

**ANTHOLOGY OF GREEK
PSYCHIATRIC TEXTS**

**This publication is supported
by the Lilian Voudouri Foundation**



Anthology of Greek Psychiatric Texts

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*Series "Anthologies of International Psychiatric Texts",
Director of the series: Driss Moussaoui*

*With unrestricted grants by the Lilian Voudouri Foundation of Greece
and Sanofi-Aventis*

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Translation: Aikaterini and Suzanna Apostolaki

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BETA Medical Publishers

3 Adrianou & Katehaki street, GR-115 25 (N. Psychiko), Athens, Greece

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e-mail: BetaMedArts@hol.gr

www.betamedarts.gr, www.betamedarts.com

EN ISO 9001:2000

Printed in Greece

ISBN: 978-960-452-128-9

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PREFACE

Greek culture is a treasure of inspiration for professionals and lay people interested in mental health and mental illnesses. An anticipation of several of the topics now being debated in psychiatry and psychology can be found in Greek philosophy, literature and early medical contributions, and quotations from, for instance, Aristotle, Hippocrates and Aretaeus can be found in several recent psychiatric papers. However, most scholars involved in the mental health field are not currently able to access these sources directly; their quotations are second hand. Furthermore, contemporary Greek psychiatry is very productive and interesting: Greece has been one of the first European countries to implement community mental health care and has a long-lasting tradition in several areas of clinical, biological and social psychiatry. For all these reasons, an anthology of classic texts relevant to mental health, originally produced in Greek and now translated for the first time in English, is likely to represent a very useful resource and a rewarding reading for every thoughtful clinician and scholar in mental health disciplines.

We are indebted to the Editors of this volume who have selected carefully the papers for inclusion, illustrating the various and interconnected influences on contemporary Greek psychiatry. The editors and their selections introduce us to the circular nature of the determinants of habits and practices in various parts of the world. In this instance, the profound influence of the ancient Greek philosophers on western thought and behaviour is brought back to Greece through the introduction of western ideas about psychiatry. This process results in the eventual adaptation and further offering of ideas and practices

from modern Greece. The editors show us that modern Greek psychiatry is remarkable for its integration with medicine, with many of the sympathetic ideas of the ancient Greek philosophers and with modern psychiatry elsewhere in the world especially in Europe.

The volume is the fifth in the series "International Anthologies of Psychiatry" initiated by the World Psychiatric Association (WPA) in 1999 to publish in English for the first time classical texts produced by psychiatrists of a given country or group of countries, accompanied by essays on their authors. It furthers the ambitions of the founder and director of the series (DM), consistent with the aims of the WPA, to facilitate contact, understanding and collaboration between psychiatrists living in different countries and belonging to different schools of thought. The series was established to foster a greater and more accurate familiarity than previously possible worldwide with the history and literature of psychiatry in several major languages. The previous volumes in the series have been produced by dedicated and thoughtful editors and contributors and the editors of this volume follow in this distinguished tradition.

The previous volumes in the series are:

- *Anthology of French Language Psychiatric Texts* edited by Francois-Regis Cousin, Jean Garrabe, and Denis Morozov, published in 1999;
- *Anthology of Spanish Psychiatric Texts* edited by Juan Jose Lopez-Ibor, Carlos Carbonell, and Jean Garrabe, 2001;
- *Anthology of Italian Psychiatric Texts* edited by Mario Maj and Filippo M. Ferro, 2002;
- *Anthology of German Psychiatric Texts* edited by Henning Sass, published in 2007.

In recognition of their value to psychiatrists everywhere, electronic versions of these volumes, are now published online by Wiley-Blackwell. They are available through the WPA website and link to onlinelibrary.wiley.com/book. These classic texts can be an inspiration to contemporary psychiatric research and practice, through full recognition of the diversity of psychiatric traditions and the links between past and present concerns in our work. We can use the modern possibilities for communication to publish and share these texts and avoid the loss of important insights from a variety of cultures and periods that is also a possible consequence of an increasingly global culture.

Helen Herrman, Mario Maj, Driss Moussaoui

INTRODUCTION

Greek Psychiatry is currently at an important crossroad of its development. Psychiatry and Neurology are now distinct at the level of training (of psychiatric and neurological trainees respectively), clinical practice, and scientific representation. By creatively assimilating important influences both from the past and from the present, by adopting an eclectic approach in a framework where all trends are represented and having acquired greater confidence in itself and a more clear vision of the future, Greek Psychiatry is establishing its independent identity and –to the extent possible– a leading role in the scientific spectrum of the country.

In this endeavour, the search for historical continuity is of great importance as this search may foster a comprehensive understanding and familiarize Greek psychiatrists and hopefully colleagues from abroad with the various stages of development of Greek Psychiatry. Under this light, it was thought that acquaintance with the scientific past of Greek Psychiatry and with the continuity that exists between the past and the present could be achieved by the acquisition of some familiarity with texts produced by Greek psychiatrists of previous generations. This "Anthology" serves this very purpose.

This edition is part of a series of similar editions of the World Psychiatric Association, whose rationale is outlined in the Preface of the French anthology. The motto of the 10th World Congress of Psychiatry "*One World, one language*" serves as a starting point to underscore the need for psychia-

trists of various nationalities, working in different countries and serving various different "schools of thought" to come closer together. Building bridges between psychiatrists of various nationalities and ethnic origins and also between psychiatric "schools" was thus placed at the top of the agenda and was pursued by establishing a "collection" of anthologies from various countries. It was this approach that was adopted in the "Anthology of Greek Psychiatric Texts".

Although Greece has become an independent state, following Turkish occupation, only in the 19th century (1828), yet it was not created "*ex nihilo*". The ideological reference point for Greek thought and science was that of "inheritance" of the scientific and philosophical work produced in classical Greek antiquity. The introduction in modern Greece of fragments of ancient Greek thinking, usually occurred through the contribution of ancient Greek science and culture to the emergence of modern European science. This new science, of course, after and through assimilation of this precious input, moved on to new paths, shaping a novel scientific environment. Based in Paris, Adamantios Korais (1748–1838), the major representative of Greek enlightenment, very characteristically called upon Greeks to "transfuse" (incorporate) those elements of European science required to forge their own modern path (report on the present state of civilisation in Greece, Paris 1803).

A remarkable number of Greek neurologists-psychiatrists, particularly over recent years, have contributed pioneering work worldwide. Others focused on the creative transfer to Greece of new psychopathological concepts and treatment practices, imported from the west. This transfer and incorpo-

ration in Greece and in Greek communities abroad of these novel concepts and practices illustrates the course of events that have occurred more globally, in the majority of countries of the rest of Europe.

The contribution of Greek physicians studying at European Universities (e.g. Padua in the 18th century, Paris, Berlin and London subsequently) is worth noting. These physicians encountered a mutated form of the medical-philosophical thinking of the Greek antiquity that has greatly contributed to the *ontogenesis* of psychiatry, at the dawn of the 19th century. Loans are followed by counter loans!

This phenomenon is particularly interesting because transfer of these mutated ancient Greek psychiatric concepts and practices to modern Greece was enriched further by the incorporation of the dominant psychiatric concepts and practices of Western Europe, including scientific interaction and rivalries between different centers of research and clinical practice. A typical example is the (heated, occasionally hostile but generally productive) interaction between French and German psychiatry, which at the end of the 19th and the beginning of the 20th century had a decisive influence on the development of modern psychiatry in Europe.

The first part of this anthology begins with some of the most characteristic samples of ancient Greek, Hellenistic, and Medieval literature that became fertile ground for psychiatric thinking thereafter. A broader reference to ancient Greek thinking, in the context of the topic in hand, would require extensive citations of the ancient texts and subsequent comments, and this task would certainly exceed the limits of this volume.

There follows the main part of the book. The authors were selected on the basis of the extent to which they influenced the development of Psychiatry in Greece and on the basis of their contribution to the development and dissemination of new ideas. Some of these authors belong to the Greek Diaspora, mainly in the Ottoman Empire. Constantin (von) Economo was also included, because of his Greek origin (of note is that in 1910–1911, he was offered the chair of Neurology and Mental Diseases at Athens University).

We set the year 1950 as the cut-off date for the book for the following reasons:

- First, we wanted to focus on the first steps in the practice of Psychiatry in Greece and on the main trends emerging in psychiatric training for which adequate criteria of evaluation exist.
- Second, because we considered that the 1950s were a milestone, as this period was characterised by decisive changes in the practice of Psychiatry. We felt that this period heralds the modern era of psychiatry and it should be examined separately.

Most certainly, the work of the authors presented in this book is not limited to the selected small sample of their writings of this volume. Many of these authors have produced extensive work that, obviously, could not be accommodated in this volume. It should also be noted that, in a period where psychiatry was not separate from neurology, such as the one examined here, it would have been unrealistic to separate psychiatric work from the parallel neurological work. For this reason, texts of neuro-psychiatric content have also been included in this book.

We hope that this volume will be useful to people interested in the historical evolution of Psychiatry in Greece but also in Europe as the texts included reflect the more general concerns and trends pertaining to the course of modern scientific psychiatry, from its appearance in the 19th century to this day.

As mentioned earlier, the period covered by this "Anthology" ends in 1950 when dramatic changes took place in International Psychiatry that were reflected in psychiatric theory and practice in Greece. The most significant changes refer to the introduction of modern psychopharmacology in the treatment of both major psychiatric disorders, schizophrenia and depression. At the local level, some early research into the efficacy of this "new" psychopharmacology was carried out.

In the area of community psychiatry, a new community-based organisation, the "Center for Mental Health" (now Hellenic Center for Mental Health and Research) was established and two new institutions for chronic patients started to operate (the psychiatric hospital at Leros island and the "Daou Pentelis" hospital for children, near Athens, which necessitated serious efforts of de-institutionalisation 30 years later). It is ironic and paradoxical that during this decade, things moved towards two clearly opposite directions – on the one hand a decisive move towards community psychiatry and psychiatric prevention with the establishment of the non-profit organisation "Center for Mental Health" and on the other hand an equally decisive move towards asylum psychiatry for chronic patients with the establishment of institutions like the Leros asylum. The importance of de-institutionalisation, rehabilitation, and preventive psychiatry took a long time to be rec-

ognized on a broader scale. A decisive and systematic move towards community psychiatry in Greece occurred much later and is still in progress.

Scientific papers and books produced during the period that followed the year 1950 are important and numerous, but this will be the subject of another "Anthology" that will hopefully follow the one that we have the opportunity to present to you at this stage.

The short biographical notes of the contributors to this volume provide information concerning the basic career course of the authors and attempt to place their work within the scientific and social context of the chronological period they lived in. Obtaining this information was a particularly painstaking process, as for several of these authors very little information was available in the usual biographical sources. We therefore had to go back to a host of other sources (information provided by colleagues, reminiscences of relatives, friends or co-workers, other publications and so forth) without always managing to collect all relevant information.

The production of this book would not have been possible without a generous donation of the Lilian Voudouri Foundation of Greece for which we are grateful. The Lilian Voudouri Foundation has funded the publishing of the book in 10.000 copies and its shipment to Argentina for distribution to the participants of the world congress of psychiatry of Buenos Aires 2011.

We would like to express our thanks to Prof. Driss Moussaoui, Director of this series, for his support, Dr J. Garrabé for his precious advice, Sanofi-Aventis which has funded the translation of the Greek book into English and especially Ms

Marie-Christine Bouri for her collaboration, Ms H. Christopoulou-Aletra, assistant professor of the University of Thessaloniki and Ms N. Papavramidou, lecturer of the University of Thrace for their assistance concerning the texts of reference to ancient Greek authors. Lastly, we would like to thank the Hellenic Psychiatric Association and more specifically the President Prof. Nikos Tzavaras and the Executive Committee of the Association for its support, as well as the administrative director Ms Eleni Gretsas and Secretaries Ms Androniki Gatzelaki and Ms Maria Loukidi for their assistance in the preparation of this book.

We hope that our "Anthology" will advance our understanding of the historical evolution of our discipline as reflected in its evolution in Greece. Scientific theory and practice do not exist in a vacuum but have roots in the past. Familiarizing ourselves with these roots will help us acquire a historical perspective of our discipline, learn from the past and build on our achievements.

G.N. Christodoulou, D.N. Ploumpidis, Ath. Karavatos

The origins of Psychiatry:

Ancient Greek contribution

Before the introduction of the term "psychiatry", in the beginning of the 19th century, the medical care of insanity has been practiced under a variety of different names.¹⁻⁴ Many of these names can be traced in ancient Greek literature.

In ancient Greek writings an explicit reference to "mental disorder" was made by Galen who wrote in his commentary on Hippocrates (*"Of the Epidemics"*): if the "spirit becomes corrupt" or its natural "blend" with the "substance of the brain" is "redirected" then "mental disease or death" will ensue.⁵ This context of the term is significant, as it probably heralds a major change. Until that time (second century AD), all illnesses were of the body. For example, *phrenitis*, was categorized by Hipparchus the Pythagorean among the somatic diseases, along with pleurisy, pneumonia, dysentery, lethargy and epilepsy.⁶ Yet, in the teaching of Aristotle there was a clear-cut contrast between "psyche" and "body", e.g. in his *Nicomachean Ethics* he refers to the pleasures of the body and the soul. Plutarch

¹ Roccatagliata G. *A history of ancient psychiatry*, Greenwood press, USA, 1986.

² Swain G. *Le sujet de la folie*. Toulouse, Privat, 1977, p. 24.

³ Yves Pelicier. *Histoire de la psychiatrie*. PUF, Paris, 1990, 4.

⁴ Simon B. *Mind and madness in ancient Greece*. Cornell University Press, 1978.

⁵ Galen's comment is mentioned. In: Papavramidou N (ed) *I ennoia tou "psychismou" kai tis "psychikis nosou" sta ippokratika, aristotelika kai galenika keimena* (*The meaning of "mental condition" and "mental disease" in the Hippocratic, Aristotelian and Galenic texts*). Doctoral Dissertation, Thessaloniki, 2006.

⁶ Stobaeus, *Florilegium*, Hipparchus Pythagorean from On leviety, Book 4, chap. 44, sect. 81. [Cited in: Pigeaud J. *La maladie de l'âme. Etude sur la relation de l'âme et du corps dans la tradition médico-philosophique antique*. Paris, Les Belles Lettres, 1989, 72].

(45–120 AD) implicitly agreed with Galen by stating: "he palpated and questioned him, (and) having found him to be feverless, he said that this must be a *disease of the psyche*" (Ethics, 524–ε).⁷

The distinction between somatic and mental disease was arrived at and stemmed from a lengthy process that evolved through the classical period of ancient Greece and subsequently through the Hellenistic and Roman eras. Worth noting is that, like in modern times, dualism was not easily accepted. J. Pigeaud has traced this evolution in detail. By summarising herein the results of this research, we must first dwell on the fact that many physicians in classical times in ancient Greece drew on philosophy for their ideas (as did philosophers from medicine) but described madness as one disease among many. In other words, there was no separate concept of mental disease. Yet, at a certain period in time, the *phylogenesis* of mental disorders begins to emerge: in the *medico-philosophical* tradition of ancient Greece and Rome, a particular way of thinking developed gradually, under the influence of dualism. The concept of a *disease of the soul (psyche)* emerged, as well as the concept of a disease of the body with repercussions on the soul and that of a disease of the "soul" with repercussions on the body.^{8,9} This composite conception required a dual awareness: medical (as it pertains to illness) and philosophical (as it pertains to the soul).¹⁰ Thus, even though the roots of the

⁷ Plutarch Ethics, Vol. 14, 524–E. Ancient Grk Littrature, "The Greeks" (Archea Elliniki Gramateia, "I Ellines"), [356], Editions Odysseas Hatzopoulos, Athens, 1984.

⁸ Pigeaud J. *op.cit.*, 15–16.

⁹ Pigeaud J, Folie et cure de la folie chez les médecins de l' antiquité Gréco-Romaine. Paris, Les Belles Lettres, 1987, 6].

¹⁰ Pigeaud J. La maladie de l' âme. *Op.cit.*, 16.

words *nosos* (disease), *hygeia* (health), *iatros* (physician) can be traced back to Mycenaean times,¹¹ (1600–1100 BC), it is only in classical ancient greek and hellenistic-roman antiquity (8th century BC//5th century AD) that the *medical* concept of a "disease of the body", as well as of a "disease of the soul (psyche)", emerged. As J. Pigeaud noted, this distinction was inaugurated in Hippocratic writings (*On Regimen* I, 400 BC) and subsequently it was integrated in the lyric poems of the Pre-Socratic period (6th–5th century BC), and evolved through the unfolding of the meaning of "pathos" (passion) in the fields of philosophy and the dramatic art during classical times. This differentiation deepened during the Hellenistic era and was consolidated in Roman times by the 5th century AD.¹²

Henri Ey¹³ argued that the initial contrast between the ethical and the medical approaches was primordial, as a distinction between sin and disease (guilt and mortal body). This contrast, however, was relative, as each part fed on the other. As documented by J. Pigeaud: ethics and medicine, although separate disciplines, jointly constitute the field of ancient "psychopathology". Medical thought contributed to a specific line of ethical enquiry, but ethics also contributed to a new line of enquiry for medicine, by investigating passions.¹⁴

Contemporary historiography of psychiatry investigates the era of emergence of modern psychiatry, as a result of the radical changes taking place both in humanities and medical

¹¹ Grmek M. Les maladies à l'aube de la civilisation occidentale, Payot et Rivages, Paris, 1994, 38.

