in determining the extent to which stability or instability actually materialize in the growing personality. Strict unfeeling parents, selfish hysterical mothers or self-absorbed brutal fathers, sternly moral or utterly immoral authority, all these will increase instability, though the form it takes may vary. Again the sudden loss of parent or sibling, and perhaps a resulting succession of foster-homes may be disastrous for developing personality (Bowlby, 79).

It is the interplay of forces such as these with the inherited degree of instability which determines which of endless fates will fall to the lot of any particular syntone or schizoid. If born a syntone he may grow up stable and happy, practical and energetic with loyal friends and a prosperous career. Or, if circumstances have been bad, he may be excitable and distractable, giving up a good wife for a gold-digger and ruining a promising business through unrealistic optimism. Again he may be a little nervous, cautious and given to fussing over money or health. Indeed he may develop any one of the personalities described in Chapter V in which event his future is precarious, neurotic symptoms probable and a psychosis possible. Which of these careers results—and there is a world of difference between them—will depend, it seems likely, as much on early environment as on heredity. Beyond this generalization we cannot go at present.

The theory is advanced then that whilst heredity is responsible for the main type to which a given individual belongs, whether he is syntonic or schizoid, infantile and childhood experience are fully as important as heredity in determining whether that individual develops a stable personality or becomes unstable and so liable to develop one of those particular forms of mental illness which his inheritance has made available for him.

Having outlined the basis upon which a useful psychiatric classification can be constructed and the nature of the determinants of any given individual's character, we can proceed to the examination of their implications in clinical practice. For a proper diagnosis and prognosis to be made on a case of functional mental disease four general questions will need to be considered :

A. His genetic type.
B. His personality sub-type.
C. His degree of stability.
D. His present state and how it developed.

Only when these questions have been answered is the psychiatrist in a position to give a reliable prognosis or the psychopathologist able to describe the psychical mechanisms specific to the illness.

The more pathological the character, the easier the first two tasks will be. For normals, however, it may be difficult to decide them because a balanced character shows few of the hall-marks of any of the sub-types. The estimate of stability is always difficult and without much further knowledge, especially follow-ups of particular characters over many years, necessarily speculative. Broadly speaking, however, the more of the traits used in this research which a person shows, the more unstable he may be supposed to be. Few of these traits are not indicative of emotional abnormality, and if these few are omitted from consideration, the number of pluses on a person's schedule is a rough guide to his instability. It should be remembered, however, that certain personalities who have only a few of these traits are liable to psychotic breakdown.

The estimation of these three characteristics, genetic type, personality sub-type and degree of instability, it should be emphasized, takes account of the patient's whole life-history and regards his present condition as but a fleeting aspect of his total life. The following is a convenient schedule.

A. Genetic Type

(*a*) Syntonic.
(*b*) Schizoid.
(*c*) ? Epileptic or any others.

B. Personality Sub-type

(*a*) 1. Cautious Obsessive.
2. Anxious Depressive.
3. Cheerful Hyperthymic.
4. Quarrelsome Hyperthymic.
5. Circular.

(*b*) 1. 'Normal.'
2. Saint-like.
3. Cold Solitary.
4. Apathetic Asocial.
5. Hysterical.
6. Shameless Antisocial.

C. Degree of Instability

Very Stable.
Fairly Stable.
Fairly Unstable.
Very Unstable.

In the course of their lives the majority of personalities will not change appreciably in any of these respects. The genetic type is probably the most invariable, presumably never changing. The personality sub-type as we have seen does alter occasionally, though this is not common and when it does happen is usually spontaneous. The degree of stability or instability on the other hand can only be altered purposively. It is this which the more thorough forms of psychotherapy, especially psycho-analysis, aim at. Indeed, it is on its success in stabilizing personalities that prolonged analysis, as opposed to a short analysis to remove symptoms, stands

or falls. Most recent experience suggests that it will stand.

Despite their possible alterations, in comparison with the present state of a patient these characteristics are comparatively fixed. Possible present states are numerous and it is by no means uncommon for one patient to pass through all the four principal phases, sometimes more than once, during his lifetime. These are some of the commonest :

D. PRESENT STATE

1. *No obvious symptoms.*

(Certain very unstable characters may be in this state temporarily.)

2. *'Neurotic' (or Minor Psychotic) Symptoms.*

Somatic 'Conversion'.
Anxiety.
Phobias.
Obsessions.
Depersonalization.
Hypochondria.
Depression.
Hysterical Attacks, etc. etc.

3. *Aberrations of Behaviour.*

Alcoholism.
Drug Addiction.
Stealing.
Mild Hypomania.
Peculiar Conduct, etc. etc.

4. *Psychotic Symptoms.*

(*a*) Affective.

Manic.
Depressive.
Mixed.

(*b*) Schizophrenic.
Dementia Praecox.
Hebephrenic.
Catatonic.
Paraphrenic.

(*c*) Paranoiac.

By way of illustration two cases are described in this way :

No. 52. Female (15).

A. GENETIC TYPE.
Syntone.

B. PERSONALITY SUB-TYPE.
Cautious Obsessive.

C. DEGREE OF STABILITY.
Fairly Unstable.

D. PRESENT SYMPTOMS.
'Neurotic.'
Headaches, ? hysterical dream-states.
Onset. Puberty.
Course. Chronic.

With this diagnosis, a prognosis of some value can be made. Without treatment neurotic symptoms will probably continue in this girl and a psychotic depression is a possibility. The personality will always be over-cautious and over-conscientious but essentially simple and reliable. Psychoanalysis would probably be successful in removing most of the symptoms, stabilizing the personality, enabling the patient to enjoy herself more, freeing her from the over-conscientious and obsessional traits which at present limit her.

No. 58. Male (18).

A. GENETIC TYPE.
Schizoid.

B. SUB-TYPE.
Cold Solitary—Obsessive.

C. DEGREE OF STABILITY.
Very Unstable.

D. PRESENT SYMPTOMS.
'Neurotic.' Severe Obsessions, Apathy.
Onset. Puberty.
Course. Getting worse.

PROGNOSIS. Neurotic symptoms will probably continue and there is serious danger of schizophrenia developing.
Psychotherapy likely to be difficult and prolonged.

The scientific value of any theory depends upon whether it is of use in simplifying data, aiding prediction or rendering other research more valuable. The theory advanced here has claims under all three heads. It brings some degree of order into the chaos of psychiatric classification, especially in its classification of psychoneuroses and character types. If true it will be of great value in prognosis in these types and should also lead to a more fruitful search in the field of psychopathology. Hitherto attempts to distinguish the psychopathology of obsessional neurosis from hysteria or melancholia have not been convincing. It seems probable that the reason for this has been a failure to realize that there are two radically different types both of hysteria and of obsessional neurosis, and that certain forms of each are different in degree only from an affective illness. It is hoped that a new start on these problems can now be made.

But a theory is of very doubtful quality if there are no means for checking its validity. Fortunately there is no serious difficulty in this case. Two methods are available.

(1) The method used in the present investigation can be extended. A large number of psychotic patients, specially selected on the grounds of unassailable diagnosis,

can be used and really comprehensive accounts of their previous personalities obtained. This would decide whether the criteria suggested for distinguishing syntones from schizoids were reliable or not.

(2) A number of normal people and a number of people suffering from psycho-neurotic symptoms could be studied, and grouped into genetic types and personality sub-types. The careers of these people could then be followed over a period of years and any psychotic symptoms which might develop noted.

This second method has the advantage that observations will not be biased by subjective wishes, as is so apt to happen in the first method. After the examination of the " normal " and neurotic patients, a prediction should be possible both as to the likelihood of psychotic symptoms and the form they will take. On the accuracy of the prediction, the theory will stand or fall.

It is true that both investigations would require considerable organization and in the second case a long period of time. But it is in the hope that research of this kind will be undertaken that this preliminary essay has been written.

Appendix A

THE SPECIFICITY OF 33 SCHIZOID TRAITS

In Chapter IV it was pointed out that there were 33 traits which seem to be more or less specific to schizoid personalities. Their credentials will here be examined in detail. We will inspect each trait on its own merits, comparing the frequency with which it appears amongst the 13 schizophrenics with its frequency amongst the 23 affectives and eking out these few observations with those of other investigators who have worked in the same field. In using the observations of others, however, caution is necessary, since different investigators do not always mean the same thing when they use the same trait-heading.

A few remarks upon the literature available in English may be useful. Broadly speaking previous studies fall into three groups : (1) those that compare and contrast the prepsychotic personalities of affectives and schizophrenes, (2) those which deal only with schizophrenes, and (3) those which confine themselves to affective patients.

(1) The most notable workers in the first group are Kraepelin, Hoch, Kretschmer and Bowman. Kraepelin's work is well known and does not need comment, but it is worth pointing out that his descriptions are often quoted from other workers, e.g. from Reiss on manic-depressive patients and from Wilmans on dementia praecox. When making references, however, I have used only Kraepelin's name.

Hoch, who was one of the first workers in the field, made a number of separate studies. In one he used 72 cases of dementia praecox, in another 38 female cases of

the same condition, and he also quotes from an unpublished paper by Kirby based on 100 cases. His views on manic-depressive personality are founded on the study of 218 cases. Hoch's work, being pioneer, has not the detail of much of the later studies but it has always been valuable in drawing attention to the shut-in personality, a concept round which most of his work centres. (In comparing Hoch's and Kraepelin's work with that of later authors it should be borne in mind that some cases which would now be diagnosed schizophrenia might then have been classed as manic-depressive.)

Although Kretschmer's findings are published at length, he does not, so far as I am aware, give anywhere the total number of patients studied on which his conclusions are based. His work, however, is by far the most detailed and ambitious and will for long be a standard source, and it will be observed that almost all of the traits classed here as specifically schizoid had previously been so classed by Kretschmer.

The observations upon which Bowman and his colleagues base their conclusions have already been described in Chapter II. It appears to be careful and reliable work which merits considerable weight whenever there is doubt about the specificity of a trait.

(2) In the second group of authors are to be found a number of men who have worked in America. Amsden personally examined 182 cases of schizophrenia and made an attempt to correlate certain specific types of schizoid personality with clinical forms of the disease itself. Three other workers have recently made a special study of catatonic schizophrenia, Faver 154 cases, Blalock 25 cases (all men), and Bigelow 35. None of them go into much detail.

(3) Of those who have confined themselves to affective psychoses, MacCurdy, Smalldon and Lewis are the most important. MacCurdy working largely on Hoch's material gives results of the examination of 76 cases of depression, but his summaries of results are very

general and there is very little discussion of specific traits. Smalldon examined 75 cases, 25 manic, 25 circular and 25 depressive, but unfortunately gives many of his results as pooled figures. Since the majority of affectives are depressive, and circulars are comparatively rare, pooled figures are in no way characteristic of the affective group as a whole. Lewis has made a close and reliable study of 61 melancholics. Unfortunately the detailed results of their prepsychotic personality have not yet appeared, but there is much in his paper which is germane to our subject.

It is now proposed to examine each of the 33 traits listed here as schizoid to see whether their inclusion is justified. On occasion it will be convenient also to discuss non-specific traits for purposes of comparison.

1. SOLITARINESS. Prefers solitude, lonely walks.

This is the trait most remarked upon in the literature and also the most frequently found amongst my own 13 patients; 11 showed it and in 7 it was a striking characteristic. It was present in only one of the 23 affectives, No. 4[1].

2. NO FRIENDS.

It is not surprising that people who prefer solitude should have few or no friends. This was the case with 8 of my schizophrenes, in two of whom it was regarded by relatives as quite striking. Whereas the average person has at least one or two friends whom they see or correspond with regularly, these patients had no one who was more than a casual acquaintance whom they might never see again. However, this trait was also shown by four depressive patients, including No. 4. The other three (Nos. 1, 3 and 6) were all exceedingly quiet men, who preferred staying at home to going out and meeting people. All three were married, however, so that their lack of friends did not result in solitude.

[1] No. 4 was in many ways exceptional and is discussed in Chapter IV.

THE SHUT-IN PERSONALITY

These two traits—" solitariness ", " no friends ", together with " cold and aloof "—can conveniently be discussed together, for they are all aspects of the type of personality described in the literature as shut-in or seclusive. All three traits occur in six of my schizophrenics or roughly half the total, and two more have two out of the three. On the other hand the only affective to show all three is No. 4, the exception.

Every worker, since Hoch first noted the frequency of the shut-in personality in dementia praecox patients, has confirmed it. Hoch himself observed it in 51 per cent of 72 cases (in 35 per cent it was particularly marked), and again in 68 per cent of 38 female patients—it being marked in 49 per cent. Kirby's observations showed its presence in over 50 per cent. Bond found a seclusive personality in 12 out of 24 dementia praecox patients, Bigelow in about half of his 35, Blalock in 9 out of 25, and Faver in 86 out of 154. Bowman found that 43 per cent of his schizophrenics preferred solitary amusements and that 54 per cent had fewer friends than normal. Kretschmer describes the characteristics "unsociable, quiet, reserved, humourless and eccentric " as " absolutely the most common in that they run like a scarlet thread through the whole schizoid characterology ".

Not only is there complete unanimity of opinion on this point, but the figures of different workers show a remarkable constancy. We are therefore on very safe ground when we conclude that *roughly one-half of all people who later become schizophrenic have had this shut-in personality before the advent of the disease.* 50 per cent is an impressively large proportion but it is far short of 100 per cent and must not be allowed to obscure *the other 50 per cent of schizophrenics who have not been shut-in.*

Amongst affectives the shut-in character is undoubtedly far less common. It only appeared in one of the 23 presented here and Hoch remarks that " the typical shut-in personality was not once found " amongst

his 218 manic-depressive patients. On the other hand Bowman found that of his manic-depressives 21 per cent had fewer friends than usual and 12 per cent preferred solitary recreations. Moreover, Lewis found that 12 of his patients (20 per cent) were seclusive, shy and unsociable. These figures, although appreciably smaller than those of schizophrenics, make it clear that some affective patients have traits which border upon the shut-in, a conclusion which conflicts with Kretschmer's view that cycloids are essentially sociable, good-natured, friendly and genial. This question has already been discussed at length in Chapter V.

3. No SEX. No apparent interest in opposite or same sex (such people sometimes masturbate).

Only 2 out of 13 schizophrenics were married (Nos. 33 and 35) as against 10 of the affective group. Of the 11 other schizophrenics, 4 had showed no interest whatever in sexual relations, all 4 being of the shut-in type. Only two of the affective patients had been equally indifferent: No. 11, a reserved girl of 21, and No. 21 a very shy boy of 17. It seems to me that this lack of interest in sexual relations is likely to be more significant in men than women and I should be disinclined to regard it as of much importance in women in the absence of other schizoid traits.

