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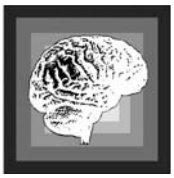

Classic Text No. 72

Non-dementia non-praecox: note on the advantages to mental hygiene of extirpating a term

by E. E. Southard [1919]

With an introduction by

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In February 1919 the Harvard neuropathologist Elmer Ernst Southard (1876–1920) presented a paper in which he outlined his reasons for dropping the term 'dementia praecox' in favour of a competing diagnostic concept and term, 'schizophrenia'. Southard's criticisms reflected the opinion of many US psychiatrists at that time, leading to the replacement of Emil Kraepelin's dementia praecox by Eugen Bleuler's schizophrenia in US psychiatry by the mid-1920s. The text of Southard's lecture is published here for the first time. Also included are excerpts from letters from US psychiatrists George H. Kirby, Albert M. Barrett, Adolf Meyer and August Hoch to Southard in response to his query as to whether dementia praecox or schizophrenia should be adopted in US psychiatric nomenclature.

***Keywords**: Adolf Meyer; dementia praecox; Elmer Ernst Southard; psychiatric nomenclature; schizophrenia*

Introduction: from dementia praecox to schizophrenia

The year 1918 marked the beginning of a new era in US psychiatry. In that year the final draft of a uniform classification system for collecting statistics on mental diseases in US institutions was approved and published by the

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American Medico-Psychological Association (hereafter AMPA) and the National Committee for Mental Hygiene (hereafter NCMH). *The Statistical Manual for the Use of Institutions for the Insane* (AMPA and NCMH, 1918) was the first formal diagnostic manual adopted for widespread use in the USA. State hospitals and other psychiatric institutions such as the various psychopathic hospitals were directed to collect statistics on their patients and submit them at the end of their fiscal year to the Bureau of Statistics of the National Committee for Mental Hygiene. By 1921 most institutions were doing so, and for the first time in the USA comparative data were available for all psychiatric institutions (see Grob, 1985: 32). The *Manual* provided psychiatrists with a menu of 21 general categories of mental diseases and one for 'Not Insane'. A special Committee on Statistics of the AMPA had been debating the classification structure and nomenclature of this document since a meeting in Niagara Falls in 1913, approving the first complete draft on 29 May 1917 at the 73rd annual meeting of the AMPA in New York City and its final draft at a meeting of the committee in New York City on 7 February 1918.

From the outset the issues of classification and nomenclature had been contentious. The single most influential psychiatrist in the USA at that time, the Swiss émigré Adolf Meyer (1866–1950) of the Henry Phipps Clinic of Johns Hopkins Medical School, opposed both the need for a formal classification system and the codification of nomenclature for mental diseases. His arguments were twofold: first, that too little was known about the 'facts' of mental diseases for psychiatrists even to begin such a project, and second, that the formal adoption of a national classification scheme for mental diseases would reify certain diagnostic terms, making it difficult to modify or reverse their use as knowledge about these conditions progressed. History would prove he was correct on both counts.

Dementia praecox had been proposed as one of the 21 categories of mental diseases. Meyer himself had imported the German psychiatric term into the USA. He first applied the diagnosis at the Worcester Lunatic Hospital in Massachusetts in the autumn of 1896 soon after visiting Emil Kraepelin (1856–1926) in Heidelberg in the spring. By 1900 dementia praecox had become an issue of discussion by US alienists and neurologists at conferences and in medical journals (Noll, 2004). But between the AMPA annual meeting in May 1917 – just one month after the USA declared war against Germany – and the approval of the final draft of the *Manual* in February 1918, there was a ground swell of support for the adoption of an alternative diagnostic term proposed by the Swiss psychiatrist Eugen Bleuler (1857–1939): schizophrenia. How much of the timing of this shift in opinion can be attributed to genuine clinical concerns and how much to the visceral anti-German sentiment among the members of the AMPA remains an open question. Certainly many members of the AMPA, especially Meyer, knew of

Kraepelin's strong and vocal support for the legitimacy of Germany's political aims and war efforts. Meyer, who at this time in his life identified himself first as American and second as Swiss, chastised his colleagues in the AMPA at the conclusion of his presentation at the May 1917 meeting by saying it was a 'distressing surprise' that 'our own committee on statistical classification should at this late hour have sworn allegiance to the German dogma' (Meyer, 1917–1918: 168). The final published draft of the *Manual* reflected both the fundamental disagreement about the clinical contours of dementia praecox and the fact that a competing term and vision of insanity were already in use in the USA. According to the *Manual*'s brief description of 'Dementia Praecox' (AMPA and NCMH, 1918: 24):

> This group cannot be satisfactorily defined at the present time as there are still too many points at issue as to what constitute the essential clinical features of dementia praecox. A large majority of the cases which should go into this group may, however, be recognized without special difficulty, although there is an important smaller group of doubtful, atypical allied or transitional cases which from the standpoint of symptoms or prognosis occupy an uncertain clinical position.
>
> Cases formerly classified as allied to dementia praecox should be placed here rather than in the undiagnosed group. The term 'schizophrenia' is now used by many writers instead of dementia praecox.