¹² Jackie Pigeaud. La maladie de l'âme.

¹³ Henri Ey. Naissance de la médecine. Masson, Paris, 1981.

¹⁴ Jackie Pigeaud. La maladie de l'âme..., 27.

practice reaching a peak at the end of the 18th and the beginning of the 19th century.¹⁵⁻¹⁷ The founding of special hospitals or "asylums" in several countries, the influences of English empiricism and sensationalism, the work of Ph. Pinel and the development of the clinical anatomical method are considered the milestones of this evolution.

Other historical approaches investigate the relationship of the history of psychiatry to the history of civilisation. The most far-reaching traces must inevitably be identified in primeval times and the era of magicians.¹⁸ Henri Ey, however, considered that the origins of modern psychiatry stemmed from rational medicine, i.e. the work of the Ionic naturalist philosophers, that he termed the *miracle of Greek naturalism*.¹⁹

The medico-philosophical approach that we mentioned earlier was particularly influential towards the end of the 18th and the beginning of the 19th century, particularly in the corpus of Philip Pinel (1745–1826), initiator of *ontogenesis* of psychiatry. In 1971, Gladys Swain underlined that "before collective memory apprehended him as the man of a single gesture [the act of breaking the chains] Pinel was seen by his contemporaries as the man of a single book" [*Traité médico-*

¹⁵ Swain G. *Op. cit.*

¹⁶ Foucault M. *Folie et déraison, histoire de la folie à l'âge classique*, Plon, Paris, 1961.

¹⁷ J. Garrabé (editor). Philippe Pinel. *Les Empêchers de penser en rond*. Paris. 1994.

¹⁸ Alexander FG, Selesnick ST. *The history of psychiatry: an evaluation of psychiatric thought and practice from prehistory times to the present*. Harper and Row 1966.

¹⁹ Ey H. *Op.cit.*, 78–79.

²⁰ Gladys Swain. *Le sujet de la folie. Naissance de la Psychiatrie*. Privat, Toulouse, 1977.

philosophique sur l'aliénation mentale ou la manie (1801)].²⁰ His approach, which was based on the clinical observation of intermittent episodes of mental diseases, sustained that the disease (alienation) does not hinder the subject from finding a way out and that in madness complete annihilation of the subject does not exist. Swain underlined, that on the one hand Pinel went against tradition, while on the other hand he remained on its side. He maintained a *dual discourse* on madness: one in the context of the general system of medicine, while the other, conversely, posited the absolute particularity of alienation. This means that he conserved the descriptive medical form of that time, in order to break away from the corresponding medical context.²¹

Pigeaud grasps the dual meaning of the *disease of the psyche* (*soul*) in ancient times: as a disease it is connected to biology, whereas with reference to the soul, it is related to the world of values. The terms *phrenitis* and *mania* in Pinel's *Nosographie philosophique* remain the same as those used by Caelius,²² whilst in his *Traité médico-philosophique*, where *mania* is ascribed the general meaning of *mental alienation*, he states: "Nobody can talk about human passions (*pathi*) as diseases of the soul, without having in mind Cicero's *Tusculanae*". In the preface of "*Traité...*", Pinel refers to Hippocrates, Aretaeus, Caelius (Aurelianus), Celsus and Galen. The combined influence of medicine and philosophy, as depicted mainly in the writings of Hippocrates and Cicero, is visible in the foundations of modern psychiatry.²³

²¹ Ibid, 61–63.

²² Jackie Pigeaud. *Folie et cures de la folie...*, 226.

²³ Ibid, 534.

In conclusion, it is obvious that the ancient greek medico-philosophical tradition, which was reproduced, filtered and eventually crystallized in later centuries, has contributed greatly to the development of modern Psychiatry. To what extent this tradition will endure in an era characterized by over-specialization and hyperbolic dependence on technology²⁴ remains to be seen.

Ath. Karavatos, D.N. Ploumpidis, G.N. Christodoulou

²⁴ Christodoulou G., Fulford B., Mezzich J-E. "Psychiatry for the person and its conceptual bases". *International Psychiatry*, 5:1–3, 2008

The development of Psychiatry in Greece From the late 18th century to the mid 20th century

The modern Greek state was created in the 19th century, following the Greek war of Independence, which started in 1821 along with the disintegration of the Ottoman Empire. The establishment of the new administration started in 1833 and brought to the fore two pressing needs, namely *education* and *public health*. Worth noting is that before the establishment of an independent Greek state a phenomenon now called the “Modern Greek enlightenment” occurred. *Education* was fostered in scattered Greek communities, primarily through study, translations and adaptations of fragments or the whole texts of European authors, but also through some original works, printed in European cities like Venice, Vienna or Paris. This way of “transmission” of updated European scientific information to the Greek communities was strongly recommended by A. Korais (1748–1833), a leading Greek scholar who was considered as one of the major representatives of Modern Greek Enlightenment. This period was characterized by the dissemination of existing knowledge rather than the production of new knowledge. The field of Medicine, generally speaking, shared the trend of “modern Greek enlightenment”, focusing more on the educational value of direct application of imported medical knowledge. This transfer of knowledge was facilitated by the presence of many Greek phy-

sicians at Universities throughout Western Europe. Imported knowledge was to continue throughout the 19th century.

A characteristic example of this trend is provided by the book review of *Therapeftiki ton esoterikon nosimaton* (*Therapeutics of internal diseases*) by I.E. Typaldos, which was issued in the journal *Iatriki Proodos* (Medical Progress) in March 1896: “The author, who managed to enrich the sparse medical literature through a noteworthy and comprehensive treatise for Greek physicians, based his work on the recently published brilliant book by Penzoldt and Stinzing and the first volume of Robin’s *Therapeutics*”.

In time, however, a partial reversal of this climate started occurring. The presentation of I. Zallonis (a physician from the Greek island of Syros in the Cycladic islands) in the First Congress of Hellenic Doctors (6–9 April 1882), as presented in the columns of the journal *Galinos* (Galen), is indicative of this climate of renovation: “*I. Zallonis who has worked for many years on experiments to prove the transmission of tuberculosis by inoculation, recently undertook other experiments jointly with his colleague Mr. Paraskevas, in order to prove that tubercles caused by other agents do not cause tuberculosis upon inoculation...*”.

It is obvious that pressing practical needs as well as clinical, epidemiological and public health problems had to be tackled. Thus, Greek medicine had to harmonize itself, albeit belatedly, with the scientific progress that occurred in Western Europe and which included production of knowledge in addition to mere dissemination of information. The topics of lectures and other presentations in the *First Panhellenic Medical Conference* (6–10 May, 1901) were characteristic of the existing interests and priorities; there were presentations on tuberculosis, alcoholism, malaria, syphilis, echinococciasis, cholera, typhus, leprosy, tra-

choma, tetanus, anaemia, difficult childbirths, public hygiene, as observed in Greece and not only as outlined in foreign books. Naturally, this development presupposed a close interaction between the Greek medicine and the main centres of production of knowledge in Europe and indeed this was the case.

Throughout the 19th century and at the beginning of the 20th century, the abundant scientific and professional relations of Greek doctors of the independent Greek State with those of the Greek communities of the Ottoman Empire, Russia, Romania and Egypt, as well as with the greater Diaspora, constituted a significant factor of progress in Greek medicine. It is characteristic that the Athens Medical Association was founded as early as 1835, only five years after the establishment of the modern Greek state, whilst the University of Athens was established two years later, in 1837.

With reference to Psychiatry, it is worth noting that when the first psychiatric institutions were established, there was rather fragmented knowledge concerning the aetiology and treatment of mental diseases and this knowledge originated from the input of not only physicians, but also philosophers, priests and educators. The crucial public health question that arose was: Whose responsibility should the management of mentally ill persons be?

The majority of patients didn't have any other "treatment" choice than the elementary medical means of the times or the blessings provided by the church. The usual response to their disturbed behavior was to tie them up. Certain monasteries, following the Byzantine tradition, accepted during the 19th century, a small number of mental patients "for safeguarding", as evidenced by reports to the state administration. Certain "old-type" hospitals (i.e. hospitals whose main concern was to

provide shelter and food and secondarily medical care to the poor, to soldiers, to marginalised individuals and to foreigners) also admitted a small number of mentally ill patients, in line with both Byzantine and Western traditions. Examples were the Greek hospitals of rich Greek communities, such as the ones on the island of Chios, in Smyrna and in Constantinople (at “Balukli”), the latter being the only hospital of the kind to continue this tradition even to this day.

The management of mental patients within a medical context, appeared in modern Greece after 1860, approximately half a century after the first similar practices appeared in Western Europe. The elements that differentiated this practice from older ones were the following:

- *The establishment of special institutions*, distinct from the old-style hospitals.
- The “*charitable*” (*mild*) *handling of patients*, which stemmed from medical traditions on the one hand and the philosophical beliefs of the Enlightenment on the other.
- The gradual abandonment of the medico-philosophical approach. This approach, which marked Medicine till the beginning of the 19th century, will remain in psychiatry for a longer time and it will be gradually marginalised in the 19th century, as knowledge on the structure and function of the nervous system progressed.
- More complete familiarization with classification, aetiology, clinical entities and treatment of mental diseases was advanced by the leading European “schools” and this knowledge was introduced to Greece by Greek doctors who studied abroad. This phenomenon occurred towards the end of the 19th century and is sufficiently illustrated in this anthology.

- *The tendency of neurology-psychiatry to gradually include within its scientific field a more extensive range of diseases, directly or indirectly linked to the nervous system.*

The patients with severe psychopathological problems (who were usually treated as in-patients) constituted only the lesser part of the population with psychopathological manifestations. Publications in the medical press and presentations in medical conferences after 1880 indicate that hysteria, neurasthenia, hypochondriasis, various clinical entities with somatic pathology, etc. that pertained more to the work of general practitioners, stirred greater interest than the cases of severe psychopathology. The work of J.M. Charcot and the related interest in suggestibility and hypnotism, is a milestone in the course of integration of conditions like hysteria in the field of psychiatry and, indeed, at that time this elicited great interest among Greek physicians and neuro-psychiatrists (“phrenologists”, according to the term used at that time).

The period of committing patients to psychiatric institutions commenced in Greece in 1838, when the *Mental Asylum of Corfu* was established by the British Governor Sir Howard Douglas. Hospitalisation was the main management strategy for patients with acute and “loud” symptoms. A full century elapsed before this trend was generalized following the creation of a network of institutions. To what extent this was a positive development is still an unresolved issue.

Greece followed the French legislation. Law ΨΜΒ, of March 1862, explicitly followed the French Law, of June 1838, as did most of the European legislations. The Civil Code, in parallel, included articles on non-responsibility of psychiatrically ill persons for a criminal act, i.e. dropping felony charges

and committing persons perpetrating a serious offence to a psychiatric facility for treatment.

In 1864, the Ionian islands (among them the island of Corfu) were unified with Greece and thus, the Mental Asylum of Corfu can be considered as the first (and sole, for a long time) mental institution in Greece. In 1887, the “Dromokait-eion” Psychiatric Hospital started operating in Athens, meeting at that time all contemporary requirements. For at least thirty years, it retained its private and exemplary character, but gradually started acquiring asylum characteristics.

Introducing the terms *psychosis* and *neurosis* in Greece met with resistance due to their linguistic double meaning. These terms are in fact scientific neologisms, with a negative (nosological) connotation, in contrast to their positive connotation in everyday Greek language (the verbs corresponding to these terms mean “reinforce” and “encourage”, respectively).

In addition, the term “psychosis” was received with considerable ideological and theoretical objections. In the three volumes authored by Professor Michael Katsaras, the first professor of Neurology and Psychiatry at the University of Athens, an organicist and advocate of the French school, the term does not exist, either because it alluded to theories involving the soul [psychogenesis] or because it had been used by the left-wing proponents of “materialism” in Greece. The first book on psychiatry published in Greek, in 1889, “*Ai Psychoseis, Meletai iatrikai, koinoniologikai kai philosophikai peri phrenopatheion*” (Psychoses: Medical, sociological and philosophical studies of mental diseases) by S. Apostolidis, adopted the arguments of the proponents of cerebral localisations and triggered reactions within the medical community, as the ideas expressed in it were considered excessively organicist and materialistic.

Professor Katsaras preferred the positivist neutrality that circumvented the dispute over body and soul.

Equally characteristic is the case of Telemachos Mitaftsis, who, in 1894, published the *Kliniki pragmateia peri phrenikon noson* (*Clinical treatise on mental diseases*), which is the Greek translation of the French edition by Dagonet and Duhamel of the German third edition of Schule's Handbook of mental disorders, "with numerous extensive additions from up-to-date French publications", mainly the "*Manuel pratique de médecine mentale*" (1892) by Regis and "*Leçons sur les maladies mentales*" (1890) by Ball. Schule himself, in a letter published in the Greek edition wishes "that the new ties between Greek and German psychiatry should serve as fertile new grounds for jointly cultivating our science". We should note further that Telemachos Mitaftsis's doctoral dissertation *Oi ekfyloi* (*The degenerates*) was published in 1899, with a preface by Jean B. Charcot, son of J.M. Charcot.

The introduction of psychiatric theory in Greece can be illustrated through Kraepelin's concept of "*dementia praecox*", which was translated into Greek as *primitive or primary dementia and early dementia* (πρωτογενής άνοια, πρώιμος άνοια), as well as "*démence précoce*" of the French School. Greek authors have discussed in detail the arguments between the "French" and "German" psychiatric schools and the interesting scientific dispute between them is clearly reflected in this Anthology. These controversies were tackled in Greece in a spirit of compromise among the various schools, rather than in a spirit of conflict. This was more or less expected, as the introduction of these concepts coincided with the "first steps" of Psychiatry in Greece and was implemented by a small group of neurologists-psychiatrists, the same ones who established the first University

department and the major psychiatric hospitals. The emerging discipline of Psychiatry was in need of other basic priorities than the unproductive rivalry between “Schools”.

In the first decades of the 20th century, doubts appeared concerning the efficacy and ethics of the treatment methods in common use at that time, (e.g. efficacy of hydrotherapy, non-specific medication, etc.) coupled with an emerging awareness of the chronic nature of mental illnesses and the threat of institutionalisation. Efforts aiming at the amelioration of the internal organisation of psychiatric institutions, the provision of entertainment, productive employment and opportunities for artistic expression of the patients tried to reinforce, in spite of the immense difficulties, the therapeutic role of the institutions. Patient discipline was along the lines of military standards and constituted a constant means of treatment in these institutions, organised around the father figure of the doctor-director. The key concept of “moral treatment” which was in time with the paternal and guiding role of the doctor was, more or less, also prominent in Greece.

Scientific presentations concerning clinical practice in psychiatric hospitals, were rather scarce, in contrast to reports concerning milder psychiatric conditions in extra-mural practice. Regarding Medicine in general, studies reported in conferences at the *Athens Medical Association* (founded in 1835) give us an idea for the areas of interest of Greek physicians:

Great interest was shown in the biological therapeutic methods of the 1920s and 1930s, like fever therapy, insulin and cardiazol convulsive treatment, which have long since been abandoned. Psychosurgery was applied from 1945 to 1950, in few selected cases, on the basis of oversimplified beliefs in cere-

Table 1
Scientific reports presented during the Athens
Medical Association meetings: 1835–1934

| Topics of reports | Number |
|--|--------|
| 1. Surgery | 426 |
| 2. Internal Medicine | 403 |
| 3. Therapeutic methods and Pharmacology | 256 |
| 4. General Topics, Medical and other | 255 |
| 5. Microbiology, Epidemiology, Hygiene | 223 |
| 6. Pathological Anatomy, Pathological Physiology | 181 |
| 7. Obstetrics, Gynaecology | 170 |
| 8. Neurology, Psychiatry | 169 |
| 9. Ophthalmology | 144 |
| 10. Venereology, Dermatology | 134 |
| 11. Paediatrics | 107 |
| 12. Urology | 80 |
| 13. History of Medicine | 77 |
| 14. Ear-nose-and-throat | 69 |
| 15. Physiotherapy, Radiology | 65 |
| 16. Anatomy, Histology, Physiology, Biology | 63 |
| 17. Forensic Medicine, Toxicology | 55 |
| 18. Orthopaedics | 41 |
| 19. Stomatology | 14 |

bral localisations. Electro-convulsive therapy which started in Greece only in 1945, generated great scientific interest, it was used, widely and stood the test of time for specific indications.

The establishment of the University of Athens psychiatric department, at the “Eginition” Hospital, in 1904, was a milestone in Greek psychiatry, as this University hospital has been for many years a centre of excellence for the management of acute neurological and psychiatric patients and many generations of neurologists and psychiatrists were trained there. In Thessaloniki, the operation of a similar University Department began after 1950.

The establishment of the first private psychiatric hospital in 1904, and a dozen more by 1940, contributed to a more humane management of patients. The public psychiatric hospitals of Souda (Crete), Athens and Thessaloniki started operating between 1910 and 1914, as small asylums, without distinct medical coverage. Indeed, an organised hospital function would only be achieved twenty years later. At the beginning of the 20th century, small local asylums with rather limited potential of care also existed, such as the *Vegeio*, on the island of Cefalonia, the *Hirsch*, department of the Jewish community hospital of Thessaloniki and the *Skylitseio*, department of the "Skyliteio" hospital on the island of Chios.