Kretschmer regards a lack of sexual desire as specifically schizoid. Amongst other workers both Bigelow and Blalock found a lack of interest in sex to be very frequent in schizophrenes. Bigelow's figures are difficult to interpret, but Blalock found that 18 of his 25 men had had no sexual affairs and were extremely shy with the opposite sex. Not one was married.

4. No HUMOUR. Lacks a warm humour (such people sometimes have a cold wit).

Six schizophrenes showed a characteristic lack of humour, five of them being typical shut-in personalities.

The only affective to be so lacking was No. 4. Whilst it is probable that the sense of humour of several other schizophrenes was hardly up to average, all the affectives seem to have been well endowed. It is constantly said of a depressive that " he likes a quiet joke " or is " very amusing in congenial company " and of course hypomanic personalities are commonly full of jokes.

It has been said of T. E. Lawrence, who had many striking schizoid traits, that he never made a joke at his own expense, although he could be amusing and witty at other people's. It is important to distinguish this type of humour, which can be very bitter and cruel and is sometimes found in schizoids, from the warm, sympathetic, good-natured humour, which is the trait we are discussing. The presence or absence of his Kretschmer regards as a fundamental distinction between schizoids and cycloids. But not only does he think that schizoids are characteristically lacking in it, he believes also that cycloids are specially well endowed compared to the average. Although Bowman agrees with his first contention, a comparison of humour in manic-depressives and controls did not support the second. He gives no figures but concludes that, whilst affectives are equal to, though not above, the average in humour, schizoids are noticeably lacking. Nevertheless, it must be remembered that, though people who lack humour are usually schizoids, not all schizoids lack humour. Amongst my own patients No. 34, for instance, was quite well endowed. Conversely there are many syntones who have a very poor sense of humour, and are instead worrying, irritable, or morose.

5. COLD, ALOOF. Withdrawn emotionally.

This tendency was apparent in no less than 8 schizophrenes. Bracketed with " no friends " it is the second most frequent trait amongst my patients, solitariness being the most common. It was present in only two affectives (Nos. 4 and 22).

It is, unfortunately, rather an indefinite trait to assess. In some people its presence is obvious ; they are rather formal, a little unresponsive, seem always to keep one at a distance ; in more extreme cases they appear to be distant, withdrawn, day-dreamy, " fey ". Then again its absence is often conspicuous, when we get warm-hearted, effusive people who quickly put anyone at ease by their immediate sympathy and understanding. It is this affective resonance which the cold, aloof person lacks, but its presence or absence is obviously only a matter of degree. It is often said that one knows a schizophrenic by the " feel " he gives one rather than by anything he says or does and this is also true of the cold personality. The difficulty of relying upon the patient's own description of himself or that of his relatives is bound therefore to be considerable. Nevertheless, despite difficulty of assessment, it is probably one of the most specific of schizoid traits.

6. DOCILE. Extremely obedient, " good ", easily led.

7. SAINT-LIKE. Perfect, saint-like equanimity, turns other cheek, *no signs whatever of hostility.*

Both these traits have at various times been regarded as characteristically schizoid.

Extreme *docility* appeared in only 3 schizophrene patients and since it was also probably present in 4 affectives, it seems doubtful whether it should be included amongst the schizoid traits. Both Kretschmer and Kraepelin comment on it, however, and Bowman found that his schizoids were often markedly under-assertive, especially in childhood. On the other hand there were other schizoid adults in his series who, in comparison with the manic-depressives, were noticeably *over-assertive.* This reminds us that because one extreme of a trait may be almost specific to the schizoid character, it does not follow that the opposite extreme never occurs. On the contrary, whilst some schizoids are meek and tractable,

others are obstinate and defiant, some carry an absence of retaliation to saint-like lengths, others flare up on a sudden. For instance, Blalock found that although 16 of his patients were very submissive, 8 were unusually assertive, only one striking a mean.

We may conclude therefore that docility or lack of assertion is extremely common amongst schizoids and may be fairly specific, but that others are markedly violent and assertive characters. (Over-assertiveness is almost certainly not specific, since it is a characteristic of many simple hyperthymic personalities.)

The description *saint-like* is intended to describe certain characters who appear to be absolutely good, kind and sweet by nature. It must be carefully distinguished from a hypocritical goodness or mere over-conscientiousness, but when once recognized it is not easily missed again. No. 28, a boy of 21, was described by his father as " so docile—his mother always calls him a *saint* ". In addition to these phrases he was said to be very " peaceful " and quiet. He was the only patient, either schizophrene or affective, of my series to show the trait. When present, however, I believe it to be extremely suggestive of a schizoid personality. It seems to have been a characteristic of Nijinsky.

Kraepelin notes that some schizoids are characterized by docility, good nature and diligence and are patterns of goodness, but I do not feel that any of these epithets quite hit the mark. Kretschmer is more expressive. He describes how schizoids, taking flight from humanity, find solace in all that is peaceful and unharmful. Others are characterized by an " unshakable peace of mind, . . . a phlegmatic state, which may be distinguished from the cycloid comfortableness by the lack of warm, emotional responsiveness towards mankind ". No other writers mention it very specifically.

It may here be worth discussing the vexed problem of the *model child*, who is always diligent and never does wrong. Kraepelin's description above is really a

description of the model child, a concept which *includes* the saint-like child, but also covers certain quiet over-conscientious children who are peevish and irritable at times. As previously remarked Bowman found that the model child was just as prone to an affective illness as to a schizophrenia ; exactly 27 per cent of each group had been model children as against 6 per cent of the control group. Bigelow found that as many as 50 per cent of his patients had been model children. These figures suggest most strongly that a model childhood presages badly for the future, whichever psychosis is developed.

It is my belief that more careful observation will enable us to distinguish between the model child who is likely to become schizophrenic and the one who may get an affective illness, but I do not here wish to discuss childhood characters in detail. Model adults, however, can almost certainly be divided into these categories. What I have described as a saint-like quality of mind, an epithet suggested by the father of my patient, seems to me a most valuable criterion. Over-conscientiousness, sympathy, religiousness and various other traits which characterize the grown-up equivalent of the model child are very frequently met with in syntones and are discussed fully in the second Appendix, but this absolute lack of revenge or aggression of any sort and an apparently unshakable peace of mind does not occur in syntones.

8. FANATIC. Self-sacrifice for great abstract or metaphysical ideal.

9. PROPHET. Feeling of a mission to save the world, etc.

Neither of these traits is easily assessed in its lesser degrees. Only one patient, No. 35, showed one of them at all markedly. (Both Nos. 20 and 27 were young men who had dedicated themselves to religion, but it is rather doubtful to what extent they should be described as having " sacrificed " themselves.) No. 35 was a man

of 34 who felt he had important ideas regarding the way the world should be run and that everyone should think the way he did. One of his chief tenets was that money was a curse and should be abolished. No affectives showed these traits.

Kretschmer elaborates upon these characters, describing their " striving after the theoretical amelioration of mankind, after schematic, doctrinaire rules of life, after the betterment of the world, or the model education of their own children, often involving a stoic renunciation of all needs on the part of the individuals themselves. Altruistic self-sacrifice in the grandest possible style, especially for general impersonal ideals (socialism, teetotalism) is a specific characteristic of many schizoids." He also points out that there is a continuous series from schizoid prophets to hypomanic ones. " Many of these active inventors and prophets have pronounced constitutional alloys and form a series from extreme schizophrenia at one end and hypomania at the other. Those who are preponderatingly schizophrenic are more peculiar, more exaggerated, more forced, more darkly vague, more mystical and metaphysical, and have greater tendency to a system and schematic formulation, while those who are rather hypomanic on the other hand, are unsystematic, they have the loudness of some itinerant preachers, they are impulsive, slap-dash, eloquent and changeable as quicksilver."

As usual the tendency for schizoid traits to have similar syntonic counterparts makes conclusions difficult and my own material is insufficient for me to add anything to Kretschmer's.

10. Occult Interests. Spiritualism, mysticism, astrology, half-baked interest in philosophy, etc.

The tendency of schizoids to be interested in philosophy, psychology and various mystical subjects is well known. It was apparent in no less than 6 of my schizophrenes and was marked in 3 of them. Three syntones, however,

also had these interests, and, although it was not marked in any of them, it is worth while investigating exceptions in some detail.

One of them, No. 23, was a young undergraduate of a hypomanic temperament, who had been taking an active, though rather uncritical, interest in philosophy and psychology. Amongst the better educated classes such interests are so common that they lose significance and only when they are carried to speculative extremes are they likely to indicate a schizoid personality. On the other hand if a less educated person takes up such interests, he is very probably schizoid.

No. 21 was a boy of 17 who had fallen ill following the death of his mother. Soon after her death he had heard a broadcast by Sir Oliver Lodge on Spiritualism and the life after death and then only had he taken interest in these matters. It was probably a reaction to the shock of his mother's death and a symptom of his illness and was hardly a prepsychotic trait. In this connection it may be remarked that many people who have no other schizoid traits whatever take an interest in spiritualism after the loss of someone who was very dear to them. This simple belief in a life after death, whether in an orthodox Christian form or in spiritualistic guise, cannot be regarded as schizoid.

It is only when spiritualism is carried further, to the belief in the detailed influence of spirits on human affairs, to attempts to control them and so on, that a schizoid make-up is suggested. No. 25, for instance, had been interested in the " Life of the World ", spiritualistic recordings and pyramidology. No. 36, although he had never been to a university, had read a number of " deep " books on psychology, astrology and kindred subjects, whilst No. 30, a better educated girl, had become interested in psycho-analysis and the " religion of the mind ".

Considering how widely held the view is that these interests indicate a schizoid personality, it is curious

to find what little mention of it is made in the literature that I have surveyed. Kretschmer as usual describes them vividly and in detail. Blalock looked for them in his 25 patients, but appears to have found no marked case, which is surprising.

It has been my impression that the current view errs only in regarding these traits as the monopoly of schizoids. A few syntones undoubtedly are interested in these topics, especially the better-educated and those who have been bereaved. Nevertheless they are probably so much commoner amongst schizoids and often take such peculiar forms that we are entitled to regard the trait as almost specifically schizoid.

11. AMBITIOUS PHANTASIES. Grandiose day-dreams, *but no attempt to realize them.*

These were elicited in only one of my patients, No. 35, who, whilst holding strong views about the reform of the world and the abolition of money, had, so far as could be ascertained, done nothing to convince other people of its desirability. No syntones showed the trait.

The tendency for schizoids to day-dream is well known. Kretschmer, Hoch and Amsden all comment on it and Blalock found that nearly half his schizophrenes had been much addicted to it ; but syntones also day-dream and it cannot be regarded as specific to schizoids. What does seem to be specific is that schizoids are apt to have ambitious day-dreams and yet make no attempt to realize them. Bowman, for instance, found that 43 per cent of his schizophrenes were extremely ambitious but only a few of them had attempted to reach their goals. Syntones on the other hand seem always to make serious efforts to make their ambitions, which are often enormous, materialize and there is therefore far less gap between the phantasy and the achievement. Although my own observations carry little weight, I have gained the impression that this trait is extremely valuable in distinguishing the types.

12. CLOSED CIRCLE. Moves in an exclusive coterie, salons.

13. PRECIOUS. Affected, posing, exquisite, extremely vain.

14. DISDAINFUL. Sarcastic, biting, superior, contemptuous (often, especially of parents).

The first of these traits appeared in none of my patients, either schizophrene or affective. The second was probably present in one affective, No. 23, but one was inclined to discount it on the ground that he was going through a phase which is common amongst undergraduates. The third appeared in the schizophrenes Nos. 27 and 36, but in neither was it very certain or marked. In view of these negative findings I must rely on the literature.

Kretschmer describes how schizoids, if they do not actively seek loneliness, often prefer to move in a narrow exclusive circle: "Side by side with simple unsociability, eclectic sociability within an exclusive circle is a characteristic especially of many highly gifted schizoids. . . . In the restricted, polished formalism of such a circle, they find all that their delicate feeling can desire . . . this cultivation of impersonal formalities hides what is so often lacking in the schizoid; he hides behind his cool and polite elegance, the lack of heartfelt feeling and direct emotional freshness, which betrays even in these sensitive natures the beginnings of an emotional coolness." Nijinsky, whose personality was so typically and pathetically that of the schizoid, provides a good example of this trait. Hopelessly shy and lost with ordinary people, he found the exclusive milieu provided by Diaghileff's circle one in which he could move undisturbed by the practical and emotional difficulties of a less secluded life. It is true that many depressive personalities prefer a small circle of friends, but this is usually characterized by a warm and simple intimacy

in contrast to the tendency of schizoids to form a cult around some impersonal ideal.

Preciousness is another aspect of the tendency of schizoids to protect themselves from their fellow men. Both speech and clothes are apt to be exaggeratedly refined, but, as in so many traits, the behaviour of people and the clothes which they wear must be assessed in relation to their social surroundings. Clothes and speech which are comparatively natural and normal to a wealthy woman might be manifestly peculiar and exaggerated in someone of less fortunate means. It is not much commented upon in the literature, but Blalock found that 7 of his 25 patients were extremely vain.

The tendency to be *disdainful* and sarcastic in a cold superior way is yet another aspect of the same reaction. Only two of my cases showed it, both schizophrenes, and in neither was it marked. Once again the literature is rather silent. The observant Kretschmer notices it and remarks that such patients often show particular contempt for their own parents, whom they feel are obstacles to their desire for the " superior life ". Indeed, some of them completely disown their parents and will tell their newer acquaintances grandiose yarns about their birth. This is sometimes also true of manics, but the contempt for their real parents is absent.

It is because these three traits do not appear amongst my 23 affectives, and have been found by other workers to be frequent in schizophrenes, that I have included them as specifically schizoid.

15. RITUAL. Apparently *meaningless* rituals, ceremonial touching, etc. (excluding repetition of ordinary actions, e.g. precautions).

Many obsessional neurotics feel compelled to repeat *apparently meaningless* rituals and experience great anxiety if for any reason they omit to do them. Although such rituals can usually be shown to have symbolic meanings, superficially they appear futile and the patient himself

is completely mystified by them. In this respect they can be contrasted with *purposeful* obsessional actions such as repetitive locking of doors or extinction of gas, the object of which is quite clear. (Of course in a few instances there may be uncertainty into which category a given act falls.) Now it can be shown that purposeful obsessional acts are very frequent in prepsychotic personalities and that they are quite non-specific to schizoid or affective psychoses. On the other hand it is strongly my impression that 'meaningless' rituals are confined to schizoid personalities.

Since no psychotic patients in this series showed them in a marked degree, no conclusions can be drawn from them. (Two schizophrenes, Nos. 31 and 32, had felt compelled to touch the walls of a room on certain occasions and one depressive, No. 19, was sometimes bothered by the cracks in the pavement.) My reason for including the symptom amongst the schizoid traits depends upon other considerations and will be found in the full discussion of the relation of obsessional neurosis to the psychoses in Chapter VII.