Even after the publication of the first edition of the *Manual,* the debate about dementia praecox versus schizophrenia still continued to occupy the most prominent figures in the US psychiatric community. Perhaps the most energetic catalyst for pressing this issue after the publication of the *Manual* was Elmer Ernest Southard (1876–1920), Bullard Professor of Neuropathology at Harvard Medical School (since 1909), Pathologist to the Massachusetts Commission on Mental Diseases (since 1912), Director of the Boston Psychopathic Hospital (since 1912), and by all accounts one of the most remarkable physicians in early twentieth-century US medicine; see Fig. 1

E. E. Southard (his intimates called him 'Ernie') was remembered by his contemporaries in metaphors more appropriate for a comet than a man. Perhaps this has to do with his sudden death at the age of 43 on 8 February 1920 from influenza that quickly transformed into fatal pneumonia. His biographer, former colleague and lifelong friend, the bacteriologist Frederick Gay (1874–1939), collected numerous memoirs from Southard's associates attesting to his boundless energy, sanguine temperament, humour, love of wordplay, scintillating intellect, power to inspire others and polymathic creativity (Gay, 1938). He exhibited an 'Edisonian habit of sleeplessness', often arriving at work in the morning after playing chess all night, sometimes competing in contests of 'blind chess' in which his extraordinary powers of visualization and spatial cognition enabled him to play as many as six games

FIG. 1. E. E. Southard in July 1919, aged 43 (source: Canavan, 1925)

simultaneously (Gay, 1938: 52–3). L. Vernon Briggs, an associate of Southard who would later write a history of the Boston Psychopathic Hospital, claimed that:

> He himself said that most people fell within one of the classifications of mental disease, and he felt himself to be of the manic-depressive type. We seldom saw the depressive side of him though it was undoubtedly there; ordinarily he appeared carried away with enthusiasm about his latest interest – and everything worthwhile interested him (Gay, 1938: 263–4)

Gay, whose biography of Southard is occasionally spiced with details not often found in such medical hagiographies, reported that his beloved friend 'had no hesitation in classifying himself temperamentally … as actually hypomanic' (Gay, 1938: 263). 'He was forever "starting things," and he has been accused of not finishing them', Gay (1938: 242) observed, and the wide range of topics explored in his neuropathological studies, his writings on psychiatric classification and nomenclature, psychiatric social work and mental hygiene attest to his wandering intellectual interests. But the flashes of brilliance in the three books and 179 published articles he left behind never compensated for one basic fact: today he is not remembered for any single medical or scientific breakthrough. However, it is clear from the testimonies of his colleagues and from his literary remains that he believed his greatest accomplishment might very well come from his future work on dementia praecox.

Dementia praecox was the subject of 13 publications by Southard between 1908 and 1919, 10 of which were either reports of neuropathological studies of the brains of persons with dementia praecox or comparisons with the brains of persons with manic-depressive illness and normal controls (Southard, 1910, 1913, 1914*a*, 1914*b*, 1914–1915, 1915, 1916, 1919*a*, Southard and Canavan, 1917, 1918). Poking fun at the schism in psychiatry between the 'mind-twist men' and the 'brain-spot men', and denying a strictly functional or a strictly organic interpretation of mental disease, Southard believed that science was best served by investigating dementia

praecox from complementary angles of approach: *both* the clinical and the anatomical, *both* the psychopathological and neuropathological (Southard, 1914*c*). As for Southard himself, his position on the mind-body problem was always uppermost in his philosophical mind: 'I wish however to say personally neither parallelism nor interactionism seems to me safe ground and that some kind of identity hypothesis for all the operations concerned would be better consonant with my views' (Southard, 1914*c*: 129). When Southard began his neuropathological study of dementia praecox in 1910, 'it seemed to [him] that very probably the brains of dementia praecox patients would be found to be normal' (Southard, 1914*c*: 121). He was surprised to find evidence to the contrary. As he expanded his series of dementia praecox subjects, he continued to find diffuse structural abnormalities in most cases, but many fewer in cases of manic-depressive insanity or normal controls. He judiciously did not over-interpret his findings to argue that dementia praecox was definitively found to be an organic disease in aetiology, nor did he claim the discovery of a definitive characteristic cellular pathology for it. Southard professed the need to keep an open mind about the matter, and often argued that his findings were provisional. The cognitive categories that guided his personal approach to understanding mental disease were *structure* and *function*, and he understood the two to be intertwined: 'Structure is in the main the spatial aspect of facts and events, function in the main the temporal aspect of the same facts' (Gay, 1938: 200). But according to one colleague who knew him well, 'Southard's conclusion regarding dementia praecox was that it is in some sense structural. Manic depressive he regarded as more likely a metabolic disturbance' (Gay, 1938: 246).

Southard was regarded as the leading neuropathologist of his generation in the USA, and his findings were difficult to ignore, even by the most ardent psychogenicists. His own colleagues marvelled at the way he could glance at a fresh human brain and instantly 'see' its uniqueness in a manner similar to the way in which he could glance at a chess board and 'see' the possibilities inherent in its implicate structure. 'While to most of us brains are as alike as Chinamen, he seemed to possess something of the "photographic mind" which instantly detects slight peculiarities', reported one colleague.

> I still retain a vivid memory of seeing him at his task of examining brains and of noting how unhesitatingly, in the course of the rapid inspection, he pointed out small variations, and how confidently, as he ran his fingertips over the fresh surface, he dictated his impression of differences in resistance. (Gay, 1938: 228)

Southard's acute sensitivity to neural tissue in an era of technological simplicity led to an observation and an interpretation about the neuropathology in dementia praecox brains that has been supported by modern neuropathological research on schizophrenia: almost every part of the brain in persons with schizophrenia has been found to have abnormalities in one

study or another, and this may be evidence in support of an embryonic or 'neurodevelopmental' origin for the disorder (Harrison, 1999).