By the 1930s, Greek neurology and psychiatry began to acquire greater impact and visibility, both on the medical and

Table 2
Psychiatric hospitals and number of beds
(Statistical Directory of Greece, 1938)

| Hospitals | Number | Number of beds |
|---|--------|----------------|
| <i>State owned:</i> | 5 | |
| Public Psychiatric Hospital of Athens | | 1800 |
| "Dromokaiteion" Hospital | | 645 |
| Public Psychiatric Hospital of Thessaloniki | | 245 |
| | | 325 |
| Public Psychiatric Hospital of Corfu | | 300 |
| Public Psychiatric Hospital of Crete | | |
| <i>Municipal and community owned:</i> | 2 | |
| "Hirsch", Thessaloniki | | 75 |
| "Skylitseion", Chios | | 63 |
| <i>National University:</i> | 1 | |
| "Eginition" | | 112 |
| <i>Charitable Institutions:</i> | 2 | |
| "Vegion", Cefalonia | | 100 |
| Mental asylum of Syros | | 60 |
| | 10 | 3725 |

social levels. Contributing factors were the increased number of neurologists – psychiatrists, their more frequent contribution to the medical bibliography and the increasing number of specialised hospitals. In contrast to the (first) psychiatric hospital of Corfu, which did not actively participate in the dissemination of ideas and the production of scientific work, the “*Dromokaiteion*”, the *Public Psychiatric Hospital of Athens*, the “*Eginition*”, the Neurology Departments of “*Evangelismos*” hospital and “*Erythros Stavros*” hospital (The Red Cross Hospital) were active in quality clinical work, as well as in research, mainly in the field of neurology, but also in psychiatry. Military physicians, such as K. Papastratigakis, D. Kouretas, F. Skouras (graduates of the Military Medical School of Lyon, in France), played an active role in the development of psychiatry in Greece. This flourishing of neurology-psychiatry led in 1936 to the establishment of the *Nevrologiki kai Psychiatriki Etaireia Athinon* (*Neurological and Psychiatric Association of Athens*) by approximately 20 neurologists – psychiatrists, out of a total of 32–35 neurologists-psychiatrists practicing throughout Greece, at that time.

The first references to psychoanalysis were made by philosophers and educators at the end of the 1910s, who maintained this interest throughout the 1920s and 1930s. The work of G. Moraitis and the “Adlerian” group, with the journal *Atomiki Psychologia* (*Individual Psychology*) and the advisory/consulting facility established, was greatly influential. Texts on psychoanalysis authored by physicians, first appeared in the 1920s, but the first attempt to create a psychoanalytic group took place in 1945 by A. Embirikos, G. Zavitsianos and D. Kouretas, led by Princess Maria Bonaparte. This attempt failed and psychoanalysis acquired an institutional presence much later. Yet it stimulated great interest in related concepts

encountered in the ancient Greek drama and literature and many psychiatrists (e.g. Prof. D. Kouretas) dealt with such topics extensively.

Psychology, as a branch of philosophy, can be found in Greek texts of the 18th century. Andreas Kalvos, the poet, taught Psychology at the Ionian Academy in 1840. Subsequently, psychology manuals appeared, translated or in the original version, focusing mainly on educational psychology. Particularly important was the work of Georgios Serouios, headmaster at the Secondary School of Ermoupolis (island of Syros), as it introduced essentially the science of phrenology in Greece. Th. Voreas (a disciple of W. Wundt), professor of Psychology at the School of Philosophy of Athens, founded, in 1926, the first experimental psychology laboratory.

As already mentioned, after World War II, the use of biological treatment methods, including insulin therapy and electro-convulsive therapy, intensified, producing high expectations. The dynamics of the 30s with respect to psychoanalysis did not have a clear-cut continuity before the 1970s, whilst certain principles of “milieu therapy” were implemented, aiming to enhance the therapeutic potential of psychiatric hospitals. Some elements of community therapy also appeared during this period, but they could not be fully implemented due to the lack of effective psychopharmacological support.

D.N. Ploumpidis, Ath. Karavatos, G.N. Christodoulou

ANCIENT GREEK CONTRIBUTION

The aim of this chapter is to highlight the influence of ancient Greek medical literature on the genesis of modern Greek psychiatry, via European medical tradition.

A systematic presentation of ancient Greek literature relevant to Psychiatry is beyond the context of this volume.

Hippocrates

Hippocratic oath¹

“I swear by Apollo, the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgment, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

¹ Translated by Michael North, National Library of Medicine, 2002, <http://www.nlm.nih.gov>

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding my voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

The sacred disease²

“I am about to discuss the disease called “sacred”. It is not, in my opinion, any more divine or more sacred than other diseases, but has a natural cause, and its supposed divine origin is due to men’s inexperience, and to their wonder at its peculiar character”.

[...]

“But this disease is in my opinion no more divine than any other; it has the same nature as other diseases, and the cause that gives rise to individual diseases.”

² Hippocrates. *The sacred disease*. Transl. WHS Jones, Vol. II, Harvard University Press, Cambridge MA, 1992, fragments of text selected from pages 139–183.

[...]

“The fact is that the cause of this affection, as of the more serious diseases generally, is the brain ”.

[...]

“This disease attacks the phlegmatic, but not the bilious. Its birth begins in the embryo while it is still in the womb, for like the other parts, the brain too is purged and has its impurities expelled before birth (...) Should the purging not take place, but congestion occur in the brain, then the infants cannot fail to be phlegmatic.”

[...]

“If the phlegm be cut off from these passages, but makes its descent into the veins I have mentioned above, the patient becomes speechless and chokes; froth flows from the mouth; he gnashes his teeth and twists his hands; the eyes roll and intelligence fails, and in some cases excrement is discharged.”

[...]

“Men ought to know that from the brain, and from the brain only, arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs and tears. Through it, in particular, we think, see, hear, and distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant (...) It is the same thing which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes (...) These things that we suffer all come from the brain, when it is not healthy, but becomes abnormally hot, cold, moist, or dry, or suffers any other unnatural affection to which it was not accustomed (...) When the brain is abnormally moist, of necessity it moves, and when it moves neither sight nor hearing are still,

but we see or hear now one thing and now another, and the tongue speaks in accordance with the things seen and heard on any occasion. But all the time the brain is still, a man is intelligent.”

[...]

“[The brain] when it is healthy it is an interpreter to us of the phenomena caused by the air, it is the air that gives it intelligence. Eyes, ears, tongue, hands and feet act in accordance with the discernment of the brain; in fact the whole body participates in intelligence in proportion to its participation in air. To consciousness the brain is the messenger. For when a man draws, and so is dispersed through the rest of the body, though it leaves in the brain its quintessence, and all that it has of intelligence and sense.”

[...]

“Wherefore I assert that the brain is the interpreter of consciousness. The diaphragm has a name due merely to chance and custom, not to reality and nature, and I do not know what power the diaphragm has for thought and intelligence. It can only be said that, if a man be unexpectedly overjoyed or grieved, the diaphragm jumps and causes him to start (...) Since it perceives nothing before the other parts do, but is idly named as though it were the cause of perception (...) Some people say that the heart is the organ with which we think, and that it feels pain and anxiety. But it is not so; it merely is convulsed, as is the diaphragm, only more so for the following reasons. From all the body veins extend to it, and it so encloses them that it feels any pain or tension that comes upon a man. (...) the heart and the diaphragm are best endowed with feeling. Neither, however, has any

share of intelligence, but it is the brain which is the cause of all the things I have mentioned.”

[...]

“So that there is no need to put the disease in a special class and to consider it more divine than the others; they are all divine and all human. Each has a nature and power of its own; none is hopeless or incapable of treatment.”

Humours³

“Among psychical symptoms are intemperance in drink and food, in sleep, and in wakefulness, the endurance of toil either for the sake of certain passions (for example, love of dice) or for the sake of one’s craft or through necessity, and the regularity or irregularity of such endurance. States of mind before and after changes. Of moral characteristics: diligence of mind, whether in inquiry or practice or sight or speech; similarly, for example, griefs, passionate outbursts, strong desires. Accidents grieving the mind, either through vision or through hearing. How the body behaves; when a mill grinds the teeth are set on edge; the legs shake when one walks beside a precipice; the hands shake when one lifts a load that one should not lift; the sudden sight of a snake causes pallor. Fears, shame, pain, pleasure, passion and so forth: to each of these the appropriate member of the body responds by its action. Instances are sweats, palpitation of the heart and so forth.”

³ Hippocrates, *Humours*, Transl. WHS Jones, Vol. IV, Harvard University Press, Cambridge MA, 1992, p.81

Plato (422–370 BC)

Timaeus⁴ (86b–e, 87a, 88a–b, 91c–d)

“Such is the manner in which diseases of the body come about; and those of the soul which are due to the condition of the body arise in the following way. We must agree that folly is a disease of the soul; and of folly there are two kinds, the one of which is madness, the other ignorance (...) he brings on himself time after time many pangs and many pleasures owing to his desires and the issue thereof, and comes to be in a state of madness for the most part of his life because of those greatest of pleasures and pains, and keeps his soul diseased and senseless by reason of the action of his body... no one is voluntarily wicked, but the wicked man becomes wicked by reason of some evil condition of body and unskilled nurture, and these are experiences which are hateful to everyone and involuntary (...) as these humours penetrate to the three regions of the Soul, according to the region which they severally attack, they give rise to all manner of rashness and cowardice, and of forgetfulness also, as well as of stupidity (86b–e, 87a)”

[...]

⁴ Plato, *Timaeus*, Transl. RG Bury, Harvard University Press, Cambridge MA, 1989, fragments of text selected from pages 233–251

“Whenever the soul within it is stronger than the body and is in a very passionate state, it shakes up the whole body from within and fills it with maladies (...) and thereby it deceives the majority of so-called physicians and makes them ascribe the malady to the wrong cause. And on the other hand, when a large and overbearing body is united to a small and weak intellect (...) the motions of the stronger part prevail and augment their own power, but they make that of the soul obtuse and dull of wit and forgetful, and thereby they produce within it that greatest of diseases, ignorance (88a–b)”

[...]

“And in women again, owing to the same causes, whenever the matrix or womb, as it is called –which is an indwelling creature desirous of child-bearing– remains without fruit long beyond the due season, it is vexed and takes it ill; and by straying all ways through the body and blocking up the passages of the breath and preventing respiration it casts the body into the uttermost distress, and causes, moreover, all kinds of maladies; until the desire and love of the two sexes unite them. Then, culling as it were the fruit from trees (91c–d) ”

Phaedo (94b–95a)⁵

“Well’, said Socrates, ‘of all the parts that make up a man, do you think any is ruler except the soul, especially if it be a wise one?’

‘No, I do not.’

‘Does it yield to the feelings of the body or oppose them? I mean, when the body is hot and thirsty, does not the soul

⁵ Plato, *Phaedo*, transl. H. North Fowler. Harvard University Press, Cambridge MA, 1997, fragments of text selected from pages 325–327.

oppose it and draw it away from drinking, and from eating when it is hungry, and do we not see the soul opposing the body in countless other ways?’

‘Certainly’.

‘Did we not agree in our previous discussion that it could never, if it be a harmony, give forth a sound at variance with the tensions and relaxation and vibrations and other conditions of the elements which compose it, but that it would follow them and never lead them?’

‘Yes’, he replied, ‘we did, of course’.

‘Well then, do we not now find that the soul acts in exactly the opposite way, leading those elements of which it is said to consist and opposing them in almost everything through all our life, and tyrannizing over them in every way, sometimes inflicting harsh and painful punishments (those of gymnastics and medicine), and sometimes milder ones, sometimes threatening and sometimes admonishing, in short, speaking to the desires and passions and fears as if it were distinct from them and they from it, as Homer has shown in the *Odyssey* when he says of Odysseus:

He smote his breast, and thus he chid his heart:

Endure it, heart, thou didst bear worse than this?

Do you suppose that, when he wrote those words, he thought of the soul as a harmony which would be led by the conditions of the body, and not rather as something fitted to lead and rule them, and itself a far more divine thing than a harmony?’

‘By Zeus, Socrates, the latter, I think’.

‘Then, my good friend, it will never do for us to say that the soul is a harmony; for we should, it seems, agree neither with Homer, the divine poet, nor with ourselves’.

‘That is true’, said he.”

The Republic⁶ (436a–441c)

“But the matter begins to be difficult when you ask whether we do all these things with the same thing or whether there are three things and we do one thing with one and one with another – learn with one part of ourselves, feel anger with another, and with yet a third desire the pleasures of nutrition and generation and their kind, or whether it is with the entire soul that we function in each case when we once begin. That is what is really hard to determine properly.’ ‘I think so too,’ he said. [436 a–b]”

[...]

“The soul of the thirsty then, in so far as it thirsts, wishes nothing else than to drink, and yearns for this and its impulse is towards this.’ ‘Obviously.’ ‘Then if anything draws it back when thirsty it must be something different in it from that which thirsts and drives it like a beast to drink. For it cannot be, we say, that the same thing with the same part of itself at the same time acts in opposite ways about the same thing.’ ‘We must admit that it does not.’ (439b–c)”

[...]

“Not unreasonably,’ said I, ‘shall we claim that they are two and different from one another, naming that in the soul whereby it reckons and reasons the rational and that with which it loves, hungers, thirsts, and feels the flutter and titillation of other desires, the irrational and appetitive – companion of various repletions and pleasures.’ ‘It would not be unreasonable but quite natural,’ he said, ‘for us to think this.’

⁶ Plato, *The Republic*, transl. P. Shorey, Harvard University Press, Cambridge MA, 1982, fragments of text selected from pages 381–407.

‘These two forms, then, let us assume to have been marked off as actually existing in the soul. But now the Thymos or principle of high spirit, that with which we feel anger, is it a third, or would it be identical in nature with one of these?’ ‘Perhaps,’ he said, ‘with one of these, the appetitive.’ (439d–e)”

[...]

“The principle of anger sometimes fights against desires as an alien thing against an alien (440a)”

[...]

“Is it then distinct from this too, or is it a form of the rational, so that there are not three but two kinds in the soul, the rational and the appetitive, or just as in the city there were three existing kinds that composed its structure, the money-makers, the helpers, the counselors, so also in the soul there exists a third kind, this principle of high spirit, which is the helper of reason by nature unless it is corrupted by evil nurture?’ ‘We have to assume it as a third,’ he said. ‘Yes,’ said I, ‘provided it shall have been shown to be something different from the rational, as it has been shown,’ he said; ‘for that much one can see in children, that they are from their very birth chock-full of rage and high spirit, but as for reason, some of them, to my thinking, never participate in it, and the majority quite late.’ ‘Yes, by heaven, excellently said,’ I replied; ‘and further, one could see in animals that what you say is true. And to these instances we may add the testimony of Homer quoted above:

He smote his breast and chided thus his heart.

For there Homer has clearly represented that in us which has reflected about the better and the worse as rebuking that which feels unreasoning anger as if it were a distinct and dif-

ferent thing.' 'You are entirely right,' he said. 'Through these waters, then,' said I, 'we have with difficulty made our way and we are fairly agreed that the same kinds equal in number are to be found in the state and in the soul of each one of us.' 'That is so.' (440e–441c)"

Phaedrus (265a–b)⁷

"Socrates: And that there are two kinds of madness, one arising from human diseases, and the other from a divine release from the customary habits.

Phaedrus: Certainly.

Socrates: And we made four divisions of the divine madness, ascribing them to four gods, saying that prophecy was inspired by Apollo, the mystic madness by Dionysus, the poetic by the Muses, and the madness of love, inspired by Aphrodite and Eros, we said was the best. We described the passion of love in some sort of figurative manner, expressing some truth, perhaps, and perhaps being led away in another direction, and after composing a somewhat plausible discourse, we chanted a sportive and mythic hymn in meet and pious strain to the honour of your lord and mine, Phaedrus, Love, the guardian of beautiful boys."

⁷ Plato, *Phaedrus*, transl. WRM Lamb, Harvard University Press, Cambridge MA, 1995, fragments of text selected from pages 531–533.

Aristotle (384–322 BC)

On the soul⁸ (403a–b and 412a–b)

“A further problem presented by the affections of soul is this: are they all affections of the complex of body and soul, or is there any one among them peculiar to the soul by itself? To determine this is indispensable but difficult. If we consider the majority of them, there seems to be no case in which the soul can act or be acted upon without involving the body; e.g. anger, courage, appetite, and sensation generally. Thinking seems the most probable exception; but if this too proves to be a form of imagination or to be impossible without imagination, it too requires a body as a condition of its existence. If there is any way of acting or being acted upon proper to soul, soul will be capable of separate existence; if there is none, its separate existence is impossible. In the latter case, it will be like what is straight, which has many properties arising from the straightness in it, e.g. that of touching a bronze sphere at a point, though straightness divorced from the other constituents of the straight thing cannot touch it in this way; it cannot be so divorced at all, since it is always found in a body. It therefore seems that all the affections of soul involve a body-

⁸ Aristotle, *On the soul*, transl. JA Smith, Kessinger Publishing, USA, 2004, fragments of text selected from pages 4–22.

passion, gentleness, fear, pity, courage, joy, loving, and hating; in all these there is a concurrent affection of the body. In support of this we may point to the fact that, while sometimes on the occasion of violent and striking occurrences there is no excitement or fear felt, on others faint and feeble stimulations produce these emotions, viz. when the body is already in a state of tension resembling its condition when we are angry. Here is a still clearer case: in the absence of any external cause of terror we find ourselves experiencing the feelings of a man in terror. From all this it is obvious that the affections of soul are enmattered formulable essences.”