16. HOMOSEXUALITY. Manifest homosexual feelings *after 18 years of age* (with or without physical expression).

Although overt homosexual relations are very common in adolescence, their continuance into adult life is confined to comparatively few, and the great majority of these I believe to be schizoid. Only two of my 13 schizophrenes showed it (and in patient No. 30 it was rather doubtful) whilst one manic patient was homosexual.

Bigelow found that 18 of his 35 catatonics had marked homosexual inclinations, but this large proportion is rather offset by Faver who found it in only 3 of his 154 cases. Another worker in the U.S.A., Henry, made a special study of homosexuals in contrast to heterosexuals. He studied 250 adult patients and classed as homosexual

all those who had derived pleasure from repeated homosexual relationships. On this criterion he found 33 homosexuals (17 men and 16 women). Of these 17 were schizophrenic, 1 paranoic, 7 psychopathic and 5 psycho-neurotic. Only 3 suffered from manic-depressive depression. It is unfortunately difficult to know from what illnesses the heterosexuals suffered. Apparently only 13 had psychoses, 12 belonging to the manic-depressive series (2 agitated depression and 4 involutional melancholia) and 1 alcoholic. It is difficult to know what these figures are worth, but they suggest a close relation between homosexuality and schizophrenia, since exactly half of the homosexuals became schizophrenic, and only 3 were manic-depressive. This last figure reminds us, however, that homosexuality is not *absolutely* confined to the schizoid personalities ; it is only relatively commoner.

17. FETICHISM.

No patients showed this symptom, as far as was known.

18. PASSIONATE ATTACHMENT. Very violent affairs, each one assumes tremendous proportions, often very changeable and fickle. Uneven sexual demands.

Whereas only one affective showed this trait, three schizophrenes had it, two to a marked degree. No. 35, a married man of 31, was extremely variable in his sexual demands, according to his wife. At times he would want intercourse nightly and then suddenly have no interest in her for months. No. 33 at times had made great demands on her husband and had accused him of unfaithfulness if he did not feel like it, and then after her first baby was born had conceived a violent dislike for him and had refused to live with him for some years.

None of these last three traits appeared sufficiently often in my series of cases to justify my drawing any conclusions from them, however. My reason for including them as schizoid traits depends entirely upon the literature.

19. SCENES. Emotional outbursts, screaming fits, hysterical laughter or tears.

Emotional outbursts such as are included under this heading are common amongst hysterics, in fact are a hall-mark of them. Only one psychotic patient, No. 33, a schizophrene, had been prone to them ; she quarrelled constantly with her neighbours and if she went to any kind of tea-party was apt to take offence and create a scene if attention was not paid to her.

The relation of hysteria to the psychoses is examined fully in Chapter VII where I have concluded that scenes of this nature are probably relatively specific to schizoids.

20. VIOLENT TEMPER. Loses temper and becomes *violent* (distinguish from mere bad-temper). Attacks people.

32. DESTRUCTIVE. Destroys property, arson.

33. CRUEL. Spiteful, mean, nasty tricks ; cold-blooded, brutal, sadistic bully.

The violent aspect of the schizoid character is less frequently manifested outside a frank psychosis than is its opposite, the docile and saint-like. It is common, of course, for schizoids when actually psychotic to be violent ; for instance the saint-like boy, No. 26, was dangerously impulsive for a short time in hospital. Occasionally, however, violent outbursts may precede, or perhaps succeed, the psychosis by a considerable period.

Four schizophrenes of my series were described as

having had fits of very *violent temper* after childhood had been passed, but this was true of none of the affectives. Sudden senseless temper was particularly common in No. 35. His wife said that it often seemed to be caused by nothing and that when angry he had sometimes attempted to whip her. Except possibly for this patient, no patients were either *destructive* or cold-bloodedly *cruel*.

These tendencies in schizophrenes have not been widely recognized, partly, perhaps, because of the preoccupation with shut-in characters. Kretschmer as usual comments on them : " A nervous inner-tension, which now, on the slightest touching of a complex in an unexpected place, may unload itself, recklessly, in the most brutal outbursts of passion, breaking through the insensitive outer covering. . . . The passionate-insensitive schizoids may be the most brutal and dangerous of tyrants in the home, who misuse their surroundings without a trace of feeling, and direct everything, regardless of everyone else, according to their own pedantic whims. Many historically famed imperial despots have, at least in externals, a great deal in common with this schizoid type." He emphasizes particularly the coolness and feelinglessness which pervades these people and which characterizes their brutal and sometimes sadistic acts. It is probably this quality which is particularly important. Whereas a person of hyperthymic temperament may lose his temper and on occasion be violent, he will never be destructive and cruel in cold blood. Of the three traits mentioned, the latter two are probably far more specifically schizoid than is " violent temper ".

Kretschmer believes these " senseless eruptive outbursts " to be related to epileptic syndromes. This seems to me extremely likely, especially in view of the similar nature of many epileptic equivalents. Bleuler also thinks that there is a family relationship between schizoids and certain kinds of epilepsy. Here again is a field for future research.

21. HATES A MEMBER OF FAMILY. Openly and constantly hostile to one or more *parents* or *siblings*. (Exclude spouse.)

Non-specific trait, No. 18. OVER-ATTACHED TO A MEMBER OF FAMILY. Very devoted to one or more of *parents* or *siblings*, can't leave home. (Exclude spouse.)

For a long while it has been held that a very close attachment to a relative, usually the mother, is specific to schizoids and amongst others Kretschmer shares the view. Recent work by Bowman, however, has made it clear that this is a mistaken conclusion. Schizoids are certainly prone to be 'mother-attached' but they are not alone. Bowman found that 39 per cent of his schizophrenes had been close to their families, but that this figure was slightly *exceeded* by the affectives. My own observations confirmed this, 10 affectives and 4 schizophrenes showing the trait (about one-third of each), whilst Smalldon, who studied only affectives, found that 30 out of 75 had a strong attachment to their families and of these 25 had strong attachments to individual members. We may conclude, therefore, that a close attachment either to the family as a whole or to one member of it is not, as has been supposed, the prerogative of schizoids, but, like a model childhood or reticence, is probably significant only as distinguishing any personality which is liable to a psychosis from those less liable.

On the other hand a fanatical and outspoken hatred for a close relative does appear to be specific and is relatively frequent amongst schizoids. Often one patient may show both traits together—a close attachment to one parent and a keen hatred for the other. Amongst my schizophrenes no less than five had a marked hatred for a relative, whereas not one affective showed it. These figures are suggestive and confirm those of Bowman, who found that about 10 per cent of his

schizophrenes had unusual resentments, which was much above the figures shown either by the controls or the affectives. Eight per cent of Blalock's schizophrenes had shown the trait, whereas Smalldon found it in only 2 out of 75 affectives. It is my impression that when present in affectives, it is in hyperthymic temperaments and not in depressive, whereas amongst schizoids quiet and rather depressed personalities often show it.

The details of these family attachments and resentments are interesting. Attachments are almost exclusively to members of the opposite sex, mother or sister in the case of the boy, father or brother in the girl. Resentments are less consistent. On balance they are more directed towards members of the same sex. The resentments of my five schizophrenic patients were as follows : No. 24, a boy of 17, hated his father who was said, by his sister, to be strict, self-opinionated and eccentric. No. 25, a man of 27, was very resentful against his father for not treating him with sufficient respect. No. 28, aged 28, had a bitter hatred of his father. No. 31, a boy of 19, had always been terrified of his father who was alleged to have bad tempers. No. 29,[1] a girl of 20, had foster-parents from the age of 2 years. They seem to have been well-meaning, but the patient had acquired a great dislike of her foster-father about whom she never had had a good word to say. (No. 30, a girl of 23, hated her step-mother very openly. This, however, is a different situation to the ordinary family relation and very probably is not confined to schizoids, and I have not marked her + for this trait.)

Bowman gives details of only 50 of his cases, 29 male and 21 female. Two boys showed keen resentment towards their father, but one picked on his aunt. One girl loathed her mother, another her sister, but again there was an exception to the rule through one girl hating her brother. Blalock's two patients were both

[1] No. 29 was probably not schizophrenic. See Note on p. 61.

men. One was antagonistic to his brother, the other to his mother.

With regard to attachments the 4 schizophrenes of my series show nothing very clear. No. 28, a boy of 21, was much attached to the family as a whole and particularly to a sister. No. 33 seems to have been very dependent on her mother and ran back to her after her first baby was born and stayed with her for some years. No. 24, who hated his father, was extremely attached to his mother and elder sister, whilst No. 30, who hated her step-mother, was extremely attached to her father and was very anxious to help him and look after him better than her step-mother did.

Amongst the 50 schizophrenes about which Bowman gives details 13 had extreme attachments, all to members of the opposite sex. Nine boys were attached to mother, one to sister, two girls to father, one to brother. Blalock's cases are similar. Eighteen men were strongly attached to mother, and the only exception is one man who was attached to his brother. All the figures point to the general conclusion that many schizoids are extremely attached to a relative of the opposite sex and that some of them also have unhidden hatreds for relatives of the same. This conclusion is confirmed by Bigelow who found that about two-thirds of his patients had " very marked Oedipus complexes ".

The 10 affectives showed a tendency to be attached to home and family life in general rather than to particular members. Three men were particularly attached to their mothers, and one woman, No. 18, had been very attached to her father, but the other 6 had no specific attachment. Two girls (Nos. 10 and 11) were both described as being specifically attached to home, such phrases as a " proper home girl " being used about them and one always wanted her mother to come with her wherever she went. Several men were similarly attached, No. 12, for instance, a man of 41, having lived the first 8 years of his married life with his parents, was

described by his wife as feeling always that he ought to look after his parents as well as herself.

Smalldon found strong attachments particularly frequent amongst patients who later suffered from depression and less in the manics and circulars.

From these observations we may conclude that an overt Oedipus complex is far commoner in schizoids than in syntones. Schizoids often show the typical attachment to the parent of the opposite sex and hostility to that of the same in quite undisguised form, whilst syntones either don't have these feelings so strongly or else contrive to cover them up more efficiently, since an undisguised Oedipus complex seems a comparative rarity amongst them.

22. MIRROR. Gazing at self in mirror for long periods, laughing or grimacing at self, exaggerated care of body.

The tendency for schizophrenes in the early stages of their illness to stare and grimace at themselves in the mirror is well known, and there is a common belief that this is much more frequent in schizophrenes than patients suffering from an affective psychosis. Since it was not included in my enquiry until later, my figures are of no particular value. Three schizophrenes had shown it, but also 2 affectives. No one seems to have studied it systematically.

23. SUPERSTITIOUS. Really upset if 13 at table, or spills salt, always on look-out for ill omens.

Although an exaggerated superstitiousness is not mentioned much in the literature, I have got the impression that it may be a good deal more common in schizoids than syntones. It was not at first included in the enquiry and so my own figures are not of much value. One out of 6 schizophrenes questioned showed it and none out of 13 affectives. Blalock, however, found that 5 (20 per cent) of his schizophrenes had been unusually

superstitious and I have included it in the list of schizoid traits largely on these grounds.

24. NUMBERS. Attaches significance to numbers, always counting things.

The evidence with regard to this symptom obtained from the psychotic patients of this series does not warrant its inclusion amongst schizoid traits, since it appeared in only two patients, both depressives, although to very minor degree. Like " ritual " it is discussed in full in the section dealing with the relation of obsessional neurosis to the psychoses. (Chapter VII.)

25. APATHETIC. No ambition or initiative, drifter.

26. INDOLENT. No energy, very ' lazy '.

The tendency of some schizoids to have no initiative or ambition and to drift about doing nothing has been widely remarked upon and has been regarded as specific to schizoids for a long time. Actually only two of my patients showed these traits (Nos. 29 and 34) and in neither were they very marked. No. 34 was interesting because after leaving school he had loafed about with no interests or ambition for several years ; then became interested in motor-cycle tests and finally got a job as an electrical engineer, in which he was a good workman and very keen, before finally developing a paraphrenia at 28 years of age. There was no suggestion that in the earlier period of inactivity he had had psychotic symptoms. It appears therefore that the apathy and indolence is not necessarily permanent but may vary over a period of years. Caution, however, is necessary because, of course, an inability to work is a symptom of an affective depression. But the feeling tone is usually quite different. Most depressives feel all the time that they ought to be working and often have to be stopped, whereas the apathetic schizoid is utterly indifferent.

Kraepelin, Kretschmer and Amsden all comment on

these traits and regard them as specifically schizoid. Bowman also found that, whereas affectives were on the average rather more energetic and ambitious than the controls, many of the schizoids were markedly lacking in ambition and had very little energy. Bowman's work, however, demonstrates that this is by no means true of all schizoids and that there is a small proportion who have considerable energy and assertion and are even characteristically over-ambitious and over-assertive. My own patient, No. 34, swung between these two extremes. This tendency to opposite extremes is confirmed by Bigelow and Blalock. Although 16 of Bigelow's 35 patients lacked initiative and 11 lacked ambition, no less than 22 were described as having " much energy ". As children, Blalock's patients fell entirely into the extreme groups, 15 being very lively, 10 very sluggish. This was not kept up in adult life, although 7 remained very sluggish at work and 13 showed no energy for games.

From these figures we can probably safely conclude that apathy and indolence are characteristic of between 25 and 50 per cent of people who fall ill of schizophrenia, and that it is far more frequent amongst them than among healthy people or those prone to an affective psychosis.

27. VAGRANT. Unable to keep job, unemployable.

If apathy and indolence are common amongst schizoids it is not surprising that many of them become vagrants. Actually none of my patients had done so, owing to the fact that the sources of my material would exclude them.

The association of vagrancy with schizophrenia has been widely recognized since Kraepelin found that 8 per cent of 600 male schizophrenics had been vagrants, and 3 per cent of 386 females had been prostitutes, a vocation closely related to vagrancy. I am not aware of any later work on this aspect of schizophrenia. It would be interesting to know what proportion of tramps showed schizoid traits.

28. INDIFFERENT—SULLEN. Apparently utterly indifferent to criticism.

29. UNRESPONSIVE. Self-absorbed, dead to the world.

A sullen indifference to praise or blame and a lack of response to people and things are closely related aspects of personality. They appeared together in the prepsychotic personality of 4 schizophrenes and in a fifth indifference was sometimes present, but I could not be sure whether there had been unresponsiveness or not. Two of the patients were of the shut-in type. Not one of the 23 affectives showed any features resembling these traits.[1]

These tendencies are regarded by Kretschmer as particularly characteristic of schizoids, although he points out that often an appearance of complete indifference covers extremely sensitive feelings, just as Bleuler found in deteriorated and apparently utterly feelingless schizophrenics. Indeed it is the fluctuation from intensely sensitive and exaggerated feelings to cold, dull and a numbed lack of feeling which Kretschmer regards as the essence of the schizothymic temperament—its psychaesthetic scale. Whether we accept this or not, it is almost certain that these traits are particularly common in schizoids, although the only other author to mention them specifically is Amsden.