Southard's suggestions for improving classification in psychiatry were among his least influential contributions. His plea for a 'pragmatic psychiatry' based on a process of 'diagnosis by exclusion' through a 'pragmatic sequence of consideration' of eleven groups of mental disorders, including one termed the 'Schizophrenoses' (Southard, 1919*b*), was never adopted in US psychiatry. In an exchange of letters with Meyer in mid-December 1918 (reproduced in Grob, 1985: 28–9), Southard was unsure about the propriety of using his position as president of the AMPA to induce 'a small controversy at the next meeting of the Association' concerning the issues of classification and nomenclature, but Meyer signalled his rejection of such public engagement. Southard attempted to negotiate common ground with Meyer and get him to agree to a need for broad classification groups, although he regarded the 'nomenclature question' as 'subordinate'. Southard wrote on 11 December 1918, 'The statistical committee could give as synonyms such names as it chose to regard as synonyms for the leading names of its list. Let any psychiatrist, however, use what name he chooses.' He thus gave Meyer the promise of allowing psychiatrists to use Meyerian terms such as 'reaction-types' if they preferred, but within the general outlines of an agreed classification grouping. Meyer would never give ground. Aware that his proposal for his classification groupings would find stiff resistance among psychiatrists, Southard opted instead to fight a battle that he might win: convincing his colleagues to adopt the term schizophrenia in place of dementia praecox.

On 20 February 1919 Southard delivered a lecture to the Boston Society of Psychiatry and Neurology on 'Non-Dementia Non-Praecox' which is the basis of the previously unpublished Classic Text reproduced below.[1] It is his clearest statement on the unsuitability of Kraepelin's term and concept of dementia praecox and his argument for the adoption of Bleuler's schizophrenia as a more palatable replacement. At the time, Southard was President of the AMPA, and this fact added weight to his argument for a change in nomenclature. The manuscript, and its supporting documents (also reproduced here for the first time), remain among the E. E. Southard papers at the Center for the History of Medicine at the Francis A. Countway Library of Medicine, Harvard Medical School. Southard prepared the text of his lecture in a typescript form that was intended for publication, but like so many other projects in his life, he never completed the task. In less than a year he would be dead.

In a post-mortem examination of Southard's brain (and its comparison with those of his father, who had died in 1910, and his mother who had died in 1921), his close friend and collaborator in his neuropathological studies, Myrtelle M. Canavan (1879–1953), recorded a rather cryptic summary of Southard's last days:

> The last year of his life was fraught with singular difficulties producing considerable mental discomfort, resulting in an edgy spirit of unrest. To compensate he worked feverishly at writing, skimmed the library for the stimulation of novel facts, poured over word studies, and became worried over facts he had hitherto neglected as unimportant. In the fall of 1919 he visited the Georgia State Sanitarium at Midgeville and came home talking much of religion, of God, and of the simplicity of Blacks. At times he said, 'I shall not live long, I must hurry; I must get lots of others busy.' (Canavan, 1925: 12–13)

Two months before his death, a medical examination from an 'endocrinological standpoint' was conducted in December 1919, and Canavan (1925: 13) interpreted Southard's escalating difficulties as consistent with 'a persistent thymic state'. Thus, a metabolic diagnosis, not a psychiatric one, was left to history by one of his most devoted disciples. Around the time of Christmas 1919, according to Canavan (1925: 14), he spoke of one of his many great unfinished tasks as 'his hope to put together all his ideas on Dementia Praecox for review and refutation of the criticisms of his 1910 studies on the subject.' This was not to be.

The archival material reproduced below includes Southard's manuscript for 'Non-Dementia Non-Praecox' and a small collection of materials that Southard apparently used when preparing his text: the full text of a letter from George H. Kirby (1875–1935), and excerpts from letters from Albert M. Barrett (1871–1936), Adolf Meyer (1866–1950) and August Hoch (1868–1919). Not included here (for reasons of space) is the text of a short summary and commentary by Southard on the views of Kraepelin concerning dementia praecox as presented in the 8th edition of his *Psychiatrie* (Kraepelin, 1913). Southard's most interesting observation about this edition is that Kraepelin renamed an illustration (Figure 154) which had also appeared in the 7th edition: he changed his description of the group of patients in the photo from 'dementia praecox patients' to 'schizophrenics'. Southard saw this as evidence of Kraepelin's acceptance of Bleuler's term, schizophrenia. In the English translation of this section, Figure 154 is renumbered Figure 3 and the photo is described as a 'group of schizophrenic patients' (Kraepelin, 1919: 38).

Southard makes several key points in his paper. First, that the neuropathological evidence is not pathognomonic for an actual 'entity' that could be named dementia praecox or schizophrenia. Second, that Bleuler's dissociative metaphor for schizophrenia is a better fit for what Southard calls the 'psycholytic' nature of the phenomena that would be placed in this broad classification group. Third, Meyer's preferred nomenclature of 'reaction-types' or 'reaction-complexes' would be equally welcome in a classification group that would include the alternative terms of dementia praecox and schizophrenia (and as such, Southard's remarks in this paper are a direct rejoinder to Meyer's AMPA address). Fourth, a classification project aimed at synthesis (in other words, accepting a classification group large enough to

contain the concepts, if not the terms, of Meyer, Kraepelin and Bleuler) is consistent with Kraepelin's own grand synthesis of hebephrenia, catatonia and paranoia into dementia praecox, and any idea that Kraepelin 'created' a new entity is wrong. Fifth, the term dementia praecox itself is 'horrible' and gives the wrong impression about prognosis. Sixth, schizophrenia is a term from which adjectives can easily be formed (e.g., 'schizophrenic'), whereas such word forms cannot be derived from dementia praecox. And seventh, by February 1919 Kraepelin himself had given up his original 1899 concept of dementia praecox, multiplying the number of forms and relabelling some patients with Bleuler's suggested term, schizophrenia.