“Consequently their definitions ought to correspond, e.g. anger should be defined as a certain mode of movement of such and such a body (or part or faculty of a body) by this or that cause and for this or that end. That is precisely why the study of the soul must fall within the science of Nature, at least so far as in its affections it manifests this double character. Hence a physicist would define an affection of soul differently from a dialectician; the latter would define e.g. anger as the appetite for returning pain for pain, or something like that, while the former would define it as a boiling of the blood or warm substance surround the heart. The latter assigns the material conditions, the former the form or formulable essence; for what he states is the formulable essence of the fact, though for its actual existence there must be embodiment of it in a material such as is described by the other. Thus the essence of a house is assigned in such a formula as ‘a shelter against destruction by wind, rain, and heat’; the physicist would describe it as ‘stones, bricks, and timbers’; but there is a third possible description which would say that it was that form in that material with that purpose or end. Which, then, among these is entitled to be

regarded as the genuine physicist? The one who confines himself to the material, or the one who restricts himself to the formulable essence alone? Is it not rather the one who combines both in a single formula? (403a–b)”

[...]

“We are in the habit of recognizing, as one determinate kind of what is, substance, and that in several senses, (a) in the sense of matter or that which in itself is not ‘a this’, and (b) in the sense of form or essence, which is that precisely in virtue of which a thing is called ‘a this’, and thirdly (c) in the sense of that which is compounded of both (a) and (b). Now matter is potentiality, form actuality; of the latter there are two grades related to one another as e.g. knowledge to the exercise of knowledge.”

“Among substances are by general consent reckoned bodies and especially natural bodies; for they are the principles of all other bodies. Of natural bodies some have life in them, others not; by life we mean self-nutrition and growth (with its correlative decay). It follows that every natural body which has life in it is a substance in the sense of a composite.”

“But since it is also a body of such and such a kind, viz. having life, the body cannot be soul; the body is the subject or matter, not what is attributed to it. Hence the soul must be a substance in the sense of the form of a natural body having life potentially within it. But substance is actuality, and thus soul is the actuality of a body as above characterized. Now the word actuality has two senses corresponding respectively to the possession of knowledge and the actual exercise of knowledge. It is obvious that the soul is actuality in the first sense, viz. that of knowledge as possessed, for both sleeping and

waking presuppose the existence of soul, and of these waking corresponds to actual knowing, sleeping to knowledge possessed but not employed, and, in the history of the individual, knowledge comes before its employment or exercise.”

“That is why the soul is the first grade of actuality of a natural body having life potentially in it (...) If, then, we have to give a general formula applicable to all kinds of soul, we must describe it as the first grade of actuality of a natural organized body. That is why we can wholly dismiss as unnecessary the question whether the soul and the body are one: it is as meaningless as to ask whether the wax and the shape given to it by the stamp are one, or generally the matter of a thing and that of which it is the matter. Unity has many senses (as many as ‘is’ has), but the most proper and fundamental sense of both is the relation of an actuality to that of which it is the actuality. We have now given an answer to the question, What is soul? an answer which applies to it in its full extent. It is substance in the sense which corresponds to the definitive formula of a thing’s essence. That means that it is ‘the essential whatness’ of a body of the character just assigned. (412a–b)”



Areteus⁹ (2nd century AD)

On melancholy

“It is a lowness of spirits from a single phantasy, without fever; and it appears to me that melancholy is the commencement and a part of mania. For in those who are mad, the understanding is turned sometimes to anger and sometimes to joy, but in the melancholics to sorrow and despondency only. (...) but those affected with melancholy are not every one of them affected according to one particular form; but they are either suspicious of poisoning, or flee to the desert from misanthropy, or turn superstitious, or contract a hatred of life. (...) If the cause remain in the hypochondriac regions, it collects about the diaphragm, and the bile passes upwards, or downwards in cases of melancholy. But if it also affects the head from sympathy, and the abnormal irritability of temper change to laughter and joy for the greater part of their life, these become mad rather from the increase of the disease than from change of the affection. Dryness is the cause of both. Adult men, therefore, are subject to mania and melancholy, or persons of less age than adults. Women are worse affected with mania than men. As to age, towards manhood, and those

⁹ *The extent works of Aretaeus the Cappadocian*, transl. F. Adams. Sundenham Society, London 1856, fragments of text selected from pages 298–304.

actually in the prime of life. The seasons of summer and of autumn engender, and spring brings it to a crisis. The characteristic appearances, then, are not obscure; for the patients are dull or stern, dejected or unreasonably torpid, without any manifest cause: such is the commencement of melancholy. And they also become peevish, dispirited, sleepless, and start up from a disturbed sleep. (...) But if the illness become more urgent, hatred, avoidance of the haunts of men, vain lamentations; they complain of life, and desire to die.”

On madness

“The modes of mania are infinite in species, but one alone in genus. For it is altogether a chronic derangement of the mind, without fever. For if fever at any time should come on, it would not owe its peculiarity to the mania, but to some other incident. Thus wine inflames to delirium in drunkenness; and certain edibles, such as mandragora and hyoscyamus, induce madness: but these affections are never called mania; for, springing from a temporary cause, they quickly subside, but madness has something confirmed in it. To this mania there is no resemblance in the dotage which is the calamity of old age, for it is a torpor of the senses, and a stupefaction of the gnostic and intellectual faculties by coldness of the system. But mania is something hot and dry in cause, and tumultuous in its acts. And, indeed, dotage commencing with old age never intermits, but accompanies the patient until death; while mania intermits, and with care ceases altogether. And there may be an imperfect intermission, if it take place in mania when the evil is not thoroughly cured by medicine, or is connected with the temperature of the season. For in certain persons who seemed to be freed from the complaint, either the season of spring, or some error in diet, or

some incidental heat of passion, has brought on a relapse. Those prone to the disease, are such as are naturally passionate, irritable, of active habits, of an easy disposition, joyous, puerile; likewise those whose disposition inclines to the opposite condition, namely, such as are sluggish, sorrowful, slow to learn, but patient in labour, and who when they learn anything, soon forget it; those likewise are more prone to melancholy, who have formerly been in a mad condition. (...) And they with whose madness joy is associated, laugh, play, dance night and day, and sometimes go openly to the market crowned, as if victors in some contest of skill; this form is inoffensive to those around. Others have madness attended with anger; (...) The cause of the disease is seated in the head and hypochondriac region, sometimes commencing in both together, and the one imparting it to the other. In mania and melancholy, the main cause is seated in the bowels, as in phrenitis it is mostly seated in the head and the senses. For in these the senses are perverted, so that they see things not present as if they were present, and objects which do not appear to others, manifest themselves to them; whereas persons who are mad see only as others see, but do not form a correct judgment on what they have seen. If, therefore, the illness be great, they are of a changeable temper, their senses are acute, they are suspicious, irritable without any cause, and unreasonably desponding when the disease tends to gloom; but when to cheerfulness, they are in excellent spirits; (...) At the height of the disease they have impure dreams, and irresistible desire of venery, without any shame and restraint as to sexual intercourse; and if roused to anger by admonition or restraint, they become wholly mad. Wherefore they are affected with madness in various shapes."



Galen (129–201 AD)

On Hygiene¹⁰

“And every year we treat not a few patients for ailments of the mind, by correcting the disorder of its activities. No mean witness of this opinion is our ancestral divinity Asclepios, who caused not a few odes to be written and humorous mimes and songs to be composed by those in whom the excessive activity of passion made the constitution of the body hotter than normal. And others, not a few also, he caused to hunt, ride, and exercise in arms; and in those for whom he prescribed this he limited not only the form of activity, but also the arms in those whom he ordered to exercise in arms. For he not only wished to stimulate passion when it was too weak, but he also set a limit to the concept of exercise. For the passion is not equally aroused against wild boars, bears, bulls, and other such big beasts, as against hares, gazelles, and such timid creatures; and not equally is light and heavy arms, not in swift and moderate running, nor in competitive and solitary sport.”

¹⁰ Green RM. *A translation of Galen's hygiene*. CC Thomas Publishing, Springfield, 1951, p. 27.

On the causes of symptoms¹¹

“Just as also the apoplexies and epilepsies seem to occur through an abundance of phlegmatous humour gathered together in the cavities of the brain itself. And because of this, both the genesis and resolution of these things is sudden, this in no wise being able to occur in the dyscrasias of bodies. The moderate damages, like the numbness of reason and of memory, occur in response to a more slight cooling, either through one of the cold medicines being taken into the body or being applied to the head, or when a cold humour has been gathered in the brain.”

¹¹ Johnston I. *Galen on diseases and symptoms*. Cambridge University Press, London, 2006, p. 263.

Soranus of Ephesus (98–138 AD)

Gynaecology Book III¹² (*Γυναικείων Γ'*)

IV. On Hysterical Suffocation

“(26) Hysterical suffocation has this composite name from the suffering part of the body and one of the symptoms, by which I mean the suffocation. Its definition is the following: there is an interruption in breathing accompanied by aphonia and atony of the senses, due to some kind of pathological condition of the uterus. Before the disease, in most cases, there appear in sequence: miscarriage, premature parturition, long-term widowhood, suppression of the menses, interruption of normal pregnancy and a distended uterus. The phenomena observed in patients during suffocation are prostration, aphonia, laboured breathing, loss of senses, clenching and gritting of the teeth, spasmodic contraction of the limbs –sometimes only a paresis thereof– swelling of the hypochondrion, rising of the uterus, expansion of the thorax, swelling of the vessels that interweave in the face, overall chill, general perspiration, total lack of a pulse or great retardation of the pulses; the patient, in most cases recovers rapidly from this state of pros-

¹² Translated from: Soranou Apanta (Soranus complete works), Vol. II (*Γυναικείων Γ'+Δ'*), ed. Kaktos, Athens 1996.

tration and frequently recalls what has happened to her; she has pain in the head and the muscles of the neck and sometimes also suffers from confusion of the mind.”

[...]

“(27) In all these diseases, taken overall, we can note the fact that in all the aforementioned cases the uterus is in a normal condition or at least not much affected, while in the case of the hysterical disease is severely inflamed, and rises upwards; furthermore, those who suffer from hysteria, in most cases, after the end of the paroxysm can discuss what has occurred, which does not apply, at all, to other diseases; furthermore, women who suffer from hysteria complain previously of their uterus, while others, suffering a loss of voice due to worms, complain of their intestines and their abdomen, and others that they suffered a headache. Furthermore, cataleptic women manifest the disease at a time they are suffering a fever, along with a distension of the eyelids and gritting of the teeth, before the paroxysm of fever, while there is an abatement at the time of the paroxysm. In contrast, the woman who suffers from hysteria has suffocation even without fever and with closed eyelids. The lethargic are characterised by fainting when they have a fever and a fast pulse, which do not appear in hysterical women, while those who present with aphonia due to intestinal worms have characteristic intermittent cries and an irregular, erratic pulse [...]”.



Nemesius (bishop) of Emesa (4th century AD)

On the human nature

(*De natura hominis, Περί φύσεως ανθρώπου*¹³)

“[...]”

On the section of the psyche concerning remembrance

[...]

“Natural concepts are those that are present in everyone without being taught, such as the existence of God. Plato considers this is a memory of ideas. We will discuss what an idea is later on.

The imaginary delivers phenomena to the intellect, the intellect –the locus of reason– receives and evaluates them, and then sends them to memory; the seat of memory is located in the posterior ventricle of the brain, which is termed the cerebellum and encranida and the spirit of the psyche is equally situated therein. As we have said, the beginnings and the roots of the senses are in the frontal ventricles of the brain; those of

¹³ Translated from a Manuscript of the 18th century found in the Municipal Library of the city of Kozani (Macedonia).

the intellectual part of the soul in the middle ventricle; whilst those of memory in the back ventricle; it is necessary to prove that these are true, so that it is not considered that we hold this belief without reason. A sufficient proof in our possession is the energy attributed to these parts; because if the front ventricles undergo any damage, on the one hand the senses are obstructed, on the other hand the intellect remains unchanged. If only the middle ventricle is damaged, then the intellect makes mistakes, the senses, however, have no problem in retaining the sensations that are natural. However, if the frontal and the middle ventricles are damaged, then both reason and sensation are lost. If only the cerebellum is affected, then memory is lost, whilst senses and intellect do not undergo damage. It is obvious that, now, we do not refer to propulsion. If the middle and posterior ventricles of the brain are destroyed along with the frontal ventricles, then sensation and reason and memory are lost, and the entire animal is at risk of being lost. And this becomes obvious from other passions and symptoms, becoming more apparent in cases of phrenitis (mental illness). Because those suffering from phrenitis do not have any problem with their sensations, the intellect alone poses problems.

[...]

Others draw on empty imagination and think that they see the invisible, while in all else they are in accordance with reason. According to the damage that each centre has undergone, its energy is hindered; the energy that is damaged in the animal, is the energy included by nature in the damaged part. For example if the foot is affected, we cannot walk, because this is the energy of the foot.”



EARLY STEPS

Constantinos Michael

(1751–1826)

Dietetics

(Διαιτητική)

Regimen proposed and a concise history of the beginning and the progress of Medical science; composed through old and more recent contributions of some of the men who have prospered through Medical science.

By Constantinos Michael from Castoria, who has also studied the medical science.

*From the press of Josef Baumeisterus,
Friendly expenditure, Vienna 1794*

[...]

When our body is in movement with moderation, this is not only beneficial to the body, but also greatly beneficial to our Mind; strengthening it in its actions and rendering it exceedingly more acute. If great exertions and exercises weaken the body, then the Mind is not capable of acting appropriately, something that anyone can observe, in himself. Yet again, if the Mind makes a moderate effort, then the entire Body is preserved in a healthy condition, despite the fact that

then the movement of the brain increases and consequently there is increased secretion of nervous fluid. And yet again, when the Struggle of the Mind is taken to extremes, then both Mind and Body are reduced to a wretched condition and both Mind and Body equally lose their powers.

[...]

The excessive Struggle of the Mind, alongside with other bad consequences, may cause insanity, apoplexy, even epilepsy, terrible and disastrous passions , which our most distinguished Physicians do assure us of in their observations.

[...]

On the other hand, Rest and the lavish Quietness and Leisure of the Mind may cause more harm than lack of Movement in the Body. Consequently, it is necessary for the Mind to Struggle and be Exercised, because occupation with studying and with the sciences, contributes not only to the embellishment of our Soul, but also to our health, granting a big benefit, if it does not surpass the Boundaries of moderation.

(ed.: The author mentions: Galen, Tissot, Rousseau and Zimmerman).



Anastasios Polyzoides (1802–1873)

Eschenmeyer. General thoughts on animal magnetism and the organic ether

(*Eschenmeyer. Σκέψεις γενικαὶ περὶ τοῦ ζωϊκοῦ
μαγνητισμοῦ καὶ ὀργανικοῦ αἰθέρος*)

Hermes o Logios, issue 7, April 1st, Vienna, 1818

Mr. Eschenmeyer attempts, with philosophical discourse and an acute mind, to argue on the existence of Organic Ether, that is to say a principle of life, which, if accepted, explains many of the phenomena of Vital Magnetism. The wonders of this Vital Magnetism, already renowned through out Germany, its peculiar influence over man, and its consequences are described in several more recent essays and narratives. Since, in this essay, the Author only mentions some of these [...]. I thought that it would be useful to provide a general idea on this issue to those curious to know more; including in summary, as in a table, the main points mentioned in detail by the Author in another essay: (a) a man under the influence of Magnetism (or in a state of so-called Magnetic sleep), is aware

of himself, his senses are transposed to the area of the stomach, the tips of his fingers, etc; he is aware of other people's condition, and demonstrates a heightened impetus of his inner nature; (b) he is able to see clearly, as if his heightened common sensibility increased his imagination, he can foresee paroxysms, his memory and recollection become stronger, etc.; (c) under the influence of Magnetism, he demonstrates a personal link (or identification) with the man administering the Magnetism, increasing his affection or dislike towards him; (d) he sees afar and his imagination soaring over many references of earthly matters in space and time, includes them in a single perception; (e) if one is ill and particularly suffering from some nervous disease, it is possible through Magnetism achieves to the best medical effect, because otherwise even the most powerful medications would be taken in vain. These things in general concern Magnetism, which has been known since some time, but has recently started to play a significant role, especially in Germany. Phenomena related to Magnetism seem to be really strange and when one listens to them for the first time they are hard to believe. Yet, what can one counterpoint as these matters have to a great extent been upheld by the experience and observation of trained men? Only the wisdom of time shall show whether these were all void and in vain, or whether they were salutary and useful for Mankind.



Georgios Serouios (1783–1849)

Elementary Psychology (Ψυχολογία Στοιχειώδης)

Printed in Ermoupolis (Syros), 1841

Psychological doctrines of phrenologists or the partisans of Spurzheim or dynamists

Gall and Spurzheim, the former of French origin and recently deceased, the latter German and still flourishing (ed. deceased in the USA, in 1832), were both chief proponents of this system, receiving the first impetus from cranioscopy and the measurement of pathological physiognomy; a system which is already slowly spreading throughout Europe.