It would probably be a mistake to regard all people showing these traits as schizoid, however, for examination of a number of chronic delinquents has suggested that syntones who have gone through certain experiences may also develop such traits. As I have shown elsewhere, children who in early infancy have been separated from their mothers, either through death, illness, illegitimacy or any other cause, and have been brought up by a series of foster-parents, habitually develop a hard-boiled attitude towards life, being pronouncedly indifferent and unresponsive. Of course, it may be that

[1] This requires qualification. See Note, p. 61.

their peculiar circumstances have made them into schizoid characters, but the considerations put forward in Chapter VIII suggest that people are born, not made, schizoid. If this is so, it appears that early breaks in the mother-child relation can make a syntone look like a schizoid in at least some respects.

30. SHAMELESSNESS. Defiant of opinion, justifies anti-social actions (may cover sense of guilt).

No psychotic patients of this series were shameless, in the sense of being actively defiant of others' opinions. It is a characteristic of psychopathic personality and has been discussed fully in Chapter VII where the relation of psychopathic personality to the psychoses is examined. It may here be said that the only two psychopathic patients in whom it appeared, Nos. 64 and 65, each showed a large number of well-attested schizoid traits, whilst Kretschmer regards it as specifically schizoid.

31. MISANTHROPIC. Active dislike of other people.

This is the ultimate stage of the unsociableness which appears so frequently in schizoids. None of my patients, either schizophrene or affective, showed it; and it has been included largely upon Kretschmer's recommendation.

32. DESTRUCTIVE.

33. CRUEL.

Both these traits have been discussed in connection with No. 20—Violent Temper.

This concludes the detailed survey of the schizoid traits. Before continuing with the non-specific traits, however, it is worth mentioning another trait which might have been included. Many schizoid characters, I believe, have peculiar lavatory habits. They may refuse to go to the lavatory, often being afraid of it; they urinate into vases and other similar vessels; sometimes they play with faeces.

Kraepelin has regarded obstinate enuresis as characteristically pre-schizophrenic. Although none of the schizophrenes in my series had shown this trait, No. 53, a boy of 18, who was not psychotic but had a typically shut-in personality, was persistently enuretic. On the other hand Addis has shown that enuresis does not affect any particular type of child and that has been my experience. Consequently I cannot agree that persistent enuresis is specifically schizoid. Peculiar lavatory habits probably are, however.

Appendix B

72 NON-SPECIFIC TRAITS

It was pointed out in Chapter IV that practically no traits are strictly specific but that there is probably a degree of specificity which may be higher or lower. The 33 traits discussed in Appendix A are believed to have a comparatively high degree of specificity for schizoid personalities. The remaining 72, on the other hand, although widely regarded as possessing some degree of specificity either for schizoids or syntones, probably in fact have none. Traits which are truly specific to the syntonic personality are extremely difficult to find and, except for the first four (" steady worker ", " practical ", " few good friends ", " quietly sociable "), none of those listed have been found to have any claim to be so regarded. In consequence, in this appendix, unlike the first, I find myself in constant disagreement with commonly accepted views. Sometimes it is important to emphasize the frequency with which a trait, hitherto regarded as schizoid, appears in the prepsychotic personality of affectives, at other times the reverse must be done. In my view, with very few exceptions, the following traits are important, not as indicating a tendency to one type of psychosis or another, but as indicating an unstable personality liable to any functional psychosis. All of them appear frequently in the personalities of people who later become psychotic, and, although a large control group would be required to prove it, it is strongly my impression that they are far more frequent and intense in prepsychotics than in the average population.

Syntones have long been divided into two or more groups according to whether they tend towards the

hypomanic or depressive pole, and it will be convenient here to divide the traits so far as possible into those characteristic of the one or the other. Unfortunately my series includes only four patients suffering from mania as against nineteen from depression. Of these only one manic (No. 21) was usually of a depressive temperament and one depressive (No. 19) commonly hyperthymic. The result is that whereas there are nearly 20 individuals who show depressive traits and afford a means of checking the conclusions of others, the four who show hyperthymic traits are too few for any original conclusions to be drawn. In discussing the hyperthymic traits, therefore, I shall be almost wholly dependent upon the literature.

The first four traits to be discussed have some claims to be regarded as specific to syntones. They are rather commoner amongst depressives than amongst hyperthymics.

1. STEADY WORKER. Sticks to his job, reliable.
2. PRACTICAL. Matter-of-fact, mundane.
3. FEW GOOD FRIENDS. Faithful to a few old friends.
4. QUIETLY SOCIABLE. Enjoys quiet company, dislikes either crowds or solitude.

These four traits, unlike those that follow, cannot be regarded as either unhealthy or uncommon in the general population. They are included here because their presence or absence gives a clear picture of the type of person we are dealing with and also because the presence of all four together is probably rare in schizoids but common in syntones.

Although taken separately there is only a small difference in the incidence of the traits in the two groups, if considered as a quartet, significant differences appear. It is probably not a coincidence that 8 of the 19 depressive patients had all four of them, whilst only 2 of the 13 schizophrenics had as many as three. The latter

(Nos. 30 and 36) were the patients who had exceptionally few schizoid traits. If we tabulate the incidence of these four traits, the different distribution between affectives and schizophrenes seems suggestive.

No. of Traits	Affectives	Schizophrenes
None	0	3
1	1 (No. 4)	6
2	6	2
3	7	2
4	9	0
Total	23	13

Individually these traits are relatively common in syntones.

1. STEADY WORKER. Sticks to his job, reliable.

2. PRACTICAL. Matter-of-fact, mundane.

In Kretschmer's opinion, diligence, capability and a capacity for hard work characterize the depressive. They are dependable and persevering workers whose chief weakness is an inability to bear responsibility with equanimity. Bowman also finds that, when compared to schizophrenes, affectives are notable for being steady, good workers, with little or no tendency to day-dream or absent-mindedness.

It was a striking trait amongst my own series of depressives, only two (No. 4 and No. 19) not showing it. In many cases the men had been at the same job all their lives. On the other hand no less than 9 schizophrenes had also been steady workers. Strict comparison is difficult since the average age was much lower, but up to the time they fell ill these patients had shown no tendency either to slack about or continually to change their job. It cannot be taken for granted therefore that because a person is steady and reliable he is a syntone.

3. FEW GOOD FRIENDS. Faithful to a few old friends.

4. QUIETLY SOCIABLE. Enjoys quiet company, dislikes either crowds or solitude.

Kretschmer describes his cycloids as typically sociable, good-natured and friendly, but he notes that the depressive personalities, although loyal to old friends, are quiet in their sociability and uneasy in the presence of people they do not know. Some of them are even " cats that walk by themselves " but, in contrast to schizoid solitariness, there is no hostile turning away from human society. The tendency of depressives to be retiring to the point of solitariness has already been commented upon when discussing schizoid solitariness, but should be emphasized again here because of the common belief that syntones are always very sociable. Smalldon found that his depressives, in contrast to manics and circulars, have few friends and are of a retiring disposition, whilst Kraepelin goes so far as to write of depressives that they " invariably have the inclination to withdraw from intercourse with others ", and that they " live solitary and secluded lives ". This last statement is almost certainly too sweeping but is undoubtedly true of some of them. For instance Nos. 1 and 6 of my series, both middle-aged depressives, were extremely retiring in their daily life and had few or no friends. Unlike schizoids, however, they were not actively unsociable or solitary ; they just lived at home with their families and went regularly to work, jogging along in a quiet rut. Bowman does not distinguish between hypomanic and depressive temperaments. Regarded as a whole in contrast to schizoids he finds affectives to have far greater preference for sociable recreations. On the other hand, as was previously remarked, there were a few of his manic-depressives who had no friends.

We may conclude then that the tendency for depressives towards quiet sociability and a few good friends, although typical for the group as a whole, may in some become so

attenuated that the only people they ever see are their immediate family. Nevertheless a *preference* for company and a dislike of solitariness serve to distinguish them from schizoids who commonly *like* to be alone. Despite this general schizoid tendency, however, two schizophrenes of my series (Nos. 30 and 36) had a few friends and obviously enjoyed sociability. Moreover three cases are discussed in Chapter VII who, whilst showing very numerous schizoid traits, were none the less extremely sociable. Considerations of this kind make me hesitant to accept the view that sociability is confined to syntones. We can probably conclude that whilst no syntones enjoy solitude, some schizoids prefer sociability.

All the evidence goes to show that these four traits—"steady worker", "practical", "few good friends", "quietly sociable",—are very common in syntones, especially the depressive group, but that they occur sufficiently frequently amongst schizophrenes to make it impossible to regard them as more than relatively specific. It seems likely, however, that all four in typical form rarely occur together except in a syntonic personality, and this is the closest that we shall get to finding specific syntonic traits.

Depressive Traits

The following 30 traits, although in no way specific either to syntone or schizoid, are characteristic of the more depressed members of each group. Since it is frequently forgotten, it must be emphasized that schizoids as well as syntones can tend towards either manic or depressive poles.[1]

5. Avoids Rows. Dislikes squabbles, always giving in, anything for peace.
6. Cautious. Careful, conservative, thrifty.

These two traits are exceedingly common amongst depressives and in many cases are extremely marked.

[1] When a patient is referred to as a "manic" or a "depressive", however, it always means a manic or depressive syntone.

Although 7 schizophrenes were described as doing their best to avoid rows, only one was said to be cautious, but this trait was not known about in half of them.

No less than 15 depressives preferred to *say nothing and give in* rather than make a fuss and risk a row. No. 12, aged 41, was said by his wife never to interfere or speak up for himself, being extremely worried afterwards if he had upset anyone. The wife of No. 8 said that he was always very afraid he might hurt other people's feelings. No. 18, a married woman of 41, was exceedingly upset if she felt that she had annoyed anyone. Her husband described how, after bridge parties, she often went round the next day to the people with whom she had been playing to apologize for some trifling action which had either passed unnoticed or been forgotten. No. 15, aged 57, described himself as hating rows and that he was " all for peace ". He said he would much rather give in than have a row. No. 13 avoided rows because he always felt that people would think badly of him if he upset them. These are typical examples of the trait amongst depressives. Of the 7 schizophrenes to show it No. 37 was the most marked. He was said to be exceedingly upset if he angered anyone.

Exaggerated *cautiousness* also appeared in at least 15 of the depressives. Nos. 11 and 12 may be quoted as instances. No. 11, aged 21, according to her mother, " always likes to feel she's on the safe side " and " would not run any risks at all ". The wife of No. 12 described him as wary, very careful and said that his mother had always brought him up to be so.

Since quarrelsomeness and recklessness are characteristic of hypomanic temperaments, it is not surprising to find that none of my four manic patients had shown these traits, and they had been conspicuously absent in No. 19, the depressive whose personality was commonly hypomanic.

Although not stressed in the literature, Kretschmer mentions both these traits and Kraepelin's "cautiousness"

as typical of the depressive syntone. It seems probable that they are typical not only of the depressive syntone, but also of the depressive schizoid, for they undoubtedly appear frequently in the latter.

7. CAN'T SAY NO. Over-sympathetic, over-generous, always helping people.

This trait was extremely common in both groups of patients. It was not investigated for every patient, but in almost every case where knowledge is available the trait is present.

The inability to say " No " is often an aspect of the desire at all costs to avoid rows, and is commonly shown by the same patients. A depressive who showed the trait very markedly was No. 10, a girl of 26, who was always excessively concerned to do the right thing by people and wore herself out helping her mother at home. No. 28 provided a good example of the trait amongst schizophrenes. He was said always to be very unselfish and thoughtful, especially for his mother. " Generous to a fault " is a phrase commonly used about these people.

An excess of generosity and sympathy are traits well known to occur in people who later become psychotic. Kretschmer regards soft-heartedness and a tendency to philanthropy as characteristic of syntones; but Amsden found that some schizophrenes, notably hebephrenics, were kind and generous and Bigelow thought that 19 of his 35 catatonics were " over-sympathetic ". These findings conflict with the usual view that schizophrenes are cold and unfeeling. Bowman's conclusions are very interesting in this connection. He found that his manic-depressives had been strikingly sympathetic in comparison to the controls, 51 per cent of the former having shown the trait as against 18 per cent of the controls, a conclusion which supports Kretschmer's view. The schizophrenes, he found, were less easily generalized about. On the one hand were some who

were extremely sympathetic, on the other were those who were utterly cold and had no feeling whatever for others. They tended towards the extremes of the trait compared to the controls. Coldness therefore is rightly regarded as specifically schizoid, but excess of sympathy, since it occurs in certain schizoids, cannot be *specific* to syntones, although it is exceedingly common amongst them.

OBSESSIONAL TRAITS

8. OVER-CONSCIENTIOUS. Worries to do work right, will work over-time to finish work.

9. ALWAYS BUSY. Makes work, on the go.

10. OVER-TIDY. Can't bear disarray, " everything has a place ", always putting things straight, etc.

11. OVER-CLEAN. Always washing, upset if even clothes get dirty, fusses.

12. REPEATS WORK. Uncertain it is right—must go over it again and again.

13. REPEATS PRECAUTIONS. Goes back to see if gas or electricity is turned off, door is bolted, cigarette extinguished, etc.

Although the specific relation of obsessional traits and symptoms to the psychoses has been discussed fully in Chapter VII, the extreme frequency with which they occur in the make-up of people who later suffer from any psychosis requires special emphasis here.

Every single one of the 19 patients who suffered from an affective depression, one of the 4 manics, and 10 of the 13 schizophrenes were regarded as *over-conscientious* in their work, and taking their responsibilities unnecessarily seriously. In a large proportion the trait was an exceedingly prominent part of their character.

Examples of depressives who showed the trait are the following. No. 9, who had a small business of his own,

was described by his wife as always having " worked too hard ". He " worried about trifling details " and " perfection is his aim in life ". He fell ill when his business was doing badly in the slump. No. 5 had been a night-watchman at a garage and was said never to have missed an hour's work. He fell ill when he lost his job. No. 12 was said to stress punctuality and was never a minute late for his work. He was most particular and took great pains over it. No. 10 was said to be too particular and fussy, laid great emphasis on right and wrong and was greatly exercised about doing the right thing by her boy friend. Many others could be quoted. Only one manic patient showed the trait, No. 21, who was described by his father as being " goody-goody ".

Of the schizophrenics who showed it, No. 34 was interesting. He was the man who spent several years after leaving school loafing about. When he did take up work, however, he became exceedingly conscientious and often went over it several times to make sure it was all right.

Obviously this over-conscientious frame of mind is one of the traits which makes a child a model-child. Considering what a large proportion of psychotics have been model children it is not surprising that over-conscientiousness is a prominent trait in their adult life. On the whole it has seemed to me rather more striking and frequent amongst syntones than schizoids.