A brief note summarizing Southard's presentation to the 'regular meeting' of the Boston Society of Psychiatry and Neurology presided over by Dr George A. Waterman on 20 February 1919 appeared in the *Journal of Nervous and Mental Disease* (Southard, 1919*c*):

> Dr. E. E. Southard spoke in regard to the unsuitableness of the term 'dementia praecox' furnished by Kraepelin, upon the badness of which term all are agreed. Some international committee on psychiatric terminology should be formed to select desirable psychiatrical terms.
>
> Neither dementia nor praecox are indispensable features of what is called dementia praecox. The use of the term brings unhappiness to patients and much wrong results from its use. Catatonia was first described in 1858. In 1896 Kraepelin used the term dementia praecox to include several types of mental disease. In 1913 he evolved thirteen types, containing nine types of dementia praecox and four of paraphrenia, and designated these thirteen types as endogenous deterioration. Bleuler later suggested that schizophrenia should be used instead of the undesirable term dementia praecox. This conveys the idea most important to this disease, the splitting of the personality, and it forms a good basis for various derivations. It does not commit one to any one notion of the mechanism involved nor of the nature of the process.
>
> Dr. E. S. Abbott said that although the term was undesirable still many cases do reach dementia. Errors in diagnosis tended rather to create caution than to the necessity of eliminating a term. There should be clearer definition of symptoms. Science he believed develops by delineation not by substituting terms. Dementia praecox has a wider significance than schizophrenia therefore there is no advantage in the latter as a substitute for the former. There should be a term separating those who dement from those who do not. There mere diagnosis is a secondary matter however in comparison with the treatment.

In the text of his 'Non-Dementia Non-Praecox' manuscript, Southard quotes from Meyer's May 1917 AMPA address, published as 'The aims and meaning of psychiatric diagnosis' (Meyer, 1917–1918) and also relies on the historical information concerning the evolution of the term and concept of dementia praecox from Morel, Hecker and Kahlbaum contained in a volume by Constance Pascal (1877–1937), *La Démence précoce:Étude psychologique*

médicale et médico-légale (1911). Pascal (1911: 6) is also the source of Southard's observation that Kraepelin's contribution was one of synthesis and not the creation of an entirely new entity. It should be noted that Pascal's interpretation of dementia praecox as a disease caused by autointoxication (Pascal, 1911: 13, 240–8), which follows that of Kraepelin (see Noll, 2007), is not mentioned by Southard, who found such an aetiology unlikely.

In late 1918, in order to prepare for his lecture and its planned publication, Southard wrote to several psychiatrist colleagues and surveyed them on the comparative suitability of dementia praecox and schizophrenia for the new American nomenclature in the *Manual.* Only the full letter of George H. Kirby, the Director of the Psychiatric Institute of the New York State Hospitals on Ward's Island, survives in full. He was not happy with either term, or how they are applied in practice. The remarks of Meyer, Barrett and Hoch are excerpted by Southard but the original letters are not to be found in Southard's papers. Meyer wished to see the term schizophrenia 'eliminated', but by May 1921 he was using the term interchangeably with dementia praecox in public presentations and publications (Meyer, 1921–1922). Hoch, who played a key supporting role in forming the first draft of the new uniform classification system, cogently listed the reasons why dementia praecox was an unsuitable term, but was lukewarm to replacing it with schizophrenia. Barrett, who chaired the Committee on Statistics when the final draft was approved in February 1918, was the only respondent to Southard who was unequivocal in his support of adopting schizophrenia and dropping dementia praecox.

The documents from the *Nachlaß* of E. E. Southard that are reproduced below provide a unique window into a critical moment in the history of psychiatry.

Note

1. Although Southard's text has never been published in full, Elizabeth Lunbeck (1994: 372) refers to the manuscript in the endnotes to her book on the Boston Psychopathic Hospital. I wish to thank the Harvard Medical Library in the Francis A. Countway Library of Medicine in Boston, Massachusetts, for permission to cite and publish these typescripts in the E.E. Southard papers [GA81, box 8].

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Classic Text No. 72

Non-dementia non-praecox: note on the advantages to mental hygiene of extirpating a term

by E. E. Southard* [1919]

A proposal to excise from our psychiatric vocabulary the term Dementia Praecox will, I think, secure strong American support. As the American vocabulary of mental diseases is just now fast stiffening into a form that, for better or worse, must serve our purposes of mental hygiene for another quarter of a century, I believe we ought to hasten the extirpation, if not of all inaccurate terms, of all terms that are both inaccurate and dangerously misleading. We ought to begin our verbal surgery upon terms that not only offend by being logically inaccurate and block scientific progress by misleading the medical profession, but also are likely positively to injure the prognosis of many psychopathic cases.