They consider, like Platonists and ordinary people, that bodies are created of themselves; and hold, from many and manifold observations and experience, that the soul does not have, as Plato supported, innate ideas, but innate forces; that the soul is not, as Plato thinks, one force or two (logical and illogical) gifted with all types available, but the sum of numerous forces: not the five according to the empiricists (sensation, memory, imagination, mind, will), nor the nine,

held by the empiricist Thoreau; but sufficient in number, as to correspond with all aspects of natural world, to lead with all kinds of qualities, the relations and harmonies thereof, showing that the so-called mind is not a single force, but a succinct name for numerous forces (which they term Logical or Reasoning forces), as many in number as are all the capital arts and sciences compounded: such as Grammar, Music, Poetics, Gymnastics, Medicine, Legislation, Judicial science, Agriculture, Architecture, Painting, etc. Similarly, what is called the will is not a single force, but a concise name for many forces (which they call Moral forces) that are as many in number as are all the capital virtues: such as Prudence, Justice, Courage, Liberality, Courage, Charity, Patriotism, Tenderness, Friendship, etc.

[...]

Therefore, according to phrenologists, every art and science and every virtue is one of the innate forces, which has in the brain and the nervous system a familiar and appropriate organ via which it acts. Moreover, it has a familiar and appropriate object in the outer world, that is to say a kind of qualities, on which it can act automatically and by transmission. By acting on it and by creating in it its emotions and ideas, art or science of the same name, such as Architecture, Mathematics etc. is created.

[...]

The energy and the result of each art and science is modified (a) in proportion to the perfect or imperfect construction of the tool or tools through which it acts; (b) in proportion to the use or abuse thereof; (c) in proportion to this or the other position of the object on which it is acting.

It therefore follows that: (a) in all forms of psychic force, energy fluctuates and the result is altered depending on the natural construction of the nervous organ, through which it acts, or to put it differently, depending on what development the nervous or material organ can brook; and this explains the following phenomena concerning man: why do not all those who study the same art or science acquire equal learning, but some acquire more, while others less? The reason is that each of the nervous organs of the corresponding force cannot develop to the same extent in everybody. Consequently, the force acts upon each one in accordance with the build of the organ; where the nervous organ happens to be susceptible to a maximum development, the force acts with its full intensity; this is why there are supernatural, exceptional, sterling individuals in each art and science; this is exactly what we name an elevated and great destiny of a man; so that destiny is nothing else than one of the psychic forces which comes upon a corresponding organ that can be infinitely developed, and thus it too develops *ad infinitum*. This is also what Plato's "each man for what he was made" means. This is also what the words intelligence, natural dexterity, natural inclination mean. This also explains the reason why children of the same parents are not all born equal and similar in inclinations and learning and why the psychic forces also suffer when the nervous system suffers either in part or entirely. More over it explains why one is an idiot, the other mad, the other foolish, etc. And in general, this explains why, although the soul is one and the same, people are born so unequal in the force of their energies, having some of them one destiny and others having another *ad infinitum*. The reason is the infinitely differing weaving of the nervous system and nervous organs, which was pre-

economised through almighty wisdom, otherwise man would not by nature seek to be social if all were made equally able to know and equally able to do things; and in nature sociability arises from nothing else than inequality in us and the needs and dependencies of each.

[...]

Moreover, one can observe that if the nervous organs corresponding to psychic forces gain a consistency and a composition that can be developed, immediately the forces that belong thereto commence acting spontaneously and purposely, as if each one of them is looking for a, not present, familiar object. This is why we see infants and children, making automatical attemptions to draw, others starting to use a turning wheel by themselves, to orate, and others having a proclivity to economy or greed or selfishness or humour, etc. This is also why we can even observe amongst savages and barbarians the first doctors, such as Chiron and Asclepius, musicians like Apollo and Hermes, and poisoners, such as Medea and Circe, sculptors, such as Daedalus, seafarers such as Jason, politicians, such as Minos, Prometheus and Deucalion. Generally the beginning of all arts and sciences was the following: apparent self-learning and wisdom that springs up instinctually.

[...]

It should be noted that Dynamists consider moral forces to be senseless and blind (just as Plato named them the Irrational soul and divided them into affective [θυμικόν] and appetitive [επιθυμητικόν]), thus moving by themselves in three directions: two extremes and a middle one (just as Aristotle also considered them to do); consequently they need the logical forces in order to direct them towards the middle way, which

is virtue; the path of the two extremes of excess and deficiency are the close-related vices of that virtue. If the rational forces direct them in an enlightened manner, all is good, otherwise ... It is obvious that the force of bravery itself may move blindly, either in the direction of insolence or in the direction of cowardice; luckily, however, sometimes it moves towards the middle; and thus bravery is the harmonious combination of insolence and cowardice in accordance with four constant terms, and this is solely the work of good judgement. Someone who is brave, can be insolent at the proper time, place, manner and degree and simultaneously a coward, at the proper time, place, manner and degree. Similarly, political liberty is the harmonious combination of absolute despotism and absolute freedom according to these four terms; similarly liberality, justice, etc.

According to phrenologists, therefore, each force of the soul is called a Force, if it has a pre-ordained external object, in one kind of qualities, on which the force acts spontaneously and by transmission, if the object, not present, seeking the force, approaches the sphere of the force's influence and its material instrument is in a condition that can be activated.

It follows, therefore, that for the dynamists, Force and action or Force acting are related just as father and son, and that Force and Passion or Force suffering are contradictory and that all the forces of the soul as well as the five senses are entirely self-activating by transmission, in contrast with the opinion of the empiricists, as we shall see herein below.

It is generally accepted by all those questioned, that the psychological system of the dynamists explains without restrictions all the phenomena concerning humans, at least most of them and particularly those hard to explain. Because it is

hard to discern the number of the major arts and sciences and virtues, thus it is also hard to discern how many intellectual and moral forces exist in the soul; because Gall did increase these to 150, while Spurzheim did decrease them to 50 (ed.: the information given is mistaken. Gall described 27 “operations” and Spurzheim 150). However, this does not affect to any degree the accuracy of the system.

It should also be noted that many phrenologists, by abusing cranioscopy and the measurement of pathological scoping physiognomy, have vulgarised this to materialism, believing that the soul and its forces and actions are the results of the body’s organisation and of the nervous system, in other words, as the harmonies of a well-tuned harp: a belief that is in everything unphilosophical, and which we intend to overturn at a later date.



Sarantis Archigenis (1809–1874)

Elements of pathological medicine

*In Paris 1843, distributed by the author
and the embassy of the Sublime Porte*

On Neuroses in general

According to Mr. Georgetos, the word neurosis signifies those diseases whose anatomical cause and organic alterations remain unknown and consequently so does their specific treatment. Their duration is long, even chronic, without fever, hard to cure, with severe symptoms, albeit without risk, occurring whilst the subject is in excellent health, lasting for a short period of time, leaving no trace behind after cessation and the patient's health returns in its original condition. In general, all neuroses occur intermittently and for this reason some authors classify them as intermittent fevers. Pinel classifies them into five categories: (a) *sensory neuroses*, including impaired hearing, mis-hearing, buzzing, deafness, diplopia, hemeralopia, nyctalopia, amaurosis; (b) *neuroses of the nervous system*, also known as general neuroses including comatose states (κωματώδη πάθη) such as catalepsy, misleading of the spirit as hypochondria, melancholy, insanity, idiotism, somnambulism, nightmares and

hydrophobia; (c) *neuroses of the motor organs*, such as neuralgia, tetanus, convulsions, chorea, and neuroses of the vocal organs as spasmodic dysphonia, nervous aphonia; (d) neuroses of the viscera, distinguishing those of the digestive organs, which include oesophageal spasm, cardialgia, pyrosis, spasmodic vomiting, dyspepsia, bulimia, pica, metal colic, ileus, those of the respiratory organs, including nervous asthma, whooping cough and asphyxia, those of the circulatory organs, nervous spasms, and syncope; (e) neuroses of the genitals, affecting males, as anaphrodisia, satyriasis, priapism, and those affecting females such as being nymphomania and hysteria. In listing these, it is obvious that many neuroses, as pathological anatomy has proven, are symptoms of other existing diseases, such as hearing impairment, deafness, amaurosis.

[...]

On hysteria

Hysteria is a chronic disease, intermittent and irregular, occurring in fits. Ancient Greeks believed that its seat was in the womb or uterus (*hystera*), hence its name; however, in our times it has been proven to also occur in males, therefore the most reasonable assumption would be that its seat is in the nervous system, and some times in female genitals. Occasionally, modification or cessation of a rash or of a normal flow can cause hysteria. It is mostly observed in women, from puberty to menopause, occasionally upon reduction or cessation of menses in highly strung individuals, given to sexual excesses, or practising masturbation.

Symptoms. Initially, yawnings, numbed limbs, involuntary crying or fits of laughter, paleness or redness of the face

occurring successively; the sufferer feels a knot somewhere in the lower abdomen, which slowly rises to the abdomen, or the chest and lodges itself in the throat, causing tightness and a feeling of imminent suffocation. Subsequently all the limbs of the body convulse, in certain cases tetanus rigidity occurs and certain parts of the body become senseless.

Diagnosis. The following characteristics of hysteria differ from epilepsy: fits do not occur unexpectedly; the sufferer feels a fit coming on and consequently hastens to lie down in an appropriate place. Fits frequently stem from deep sadness, pain, offended moral principles. Hysteria never progresses further, nor brings on mania or insanity or witlessness. Hysteria does induce feebleness and frequently the body becomes emaciated. Conversely, epilepsy causes obesity.

Treatment. If hysteria is brought on by a disease or irritation of female genitals or cessation of the menses, leeches are applied on the vulva and on the thighs, foot baths and hip baths are undertaken, vapours of asafoetida or medicinal herbs directed to the uterus, mainly near menses time. Deliquescent drinks are prescribed and, if masturbation is suspected, some seeds of camphor are added, which the patient takes in the evening when going to sleep. Bodily exercise is essential. However, if the above prove ineffective, then an arranged marriage is required. If the disease is caused by irritation of the nervous system, we prescribe bodily exercise, studying, cool baths, dousing, regular diet, tonics, food containing iron, bitters and aromatics. If the menses are not regular, nor abundant, but are at the same time frequent, a phlebotomy is performed and cool baths are prescribed, as well as wraps, hydrocyanic acid, cherry bark stem infusions, flushing agents for the lower limbs. If there is concomitant gastroenteritis, ini-

tially leeches are applied to the abdomen, baths, and emollient drinks are administered, or the aforementioned methods are put into practice. If caused by modification or cessation of a normal flow, we replace this with lancets or syringes, catheters etc. However, if all the present means are ineffective in the treatment of hysteria, anticonvulsants are administered.

During an attack, all constraints on the body are loosened, the face is doused with cold water, and a spoonful of spearmint water mixed with a few drops of ether is administered. If fainting occurs threatening life, mustard poultices are applied to the lower limbs, dry figs to the abdomen, the body is rubbed with alcoholic unguents; stimulating liquids, ether, herbal tinctures and stimulating enemas are administered.

On hypochondria

A chronic disease, which can be irregular or transient, mostly observed in men in their prime. Hypochondria is characterised by a confusion of the powers of intellect, as the actions of digestion and the liver. Concomitant symptoms include sadness, impatience, fear, infidelity to the most honest of friends, incessant restlessness and fear of death; disturbed sleep, headache, dizziness to the point of fainting, difficult digestion, bloated and distended stomach and intestines, stomach rumbling, colic, flatulence, frequent constipation, occasional diarrhoea; a pulse that is either fast, weak and intermittent, or slow and irregular; pains, palpitation, fainting, irregular pulse in the abdomen, frequently difficulty in breathing. Hypochondria can end in monomania or a bodily disorder, mainly tuberculosis.

Treatment. If a cerebral hyperaemia occurs, a phlebotomy is performed, leeches are applied on haemorrhoids of the anus,

foot baths and deliquescent drinks are prescribed, as well as easily digestible food abstaining from irritants, somatic exercise and an after-dinner walk. If we observe signs of chronic gastroenteritis, a lacuna is opened on the arm. Thereafter, deliquescent drinks are discontinued and tonics, bitters, aromatic herbs, such as gentian, chicory, sisymbrium extract, mixed with titanium water, milk, alkaline waters, etc. are served occasionally before dinner; syrup of cinchona and powdered rhubarb rendered beneficial results, as well as a belt drawn moderately tight over the belly, transitional vesicants and rubs with stimulating ointments. If eructation is not caused by a stomach alteration, then it frequently stopped by using cold water, ice-cream after dinner or bismuth subnitrate or titanium subcarbonate or magnesia. Wind can be treated with spearmint, orange blossom, cold enemas, carbon powder, with syrup of cinchona, with cold compresses on the abdomen and finally with a belt. Whey, relaxing enemas and equivalent salts are prescribed for constipation. Antispasmodics, wraps, food containing iron, tonics, fresh baths, rubs are administered for palpitations, fainting, choking and arrhythmias. If there are signs of monomania, entertainment, long walks and various forms of exercise are prescribed. Frequently, a vivid emotional experience or a sudden danger bring about improvement. If the disease is induced from sexual excesses or masturbation, an arranged marriage and scientific or literary studies are prescribed.



Spyridon Mavrogenis (1816–1902)

**On life and psyche and the relationships
linking these**

(Περὶ ζωῆς καὶ ψυχῆς καὶ τῶν πρὸς ἀλλήλας
σχέσεων αὐτῶν)

*The Bulletin of the Greek Literary Society of Constantinople, 1864
Year II, issue ε' 111–126, issue στ' 266–282, issue ζ' 1–24*

Part B: On the psyche

*[The main reference was the textbook of Feuchtersleben:
“Lehrbuch der aerztlichen Seelenkunde”]*

[...]

Man did not commence cutting open the brain and studying its functions before the idea of the mind appeared. But the idea of conscience, the higher manifestations of mind, its links to virtue, truth and goodness, the law of duty, the faith in a Being greater than those on earth: all this wisdom had long existed and had long ago flourished, before the idea

arose that the cause of such marvellous actions may be investigated in the human organism. Two worlds –one intellectual, the other tangible– were given to us simultaneously from the very beginning, and all studies and tests aiming to produce them through any other principle than the one of the divinity, have floundered. This pair, the intelligible and the perceptible, defines mankind. Within these boundaries philosophy triumphs, but when it seeks to dig beyond these, philosophy is ruined. On the one hand the intelligible world is manifested to us by the laws of truth, virtue and goodness; on the other hand the natural world is manifested through the laws of bodies moving in time and space. We are and shall remain ignorant of what lies beyond these laws, the essence of these two worlds (ed: references to Spinoza, Schelling, Fichte, Hegel, Kant).

It is accepted that spirit and body have a separate existence. On the one hand, the properties and potentials of the body without the spirit are examined by physics in general and physiology in particular; on the other hand, the laws of the spirit without the body are examined by metaphysics. In a way that we cannot understand, the spirit is connected to the body forming a bond with it, which we call psyche, and this double union we call a man. Through these three words “spirit, psyche and body” the concept of a triad is by binary compromise reduced to a single unit. Through the word “spirit” we mean, by abstraction, a principle being over matter, while with the word “psyche” we mean the spirit bonded with the body, in parallel. Thus, the sources of our investigations on the psyche are sought in psychology and physiology.

[...]

We have to consider that the psyche is connected to the body and through mutual action neither the spiritual essence of the

one, nor the somatic nature of the other are neglected. We shall call physiology of the psyche this way of investigation. This is neither physiology of the body nor simply psychology as commonly accepted, because the first one describes the qualities of the living body, while the other those of the psyche. Physiology of the psyche is the science teaching us the relationship between psyche and body, which are ineradicably bound together. The psyche is not simply the interior and the body is not simply the exterior. Interiority and exteriority refer to concepts concerning the differences in the spatial location of the bodies: However, the psyche is immaterial and is not situated within space. Yet its actions are no less present in the body. Having set these preliminaries, we proceed further in the investigations of the relationship between immaterial and material world.

[...]

External and internal senses create an impression –or, in general, a modification in the peripheral extremities of the nerves– which is instantaneously transmitted, through a process of electric current, from the extremities towards the centre where, as in a telegram, the image of the object is engraved. As all the central nerves assemble in the brain, the brain is considered to be the main location, where all perceptions of images are directed; hence it has been called *sensorium commune* (ed.: collective site for processing sensations). The eye does not see, the ear does not hear, but the brain sees through the eye, the brain hears through the ear, or rather the psyche sees through the brain and the eye, the psyche hears through the brain and the ear and so forth. For the time being science has not proven where this sensory organ (*sensorium commune*) is located in the brain and which is its particular location. Many have attempted to locate it, whether in the solid parts of the brain [Soemmering, “Org. Der Seele”], or in the fluid part [ibid, but Rudolph disagreed] All these (local-

ization efforts) were in vain, as proofs were not solid, because the links between the central and peripheral parts of the nervous system are not always incontrovertible, nor has it been everywhere unquestionably proven which organs of the brain should be considered as direct continuations of the sensory nerves.

[...]