The tendency, which some people have, to be *always busy* and to make work is obviously only another aspect of over-conscientiousness. It was present in at least 8 depressives, one manic and 4 schizophrenes. But these figures are almost certainly too small. The married woman, No. 18, was a good example. She was always fussing round the house, " too energetic ", and consequently invariably tired and good-for-nothing in the evenings. No. 33, a schizophrene, behaved in a similar way.

It is not unnatural that people who are so distressingly worried about doing their work properly should sometimes get into the habit of *going over it again and again* to make sure. Seven depressives and five schizophrenes did so, but no manics. Although the tendency was present in about a third of each group, none of them did it very much. No. 1, a depressive, had the job of winding the clocks at his work and he was inclined to go round them all a second time to make sure they were done. No. 32, a schizophrene, had got into the habit of checking over his bacon-slicing machine a number of times and No. 34 went over his motor-bicycle repeatedly. All of them knew that the job had been properly done before, but could not resist the impulse to make sure again.

The repetition of work was not carried very far by any patients, but the *repetition of precautions* such as turning off lights and gas, locking the door and so on was very marked. It was shown by 7 depressives, one manic and 5 schizophrenes, roughly the same number and almost all the same patients who had repeated their work. No. 12 had gone back to make sure the gas was turned off and the door bolted at least once every night since his wife had known him, often getting out of bed to have another look. No. 1 said he sometimes did it as many as four times. No. 10 said she returned often to see that she had locked the door of the shop where she worked whenever she had been entrusted with this duty, and also returned to see about the gas " several times ". No. 16 repeated the gas two or three times and would worry if he saw a fire engine when he was out lest it should be going to a fire at his house. Amongst the schizophrenes No. 31 went back " always an extra once to make certain ", No. 32 often repeated the whole performance of putting out the lights, turning off the gas and locking the door twice after he had originally done it. These examples may show how frequently this trait is met with in people who later become psychotic.

No less than 16 of the depressives, 3 of the manics and 3 schizophrenes were fussy and particular *about everything being tidy* and just so. It is noticeable that practically all the syntones, of whom there was any record, showed it, the chief exception being No. 18 who was noticeably untidy. No. 3 said that he was " terribly fussy ", No. 17 who was a letter-sorter was described by a great friend to be very particular, " everything must be just so ". No. 6 was described by his wife as being " too particular ", and No. 15 said of himself that he was " naturally tidy—I am always tidying things up ". Similar remarks apply to the majority of the other patients. The schizophrenes did not show the trait to anything like the same degree.

Emphasis on *cleanliness* was almost as widespread amongst the syntones as it was on tidiness, at least 14 depressives and 2 manics showing it. Only 3 schizophrenes paid special attention to it, but in each case it was prominent. Amongst the depressives No. 10 carried cleanliness to great lengths. Ever since she was a small child she had never been able to bear dirty hands or a dirty dress and was said to be " always washing ". No. 12 spent at least three-quarters of an hour washing on his return from work (gas-fitter). No. 19 said he could never bear dirtiness, he had " a horror of dirt ". No. 17 was always busy about the house and garden and liked " everything clean and spotless ". Of the manics No. 23 said that he was extremely fussy about everything being clean and that he " used to be very fussy indeed ". Of the 3 schizophrenes, No. 33 was perhaps most upset by things being dirty. Her husband said that she would burst into tears if a cup of tea was spilt on the floor and wore herself out doing unnecessary cleaning.

Another obsessive trait which might have been included in the inventory is *indecision*. A large proportion of patients who show the traits already discussed are chronically indecisive, not only when big issues are at stake, but even when writing some unimportant business

note. Whilst on the way to the pillar-box they will reconsider what they have written, open their letter to make sure there is nothing rude in it (they are usually afraid they might hurt the recipient's feelings) and then write out another envelope. Many instances could be given from this series of patients and it is a trait widely commented upon in the literature.

Such details may give some indication of the very *widespread incidence of obsessional traits in the prepsychotic personalities both of affectives and schizophrenes.* Although full details are frequently lacking in the case of the schizophrenes, I have the impression that they are more uniformly and constantly present among depressive syntones than among schizoids. A full discussion of the literature will be found in Chapter VII but the neglect of these traits as an essential part of the depressive syntonic personality should be mentioned. It is true that Abraham commented upon them and recently Lewis has drawn attention to their appearance in as many as one-third of 61 melancholics, but few textbooks mention the association. For instance, Kretschmer, usually so accurate, although describing obsessional traits *en passant* in several case histories of depressives, allows the notion that it is only schizoids who are pedantic and scrupulous to pervade the rest of his book.

14. RETICENT. Keeps self to self, prefers not to discuss private affairs.

This trait has been so widely and so long regarded as specifically schizoid that there may be surprise to find that *practically all the depressives of this series were characteristically uncommunicative.* Only one was not so regarded and two were unknown. Only one manic patient had shown the trait for certain. Schizophrenes also showed it with great frequency which suggests that marked reticence is a trait specially common in people liable to a psychosis, but bears no relation to the particular type.

Phrases such as " he keeps himself to himself " or " she's very reserved " were used again and again by the relatives of depressive patients as well as of schizophrenics. No. 6, aged 36, was described by his wife as " very quiet and reserved " and when asked about friends she remarked " we always keep ourselves to ourselves ". No. 14, aged 45, was said to be very reserved and seclusive about his private life, although he could be bright and cheerful in company. The wife of No. 12 complained that her husband was so reticent about his feelings that she never knew how he was—" I have such a job—he would never complain "; whilst No. 11 was described by her mother as " very reserved in every way—very quiet ". It is hardly necessary to give examples of schizophrenes who show the trait. However, No. 26, the saint-like boy, was described by his father and uncle as extremely uncommunicative and difficult of access and this was true in varying degrees of other schizophrenes.

In view of current opinion it is not surprising that whereas most psychiatrists mention reticence as characteristic of schizoid personalities, so far as I know only one, Bowman, has recognized its frequency in syntones. It is interesting that three separate workers, Bigelow, Blalock, and Bowman each found that about two-thirds of their schizophrenic patients showed the trait. As against this figure, Bowman found that it was characteristic of only 40 per cent of his manic-depressives. This is markedly fewer, but since the controls only showed 13 per cent he feels justified in concluding that reticence is a significant trait for those disposed to an affective illness as well as for those liable to schizophrenia, a conclusion confirmed by my own observations.

Nevertheless all prepsychotics are not reticent. Although fewer than in the control group (27 per cent), Bowman found that there were a number of both affectives (16 per cent) and schizophrenes (7 per cent) who had appeared notably *frank and open* before their illness. Of my series of patients 5 affectives had been

given to talkativeness (3 of these were markedly hyperthymic), and one schizophrene (No. 28) was in this category.

Although Bowman draws no distinctions between depressive and hyperthymic types, it seems extremely probable that reticence is a trait shown principally by the depressive personality, and in any given series of syntones the proportion who are specially reticent will vary directly with the proportion who are depressive. It is possible that Henderson and Gillespie were thinking particularly of hyperthymics when they wrote that manic-depressives are commonly frank and open. As a description of the group as a whole it is unquestionably wrong.

15. ASCETIC. Regards pleasure as bad, very frugal.

16. TEETOTAL

The information which I obtained about these two traits is inadequate. It has been my impression, however, that depressive personalities of either the syntonic or schizoid type are inclined to show the traits rather frequently.

Kretschmer regards asceticism as particularly characteristic of schizoids and the probability is that if a schizoid is ascetic, it will be in a dramatic and striking way. But Kraepelin notes the frequency with which depressives practise "exaggerated frugality" whilst Bowman, studying the prepsychotics' addiction to alcohol, found that, as compared to the normal, they were apt either to be teetotal or to take too much. Exactly two-thirds of each group (schizophrene and affective) was teetotal as compared to 40 per cent of the controls, whilst 3 per cent of each group was alcoholic as against nil in the controls. Since the psychotic group had also been inclined either to be non-smokers or to smoke excessively it seems fairly certain that these extremes are important non-specific prepsychotic traits.

17. HATES KILLING. Can't kill a fly (often vegetarian and anti-blood sport).

This trait is allied to the tendency to avoid rows. It was present in at least 8 depressive patients and 2 schizophrenes, but this is probably an under-estimate as it was not enquired for in several patients. The wife of No. 5, an elderly depressive, was very contemptuous of her husband because although he kept chickens he would never wring their necks and had to get in a neighbour to do it for him. No. 9 was said to be so kind that he would not hurt even a mouse and No. 8 was said never to hurt anything, his wife adding that he was " more like a girl in his sensitive feelings ". No. 11, aged 21, was said by her mother never to have pluck enough to kill a fly or a beetle.

The schizophrenes did not show the trait so unequivocally.

Only Kraepelin and Kretschmer mention it. Kraepelin speaks of a " weak sentimentality " which may lead to vegetarianism as common in depressives, whilst Kretschmer includes it as part of the saint-like quality of some schizoids. There seems to be no reason to regard it as commoner in the one than the other.

18. OVER-ATTACHED TO FAMILY

This has already been discussed with schizoid trait No. 21, " hates family ", in Appendix A.

19. WORRY OVER RELATION'S HEALTH. Upset and fussing if any relation is ill.

This trait has much in common with No. 7 of the non-specific group (Can't say No) and, like it, was found extremely commonly in both affectives and syntones.

Of the large number of patients who showed it No. 18 may be selected as an example. She had one boy, aged 10, who could never have a cold or a pimple without his mother fussing, calling in the doctor and applying a variety of remedies. If her husband came

back late from work she had always anticipated a serious accident and was thoroughly worked-up by the time he returned. Both Nos. 8 and 12 had been very upset when their wives had miscarriages.

Although only 3 schizophrenes were definitely known to have worried excessively over their relations' health and the literature breathes not a word of it, it has nevertheless seemed to me likely that it is a common prepsychotic trait amongst them. This view is based on the fact that in a considerable proportion of schizophrenes (about 10 per cent) the illness can be dated from the death or serious illness of a close relative and much other evidence which goes to show that psychological shocks of this kind can be the precipitating factor for such an illness. The same is true of affectives and it is reasonably certain that no less than 5 of my series (about 20 per cent) were precipitated into illness by such an event. These patients were Nos. 1, 10, 13, 16 and 21.

No writer seems to have singled this trait out for special comment, but several (Kraepelin, Hoch, MacCurdy, Lewis, Smalldon) remark on the tendency that many depressives have had all their lives towards worry and anxiety. Kretschmer quotes the case of a male depressive who had never married because of the " anxiety that he might have a diseased wife and sick children ; or one or other might die ". It is no doubt anxieties of this kind which frequently lead to the exaggerated caution which has already been noted as a depressive trait.

20. Pessimistic. Gloomy.

My information on this trait is also deficient. Roughly 8 depressives and one manic were noticeably pessimistic people ; the fact that none of the schizophrenes were marked so should be disregarded.

The trait has been widely commented upon in the literature. Hoch, Kraepelin and Kretschmer all regard it as typical of the depressive type and Smalldon

confirmed this view. Henderson and Gillespie mention it and Lewis found a "gloomy, pessimistic, worrying disposition" in no less than 30 (50 per cent) of his melancholics. As previously mentioned one of the most frequent topics to be worried over is the health and safety of relatives.

Whilst it is possible that pessimism is more noticeable in the depressive syntone, I should be very much surprised were it to prove rare in depressive schizoids.

21. OBSTINATE. Very intractible, negativistic.

Once again information is deficient, but there is probably enough to dismiss the theory that obstinacy is specifically schizoid. No doubt Kraepelin and Kretschmer are right in holding that it is common amongst schizoids, since Blalock found it in about one-quarter of his catatonics and 4 out of the 6 of my series investigated had shown it. For instance, No. 24 was extremely negativistic if put out. But several affectives were also obstinate, particularly the depressive No. 19, who was usually of a hypomanic disposition. Smalldon's observations are interesting. He found that obstinacy was common amongst affectives although almost confined to the hypomanics. Depressives were not obstinate, which is in accordance with our previous finding that most of them are anxious to please and avoid rows at any cost. Perhaps the trait should appear amongst the hyperthymic rather than the depressive traits therefore.

22. SUSPICIOUS. Feels people are working against him.

Although no less than 7 schizophrenics of my series were regarded by their friends or relatives as suspicious individuals (4 markedly so) it is unlikely that this is a specifically schizoid trait as, following Kretschmer and Amsden, I had at first supposed. Of my affectives 5 were regarded as suspicious (2 strikingly) and Lewis found the trait in 9 out of his 61 melancholics (15 per cent). Blalock found it in only one of his 25 catatonics.

It is possible, however, that, like other non-specific traits, extreme forms of it may be confined to schizoids and it may be relatively more frequent amongst them. Lewis's figures prohibit its inclusion as specifically schizoid.

23. OVERSENSITIVE. Feelings easily hurt, sees slights, touchy.

The tendency to be sensitive and touchy has been widely commented upon in the literature upon pre-psychotic personality. In certain quarters there has been an inclination to regard it as a schizoid trait but other evidence has made it abundantly clear that it is quite non-specific, and that it is far commoner amongst those liable to psychosis than in the ordinary person.

In my series, 14 depressives, one manic and 7 schizophrenes were markedly oversensitive, it often being the trait most commented upon by relatives. Examples of oversensitive depressives are the following. The wife of No. 5 said that he was " worried about trifles " and that he would get " irritable and fidgety if anything went wrong ". No. 6 was said by his wife to be " specially sensitive ". She said he would keep worries to himself and brood over them. No. 9 was said to be " super-sensitive " ; brooded a lot and " would not hit back " if attacked. No. 8's wife said that he was " more like a girl in his sensitive feelings ". No. 18, the woman who fussed so about her son's health, was said to be " frightfully sensitive to criticism " and took all sorts of small things to heart. When it was said that she had an " inferiority complex " or was a " doubting Thomas " she brooded over it for days.

The schizophrenes showed similar tendencies. No. 31 was said to be " very sensitive and easily upset ". No. 32 said that criticism upset him and made him feel " ill and flustered ".

Kretschmer's description of cycloids, whilst extraordinarily illuminating and accurate for the most part, seems to me to give quite a wrong impression regarding

sensitivity. Cycloids and schizoids are implicitly contrasted when, in one place, he writes that " cycloids have no, or very few complexes " and implies that they do not get upset and brood over things, and elsewhere he remarks on the " sensitivity, susceptibility, and a passionate violence which springs from the presence of complexes " as being characteristic of schizoids. He further describes cycloids as " able to give themselves up to the momentary mood of the milieu ", and comments on " the absence as a general rule of strong inhibitions, jerkiness, stiffness and awkwardness ", implying that they hardly suffer from shyness or self-consciousness which, of course, are closely related to touchiness. It has seemed to me that Kretschmer is markedly biased in all this. There can be no shadow of doubt that a large proportion of syntones, especially those liable to psychosis, are full of strong repressed emotions which make them pathetically sensitive to criticism and the misfortunes of life. It will also be seen that self-consciousness tends very much to isolate them in a gathering of strange people and that often their inhibitions make it quite impossible for them to " give themselves up to the momentary mood of the milieu ". Many others have realized this, notably Hoch, MacCurdy, Lewis, Smalldon, and Bowman. Lewis found that just over half of his melancholics had been specially sensitive and touchy ; Smalldon noticed it in 44 of his 75 manic-depressives, 27 of whom were also easily offended.