The statistical committee of the American Medico-Psychological Association specifically allows us the use of the term Schizophrenia in place of Dementia Praecox – a proper concession to the increasing local and general usage of this far more exact and less misleading term, proposed by the eminent Swiss psychiatrist, Bleuler, for Kraepelin's term Dementia Praecox. As I write, the public history of the term Dementia Praecox in Kraepelin's sense is not twenty years old, dating from the issue of Kraepelin's edition of *Psychiatrie* in 1899. Bleuler's suggestion is 8 years old, if we date from his lucid volume *Schizoiphrenie* in Aschaffenburg's *Handbuch*, published in 1911. It is probably safe to say that neither of these terms is case-hardened enough to last say a century of further progress in psychiatry. Neither term has the look of age and respectability that say the terms General Paresis, Delirium Tremens, Senile Dementia, assume. Yet none of these latter terms is quite unassailable, and it may even be claimed that no nosological term will ever be impregnable. Witness the very considerable vogue of Babinski's proposal of Pithiatism for Hysteria, the latter term logically inappropriate enough, but (everybody thought) a perfect *succes de scandale*. Yet a very real progress was registered by the discussion which ensued upon Babinski's thesis – and one may concede the progress without accepting the thesis. In short, we should maintain a constant theoretical fluidity in the nomenclature of

* Southard's spelling and punctuation are retained; words that are underlined in his typescript are printed here in italics.

mental diseases, despite a solid practical agreement from decade to decade as to the terms we shall use for accepted entities.

In the midst of this theoretical fluidity of terms, can we agree on Dementia Praecox as in any sense an isle of safety in present-day traffic? But, is Schizophrenia safer?

Before answering these questions, one may pause to consider whether there is any such entity sufficiently well established to deserve a heated discussion of nomenclature – is there an accepted entity deserving some such title as Dementia Praecox or Schizophrenia? It is not my primary object here to discuss classification, but to limit discussion to nomenclature and the terminological difficulties that the Krapelinian nomenclature leads us into. But the deeper and more fundamental question of classification still remains open. For some years past I have spent a good deal of time on the anatomical side of the question. Anatomical solutions are difficult by reason of the grave doubt which may attach to the clinical diagnosis of a large minority of cases of so-called Dementia Praecox. I conclude that there are a few (but a very few) cases of so-called Dementia Praecox that do not possess demonstrably anomalous brains and that *all* cases of Dementia Praecox (except possibly those of a few weeks or months duration) show demonstrable microscopic cortex changes. Concerning the anomalies, I see nothing therein to indicate that a person with such an anomaly needs *must* go the clinical way of Schizophrenia. Nor is there really anything differential in the microscopic lesions found, if we abstract from the situation of the lesions. But, if the nosologist should claim (on the basis of the occasional absence of brain anomalies and the non-differential quality of the cortex changes found) that Schizophrenia is a disease as "functional" as so-called manic-depressive Psychosis, I should be inclined to deny the nosologist that right. For very few, if any, cases of so-called Manic-depressive Psychosis show such brain abnormalities as cases of Schizophrenia. In fact, in my experience, the brains of so-called manic-depressives (cyclothymias I prefer to term them) are not grossly distinguishable from the brains of normal persons with respect to anomalies.

Now, suppose we grant the existence of gross brain anomalies in Schizophrenia (and concurrently grant their relative non-existence in General Paresis, in Cyclothymia, in normal subjects), is it at all necessary to conclude that Schizophrenia is an entity? I think not, for a variety of reasons. For one reason, the anomalies of the brain in Schizophrenia often strike one as of embryonic or early origin and shade over into the usually more pronounced and bilateral anomalies of the feeble-minded brain. It is clear that a brain anomaly is a pretty wide-meshed sieve that could let through all sorts of conditions. There is no reason in the brain anomalies for asserting the unity of Schizophrenia.

A logically identical argument runs from the microscopic lesions. Their universality in the brains of schizophrenics does not argue the unity of schizophrenia, any more than the universality of microscopic lesions in senile psychoses allows one to assert the unity of the senile psychoses.

In fact, both the gross anomalies and the microscopic changes are entirely consistent with a tremendous clinical variety in conditions known as Schizophrenia. They are also consistent with great variations in curability. For it seems clear that these anomalies may exist in a man's brain for decades without the appearance of a psychosis. And the microscopic lesions are far less striking than those in General Paresis, which are consistent with extensive remissions or perhaps with complete (salvarsan) cure. Even the death of numerous neurons seems consistent in general Paresis with relatively perfect restoration of mental health for long periods.

I conclude, then, that for the present neither the anatomy nor the microscopy of cases of so-called Dementia Praecox indicates with more than probability the existence of an entity. In some recent papers I have approached the question of finer correlations of a stratigraphical and topographical nature with some of the more definite symptoms in Schizophrenia. However interesting or suggestive these anatomoclinical correlations may be, it is doubtful whether they throw light on the entity question. Just as the tissue process is largely one of destruction of neurons (neuronolysis) with some reparative or reactive processes superimposed, so the mental processes are largely also destructive or dissociative ("psycholytic"). Where I most signally failed in correlation was with certain synthetic mental processes (a sort of paranoiac *concretion* of mind). But the majority of processes, from the mental side, are doubtless lytic rather than combinatory: hence the value of Bleuler's term Schizophrenia, "split-mindedness."