It is necessary, for now, to accept that the brain is the centre of the images of all concepts and thus to consider the brain as the major instrument of psychic energies. This is in fact supported by the following:

- a. When the brain is intact, every other organ of the body may be partially harmed or fully damaged, while the actions of the psyche flourish. If a damage has occurred to physical existence, then all actions of the psyche cease to exist simultaneously, because in this case every bond between psyche and body is broken. On the contrary, if the brain is harmed, there are instances where physical actions are not affected.
- b. Organic lesions of the brain impair the functions of the psyche. Thus, a strong influx of blood into the brain and rupture of vessels and spilling of blood, fragments of bones of the skull and noxious products of the brain exercising pressure abruptly or gradually thereon, remove sensation; infants born headless develop no psyche and are not viable. Experience has shown, that adversities can be repaired first of all due to the fact that the brain is double in its parts, both corresponding parts are not harmed simultaneously, so the secondly part remaining intact may replace the functions of the harmed one and, second, in the functions of the body we frequently come across various injuries in organs, whose function is sufficient for survival, as it can happen in the lungs, kidneys, the liver and so forth...
- c. Once the morbidity of the brain is cured sensation returns.

- d. The psychic worth of beings increases in direct proportion to the development of the brain.
- e. In each individual the powers of psyche proceed in parallel with the development and the condition of the brain.
- f. The sensations arising from those nerves, whose contiguity with the brain is broken off, become faint and insignificant.

[...]

In the past, naturalists and philosophers, considering the key importance of consciousness, attempted to find an organic locus and place in it the seat of the psyche. For goodness' sake, there is no point in the body, where they did not presume the seat of the psyche to be. Moses and Empedocles asserted that this was the blood; Diogenes of Apollonia, a contemporary of Empedocles, claimed it was the right chamber of the heart; Chrysippus supposed it was the heart itself; van Helmont the pylorus; Descartes the pineal gland; Digby the transparent diaphragm of the brain; while Lancini and La Peyronie the corpus callosum; Soemmering the cerebrospinal fluid of the brain; while others offered entirely contradictory opinions. Ideas concerning the seat of the psyche in such differing dogmas were as different as earth is from heaven. These different schools of thought concerning psyche's seat, were often to some extent based on the observation of material differences after death, and to a great extent their assumptions were shaky as they were based on unsound hypotheses. On the other hand, there was also an undisputable observation, that except for the pineal gland, which is single, all the other parts of the brain are double, one could say, that if the seat of consciousness was designated, it should have two parts, so if one part was damaged, the other could remain active. But even if that was the case, it would be absurd to say that consciousness is also double.

[...]

Petros Kallivoursis

1. On hypnotism

(Περὶ καθυπνισμοῦ)

*Revue "Hippocrates", 1865, vol. 3, fascicules B' (31–32),
Γ' (54–56) and Δ' (79–80)*

On hypnotism under normal and surgical conditions

Mr. Azam, a physician in the mental asylum of Bordeaux, found a truly simple new method of anaesthesia, superior to chloroform (thus eliminating the associated risks), which method consists of fixing the gaze on a gleaming object, that is held a few inches away from the mid-brow. Of course this astounded the scientific community and caused an up-roar in most European academies and scientific societies (first and foremost in Paris, in the Academies of Sciences and of Medicine). Mr. Azam claims that if an individual stares unblinkingly at the object for a few minutes he would fall into a deep sleep and not feel a painful stimulus. Moreover, an individual put to sleep in such a way could be woken up by calmly rubbing his neck or eyes. The doctor furthermore asserted that if

one finger of somebody's hand touched the hand of a person put to sleep in such a way, who is already asleep, and one of the fingers of his other hand was placed on the subject's head, an electrical shock immediately convulsed the body of the hypnotised individual.

We deem that giving due consideration to this curious issue in the pages of "Hippocrates" would be a useful exercise, not entirely devoid of enjoyment, taking into account the rather incredible claims that have been published on this case.

Braid, an English surgeon, was the first to try to ascertain through experiments if these phenomena, attributed to animal magnetism and mesmerism, were true and to distinguish any existing real and actual data from false ones (either as a figment of imagination, or having a malicious intent). The outcome of his research is outlined in his publications on "*Ecstasy*", "*Electrobiology*" and "*Hypnotism*" proving therein that all phenomena produced by "mesmerists", "odylists", etc. (ed: odyllism: the theory of od or odylic force, supposed to exist in nature and manifest itself in such phenomena as hypnotism, magnetism, light, etc.), what he concisely termed "hypnotic phenomena", were in all aspects unrelated to magnetic forces and all other forces stemming from another individual. However, all these phenomena can be engendered by both eyes staring fixedly on any small object (for example, a piece of cork) suspended on a string in front of the eyes with the head bent. The result of this attunement of both eyes, brought about by fixing them on an object for a period of time, is a condition similar to sleep, which, according to Braid, consists initially only of a high level of mental distraction, and subsequently the full loss of sensitivity. According to Braid, the sequence of these phenomena shows that, when forces of thought and will are missing, only

awareness remains. During this stage, it is possible to change completely the hypnotised person's way of thinking, by stimulating his memory or imagination or sensory organs, producing the so so-called "electrobiological phenomena". During the second stage, which is the direct opposite of the first, there is a complete anaesthesia concerning external impressions, which, in certain cases, is so great, that even if we subject the hypnotised person to the most grievous pain, he does not feel it.

Braid's research was only fleetingly mentioned in numerous medical publications (i.e. in the British "Encyclopaedia of Anatomy and Physiology" by Todd, in Nysten's "Medical dictionary", and in Berard's "Elements of physiology"), but otherwise was set aside and finally completely forgotten.

[...]

In the previous issue, the readers of "Hippocrates" were informed that Doctors Folin and Broca, in Paris, used the method of hypnosis to put a woman into such a deep sleep that they were able to open up an abscess through a large incision. The patient remained entirely motionless throughout the operation feeling no pain. The anaesthesia remained even after the shiny object was removed from her sight. It should be added that after her fingers were rubbed for a short period of time and her eyelids subjected to a current of cold air, the patient began to move slightly. Upon being asked whether she felt something, she responded that she was unaware of all that had taken place. With both hands and her left foot remaining in the positions they had been placed, and pricked until blood was drawn, the patient showed no sign of pain. Finally, when Mr. Broca rubbed the patient's eyelids again more strongly (approximately twenty minutes after the experiment was started and twelve minutes after the abscess was opened)

and blew on her face longer, she awoke and her limbs, which had been floating over the bed, fell on the bed (both hands and left lower limb). When the patient came to completely, she asserted that she had not felt any pain from the operation and wondered at the fact that it had already been performed. Moreover, the state of the woman upon awakening was the same as the state produced by any other anaesthetic means, the sole difference being that in her case, shifting from sleeping to consciousness occurred immediately, neither through a state of nervous excitation nor a delusional one. After few moments, the patient who had undergone the operation complained of a weak pain around the wound, which she could easily tolerate. The anaesthesia had lasted for approximately one quarter of an hour.

This case was documented beyond a shadow of a doubt and therefore caused quite a sensation to the entire scientific world and paved the way for similar procedures to take place. The outcome of many similar tests, conducted in various locations, is outlined below. The issue of hypnotism was reported to the Academies of Sciences and Medicine of Paris, mainly by Velpeau, but it was not discussed to the extent that it should have been. In contrast, the Paris Surgical Association established a committee to examine the issue. However, to date we are not informed of the outcome of this examination, as the committee has not yet published a report.

Since then, many doctors have repeated the procedure in order to further explore the issue in question.

[...]

With respect to a physiological explanation, it is possible that similar phenomena, induced by both eyes gazing fixed-

ly at an object a small distance away from the middle of the brow, are probably due to the tuning of the eyes resulting in the hyperaemia of the brain, and particularly of tetralofon (ed: tectum). This condition is similar to normal sleep and is accompanied by all those phenomena that accompany normal sleep, which, furthermore, occur in the same order.

Knowledge of the said phenomenon is not as recent as one might think, as hypnotism was known and used in the past as an ascetic exercise for religious exaltation of the mind.

[...]

Indeed, some professional magnetists claim that animal “magnetism” and hypnotism have the same origins. Lafontaine, the author who wrote most recently on “animal magnetism” (who was present in Manchester when Braid performed his first experiments investigating hypnotism) concluded that hypnotism is induced by stilling the activity of the brain. Dr. Philippi, one of the most zealous exponents of “mesmerism”, considers the so-called “magnetic force” and “Braidism”, i.e. sleep induced by fixing the gaze, as one and the same thing. These two phenomena –the so-called magnetic sleep and the phenomenon mentioned here– differ only in name, since both share the same sequence as natural phenomena in spontaneous sleep, making plausible that the anatomical seat of physiological phenomena in normal sleep is located in the optic chamber (posterior cerebral ganglion) and the tetralofon (tectum).

Hence, the following conclusions can be drawn :

- a. Hypnotism, i.e. the sleep-like condition induced by staring fixedly at any vague point, which is characterised either by symptoms of catalepsy or by blunted sensitivity or even by

complete anaesthesia, is sometimes a pathological phenomenon, which can be more easily brought about in hysterical female individuals.

- b. Hypnotism can only be used in exceptional circumstances as an anaesthetic for the purposes of surgery. Indeed this method cannot be considered as a sufficient means of anaesthetic able to replace chloroform or sulphuric ether, as the induction of the aforementioned sleep-like state is uncertain and, more, the necessary concentration in order to achieve a hypnotic state is sometimes absent. Indeed, in order to achieve this sleep-like state, the mind should be concentrated and the willpower co-ordinated, which cannot be unaffected and undisturbed when the subject knows of being prepared for an operation and feels fear...
- c. On the contrary, hypnosis can be considered as a means to alleviate and blunt nerve sensitivity and can be used to treat neuralgia, particularly of the uterus and genitals.

2. On hysteria (hysteritis) and its treatment

(Περὶ ὕστερίτιδος καὶ τῆς θεραπείας αὐτῆς)

Revue Hippocrates, 1865

Preliminary observations

Hysteria (Morbus hystericus, Malum hystericum, Hyster-algia, Vapores uterini, Vapeurs, Affections vaporeuses), which affects only women and is manifested in various nosological forms, is attributed by ancient and many modern medical authors to neuropathies, as a result of a nosological process (of unknown nature) related to nutrition and development of either the entire nervous system or certain parts of it. In this disease the brain, the spinal cord and the peripheral structures of the dorsal and sympathetic components of the nervous system present greater excitability and a marked reduction in the body's capacity to withstand harmful influences. The body's vulnerability is increased beyond the normal levels, so that even impressions, which in a healthy body would not cause any functional disorder, in this condition bring about various functional disorders, seated in different organs and parts of the diseased body.

Hysteria is a disease, which can become permanent and is difficult to dislodge; often a woman can suffer from it for many years, even for her entire life, and if remission of the predominant symptoms occurs (such as predisposition to fits and pains), the disease nevertheless persists, the excitability of the nervous system remains unmitigated and sometimes is so heightened that even the slightest internal or external

stimulation, completely imperceptible to a healthy woman, may produce a multitude of diverse nosological phenomena. For this reason, Sydenham stated that hysterical complaints comprised more than half of chronic disorders of women's health. Due to the frequency of this disease, its numerous forms and difficulty in diagnosis, every treating doctor requires precise knowledge of the symptoms in question, which make up the nosological system. For this reason, we wish to discuss these at length, as we know from experience, that only an exact examination of symptoms of the said disease (which is like Proteus in its ability to change form) may prevent the physician from diverse errors in diagnosis and prognosis, which are easily committed, in particular for those physicians involved in gynaecology, as the diseases that fall within their compass, are frequently complicated with hysterical symptoms may manifest in different forms becoming consequently harder to distinguish and therefore harder to treat.

[...]

On mental symptoms of hysteria

The depiction of the psychological character of symptoms of hysterical women is a task, which requires deep knowledge of the normal psychological urges and manners of women, as well as an observational acuity, in order to identify these abnormalities, and a theatrical talent to be able to reproduce them. Despite all these qualities, however, one might well feel powerless in front of the infinite variety of irregular and strange manifestations of a hysterical female disposition.

The most prevalent psychological elements, which make up the character of a hysterical female, are weakness of will, which, in certain cases, can be considered as a complete lack of willpower. The patient is unable to resist impressions to which she is subjected, she can not stand even the slightest of physical or mental stimuli and changes and, instantly, can suffer all forms of bodily and mental disorders. Many sufferers are conscious of this great weakness of willpower and complain that they try in vain to resist the slightest sensory or mental impressions.

Moreover, it is worthy of note that many hysterical women have a tendency to seek attention as patients and want their disease to become an object of research. Whilst they patiently bear their illness if people around them believe their complaints, they become incensed if anybody displays even the slightest doubt that their complaints are genuine. In these cases, it becomes very difficult for the treating physician to find the appropriate means to deal with this behaviour, as he has to avoid, among other things, contradicting the sufferer and expressing overt disbelief on her account of her complaints. On the other hand he must not accept as true all her complaints. Either of these exaggerations may have a harmful effect on both the entire disease and its partial components.

The tendency of hysterical females for increased nervous sensitivity (as stated elsewhere in the treatise), which is called nervous excitability, is expressed in many psychological phenomena. This morbid outburst is usually the origin of the mood swings that are frequently observed in some hysterical women. These females are taken to sudden uncon-

tained laughter, for the slightest of causes, which is followed by great melancholy. The most mild mannered and patient women are transformed into waspish and refractory females, making life miserable, if not impossible, for their relatives and themselves. These women are swift to repent the injustice wrought without cause and to try to make up to those whom they have unjustly slighted, but before long they turn against them, once more without cause. Certain specialists put forward, with reservations, the observation that after a particularly strong fit of hysterics the mood normally stabilises, and remains so for a lot longer than in those patients who do not manifest such strong hysterical fits, or who rarely experience them.

The morbid outbursts of recurrent nervous excitability are also manifested through outbursts (which are frequently observed in hysterical females and are caused by the slightest of reasons, particularly in sleep time). These women can be irritated by the creaking hinges of a door by a voice, they cry out at the sound of a passing carriage, the flash of lightning and generally fly off the handle as a result of any strong auditory or visual impression. Many confirm that frequently when sleeping and particularly when falling asleep they are awakened by a very unpleasant feeling, like a thrust originating from the abdomen. This is one of the most common symptoms of hysteria.

Frequently, the appetites of hysterical females are capricious. By way of example several amongst them feel an aversion to certain colours (usually red and yellow), others to singing, others to music played on instruments, and others to certain musical notes only. Scanzoni mentions the case of

a hysterical young woman, treated by him, who felt such an aversion to the musical note, ('f'), and would get so upset in hearing it, that she was forced to refrain from practicing piano. Indeed, not only hearing, but also the sense of taste deviates from normal in some hysterical women. Certain females subject to this affliction feel revulsion for specific foods (and in particular for meat), which are usually to the liking of healthy people, and on the contrary find great pleasure in eating inedible and even revolting things. Other sufferers feel an excessive aversion to certain animals; indeed some females have a fit of convulsions if a cat touches them, as if hundreds of volts went through their entire body. In the communications on this disease there are many cases of hysterical females feeling an insurmountable horror towards caterpillars, snakes, frogs, lizards, mice, hedgehogs, and so forth.

The clairvoyance demonstrated by these hysterical females is attributed to the mental disorders outlined in this chapter, because the perception disturbance creating visual impressions, has no relationship to the objective reality. However, if we think, as mentioned above, that hysterical females have a tendency to draw attention to their presumed disease, it is obvious that we have to be careful, in order to avoid considering their pretended clairvoyance as being real.

Relevant to the above is the so-called "delirium hysteri-cum". This symptom characterises the most severe hysterical outbreaks. In most cases, the sufferer loses consciousness after severe tremors of muscles affecting the entire body or a part of it. Whilst unconscious she sings, cries, laughs, prays, curses and so forth. If somebody speaks to her or puts a hand upon her, then the sufferer spits on those present or tries to mal-

treat them or conversely falls upon them in order to embrace and kiss them. In many cases, during these bouts of hysterical outbursts, the sufferer shows revulsion for certain persons, for whom she normally has a fondness while, on the other hand behaves in an extremely friendly way to others, whom she normally dislikes. Frequently, these states take on an erotic nature, which is guessed by the inflection of the voice in saying or mumbling words, by the posture adopted by the body and particularly by lascivious movements of pelvis and legs. It is extremely rare for a hysterical outbreak to occur immediately after sexual intercourse.

Hysterical outbursts sometimes result in fainting, or even in a real coma, which can last for hours, even for entire days in some cases. In the chronicles of science have been documented numerous, sufficiently certified, cases of females, apparently dead after a coma brought on by hysteria and escaping, in extremis, the burial or the scalpel of the anatomist.

[...]



**THE DEVELOPMENT
OF PSYCHIATRY IN GREECE**

Christos Tsirigotis (1841–1919)

Letter: In Corfu, on December 17th, 1879

Published in: Galenos (Γαληνός), 1880, No 6, pp. 88–91

Dear colleagues,

As a subscriber to your medical-surgical journal “Galenos”, I decided that I must offer, with the means at my disposal, my dues for the common good, by filling in the lacunae that I have observed since a long time in this journal. While the splendid and select material concerning various branches of our science adorns “Galenos”, there has been no mention therein of mental diseases. I believe it is my duty to fill this lacuna, disposing particular knowledge due to my position, and I begin today, to carry out what I have long been willing to do, in the form of an epistolary dissertation on the topic of the treatment of mental patients. I examine it, not from the point of view of a pharmacological treatment, but rather as regards the appropriateness of the environment, where the overall treatment of mental patients should take place; in other words, which is most conducive to treatment: the mental asylum (*phrenokomion*) or the family?