Bowman's figures are as interesting as usual. An attempt was made to gauge the sensitivity of patients and controls both in childhood and also in adult life. It was found that there was no appreciable difference in the sensitivity of the three groups in childhood—about 50 per cent each of schizophrenes, manic-depressives and controls showing the trait ; but when adult life was reached, whereas the proportion of controls who remained sensitive halved, both schizophrenes and manic-depressives showed a slight *increase*. These are the figures :

	Per cent extremely sensitive in (A) Childhood	(B) Adult Life
Schizophrenes ..	52	57
Manic-depressives ..	44	50
Controls	52	19

They show also that there is not much difference in the proportion of schizophrenes and manic-depressives who are over-sensitive. Its frequency in schizophrenes is confirmed by Blalock and Bigelow. The former found it in about two-thirds of his patients whilst the latter found it in no less than 31 of 35 cases.

All the evidence then goes to show that over-sensitivity is a trait which is characteristic of from one-half to two-thirds of all patients liable to a psychosis and that it is absolutely non-specific.

24. BROODS. Can't forget it.

25. DEPRESSIONS. Gets very depressed at times.

Sensitive people show a variety of reactions to criticism, the commonest perhaps being a tendency either to take it to heart and brood over it or else to flare up and be angry with the critic. It is particularly characteristic of the depressive temperament to take things to heart and to be depressed, whereas the hyperthymic becomes angry and often abusive.

It is probable that the inclusion of both these traits is unnecessary, for depressions are commonly prolonged bouts of brooding. The figures relating to the two are, moreover, very similar. Of the 19 depressives 12 were given to brooding and 11 had depressions. Two manics brooded and one had depressions, whilst schizophrenes were 5 and 7 respectively. Examples of depressives who brooded much over criticism were given in the discussion on over-sensitiveness. No. 19 was interesting as showing variations of response. Unlike the great majority of the depressives of this series, who were

uniformly quiet, pessimistic, cautious individuals, this man was typically variable in mood, sometimes excited and at others depressed. Respecting his reactions to criticism his wife remarked that he was " easily put out and quick to take offence ", whereas he described himself as " taking things to heart ". There were two sides to his character, one seen by friends, the other by himself. This man had also been prone to fairly severe depressions throughout his life, when he felt incapable of doing his work and meeting people and retired to bed for a few days. Several others had had bad bouts of depression following some upset, but usually not severe enough for them to throw up their work.

Several schizophrenics had also had frequent depressions. Ever since leaving school about five years previously No. 32 had been prone to severe depression and shortly before becoming obviously schizophrenic seriously considered suicide. No. 29, a girl of 20, had a very similar history. She felt fated to end in the gutter and very nearly succeeded in gassing herself. No. 34 had regular depressions when he used to drink and go with prostitutes. He said that he had " got used to them ".

Although both types are inclined to hide their depressions from others, one gets the impression that schizophrenes do it more successfully. It is surprising what deep depression can be hidden from the eyes of not too observant relatives. It seems worth calling attention here to the frequency with which schizophrenics get depressions because the literature does not emphasize it. Kraepelin, Bleuler, Kretschmer, MacCurdy and Smalldon all regard the tendency to brood as typical of the depressive syntone but none of them relate it to schizophrenia, although Kretschmer describes some schizoids as morose and sulky. It is consequently interesting to find that Bigelow and Blalock each found about 40 per cent of their catatonics had been given to brooding or moodiness.

26. SELF-DEPRECIATORY. "Inferiority complex", apologetic, lacks confidence, feels guilty.

Bitter self-reproaches are the hall marks of a depressive state and so it is no surprise to find that many of the patients who suffer such an illness have previously shown the tendency to self-reproach, though never in such violent form. At least eight depressives of my series had been inclined to blame themselves when things went wrong, to under-estimate their abilities or to feel that they were worthless human beings. None of the 4 manics showed the trait and only 2 schizophrenes, but these figures are certainly under-estimates.

Three depressive patients who showed the trait characteristically were Nos. 10, 12 and 15. No. 10 was thought well of at work. Nevertheless she was afraid to take a better post when offered for fear she might not be good enough at it. This refusal of promotion is frequent amongst depressives; they prefer a safe job which they know they can manage to the difficulties and responsibilities of something more glorious. No. 12 had also refused a better job and his wife said that "he would not think he could do what he could do". No. 15, an elderly bachelor, had been secretary of a charitable organization. Judging by its rapid growth it seems that he was energetic and successful in his work, but even so he had for many years been haunted by the fear that he was "not up to the work". He had felt that it was getting too much for him—"it was increasing whereas I was getting older. I was always afraid that I would not be able to do the work right". When he caught a heavy cold and was confined to bed for a day or two these fears were confirmed, and this was the beginning of his depression. In hospital he remarked, "the mere fact of lying up at all confirms my fears that I'm not up to the job".

This feeling of not doing work properly accounts of course for the over-conscientiousness and tendency to repeat work again to make sure that it is right, also

for the over-sensitiveness to criticism. " If the cap fits put it on ! " Depressive personalities constantly feel that the cap does fit and read criticisms of themselves into the most harmless utterances or take a casual comment as a serious reflection on their work. Being in exaggerated form a symptom of depression, it was early noted as occurring also in the healthy phases of depressives. Kraepelin comments on their feeling of guilt, often over masturbation, their lack of self-confidence and their tendency to avoid tests which might show them up, such as examinations, whilst MacCurdy noticed that many of his depressives were notably lacking in confidence, noting especially their fear of responsibility.

Although it seems probable that the trait appears more commonly and in more undiluted form in depressives, there can be no doubt that it is also a feature of schizoid personality, a fact which has been a little overlooked. Amsden regards lack of self-confidence as specially frequent in hebephrenics, whilst Bigelow found that about half of his patients had suffered from a " conviction of guilt ". Since over-conscientiousness and a heightened sensitiveness to criticism are both non-specific traits and are also functions of self-depreciation, it follows that self-depreciation is also likely to be non-specific.

Of recent years we have heard much about the " inferiority complex " as the cause of neurosis. Although there may be differences of opinion regarding its origin and its relation to moral inferiority or guilt, it is certain that a large proportion of psycho-neurotics suffer from it. The fact that psychotics also manifest it both frequently and strikingly strengthens the view that psycho-neurotics and psychotics differ quantitatively and not qualitatively.

27. SELF-CONSCIOUS. Shy, fears blushing, feels people look at him, always bothering about appearances.

Practically all the patients of my series, depressive, manic, and schizophrenic, complained of being very

self-conscious at a party or in a public gathering. There can be no doubt that this trait is quite non-specific and the frequency with which it appears prepsychotically suggests strongly that psychotics are drawn from the ranks of the self-conscious.

Of the 16 depressives who were noticeably self-conscious, No. 8 was said to be " very shy and reserved " when there were people present whom he did not know. No. 10 was said by her mother to be very nervous at parties, although, despite her shyness, she would play the piano and sing. The sister of No. 15 stressed his self-consciousness particularly. He himself said that he was never comfortable at parties and felt tongue-tied, that he avoided the limelight and hated being conspicuous. Three out of the 4 manics said that they were usually shy. No. 20 had resigned rather than be soloist in the choir in which he sang and said he hated the company of strangers because of self-consciousness. If he was wearing a new suit he always felt that people were looking at him. No. 21 felt shy with girls, complaining that they stared at him and made him feel very uncomfortable. The fact that he was only 17, an age when many boys are self-conscious, makes it less important. No. 23 complained of having been morbidly introspective between the ages of 16 and 18.

At least 9 of the schizophrenes had been bashful. No. 24 was described by his sister as very " shy and bashful " especially with girls. The father of No. 27 said that he was " very shy " and the patient himself complained of being " very self-conscious ". He said that he could " not stick being in company with a new suit—everyone is thinking about you ". It is noteworthy that he had hardly ever been to parties or cinemas. No. 28 had been " very, very shy " with girls and his parents said he had been " very shy and sensitive ". He had often felt that people in trains were looking at him. No. 32 was described by a friend as excessively self-conscious and " nervy in company ", whilst No. 34

said that he had always been self-conscious in a restaurant and that latterly it had become impossible for him to go into one.

Perhaps the schizoids are more acutely self-conscious than the syntones but there seems little ground for Kretschmer's view that excessive shyness is probably due to schizoid constitutional components. Both Kraepelin and Smalldon found shyness frequently amongst their depressives, whilst Amsden and Bigelow note it commonly in schizophrenes. Self-consciousness is first cousin to ideas of reference and feelings of persecution, symptoms which occur almost as frequently though less dramatically amongst affectives as schizophrenes. Once again then we find that most of the patients who are liable to the symptom have shown the corresponding personality-trait whilst in health.

CONCERN FOR HEALTH

28. PATENT MEDICINES. Persistent addiction to medicines, excluding laxatives.

29. WORRY *re* BOWELS. Upset if motion is missed, takes frequent laxatives, diets, etc.

33. INVALIDISM. Always looking after self because of supposed ill-health, wanting attention from relatives and doctors.

An addiction to *patent medicines* is a symptom of anxiety over health and is very common. Although it is my impression that some of the most persistent addicts are to be found amongst schizoids, its frequency in syntones is such as to make specificity difficult to prove. Four schizophrenes and 5 affectives of my series had taken them persistently. Had laxatives been included under this heading the proportion in each group would have nearly doubled.

Unfortunately I did not at first enquire into the tendency of patients to *worry over their bowels* ; no less

than 6 out of the 15 affectives questioned did so, however, and 3 of 6 schizophrenes—nearly 50 per cent of each. These figures suggest that the trait is common to the psychoses and not specific. None of my patients showed symptoms of actual *invalidism*, but it has been my impression that patients who do are as often depressive syntones as schizoids.

Hypochondriacal delusions are so common in both depressive states and schizophrenia that it is not surprising that worry over health should appear frequently in the prepsychotic personalities. Kretschmer seems almost to suggest that a tendency towards hypochondria is specific to schizoids but it is quite certain that this is not so, though it is possible that some particular hypochondriacal traits may be. It is true that nearly 40 per cent of Bigelow's schizophrenes were hypochondriacal before falling ill, but 20 per cent of MacCurdy's depressives were hypochondriacal also and both Kraepelin and Bleuler regard this worry over bowels and other hypochondriacal speculation as particularly common in depressives. Bowman did not include these traits in his investigation.

The frequency with which hypochondria precedes psychosis should make us chary of classifications which attempt to set it up as a separate " disease ".

30. PAINS. Functional pains, headache, indigestion, ' neuritis ', etc.

Functional pains are usually regarded as symptoms of conversion hysteria and it is under this heading that a full discussion of their relation to depression will be found.

Five patients of this series, all depressives, had suffered from severe pains of various kinds before their breakdown. Considering how common indigestion and headaches are this is not a very high proportion, but information is missing regarding a number of patients. No. 1 had suffered from constant headaches, though they

were not bad enough to make him leave work. No. 12 had been subject to attacks of " tummy trouble " and a dragging pain in the left side which he believed to be colitis. Ever since serving in Mesopotamia during the War, No. 15 had had indigestion and constipation, which may have been due to dysentery. But he had also had attacks of ' neuritis ' in his neck and left shoulder. They lasted 4 to 5 days and came on irregularly at intervals averaging about six months. The depression in which I saw him was his fourth and he alleged that during each of his depressions " all these things vanish ", " bowels act like clockwork ", and he had " no trace of indigestion ". Of the two women, No. 10 had had extremely painful dysmenorrhœa. From the age of 11 to 24 she had been sick and always had to take a day off from work. No. 18 was always complaining of a headache and indigestion or some other little ailment.

31. TIC, SPASM, ETC. Functional movements of all kinds, hysterical vomiting.

Functional movements are also discussed fully in the section on conversion hysteria.

Only two patients were known to have suffered from these disorders, one depressive, the other schizophrenic. The depressive, No. 15, had had a previous attack of depression about 6 years earlier. It lasted about 4 months and during part of this time he had shown unilateral twitching of his left arm. The schizophrenic No. 36 had had St. Vitus' Dance when 10 years old. Following a shock he had developed unilateral movements of the left arm which lasted 6 to 9 months and seem to have been functional in origin.

32. IMPOTENCE (OR FRIGIDITY). Partial or complete ; ejaculatio praecox.

It is of course impossible to assess this trait in patients who have never attempted sexual relations. Only one schizophrene had suffered from it, whereas 3 affectives,

all depressives, had been troubled. This amounts to some 12 per cent of the affectives, which seems to me significant. Both Kraepelin and Henderson and Gillespie mention psychic impotence as a characteristic of the depressive temperament, and with this I should agree with the proviso that schizoids probably suffer from it quite as often.

33. INVALIDISM

This has been discussed in conjunction with Nos. 28 and 29 of this series.

34. ACCIDENT-PRONE. Always getting involved in accidents, either major or minor.

It has been known for some time that certain people are especially liable to accidents. Since in some instances it is clear that an unconscious suicidal impulse is present, it seems likely that many of them will be of the depressive temperament. This is hypothesis and I have no confirmatory evidence. Actually only one patient of this series had had many accidents ; he was a manic (No. 20). His father described him as " unlucky " in sports owing to his tendency to get injured. Since, so far as was known, no depressive showed the trait, it seems unlikely that it is such a constant part of the depressive character as, say, over-conscientiousness or reticence. It is not commented upon in the literature, but Kraepelin remarks that depressives are very liable to experience unaccountable " ill-luck ", which would presumably include accidents. Of course the best way of testing the suggestion that depressives are accident-prone would be to examine a number of people known to be accident-prone to discover whether they have the traits characteristic of depressives.

ANXIETY TRAITS

The previous 34 traits are frequently found together in depressive personalities, all of them being consistent

with the others. The following 11 are in many cases the opposite of, or at least incompatible with, many of the previous traits. Although they appear sporadically in many depressive patients, when they are present as a syndrome they indicate a particular type of depressive and one which, when not coupled with schizoid traits, is probably particularly liable to an *agitated* melancholia.

35. ANXIOUS. Openly worried and anxious, fusses, nervous ; gets upset if relations come home late, fears an accident, etc.