Schizophrenia is not the only nomenclatural suggestion that indicates the preference of many workers for some term expressive of the psycholytic nature of most of the phenomena in the group. The *Dementia sejunctiva* of Gross is an analogous term with Wernickean reminiscences. The neat adjective "sejunctive" ought, one believes, to be used more frequently of psycholytic processes of various sorts. But "dementia" has decisive drawbacks (see below). A like argument holds for *Dementia dissecans* of Zweig. *Dysphrenia*, proposed by Wolff, is an example of terms logically too wide, covering virtually all forms of mental difficulty that are predominantly intellectual in their symptoms, and hence inappropriate for purely psycholytic processes.

It seems to me, therefore, that the statistical committee of the American Medico-Psychological Association is very sound in allowing the use of Schizophrenia as a term in place of Dementia Praecox. Schizophrenia at least means something fairly definite, referring as it does to a disease in which splitting or dissociation processes occur. Precisely insofar as the *association* theory

holds good in psychology, just so far will it be possible to render the facts of psychopathology in terms of *dissociation*. The "mental chemistry" of John Stuart Mill, so far as it is valid at all, will prove to have its analytic as well as its synthetic division. Observing processes of hallucination, "disruption of judgment," emotional apathy, catatonia, we ask: What has split this mind? What is dissociating the processes that normally run together? And we conclude that, whether the interruption of mental processes be by means of hallucination, emotional or volitional disorder, the result is an interference with the normal flow of thought, not readily named better than by the term Schizophrenia.

But does not priority so rule as to give Kraepelin the right to his own designation, Dementia Praecox? Not, I believe, if the term conveys a logically wrong impression and pragmatically tends to injure the patient's prognosis. Kraepelin himself has shown a willingness to use the term schizophrenic of various symptoms and even in a later edition of his text book re-labels certain patients "schizophrenic." Moreover, Kraepelin, has himself named a variant of his Dementia Praecox, following the analogue of Bleuler's term, Schizophasia (Wortverwirrtheit). In general he now tends to think of a larger group of cases as "endogenous deteriorations," a group containing nine variants of Dementia Praecox and four of so-called Paraphrenia. We are entitled to believe, I think, that Kraepelin not only did not in 1899 carry his synthesis of entities far enough, but also lent an unfortunate weight to the designation, Dementia Praecox – really only an intermediate product in the logical digestion of mental diseases.

The group of so-called "endogenous deteriorations" (Dementia Praecox and Paraphrenia) has not been given a Hellenized or Latinized scientific name by Kraepelin. I have myself proposed to follow the suggestion of Bleuler and adopt the term Schizophrenia as a general name for sundry of these diseases. I have further proposed the uniting of these genera into an order, Schizophrenoses. This order, Schizophrenoses, would stand to its included genera (of Schizophrenia simplex, Catatonia, etc.,) as *Rosaceae* to *Rosa gallica, Rubus strigosus*, etc. Just as the roses, in the extended sense of *Rosaceae*, include not just nosegay French *roses* but also American red *raspberries*, so the "mind-splits" would include not only simple "splits" but "muscle-hypertensives" or whatever you wish in common parlance to term the catatonics.

Not only does Kraepelin himself incline to the use of the *schizo-* concept of Bleuler at least in symptom descriptions, but also he has left unnamed (scientifically speaking) the larger group in which these cases belong. Finding it desirable in recent work to name scientifically all the larger groups of mental disease, I found no terminological difficulty greater than in this very group, characterized so far as I could see chiefly by the common factor of "splitting," dissociation, sejunction, schizophrenia. Finding that "schizophrenia" would readily form compounds, especially adjectives, I adopted the term as the basis

of the group designation, Schizophrenoses, on par with Syphilopsychoses and Epileptoses.

My more general propositions concerning the great groups of mental disease ought to get reasonably good reception in America, representing as they do with a slight rearrangement nothing but the main groupings of representative American textbooks. Incidentally, I feel that these groupings and that of the Schizophrenias in particular, go far to cut under the main objection which Adolf Meyer had brought to the results of the labors of the Statistical Committee of the American Medico-Psychological Association. "That our own committee on statistical classification," says Meyer, "should at this late hour have sworn allegiance to the German dogma *without provisions for mixed and merely allied types* (italics mine)* was a somewhat distressing surprise. Fortunately we still constitute a free country and have reason to hope that if a cause is just it will ultimately find a majority."

The general impression which I retain from modern American diagnosticians is that the term "Dementia Praecox" attaches more to a group of probable and possible entities than to any single supposed entity. If this is the acceptable view to most American diagnosticians, I hold that this view is in accord with Kraepelin's own trend to larger syntheses, with Bleuler's grouping of over a score of entities or conditions under Schizophrenia, and with Meyer's plea for less nosological rigidity.

We must all agree with Meyer that the last point in psychiatric work is "weighing the case" according to whether the case does or does not coincide with a well-defined practical type "so that it may be" classified as identical with, or akin to, "a standard unit such as we keep for our statistics and for elementary teaching." Also we must heartily agree with Meyer's dictum that "we may have to get away from the idea of 'one person, one disease.'" At least we must do so if the distinction rests on the thought that the American red raspberry is as distinct from the French rose as it is from the crabapple. The genus-species distinction allows great latitude in descriptive analysis of cases. If the higher grouping of the "orders" is superadded to the genus-species groupings and a generous sprinkling of varieties be allowed for the subdivision of the species, a tremendous range and nicety of diagnosis is permitted.