On this entirely practical issue, many renowned alienists have dealt with it thoroughly, so I am by no means worthy of

offering anything new to the science, but simply I believe it is my duty to communicate, via your journal, the experience I have obtained on this topic, has proved to be most efficacious.

The first one to deal with this issue, and most excellently, was the true founder of medicine of the insane, the renowned Esquirol and various others alongside him came to similar conclusions based on many years of experience. One of them is Professor Verga of Milan in Italy, who excelled in front of a multitudinous assembly of physicians, present for the opening of the mental hospital of Milan. In his unique and skillful dissertation on the issue, based on more than twenty years of personal experience, he confessed that the laurels of being first must go to Esquirol and with the modesty that characterises true scientists said the following, verbatim:

“So di trattare un argomento già trattato magistralmente da Esquirol, e sento ciò avrebe dovuto bastare perchè io non ardisi di mettermi la mano; ma le cose vere ed utili non saranno mai abbastanza ripetute, finchè non sieno penetrate nella coscienza universale” (I know that I am dealing with a subject already dealt magisterially by Esquirol, and I feel that I should not add anything to this, but true and useful things can never be repeated enough until they penetrate the universal consciousness).

It is well known, that whenever the doctor is called upon to attend a mental patient, if he is convinced that there is no doubt as to the patient having such a disease, the issue arises whether he should recommend a confinement within a mental asylum, as being most effective, or nursing within his family?

It is obvious that in practice there is nothing absolute, therefore the doctor, weighing the various circumstances, has

the duty to order what should be done definitely and without circumambulation. Insanity is not a divine punishment, as was believed in antiquated times, when the treatment of mental diseases was still in its infancy, but a disease like any other. Consequently, a variety of causes intervene in the case of insanity, as with any other disease. The causes acting on the development of mental diseases find fodder, one could say, in all social classes without distinction, irrespective of descent and high standing; consequently, the solution of the problem is not aiming solely the mentally ill who are destitute, but all mental patients, without distinction.

Certainly a doctor would encounter no difficulty in resolving the problem if it concerned the destitutes alone, as the poverty of these unfortunates is well known, they inhabit houses which are dirty and damp, with inadequate lighting and air, and they are often exposed to various atmospheric contaminants. Whereupon the question concerns mental patients who belong to this class, the doctor must order an immediate confinement to a mental asylum.

In cases where the patient is not entirely povertystricken, but belongs to what is commonly called the artisan class, who live a better life, through the proceeds and benefits of the craft they practice, here too it is considered absolutely necessary to confine the patient immediately to a mental asylum, because, depending on circumstances, the patient's family is incapable of implementing and carrying out the various means of treatment ordered by the doctor, both pharmaceutical and moral, however hard they might attempt to do so.

If the mental patient belongs to the moneyed classes, who are able to bear any form of monetary sacrifice, in order to implement the treatment prescribed by the doctor, then, in

this case also, the doctor must advise immediate confinement to a mental asylum, as being more likely to procure a treatment for the patient. In this case, however, it is worth observing that oftentimes families refuse to carry out this order, considering such a measure to be vile and unworthy of their social position. What should be done then? If the patient's family is wealthy, in the full meaning of the word, then the doctor can temporarily advise that the patient should attempt a short trip for the purpose of pleasure, for those who are, for example, melancholic and later to confer again with the family. But in cases where the form of mental disease makes it impossible to realise a trip and implement moral treatment through this trip, then, if the family continues to refuse, the doctor has the duty to order that the house or one of its wings, should be converted into a form of private mental asylum. But even in the exceptional case, where the doctor considers that immediate confinement to the asylum may be deferred, due to the family's provision of all means necessary for the full and complete treatment of the patient, an exception must be made for those patients who manifest an aversion either to the entire family, or only to a single member thereof, as well as for those mental patients presenting an exceedingly strong aversion towards familiar objects surrounding them. Exceptions to home nursing must also be made for patients whose family has prejudices regarding the nature of mental disease, where treatment, whatever form that may take, will most regularly aggravate rather than improve the patient's condition.

No statistical results exist for those treated at home. However, patients in mental asylums heal faster and in larger numbers. This is why Esquirol states, unequivocally, that these asylums are the best medicine for mental diseases. Verga also

states that “*Nei manicomi si ottiene una piu ricca proporzione di guarugione che fuori, ed e conforme percio alla logica e al buon senso il consigliare in generale il pronto ricovero degli alienate nei manicomi, salvo certi casi.*” (In mental asylums one obtains a greater proportion of recovery and so it is logical and common sense to generally recommend the prompt treatment of mental patients in asylums, except in certain cases).

It is, in fact, physically impossible, no matter how well off the family is, to assemble in a private home and to gather therein all those means which medicine for the insane has implemented in mental asylums and which increase constantly, in order to obtain a swifter cure and a better life for patients.

Today, all governments of various nations compete to find the most beneficial means to treat mental patients, by constructing magnificent buildings in order to assist science, where every class of society can find the most perfect means contributing to the relieve of those suffering from mental diseases.

We therefore conclude, that medicine for the mentally ill considers an immediate confinement of mental patients in a mental asylum as a scientific fact. Nonetheless certain mentally ill individuals, can be treated at home constantly, there being no need to confine them in a mental asylum. Dear colleagues, I intend to address a second letter concerning these, if you consider the present letter worthy of publication.

Please receive, etc.

Your Colleague

Chr. Tsirigotis



Rigas Nikolaidis (1856–1928)

On hypnotism

(Περὶ τοῦ ὑπνωτισμοῦ)

*Attikon Hemerologion (Attica Diary),
edited by E. Asopios, year 1889*

[...]

Hypotheses on the essence of hypnotism

In the previous chapters we presented various phenomena of hypnotism and methods inducing a hypnotic state. The description of natural phenomena is not sufficient for the human mind, which seeks, if possible, to give an explanation thereto. Describing phenomena is not scientific, explaining them is the very essence of science. Unfortunately, comprehensive, mathematical explanations exist only in a few natural sciences; indeed in the so-called biological sciences we are forced to resort to assumptions in order to explain these phenomena. These assumptions are acceptable, provided

they are not fanciful or figments of our imagination, but are of an objective nature. Any new event not fully explained by a hypothesis, can refute this assumption and replace it with another until truth is discovered. Many branches of physics have followed this way.

For the time being, in order to explain the phenomenon of hypnotism, we are forced to take recourse in assumptions on certain events, which, as we shall see, are well founded.

In order, for readers, to understand the prevailing ideas on the substance of hypnotism, I deem it necessary to provide at least a general idea of the primordial functions of the central nervous system: Because, as already stated, hypnotism is an alteration in the central nervous system.

The central nervous system is made up of three major centres. The first one is the spinal cord, which in conjunction with the peripheral nerves attached thereto produces simple reflexive phenomena. The second, which consists of numerous subcentres, i.e. the medulla oblongata, the cerebellum and the so-called major cerebral ganglia, is related to the first centre, as well as to the sensory nerves, and is contributing to the production of extremely complex reflex phenomena, which include the participation of remote parts of the body. The third superior functional centre is the cerebral cortex, which is related to all the other centres. Over the last few decades, it has been proven that this centre's function (cerebral cortex) is not the same throughout, but rather the cortical matter of the brain is distributed in such a way that parts thereof preside over the movement of the limbs, other parts over the perception of visual sensations and others over those of hearing etc. The cerebral matter of the brain is the seat of the mental func-

tions, which has been proven in many ways. Any lesion to the cortical matter causes a reduction and even complete destruction of mental functions. External facts leave impressions in the cortical matter, wherein they remain, forming the experience of an individual, which can have a significant influence on instantaneous motor manifestations stemming from fleeting events. The stimulation of the superior centre, i.e. the cortical matter, is associated with representations, permitting to the individual a sense of self or rather, according to the technical term, of consciousness.

After this brief description of principal functions of various parts of the central nervous system, the question is which of these parts is mostly affected in a state of hypnosis. As we have seen, one of the main phenomena of hypnotism is the complete lack of consciousness. Therefore, consciousness, i.e. its very existence, depends on the integrity of the cortical matter of the brain, therefore the lack of consciousness during hypnotic states can be explained only by the assumption of some disturbance impeding the function of the cortical matter of the brain.

What is the cause impeding the functioning of the brain's cortical matter? Initially, the assumption was made, that stimuli acting on the sensory organs caused a reflexive convulsion of the brain's arteries, resulting in anaemia therein or at least in parts of the brain. All doctors know that a sudden onset of anaemia results in loss of consciousness. Moreover, this can explain certain symptoms of hypnotism, but a lot has been said on the absence of anaemia during hypnotic conditions. The face of those hypnotised is not pale, upon examination the vessels of the retina were found not to be small in diame-

ter. These and many other uncontested facts, which cannot be analysed herein, counter the theory of anaemia of the brain. Therefore, anaemia is not the cause that hinders the functioning of the brain and another cause hindering the functioning of the brain must be found.

Based on many facts, Heidenhain deduced that inhibition of functioning of certain nerve cells in the cortical matter, was the cause of the hypnotic state, which may be caused by close and continuous stimulation of the nerves of the face, optic and auditory nerves. It is known that the cortical matter of the brain is mainly composed of many nerve cells adjacent to nerve fibres; those of the anterior motor region of the cortical matter with motor nerve fibres, those of the posterior sensory area with sensory fibres. Therefore, many facts can convince us that the functioning of nerve cells may become inhibited by contiguous nerve fibres. We have an example of such an effect in the heart. The heart contains nerve cells, which at certain intervals act on the motor nerve fibres of the muscular fibres and therefore cause its contraction. However some branches of the vagus nerve enter the heart from outside, having the capacity to inhibit the function of the heart's nerve cells. Therefore, if we stimulate those branches with an electrical current produced by induction, the heart stops pulsing and remains in dilation throughout the duration of the stimulus.

Not only can the function of the motor neurons be suspended by stimulation of fibres adjacent to them, but also by stimulation of the sensory nerves. Many events, that we can not discuss at length here, provided Heidenhain with argu-

ments in favour of the aforementioned assumption regarding the essence of hypnotism.

We are not in a position to ascertain whether, apart from cortical matter, other nervous centres, included in several parts of CNS, are also involved. Only for a limited number of these it can be stressed that their function is not inhibited during a state of hypnosis, that is the centres of the brain related to normal movement. As normal movement is not affected in a state of hypnosis – those who are hypnotised can walk like sleepwalkers – therefore the cerebellum, the tectum, etc. are not hindered in their functions during a state of hypnosis.



Simon Apostolides (1853–1919)

Psychoses. Medical, Social and Philosophical Studies on Mental Diseases

(Αἱ Ψυχώσεις: Μελέται Ἰατρικαί, Κοινωνικαὶ
καὶ Φιλοσοφικαὶ περὶ Φρενοπαθείας)

Printing press of N. Igglesis, Athens, 1889

PART ONE

Chapter A

A brief history of the mentally ill and the mental asylums

Mental illness is contemporary with the first societies of men, which acceded to elementary civilisation. It is almost inexistent amongst the savage and barbarous nations and extremely rare in animals. This fact proves that the further man's brain develops, or as is almost equivalent, the more mankind becomes civilised, the more frequently man becomes susceptible to mental illness; as is also the case with other human diseases.

Explorers, with Humbold being one of the first, assure us that amongst the savage nations of Central Africa, Oceania and America, they have never encountered one mentally ill individual. Missionaries who live amongst the barbarous nations also assure us of the same. American physicians authorized by their government with studying the diseases

of the American Indian peoples have never seen or heard of cases of mental illness. They further observed that black people coming into contact with European civilisation started suffering from mental illnesses, because on becoming free they accepted a way of life very similar to the European one and, consequently, all evil and harmful things the civilisation of the latter held. On the contrary, when enslaved, this race of black people was entirely free of all mental disturbances. It is evident that we are talking of major mental illness and not of mental disturbances due to the abuse of alcoholic beverages, which are used immoderately by savage and barbarous races. Such an abuse brings about stupidity and degeneration until the final disappearance of these peoples.

Doctors who have resided for extended periods, or have simply visited the Indies, Nubia, Abyssinia, Kordofan, Senaar, Egypt and some parts of Turkey certify the same.

In these countries, major forms of mental disease are either entirely absent, or their numbers are minimal compared to the overall population. In Turkey, however, we believe that Muslim mental patients are far more numerous, than in countries mentioned of the same creed, as they have more extensive and regular contact with European civilisation and other nationalities, and also because they are, compared to other Muslim nations, the most anthropologically developed race.

Therefore, it is beyond any doubt that mental illness has the honour to march in parallel with civilisation in the course of humankind. One can, even, say that one nation is civilised when having the largest number of mental patients! And in such a civilised world, the urban population produces far more mentally ill individuals than does the rural one.

The cause of this sad event can be summarised in the following few words: civilisation, by multiplying material and

moral benefits, by multiplying ideas, needs, passions and pleasures, and by rendering more vivid the overall struggle for existence, motivates man to a greater and feverish activity, aiming not only to secure his own life, but also his well-being. As the number of fighters who participate in this struggle increases, so does the number of dead and injured. Never before, as in the current 19th century, have almost all social classes played such an active part in this struggle. For this reason the numbers of mentally ill are greater today, than ever before. The more intense the functions of the brain become, the more easy it is for them to deviate from what is natural. This is also true for all other organs in the human body.

Regarding the form of mental illness, in general, it depends on the season, morals, race, intellectual development, climate, religious and political beliefs, inherited traits, etc.

[...]

PART TWO

Chapter A (ed: divided in the following parts):

- The subjective method for the study and comprehension of psychological issues is imperfect
- The need to study the so-called pathological phenomena of the psyche
- The study of mental patients is useful in order to discern certain philosophical issues, to alleviate superstitions concerning these patients, to resolve and comprehend certain social by problems
- Sudden tragic events
- Mistaken ideas held by the public on the mentally ill.

[...]

Chapter B (ed: divided in the following parts):

On mental illness in general

- i. Difficulties in defining health and disease in general and specifically sanity and insanity. Disposition and predisposition. Every man can be healthy and ill at the same time, can be sane and insane simultaneously. There are no exact boundaries between them. Any definition of mental illness is flawed.
- ii. General and essential qualities of mental illness. These very qualities are in themselves inadequate. Similarity of a society composed of those with a sound mind with a society of mentally ill. Various kinds of misconception. The misconception of the insane or delusion. Man's moral freedom is relative and not absolute.

[...]

Chapter C (ed: divided in the following parts):

History of beliefs concerning mental illness. Changes occurring through mental illness (ed: Chapters):

(1) Beliefs of the ancient Greek philosophers concerning the soul (psyche). Influence of this philosophy on Medicine. Empedocles, Heracleitos. (2) The ideas of Hippocrates and knowledge concerning mental diseases. (3) Plato, Aristotle, Theophrastos. (4) Alexandrian or Neoplatonic School. Erasistratos, Herophilos. (5) Greek physicians in the Roman Era: Aretaeos, Galen. (6) Influence of Christianity on Medicine. Miserable condition of Medicine during the Middle Ages. The Renaissance era. (7) Animism and psychism in Van Helmont and Stahl. Their metaphysical and ideological theory on mental illness. (8) Anatomical or somatic school in Germany, Nasse, Friedreich, Jacobi et al.

The science of psychiatry followed an almost identical path in France. (9) Pinel and Esquirol. The medico-psychological school they established. Influence of spiritualist philosophy and abstract psychology on the ideas of that school. Giant leaps of phrenology through the work of Pinel and Esquirol. (10) Reaction of the anatomical school in France. Calmeil, Bayle Georget, and others. Their discovery of General Paralysis of the insane. Reversion of certain disciples of this new school to the dogmas of Pinel and Esquirol. (11) Psychosomatic or mixed school. (12) Integral bonds link ideas on insanity with philosophical elements. Materialist doctors, shades of materialism. Positivist physicians and sceptic physicians. Moreau de Tours, Griesinger. The main materialists. (13) Discord amongst supporters of the anatomical or somatic school concerning alterations of the brain in mental illness. (14) Common alterations of the brain. (15) Interpretation of these alterations.

[...]

Conclusion: From what has been said, we can conclude the following, clarifying and delineating the position held by science today on the issue of mental illness.

1. Simple, common, classical mental illness (vésanie-insanity) is a disease of the brain. A material, invisible alteration of the internal texture of the brain, due to moral or physical causes, which modifies the terms of normal physiological function or dynamism thereof, acting in general as a functional or dynamic disease.
2. After a shorter or longer period of time, permanent secondary alterations are, almost always, identified, which explain the mental collapse and the intellectual decline.
3. There are no clear and clear cut boundaries between mental illness and other organic and obvious alterations of the

brain, which constitute what are known as ordinary and especially as brain diseases, with mental diseases sometimes progressing into brain diseases and the latest being frequently manifested by the sort of symptoms characterising mental illness.

4. A study of mental illness must form a special branch of internal medicine, due to the specific nature of its symptoms, which also involve various other issues beyond those mainly medical.

[...]

PART THREE

Currently prevailing psychological notions

Chapter A (ed: divided in the following parts):

Normal Psychology and General Mechanics

I

1. The atomic theory of Ancient Greek philosophers is confirmed by modern science.

Abstract psychology as a specific science, without any knowledge of anatomy and physiology of the nervous system, in other words without knowledge of physiological psychology, cannot exist. All phenomena, whether natural or biological, psychological or social can be reduced, finally, to one science: General Mechanics. Knowledge concerning this science is incomplete.