Excessive care over precautions and worry over relations' safety are both symptoms of an anxious frame of mind and it might seem hardly necessary to include this heading separately. Some people manage to cloak their anxiety, however, and this heading is meant for those who manifest it openly and often. At least 8 depressives and 4 schizophrenics were noted down as being obviously anxious personalities who were constantly fearful of some impending disaster.

The tendency of depressives to be anxious has been very widely recognized. Kraepelin describes them as anxious and despondent with extreme facility and quotes one as remarking " I was born in anxiety ". MacCurdy also found it in a number of his cases. It is consequently surprising to find Kretschmer saying that the " cycloid is either sorrowful or hot-headed, but he is never in the very least nervous ". It is true that he modifies this later but even so he does not regard nervousness as common amongst cycloids, and feels that anxiousness usually indicates a schizoid component. The evidence of anxiety amongst the affectives of this series together with the observations of others should be sufficient to disprove Kretschmer's view. There can be no doubt however that anxiety is a feature of the schizoid personality also. In addition to Kretschmer, many investigators have commented upon it including Kraepelin and Amsden. Blalock found it in about a quarter of his

catatonics. The relation of anxiety states to the psychoses has been discussed fully in Chapter VII.

36. PHOBIAS. Of dogs, horses, etc., fear of burglars at night, terrified of thunderstorms (gets under bedclothes), claustrophobia (fear of going in tubes).

Whereas the term anxiety is commonly confined to fearful expectation of the unknown event, the fear in phobias is more defined, attaching itself to some special object. Only two depressives and one manic were known to suffer in this way, though this is probably an underestimate. Both Nos. 16 and 18 were terrified of thunderstorms and the former was also very afraid of dogs. The manic, No. 20, was afraid of electricity, and when on a tram was afraid it might fall over.

Four schizophrenes had had phobias. No. 31 was afraid of dogs, No. 32 got nervy and excited over thunderstorms and was also "frightened to death of spiders", No. 33 was constantly terrified of burglars, whilst No. 34 had fears of both thunder and animals.

37. UPSET BY ACCIDENTS. Alarmed by blood.

38. FEARS BEING ALONE. Must have companion.

These are both specific situations in which anxiety is called forth in anxious personalities. They were not included in the enquiry sufficiently early for any conclusion to be drawn about them, nor does the literature discuss them.

39. ERRATIC. Good and careful one day, bad another.

This trait, being the opposite of steadiness and incompatible with an obsessive character, is found in only one depressed patient, No. 18. Two manics show it, however, and 5 schizophrenes.

No. 18 was an anxious "hysterical" woman who was very variable, one day doing her work excellently, the

next getting into a muddle. The two manics, Nos. 21 and 23, were rather changeable at their work, but were not very markedly unreliable. Of the schizophrenes No. 33 was very like No. 18, No. 34 would work very well for several weeks, then be depressed, drink and go to bits for a time, whilst No. 35 had had numerous jobs, constantly taking something up enthusiastically and then dropping it.

In this series of patients it is commoner amongst the schizophrenes, but many hyperthymic personalities show the trait markedly and it is certainly not specifically schizoid.

40. SPASMODIC ENERGY. Works in fits and starts.

A very variable energy output was seen in 2 depressives, one manic and 4 schizophrenes. No. 18, the 'hysterical' woman, was apt to work hard for a day or two and then go "flat". No. 19, who was of a circular temperament, fluctuated greatly in his work, sometimes working at high pressure, at others feeling depressed and staying in bed. The other patients showed similar variations though in some cases the periodicity is a matter of weeks, in others of hours.

41. VERY UNTIDY. Leaves things all over the place.

In opposition to the exaggeratedly tidy obsessive characters, anxious personalities and some hyperthymics are apt to be extremely untidy. They keep their possessions in a hopeless muddle, never know where anything is and leave their bedroom strewn with garments. Nos. 18 and 19 were like that amongst the depressives. In addition 3 schizoids tended that way.

The literature is comparatively silent on the last 5 traits. It is clear from my own series of patients that they are not specific to either syntone or schizoid, but there is insufficient evidence to know whether they are commoner in prepsychotics than in controls. It would

surprise me if they did not turn out to be more frequent in the prepsychotics.

42. UP and DOWN. *Rapid* changes of mood.

The term manic-depressive as applied to the group of affective psychoses has led to the widespread delusion that anyone liable to a manic or a depressive attack has always shown excessively variable moods. Henderson and Gillespie, for instance, talk about the syntonic personality as " characterized by its affective lability and responsiveness " and also describe the manic-depressive disposition as one in which " the affect swings from states of elation to states of depression in people who are generally recognized to have frank open personalities ". Now of the 23 affective patients of this series only 4 showed markedly labile moods, though 6 others had some tendency to variation. A large number of the obsessive personalities were conspicuous for the evenness of their moods. Everyone shows some variation and no doubt these quiet obsessive people changed, some days being more cheerful than others, but it must be emphasized that only 4 out of 23 patients had shown anything corresponding to the " swings from states of elation to states of depression " of the above description.

No. 19 was one of the 4. He described how he varied from " great heights to great depths " and seldom struck a happy mean. On several occasions he felt he had " outdone his strength through sheer excitement " and frequently his feelings ran away with him. On the other hand he would fall into deep depression at times and do no work for 2 or 3 days together. This patient was a typically circular personality and as such has been described in Chapter V. No. 16 was not so markedly circular. He was prone to depressions, however, and occasionally became euphoric, sometimes spending more than he could afford on clothes. Not long before his breakdown he had taken up professional dancing in addition to his garage work. These 2 patients showed

variations which had a comparatively long periodicity. No. 18, on the other hand, varied almost from minute to minute. One moment she would be despondent and depressed, the next cheerfully entertaining friends who might have dropped in.

In none of the schizophrenes was variability of mood so marked though it is my belief that certain hysterical schizoids are liable to great fluctuations of feeling (see Chapter VII).

It is interesting to note that Kretschmer does not include lability of mood as one of the chief cycloid traits ; indeed it figures very little in his description of cycloids. Bowman does not appear to have studied it particularly but his characterization of affectives as steady good workers with a great energy output is clearly inconsistent with violent fluctuations of mood. Both Kraepelin and Smalldon found that this variability of mood is confined to the irritable or cyclothymic group of manic-depressive patients and is not common in either depressive or hyperthymic personalities. Lewis found " variability of mood " in only 19 of his 61 melancholics. From these figures we may conclude that descriptions of syntones as suffering typically from marked fluctuations of mood are grossly misleading. Not more than a third of affective psychotics have previously been of this temperament.

Its incidence in schizoids is not much discussed. There is little doubt that it occurs but probably in only a very small proportion, perhaps 5 to 10 per cent.

43. IRRITABLE, SULKY. Bad-tempered, morose.

In opposition to people who are either habitually good-tempered or who flare up quickly and then regain their tempers are people who, when frustrated or criticized, become irritable and sulky, their bad temper smouldering beneath a petulant exterior. It has already been pointed out that many depressives go out of their way to avoid being offensive in any way and this is

probably the explanation for so few being notably irritable. Only 5 were given to bad-temper, No. 1 tending to be grumpy, Nos. 3 and 19 flaring up and No. 5 sometimes one, sometimes the other. Sulkiness was found in no manics and only one schizophrene.

It is difficult to discuss the literature because the distinction between sulking and flaring up as a result of being irritable is not always made.

44. SELF-PITY. Martyr, "nobody loves me", feels thwarted.

This trait is typical of the egocentric, hysterical type of person. Although not carefully looked for, it was probably not common amongst the depressives. It had been shown definitely only by Nos. 18 and 19. No manics or schizophrenes were known to have shown it.

Kretschmer regards it as rather more common in schizoids, but it seems probable that it simply denotes an hysterical factor which may appear in either syntone or schizoid.

45. JEALOUS. Acute jealousies.

Jealousy was not a trait carefully investigated. The only patients known to have shown it were 4 depressives (Nos. 18 and 19 very markedly) and one schizophrene. No. 18 had always been intensely jealous of her husband and had threatened to break off the engagement because he went out one evening with his cousin. No. 19 had been exceedingly jealous of a business partner.

Although the most noticeable examples of jealousy in this series were amongst the depressives, it has been my impression that the most intense of all are shown by schizoids. One patient who had a schizophrenic attack 5 years ago and whom I have seen recently suffers from the most dreadful jealousy whenever she sees another pretty girl. Bigelow and Blalock each found jealousy in about a quarter of their catatonic patients. Intense jealousy indeed may be considerably more frequent in

schizoids than syntones, but since Kraepelin found it common in his irritable depressives (and this is also my own finding in 2 cases) it is certainly not absolutely specific to schizoids.

Hyperthymic Traits

The following 18 traits have been widely recognized as characteristic of the sanguine temperament. Common everyday experience leads one to expect them to be found together in the same personality and most of the work which has been done has confirmed this view. Indeed there is probably less conflict of opinion about these traits than about any others. The descriptions of the manic personality given by Kraepelin and Kretschmer are very similar and include practically all the traits here listed and of course some that are not. Both Wertham, who investigated a number of cases of chronic mania, and Smalldon comment upon about half a dozen of them. Bowman, however, did not pay them much attention.

Since there are only 3 or 4 hyperthymic personalities in my series and so far as they go they confirm the accepted opinion I do not propose to deal with these traits at any length. It is important, however, to consider their relation to schizoid personalities. When dealing with depressive traits, it was constantly my aim to make it clear that many traits which are commonly regarded as specifically schizoid, such as sensitiveness and self-consciousness, are not so at all, being equally common amongst prepsychotic syntones. It was also necessary to emphasize how few, if any, traits could be regarded as specifically syntone. This is again the case here. Practically all of these traits occur occasionally in schizoid personalities, and it is doubtful whether even when a group of them is considered together any significant differences appear.

The first 7, like the first 4 non-specific traits, are all more or less healthy and desirable.

46. MANY ACQUAINTANCES and friends.

47. ENJOYS PARTIES. Happiest in a crowd, good mixer.

48. JOLLY, CHEERY. Makes jokes, laughs a lot.

49. PRACTICAL JOKES. Comedian, buffoon.

50. OPTIMISTIC. Always hopeful.

51. LEADER. Takes responsibility and lead at parties, clubs, etc., independent.

52. OPPORTUNIST. Has an eye on the main chance—seizes opportunities.

Although these traits are unquestionably characteristic of the hyperthymic temperament they do occasionally appear in personalities which are preponderantly depressive. The six circular personalities show them fairly frequently, although only one (No. 19) to a marked degree.

Of these traits probably that most characteristic of syntonic personalities as opposed to schizoid is *jollity*. It has previously been remarked that a lack of humour is one of the most typical schizoid traits and it seems likely that few if any schizoids show a warm, jolly personality like, for instance, that of No. 17, a circular. He was known at the office as " Old Happy " and was said to keep the whole place moving by his never-failing good-humour and fun. Only two schizophrenes were marked as showing the trait and in both cases it was doubtful.

However, except that none was regarded as optimistic, all these traits had been shown by one or two schizophrenes.

The literature concerned with hyperthymic traits gives a very different impression. Throughout there is the suggestion that these traits are not found in schizoids. Nevertheless Bowman found that 5 per cent of his schizophrenes had a *large number of friends* and 14 per cent were particularly *sociable* in their recreations. Whilst these figures are much smaller than those for either the

manic-depressive group or the controls, they are important as stressing *the existence of actively sociable schizoids.*

	Very Sociable Recreations	Large No. of Friends
Per cent of:		
Schizophrenes ..	14	5
Manic-depressives ..	42	25
Controls ..	28	15

This proportion is similar to that found by Faver. Of 154 catatonics, 12 were found to have been good mixers and the " life of the party " when in a social gathering.

Another trait specially studied by Bowman was *leadership.* This he found to be significantly commoner amongst the manic-depressives than in either schizophrenes or control groups, though he gives no figures. It is not a monopoly of syntones, however, as two of my patients demonstrate. No. 28 had been the energetic secretary of his firm's tennis club for two years, whilst No. 36 had established a small factory of his own and employed 4 men at one period.

No other detailed work has been done but I think it may be safely concluded that, although these traits undoubtedly denote a hyperthymic personality, unless a jolly humour is a feature, their presence does not preclude the possibility of a strong schizoid factor.

The following 11 traits are widely regarded as hyperthymic. They are clearly less desirable than the 7 just discussed and when present to more than a small degree are quite as suggestive of an unstable personality as the more obviously ' neurotic ' traits such as obsessions or phobias. Indeed there is a widespread tendency to underestimate the pathological significance of these traits and to include only the anxious and depressive ones.[1]

[1] Some of the " neurotic inventories ", for instance that compiled by Thurston, have omitted these traits, a fact which may account for Smith finding that manic-depressives have fewer neurotic traits on this scale than schizophrenes ; since hypomanic traits, though present in some schizophrenes, are certainly more frequent in manic-depressives.

53. OVER-AMBITIOUS. *Actually attempts* big schemes, always undertakes too much.

54. MOVEMENTY. Great enthusiasms, too many interests.

55. DISTRACTABLE. Changes job, no perseverance, always finding " better " things to do.

56. OVER-TALKATIVE. Talks too much, eloquent, verbose.

57. LAUGHS AT CRITICISM. Laughs it off.

58. EXCITABLE. Becomes over-excited at parties.

59. SLAP-DASH. Quick, careless worker.

60. RECKLESS. Hot-headed, imprudent, rushes into things.

61. BOASTFUL. Conceited, swollen-headed, over-confident.

62. EXTRAVAGANT. Spendthrift.

63. GRANDIOSE, LOUD. Grandiose style, extravagant gestures.

Kraepelin includes practically all of them in his picture of the hyperthymic individual, whilst Kretschmer and Smalldon each include about half.

My own few cases afford no check on the frequency with which these are found in hyperthymic syntones, but that they are not confined to syntones is demonstrated by the schizophrene patients, who between them demonstrated most of the traits. For instance, a tendency to be *excitable* was shown by no less than 5 schizophrenes. Kraepelin remarks on its frequency especially in female schizophrenes, and Kretschmer writes " psychic over-excitability has been far too little appreciated as an essential ingredient of the total schizoid personality ". No other trait was shown by more than 3 schizophrene patients.

A *garrulous* disposition was shown by 2 and in this connection it is interesting to note that Bowman found

that 7 per cent of his schizophrenes were unusually frank and communicative.

Recklessness had been a striking trait in one schizophrene, No. 43. He had played truant from school and had later become a motor-cycle test driver.

Boastfulness was probably present in 2 schizophrenes in my series, but not very markedly. Kretschmer does not include it amongst his schizoid traits, but Amsden found that it occurred sometimes in patients who later developed a paranoid schizophrenia, which, considering their tendency to megalomania, is not surprising.

64. PROMISCUOUS. Numerous affairs (includes being a prostitute).

Two schizophrenes showed a tendency this way and 5 affectives. This is roughly an equal proportion of the two groups. It is discussed more fully in Chapter IV.