Now Meyer's own process he briefly describes as in the first place a sort of rough grouping not far if at all removed from the processes of other workers. Thus says Meyer, "I force myself first to get my facts concerning the total-reaction or reaction-type or reaction-complex." What are these? Meyer's (possibly incomplete) list is "organic, or toxic-delirious, or affective, or paranoiac, or a benign or a malignant substitutive process, or a constitutional defect or perversion, or a mixture."

Accordingly, when Kraepelin tries to effect a first synthesis of older entities under the name Dementia Praecox and proceeds later to evolve a larger

* The words in brackets were added to the typescript in Southard's handwriting.

synthesis under the name Endogenous Deteriorations, he arrives at a broad grouping that reminds us of some of the best French work and is on all fours with the above quoted groupings of Meyer – the so-called reaction-types. Is there any essential difference in the logical idea that lies at the bottom of Kraepelin's Endogenous Deteriorations, of certain of Meyer's Reaction-types, and of the Bleuler concept of the schizophrenias? Is it not a question merely of the better way of saying the same sort of thing?

According to Meyer's gibe, Kraepelin created "manic-depressive insanity," "dementia praecox," and a few other entities, "in a fit of indignation against Ziehen" and praised them to the world "owing to the prognostic virtues and ultimate simplicity of his nosological schemes." It is very doubtful to my mind whether Kraepelin created any new "entities" whatsoever. It seems to me that he did nothing more than regroup some old entities in a more or less profitable way. It seems to me that Kraepelin's chief contributions have been synthetic rather than analytic – witness the "dementia praecox" group now swollen to include various "endogenous deteriorations," witness also the "manic-depressive group" with its various "forms," witness his more recent efforts at synthesizing the "psychogenic psychoses," witness the vaguer efforts at calling hysteria and paranoia both infantilistic.

Omitting superficial differences, are not modern psychiatrists at one in developing the idea of certain classes of mental disease that represent higher and more general categories than the familiar entities of the books? And, if this tendency to more general groupings is as sound as it appears to be widespread amongst psychiatrists of every stripe, shall we not seize the opportunity to give these more general groups the most appropriate designations? In particular, shall we not with most meticulous care see that the objectionable term "Dementia Praecox" does not get attached to that higher grouping in which so-called Dementia Praecox in nine forms and Paraphrenia in four forms appear, viz. Kraepelin's "Endogenous Deteriorations"? Personally I hold no brief for the term "endogenous deteriorations," because the term "deterioration" is so broad as to let in the tide and because the term "endogenous" commits us to a particular kind of (unproven) etiology. But, though the term is not perfect, it is manifestly superior to Dementia Praecox, and Kraepelin can rightly claim to be several laps ahead of critics who confine their disfavor to the term Dementia Praecox. Kraepelin has gone on his synthesizing way and, as it seems to some of us at least, has virtually given up the Dementia Praecox idea in its original form.

Aside from the question whether a disease *X* (sometimes known as Dementia praecox) really exists and aside from any changes of heart which Kraepelin may or may not have experienced concerning this disease X, the fact remains that the term "Dementia praecox" still persists to plague us with its inexact denotation and its horrible – I speak by the book, *horrible* – connotation.

The nineteenth century history of the term has been summarized by Mlle. Pascal, who ascribes the creation of the term to Morel in 1858. Morel, it appears, was really describing what came later to be termed by Kahlbaum in 1874 Catatonia. Morel's list of symptoms of his *démence précoce* contained nihilism (i.e. negativism), catalepsy, stereotypes, emotional indifference, loss of family feeling, outbursts of laughter, and Morel described the tendency of these cases to mental impairment.

Pascal attributes the long burial of Morel's idea to the preoccupation of the psychiatrists of that day with heredity (it was the early day of Darwinism) and "degeneration." She calls attention to a like burial for a long period of the ideas of Kahlbaum (hebephrenia, 1863, catatonia, 1874).

Doubtless it would be chronologically unlikely that the originators of such ideas as hebephrenia and catatonia would live long enough (or remain scientifically active long enough) to learn whether "dementia" was bound to set in and especially to learn whether a peculiar and characteristic "dementia" was bound to set in. Morel's insight – as man of his insights – was remarkable in his choice of the term "*demence precoce*" (1858) for Kahlbaum's disease "catatonia" (1874), that was later to prove an important constituent of Kraepelin's new synthesis "dementia praecox" (1899). Probably two generations of men will always be necessary for the establishment of any such conception as that of a disease *X* with a characteristic deterioration, scheduled to take place in certain cases as a period of decades! Perhaps a third generation of men will be necessary for an assessment of the conception's value. Kraepelin had the work of Morel and of Kahlbaum and Hecker in mind when he synthesized his "dementia praecox" from their products. As Mlle. Pascal points out, Morel and Kahlbaum and Hecker could see only symptoms and syndromes and not the disease. Kraepelin could start with the established descriptions of his distinguished predecessors and observe the course and outcome of these symptoms and syndromes.

Letter from George H. Kirby, Director of the Psychiatric Institute of the New York State Hospitals, Ward's Island, to Dr. E. E. Southard, February 24, 1919

Dear Doctor Southard:

Owing to circumstances connected with my military duties, I did not get around to answer your letter in reference to the possible replacement of the term dementia praecox until today, and now I notice that you were to read your paper last week. So what I have to say is probably too late to be included in your collection of opinions.

I might say, however, that my experience in the Army has made me keenly aware of the existence of a widespread, extremely loose and wholly

unjustifiable use of the term dementia praecox. It is apparent that dementia praecox has become the popular designation for the greatest variety of diverse conditions with the result that much unnecessary consternation, anxiety and suffering are caused to both patients and relatives. This is one reason why I would welcome a term with less severe implications, although a single substitute would not in any way advance our knowledge of psychiatry. I do not think that "schizophrenia" is a very good substitute and American psychiatrists have never used the term in nearly so wide and all-embracing a sense as Bleuler who introduced it. I would not, however, in the absence of anything better oppose its recognition in our official diagnostic groupings. I feel that several terms must eventually be devised to provide for the breaking-up of what is now included under dementia praecox. The latter will probably remain in use until sufficiently narrowed down. It is hard to make physicians of limited clinical experience sufficiently cautious about forcing diagnoses in psychiatry. Good anamneses, a careful study of the evolution of symptoms and their general setting and a reasonable period of observation must continue to form the foundation for clinical differentiations and prognoses. A great many cases can not of course be worked up satisfactorily in army practice or in clearing houses or clinics where cases are rapidly disposed of. I find that physicians without a State hospital experience are much more free in making diagnoses of dementia praecox than are physicians attached to State institutions. Incipient and non-institutional cases are probably more difficult to classify than cases which reach State hospitals. I have considerable evidence to show that the dementia praecox group in the best State hospitals is quite as definitely and satisfactorily circumscribed as is the manic-depressive or the alcoholic group and, until recently, as even the general paralysis group.

Yours very sincerely,

[signed] George H. Kirby

Southard's quotation from a letter (date unknown) from Albert M. Barrett

Dr. Albert M. Barrett on the extirpation of the term "Dementia Praecox."

For some time past, in this clinic, we have been using the term "dementia praecox" less frequently. Without having taken a fixed attitude in the matter we have happened to use the term "schizophrenia" in a more or less interchangeable way with dementia praecox. A considerable number of cases, which formerly might have been placed in the group of dementia praecox, have come to be placed under the heading of paraphrenic disorders.

We have appreciated that schizophrenia conveys a clearer expression of the disorder than does dementia praecox. It fits in better with the interest that

is now shown in the underlying factors in the development of psychoses. It conveys a description of a purposive mechanism rather than of a group.

Discarding the term "dementia" is an advantage in teaching. It is always difficult to maintain in the student's mind the distinction between the dementia of dementia praecox and that of organic psychoses.

It would be a gain also in the matter of prognostic distinctions. The assignment of a case to the group of dementia praecox had always implied a greater degree of hopelessness in the outcome than experience warrants. In this respect the term "schizophrenia" is less committal as to the outcome. It emphasizes more the aspect of the development of the disorder and places etiological factors in the foreground that may be taken advantage of in therapeutic directions.

Schizophrenia is not altogether a satisfactory term. Schizophrenic mechanisms occur in disorders that would not be regarded as dementia praecox and there are cases of dementia praecox in which the schizophrenic features are impossible to demonstrate in a clear way. On the whole I believe that the term "schizophrenia" is preferable to dementia praecox.

Southard's quotation from a letter (date unknown) from Adolf Meyer

Professor Adolf Meyer writes me in a personal letter as to the attitude of the Phipps Clinic concerning dementia praecox and schizophrenia:

"We use the term schizophrenia and speak of benign and grave forms and residual states. I hope that the elimination of the term schizophrenia will follow, as too broad an entity. I really feel that the elimination of the concept of terminal dementia was a grave mistake, inasmuch as I believe that various processes can lead to the ultimate result, and psychiatry would have been much better off if the fundamental and initial facts had been studied for what is present in the case, instead of dreaming what might be found in the terminal stage and at the autopsy. We certainly want to learn all we can from the autopsy and from the retrospect, but I am inclined to think that the emphasis ought to be laid on the synthetic side of the disease picture, the possibility of its analysis and the singling out of the modifiable points."

Southard's quotation from a letter (date unknown) from August Hoch

Dr. August Hoch writes as to his attitude toward the terms dementia praecox and schizophrenia as follows:

"I do not have such a strong feeling about names as you seem to have and have never felt, for example, like abandoning the term 'shaking palsy'

because the patients sometimes do not shake. Therefore I am not at all certain whether I shall definitely abandon the term dementia praecox, since everybody has gotten so used to it, but I quite agree with you that the term is not good for the following reasons:

(1) Not all the cases deteriorate and few deteriorate progressively.
(2) The disease may come on at almost any age.
(3) It is unfortunately too pessimistic a name to use with laymen.
(4) I always had a feeling that behind the term dementia praecox there was an idea of some sort of a relationahip between dementia praecox on the one, and senile dementia on the other hand. But with the exception of the fact that you find fat in the nerve cells of both disorders, I can see no parallelism between the two, certainly the clinical structure of the dementia as such is absolutely different and therefore if the name to any one suggests something like such a relationship, this is also a point against it.

"I am not specially pleased with schizophrenia. It is a rather uncouth term, and I remember, when it first came out, how I balked at it and how, when I read my review of Bleuler's schizophrenia at the New York Psychiatrical Society, all of them made a lot of fun of the term. But it is remarkable what one can get used to. Of course a lot might be said against schizophrenia from the point of view of the concept behind it, but we are not talking of this at present. I guess my personal antagonism against discarding completely dementia praecox and standing up for schizophrenia is in part due to a feeling that after all they both imply all sorts of things which are not proven."