65. DRUG ADDICTION

None of my patients were drug addicts, so far as I knew, and I have no observations to offer. Although it seems likely that many drug-addicts are schizoids, it is my impression that circular and anxious personalities are also liable to it.

66. ALCOHOLISM

Alcoholism in bouts had been present in 2 depressives, one manic and one schizophrene of my series. None of them were regular steady drinkers. Bowman found that there was no difference in the proportion of schizophrenes and manic-depressives who had shown this trait, about 3 per cent of each having been alcoholic. Both Kraepelin and Kretschmer regard it as characteristic of the manic temperament, but whilst probably rather commoner in personalities with a strong hyperthymic component, it occurs also in some depressive personalities.

The final 6 traits are frequently features of people with a strong paranoid tendency.

67. OVER-ASSERTIVE. Arrogant, dictatorial, takes law into own hands.

68. RESENTS AUTHORITY. Insubordinate, impertinent, rebellious.

69. FEUDS. Relentless insistence on "rights", gets what he wants by making a row.

70. SELF-RIGHTEOUS. Proud, never admits being in the wrong, deceives self.

71. ANGRY IF CRITICIZED. Takes offence, abusive, flares up, breaks friendships.

72. DISSATISFIED. Grumbles, criticizes and blames others for everything.

Whereas depressives take criticism to heart and reproach themselves, avoid rows and bottle up their spleen, paranoid personalities direct all their feelings on others, finding everyone to blame except themselves. Consequently these traits are not found commonly amongst the pure obsessive depressives, but are more frequent in hyperthymic personalities and irritable and anxious people.

It is curious to find how diversely this group is classified in the literature. Many regard the traits as typical of the prepsychotic manic; amongst these are Kraepelin, Kahn and Smalldon. Kretschmer includes "over-assertiveness" in his picture of the epileptic, the hypomanic, and paranoid individuals, marks "feuds" and "self-righteousness" as typical of hysterics and "dissatisfied" as schizoid.

My own patients are too few to be of much use in settling such points, but they make it clear that the traits are specific neither to syntone nor schizoid. Many of the traits appear sporadically amongst each class of patient, but 3 patients each show 4 or more of them.

For instance, No. 19, a predominantly manic circular, had them all except the last, and No. 44, a schizophrene, had most of them. It is interesting to note that both these patients had paranoid delusions as part of their psychosis. Recent work has shown that paranoid delusions are almost as common in affectives as in schizophrenes and that the patient with paranoid delusions alone is rare. This suggests that paranoid traits are likely also to appear as often in syntones as in schizoids, an expectation which, so far as they go, my observations confirm.

Of the individual traits, a *resentment of authority* is specially frequent amongst schizoids, no less than 6 showing it. Amsden also found the trait frequent in paranoid schizophrenics, many of them being extremely stubborn and disobedient.

Outbursts of *temper on being criticized* appeared in 4 depressives, one manic and 3 schizophrenes. For instance, No. 3 was said to have a quick temper if anyone criticized him—" he gets so wild "—but he did not do any damage. No. 19 was apt to take offence and be rude to the offender. Amongst the schizophrenes No. 25 whilst sometimes indifferent to criticism at other times would fly into a temper. No. 33 was exceedingly suspicious of her neighbours and was always having rows with them, believing that she had been slighted. As a result all the patients were quarrelsome and unpleasant.

This trait must be distinguished from sulky *dissatisfaction* inasmuch as the anger is vented in the former, but not the latter. Both Kraepelin and Kretschmer found grumbling amongst syntones, but neither notes its appearance in schizoids. On the other hand the tendency to be irritable was found both by Bigelow and Blalock to have been a feature of more than a third of their schizophrenes and was also noted by Kraepelin. From this we can conclude that, although probably more common amongst hyperthymic syntones, this trait is not confined to them, but appears also in paranoid schizoids.

BIBLIOGRAPHY

(1) ABRAHAM. "A Short Study of the Development of the Libido", *Selected Papers*. London, 1927.

(2) ADDIS. "Statistical Study of Nocturnal Enuresis", *Arch. Dis. Childhood*, X, 169-78. June, 1935.

(3) AMSDEN. *A Guide to the Descriptive Study of Personality*. Bloomingdale Hosp. Press, 1923.

(4) AMSDEN. "Mental and Emotional Components of the Personality in Schizophrenia," *Proc. Ass. Res. Nerv. and Ment. Dis.*, V (Schizophrenia), 1928.

(5) BIGELOW. "Prepsychotic Personality of Catatonic Schizophrenics." *Psychiat. Quart.*, VI, 1932.

(6) BLALOCK. "Personality and Catatonic Dementia Praecox," *Psychiat. Quart.*, VI, 1932.

(7) BLEULER. *Textbook of Psychiatry*. 4th Edn. (English Translation). New York, 1930.

(8) BOND and ABBOTT. "A Comparison of Personal Characteristics in Dementia Praecox and Manic-Depressive Psychosis." *Am. Journ. Insanity*, LXVIII, 1912.

(9) BOND. "Personality and Outcome in 200 Consecutive Cases." *Am. Journ. Insanity*, LXIX, 1913.

(10) BOND and PARTRIDGE. "Interpretation of Manic-Depressive Phases." *Am. Journ. Psychiat.*, IV, 1924-5.

(11) BOWMAN. "A Study of the Prepsychotic Personality in Certain Psychoses." *Am. Journ. of Orthopsychiatry*, IV, 1934.

(12) BOWMAN and RAYMOND. "A Statistical Study of the Personality in Schizophrenic Patients." *Proc. Ass. Res. Nerv. and Ment. Dis.*, X (Schizophrenia), 1931.

(13) BRILL. "Schizoid and Syntonic Factors in Neuroses and Psychoses." *Am. Journ. Psychiat.*, IV, 1924-5.

(14) BRYANT. "The Constitutional Psychopathic Inferior." *Am. Journ. Psychiat.*, VI, 1927.

(15) CATTELL. "Temperament Tests." *Brit. Journ. Psychol.*, XXIII, XXIV, 1933.

(16) *Idem*. "Temperament Tests in Clinical Practice." *Brit. Journ. Med. Psych.*, XVI, 1936.

(17) CRAIG and BEATON. *Psychological Medicine*. London, 1926.

(18) CURRAN. "The Differentiation of Neuroses and Manic-Depressive Psychoses." *Journ. Ment. Sci.* LXXXIII, 1937.

(19) FARRAR. "Some Factors in Schizophrenic Dementia." *Psychiat. Bull. Utica*, IX, 1916.

(20) FAVER. "Study of Personality in Persons Developing Catatonic Dementia Praecox." *Psychiat. Quart.*, VI, 1932.

(21) FENICHEL. *Outline of Clinical Psycho-Analysis*. London, 1934.

(22) FREUD. "The Justification for Detaching from Neurasthenia a Particular Syndrome: The Anxiety Neurosis" (1894). *Collected Papers*, I. London, 1924.

(23) GILLESPIE. "Constitutional Psychopathy." *Proc. Roy. Soc. Med.* XXVII, July, 1934.

(24) GLOVER. "A Psycho-Analytic Approach to the Classification of Mental Disorders." *Journ. Ment. Sci.*, LXXVIII, 1932.

(25) GORDON. "Obsessional Phenomena in Schizoid Individuals in relation to Eventual Schizophrenia." *Psychiat. Quart.*, VII, 1933.

(26) *Idem*. "Obsessions in their Relation to Psychoses." *Am. Journ. Psychiat.*, V, 1926.

(27) HARROWES. "Personality and Psychosis." *Journ. of Neurology and Psychopathology*, X, 1924.

(28) HEALY, CLARKE and KASANIN. "A Study of Abnormal Personalities." Read at American Psychiatric Association, 9.v.35 (not published).

(29) HENDERSON and GILLESPIE. *A Textbook of Psychiatry*. 3rd Edn. Oxford Univ. Press, 1935.

(30) HENRY. "Psychogenic and Constitutional Factors in Homosexuality." *Psychiat. Quart.*, VIII, 1934.

(31) HOCH and AMSDEN. "Guide to Descriptive Study of Personality." *State Hosp. Bulletin*, Nov., 1913, also *Rev. Neur. and Psychiat.*, XII, 1913.

(32) HOCH. "Personality and Psychosis." *Am. Journ. Insanity*, LXIX, 1913, and *State Hosp. Bulletin*, VI, 1913.

(33) *Idem*. "A Study of Mental Make-up in the Functional Psychoses." *Journ. Nerv. and Ment. Dis.*, XXXVI, 1909.

(34) *Idem*. "Constitutional Factors in Dementia Praecox Group." *Rev. Neur. and Psychiat.*, VIII, 1910.

(35) JAHRREISS. "Obsessions during Schizophrenia." *Arch. f. Psychiat.*, LXXVII, 1926.

(36) JUNG. *Collected Papers on Analytical Psychology* (English Translation). London, 1917.

(37) *Idem*. *Psychological Types* (English Translation). London, 1924.

(38) KAHN. *Psychopathic Personalities* (English Translation). Yale Univ. Press, 1931.

(39) KARPMAN (edited by). "The Psychopathic Individual: a Symposium." *Mental Hygiene*, VIII, Jan., 1924.

(40) KASANIN and ROSEN. "Clinical Variables in Schizoid Personalities." *Arch. Neur. and Psychiat.*, XXX, 1933.

(41) KIRBY. *Guides for History-taking, etc.* State Hosp. Press, Utica, N.Y., 1928.

(42) KNOPF. "Preliminary Report on Personality Studies in Thirty Migraine Patients." *Journ. Nerv. and Ment. Dis.*, LXXXII, 1935.

(43) KRAEPELIN. *Manic-Depressive Insanity and Paranoia* (English Translation). Edinburgh, 1921.

(44) *Idem*. *Dementia Praecox and Paraphrenia* (English Translation). Edinburgh, 1919.

(45) KRETSCHMER. *Textbook of Medical Psychology* (English Translation). Oxford Univ. Press, 1934.

(46) *Idem. Physique and Character* (English Translation). London, 1925.

(47) LANDIS. "Questionnaires and the Study of Personality." *Journ. Nerv. and Ment. Dis.*, LXXXIII, 1936.

(48) LEWIS. "Inheritance of Mental Disorders", from *The Chances of Morbid Inheritance*, edited by C. P. Blacker. London, 1934.

(49) *Idem.* "Melancholia: A Clinical Survey of Depressive States." *Journ. Ment. Sci.*, LXXX, 1934.

(50) *Idem.* "Problems of Obsessional Illness." *Proc. Roy. Soc. Med.*, XXIX, 1936.

(51) MACCURDY. *The Psychology of Emotion.* London, 1925.

(52) MAPOTHER. "The Schizophrenic-Paranoid Series" (Early Mental Disease). *Lancet*, London, 1926.

(53) MCINNES. "Observations on Heredity in Neurosis." *Proc. Roy. Soc. Med.*, XXX, 1937.

(54) PAGE, LANDIS and KATZ. "Schizophrenic Traits in the Functional Psychoses and in Normal Individuals." *Am. Journ. Psychiat.*, XIII, 1934.

(55) PARTRIDGE. "Personality and the Concept 'Manic-Depressive Psychosis.'" *Proc. Ass. Res. Nerv. and Ment. Dis.*, XI (Manic-Depressive Insanity), 1931.

(56) *Idem.* "Current Conceptions of Psychopathic Personality." *Am. Journ. Psychiat.*, X, 1930.

(57) *Idem.* "Sociopathic Behaviour in Women: A Study of Nine Cases." *Am. Journ. Psychiat.*, X, 1931.

(58) *Idem.* "A Study of 50 Cases of Psychopathic Personality." *Am. Journ. Psychiat.*, VII, 1928.

(59) *Idem.* "Psychopathic Personalities among Boys in a Training College." *Am. Journ. Psychiat.*, VIII, 1928.

(60) *Idem.* "Psychotic Reaction in the Psychopath." *Am. Journ. Psychiat.*, VIII, 1929.

(61) *Idem.* "Psychopathic Personality and Personality Investigation." *Am. Journ. Psychiat.*, VIII, 1929.

(62) PETRY. "Role of Personality in the Determination of Types of Functional Psychoses." *Penn. Med. Journ.*, XXXIV, 1931.

(63) PRINCE. *The Dissociation of a Personality.* 2nd Edn. New York, 1908.

(64) ROSS. *An Enquiry into Prognosis in the Neuroses.* Cambridge Univ. Press, 1936.

(65) RYLE. "Anorexia Nervosa." *The Lancet*, Oct. 17, 1936.

(66) SLATER. "The Inheritance of Manic-Depressive Insanity." *Proc. Roy. Soc. Med.*, XXIX, March, 1936.

(67) SMALLDON. "Prepsychotic Personality of Manic-Depressive Patients." *Psychiat. Quart.*, VIII, 1934.

(68) SMITH. "A Study of the Neurotic Tendencies Shown in Dementia Praecox and Manic-Depressive Insanity." *Journ. Soc. Psychol.*, IV, 1933.

(69) STRECKER and WILLEY. "Prognosis in Schizophrenia." *Proc. Ass. Res. Nerv. and Ment. Dis.*, V. (Schizophrenia), 1938.

(70) STRECKER, *et al.* "The Prognosis in Manic-Depressive Psychoses." *Proc. Ass. for Res. Nerv. and Ment. Dis.*, XI (Manic-Depressive Psychosis), 1931.

(71) STRECKER and WILLEY. "The Analysis of Recoverable Dementia Praecox Reactions." *Am. Journ. Psychiat.*, VIII, 1924.

(72) SULLIVAN. "The Relation of Onset and Outcome in Schizophrenia." *Proc. Ass. Res. in Nerv. and Ment. Dis.*, X (Schizophrenia), 1931.

(73) THURSTONE. "A Neurotic Inventory." *Journ. Soc. Psychol.*, I, 1930.

(74) TOURAINE, GRACE and DRAPER. "The Migrainous Patient." *Journ. Nerv. and Ment. Dis.*, LXXX, 1934.

(75) TREDGOLD. "The Definition and Diagnosis of Moral Imbecility." *Brit. Journ. Med. Psych.*, VI, 1926.

(76) VERNON. "Tests of Temperament and Character" (in booklet). *The Testing of Intelligence.* University of London Institute of Education, 1935.

(77) WERTHAM. "Group of Benign Chronic Psychoses; prolonged manic excitements with statistical study of age, duration and frequency in 2,000 manic attacks." *Am. Journ. Psychiat.*, IX, 1929.

(78) YELLOWLEES. "The Role of Anxiety in the Psychoses and Psycho-neuroses." *Brit. Journ. Med. Psych.*, IX, 1929.

(79) BOWLBY. "The Influence of Early Environment on the Development of Neurosis and Neurotic Character." *Intl. J. Psych. Anal.* XXI, April, 1940.

INDEX