2. What is life? Force cannot exist, or even conceived, without matter. The isometric attribute of bodies.
3. The need to study the physiological characteristics and the reciprocal anatomical relationship of the nerve cells of the

brain, in order to understand the mechanism of psychological activity.

4. A schematic representation of the entire nervous system.

II

1. Fundamental qualities of nerve cells: their number in the cortical matter of the entire surface of the brain. How many words did Shakespeare use in his dramas and how many did Milton?
2. Schematic representation of the intellect.
3. The mechanical construction of the brain is a Logic or Conclusional Device (Schluss-apparat). Intellect is the result of complex and manifold sensations.
4. Intellect and words or language. Interaction in order to attain mutual perfection.

[...]

Chapter B

The Mechanism of speech – Aphasia

(ed: divided in the following parts):

1. Broca; Areas of the brain, whose damage brings about a disturbance in the mechanism of speech. Definition of Broca's aphasia. Different forms thereof. Psychic deafness: the patient hears and is able to speak, but cannot comprehend others speaking the same language. Psychic blindness: the patient writes, but cannot read what he has written etc.
2. An explanation of these phenomena.
3. Various types of memory and inequity in the development thereof. Visual types.

4. Auditory Types. Why some novelists provide vivid and successful descriptions of places or objects. Artistic painters Vernet and Doré. The precocious mathematical genius of certain children. The memory of Frederick the Great and Napoleon. Légouvé, Scribe, Diderot.
 5. Why Socrates used controversial dialogues.
 6. Graphic types, Georges Sand.
 7. Kinetic or articulating types. Those among them who speak in loud voices and who gesture. Orators. Why orators are much more eloquent when speaking than they are when writing.
 8. Post-mortem anatomical observations on the brains of attorneys, judges, and politicians known for their eloquence. Gambetta's Brain. The Society of Mutual Autopsy in France (Société d'autopsie mutuelle).
 9. Strange forms of aphasia.
 10. Amnesia. Examples. Distinction between aphasia and amnesia.
- [...]

Chapter C

The theory of evolution and psychic phenomena

(ed: divided in the following parts):

I

- 1,2. The study of the evolution of the species and comparative physiology are necessary to define the idea of the psyche.
3. Gradual evolution and specialisation of the organs in organisms. Nerve cell lineage.

II

1. Evolution of the nervous system and comparative anatomy and physiology.
2. The four centres of the nervous system. Their close links and hierarchy.
- 3–6. The data from embryology. Phases in the development of the nervous system. Comparative brain anatomy.
7. Nature's inclination towards a centralised or authoritarian system in the management of organisms. This system is perfect. Similarity in the administration of human society and the nervous system. The ideal administrative system for a society will be achieved when it simulates the nervous system.
8. The authoritarian system does not exclude partial autonomy. Automatic intellectual acts.
- 9–10. What species and what degree of consciousness do various portions or centres of the nervous system have, and what do beings inferior to man have? Comparative experimental physiology. Anura (the order of frogs), fish, birds, mammals.
- 13–14. Following perfection of beings, psychic qualities are located ever more in the higher points of the cerebro-spinal axis. Conditions for the birth of consciousness. Transformation of conscious acts to automatic and unconscious acts. Human beings in a condition of a machine can constitute a means for progress and intellectual perfection. The monist theory seems the most plausible.

PART FOUR ON MENTAL PATIENTS

Medical and sociological study of mental patients

*Perspective of the examination of mental patients –
Division into categories*

The examination of mental illness in general, of its different forms and their classifications, as well as of symptoms, the progress of the disease, its outcome and treatment, in one word the nosology of mental illness, lies in special treatises which deal, fully, with this subject in science. Here we intend to examine mental patients taking into consideration the degree, the extent and the kind of mental disturbance existing in them.

We are going to examine the division of mental patients into certain categories, which we shall carry out herein on the basis of the degree and kind of psychological damages. This division is neither proper nor natural, nor can it be achieved from a theoretical and scientific point of view, based as it is on hard to define, vague and easily variable psychological elements, because there are no precise natural boundaries to psychological injury. However, from a practical point of view, this study and division has its own value, based on prior nosological knowledge of mental patients, i.e. the various forms of mental disease.

Is someone's mind ill, or is it not and to what extent? All issues come finally to this point, when a man manifests some anomaly of the mind and is about to be judged by society or by the law.

In two cases the psychological condition of a man places him beyond the purview of the law: (a) loss of selfgovernment (αυτεξούσιο) with concomitant loss of conscience of the meaning of his actions; (b) loss of selfgovernment due to some patho-

logical reason, even though conscience of his actions remains unimpaired or almost unimpaired. These cases are not always so clearcut and easy to discern. Gradual transitions and intermediate conditions exist between what is pathological and what is normal. Nonetheless, these two basic psychological states should be taken into consideration, as a general criterion, in order to understand methodically each individual case. Forensic and psychological views will lead us, imperceptibly, to approach another perspective of this issue, that of sociology, in other words to study a mental patient as a pathological member of society, to examine his position and influence on society.

By defining the elements constituting mental disease, as we were informed in the chapter on mental disease, we are now able to formulate a general, although incomplete, definition of the mental patient. Many have attempted to render in a few words and as accurate as possibly the definition of a mental patient. However, many of these definitions, particularly those of certain psychologists and moralists, may well include people with sound mind, or may exclude many kinds of mental patients. The difficulty to provide such a definition has already been examined when discussing mental disease. The most complete and accurate definition may be considered to be the following, which is mostly similar to the one given by Esquirol:

A mental patient is a person, who has lost to a greater or lesser degree his self-governance (his moral freedom), due to disturbances of his intellect, of his psychological sensibility, of his affects and his will. Usually, he is not conscious of the disorder and consequently has ceased to be responsible for his words and actions.

What extent must a disorder reach concerning one or all three functional factors of the brain (ed: intellect, affect, will) and to what degree must a man lose his free will (*libre arbitre*) in order

to be considered mentally ill and not responsible for his actions? It is better to observe each mental injury as a special case, but in order to facilitate the examination of this issue we have chosen to divide mental patients into certain general categories, having in mind certain essential psychological traits thereof.

Chapter A

First category

The major or classic mental patients
(ed: divided in the following parts):

Cases where mental injury is complete, deep and generalised. The general and essential feature of this category is the complete lack of insight of the patients concerning their condition. Manic or frenzied, lypomanics, etc.

A subcategory of the first category: the partially mentally ill. What do we mean with the term partial mental illness? Its characteristics.

[...]

The Latin word *alienus* and the French word *aliéné*, alienation meaning being stranger to oneself, which we can most closely translate into Greek with a word that means insanity (*αλλοφροσύνη*), in other words, someone having a conviction that is not his own, but of another one, expresses precisely the same degree of mental disturbances. Thus, the words *aliéné/aliénation* are used as a general term in French to include all kinds of mental illness. An equivalent meaning is expressed by Greek terms on insane (*paraphron* – *παράφρων*) or mental patient (*phrenovlaves* – *φρενοβλαβής*) and mental disease (*phrenovlaveia* – *φρενοβλάβεια*).

[...]

Here are classified all those patients who suffer from any form of mental disease, of all kinds of causes; whether it happens to be a simple mania or lypomania, occurring without any organic injury (*folies essentielles, vésanies*); or a result of organic injury, like an acute delirium (*délire aigu*), general paralysis of the insane (*paralyse générale des aliénés*); or insanity is caused and rooted on neuroses (hysteria, epilepsy, chorea); or chronic poisoning by alcohol, lead or narcotics, etc. (*alcoolisme, saturnisme*); or diseases due to sympathy with some organ in the body (*folies sympathiques*), etc. All the above mentioned comply with two essential terms: first, that there should be some form of psychological disturbance and second, that the sufferer should have no conscience of the onset of this injury.

These classical or principal mentally ill patients can be diagnosed at first glance and thus we will not insist herein on providing a detailed description.

[...]

In a sub-category of the first category we will include those forms of mental disease in which reason and insanity exist alongside with each other in the same individual, and proceed in parallel for an extended period of time or indefinitely.

The sufferer presents two aspects and seems to consist of two personalities, the first one being reasonable while the other, entirely insane, without having any insight. Such a paradoxical contrast is unusual and startles anyone who comes face to face with such a phenomenon, because it seems to completely compound the common and fundamental idea we possess on the intellectual and moral unity of an individual and our preconception concerning its indivisible nature.

To this category fall certain mental patients, who are called, incorrectly, monomaniac or partially mentally ill, i.e. having

some steady, limited and illogical ideas (*idées fixes*), beyond the scope of which these sufferers can be sound in mind and for long periods of time behave in society just as ordinary people would. Some of them have enviable positions among the great geniuses. They have enlightened humanity, showing the path to progress, and influenced society. Many famous men were insane in a great extent, providing, despite this, examples of sanity and high intellectual work J.J. Rousseau, for example, was insane when he wrote “Confessions”.

[...]

Patients of this kind belong to the category of the principal or classical mentally ill, but we classify them separately, because they maintain a sufficient part of their reason, for a very extended period of time before becoming entirely mentally ill. Thus, they have a particular physiognomy, and constitute an intermediate class between the principal mentally ill and the large class of the degenerates (*dégénérés*), that we will discuss below.

[...]

Second category

Insane and semi-insane

(ed: divided in the following parts):

The major class of mentally ill due to hereditary degeneration

- *Preliminaries concerning mental disease of degenerates and monomaniacs: Monomania and monomaniacs. These terms were derived from mistaken dogmas of ancient abstract psychology. Degenerative or hereditary mental disease (Morel, Magnan, etc.). Interpretation and definition of the meaning of various scientific terms that are in use.*

- *Hereditary mental disease, the degenerate or perverse mentally ill: Homogeneous and transformative heredity. Links between a predisposition to neuropathy and other general predispositions, such as to arthritis, rickets, scrofula, etc.*

Simple and aggregate heredity. Degenerate mental patients, in particular, belong to this latter group. Their characteristics are anatomical, physical and psychological. Children who are obstreperous, with precocious intellectual development, arrested development and intellectual poverty. Partial genius. Intellectual contrasts and anomalies and firstly moral contrasts in poets as well as artists in general. Future criminals. Psychological gaps in distinguished or eminent people. Paradoxical liking and antipathy. Zoomaniacs. Immoral and uncompromising individuals. Rebels, fanatics, wits. Physiognomy, which is assumed in manifest mental disease of degenerates, hereditary insane and their nosological traits. The division of the degenerate mentally ill into groups, on the basis of their overriding psychological characters and symptoms:

[...]

- *The impulsive (degenerates).* Impulse or proclivity to murder and suicide. Psychological nature of the impulses. Difference between these and the impulses of major mentally ill and epileptics. Precursors or accompanying symptoms Proclivity to suicide. Group suicides that wipe out entire families. In some cases multiple impulses co-exist in the same individual. Interpretation of these phenomena. Various impulses: cleptomania, pyromania, shopping mania etc. .

[...]

- *The Obsessive and emotive (degenerates).* The scrupulous (scrupuleux). Monomania of doubt (delire de doute). Ques-

tioners. Onomatomania and arithmomania. Coprolalia, echolalia. Touch monomania (délire de toucher). Agoraphobia, megalophobia. Mimics.

[...]

- *The sexual (degenerates)*. Simple anomalies in the sexual urge: Anatomical anomalies of the sexual organs or the body. These anomalies are a mark of an individual's degeneracy. The Ancient Greeks depicted the Satyrs and Silenoi as unsightly forms. Premature stimulation and hyperstimulation of the sexual appetites in infants, children and adults. Absence or reduction of the sexual urge. Perversions of the sexual urge: Reversion of the sex. Intimate congress between men, Intimate congress between women. Necrophilia, sanguinary aphrodisiacs, cannibalism. Notorious cases in the medical chronicles.

[...]

- *The criminal (degenerates)*. Degenerate mentally ill criminals or morally mentally ill (fous moraux). Differences between these and the classical mentally ill criminals. Identification of degenerate mentally ill criminals with born criminals and professional criminals. Historical view: one wise criminal, Marquise de Brinvilliers, poisoner Marie Jeanneret, Caligula, Nero...

[...]

Crime and mental disease

An examination of the relationship between crime and mental disease. Degenerate mentally ill criminals (fous moraux criminals) have both anthropologically and psychologically the same characters as common criminals (criminals nés).

Phrenologist physicians believe the following with regard to criminals: The theory of degeneration. The belief of anthropologists/criminologists: The Italian School theory of atavism, Lombroso, Garofalo. Identification by Lombroso of the morally mentally ill criminal (*fou moral criminel*) along with the congenital criminal (*criminal né*) and the synthesis of these two beliefs by him. Relationships between degeneracy and criminality. Practical conclusion on beliefs concerning criminals. Legislative measures taken and proposed for criminals. Current felony laws having a vengeful nature replaced the old custom in barbarous countries of permitting by law individual vengeance (*vendetta*) with a state *vendetta*. Events and anecdotes concerning notorious criminals showing how irredeemable and incurable criminals can be, as well as the pathological nature of the perversion of morality (*sens moral*).

[...]

Chapter C

Various types of degenerate mentally ill and semi-mentally ill. Lunatic idiosyncrasy in sane people
(ed: divided in the following parts):

Continuing the description of degenerate mentally ill. The mental halfcastes or borderline types. Characters or types of people in society reminding us of the mentally ill and their affinity. Lunatic idiosyncrasy: (a) jolly types, obstreperous, frivolous, adventurers; (b) arrogant, prodigal, vain; (c) misanthropists, egotists; (d) the fanciful (inventors, daydreamers, utopians, those seeking to square the circle, inventors of machines of perpetual motion, rudders for air balloons, pana-

ceas, those who seek the means to immortality and so forth), failed and unappreciated poets, writers, artists and sociologists; (e) persecutors and litigation-mad; (f) erotomaniacs: the close ties between Platonic love and erotomania (excessive sensibility is a symptom of a degenerate individual), normal and pathological erotomania (Paul and Virginia, Don Quixote and Dulcinea), degenerates in literature, i.e. the heroes of novels and characters in dramas and the symptoms of erotomania – shifting from pure to material love; the passionate hymns and the hagiographies of ascetics and monks; (g) ecstasies, mystics or theomaniacs and visionaries, fanatics, reformers (prophets, leaders of theocratic heresies, ascetics, religious maniacs, the gullible, socialists, dynamitists, anarchists, regicides). The cause of the psychological conditions of such abnormal individuals.

[...]

Chapter D

Genius and mental disease – Civilisation

and degeneracy (ed: divided in the following parts):

The relationship between genius, outstanding merits of an individual, and mental disease or neuropathy. The initial source of both is the same. Why eminent men are often subject to mental or nervous diseases. Certain conditions in the origin of genius and exceptional talents, both internal and external. A parallel increase in the number of eminent men in a country and the cases of mental and nervous diseases. The nature of genius and of diseases of the nervous system is identical, proving also the phenomenon of the degeneracy of the ancestors of eminent men. Evidence provided by Aristo-

tle. Because the children of eminent men are often lesser than their fathers, as is often the case with ordinary men. Civilisation and degeneracy (Jacobi). Exhaustion and degeneracy of privileged social classes. The flow of a country's population to large cities and its beneficial and destructive consequences . The decline of Spartans and Romans. The weakening of the royal dynasties and aristocratic families. The royal houses of Sparta, Rome, Persia, Philip, and the heirs of Alexander the Great, of Italy, France, Spain, England, etc. Social dynasties, which form eminent orders not through birth, but rather through individual ability are equally prone to degeneration. The causes of rise and decline of nations and individuals. Pessimistic scientific ideas. Fervent geniuses and their proclivity or decline into insanity. Pathological psychology as an assistant in the philosophy of history. Beneficial influence of mentally ill and partially mentally ill individuals on the progress of humanity.

[...]



Antonios Mavroukakis

Neurasthenia and suggestion

(Οἱ νευρασθενικοὶ καὶ ἡ ὑποβολή)

*Iatriki Efimeris (Medical Journal) year 3rd,
1890, 10, 590–596*

Over the past few years many things have been written and even more have been said on the major issue of neurasthenia, which has preoccupied those doctors specialising in nervous and mental (phrenic) diseases. Leaving the description of the disease to others, we will examine neurasthenic individuals in relation to suggestion. However, in order to avoid misunderstandings, it should be stressed at this point that we follow Regis's division, classifying neurasthenics within the class of degenerates and admitting five forms (ed: of degeneration), cerebral, spinal, cerebro-cardiac and genetic. We will not discuss each one of these, from a psychotherapeutical point of view, as we do not distinguish neurasthenics into classes nor we divide them into further classifications.

Many psychiatrists claim that neurasthenics are less susceptible to hypnotism and thus less responsive to therapeutic suggestion. As a consequence of our, not particularly exten-

sive, experience in the department of our teacher, Professor F. Berillon, we have formed the opposite conviction. Among many neurasthenics we treated, we found only a few not responsive to the treatment. The difference is related to the degree of resistance opposed to hypnotism. If, for example, the resistance of any random person is rated at 1 degree, then the one of a neurasthenic individual may be equal to 5–10 degrees. We are not unaware of the fact, that it is rare to find a neurasthenic who can be hypnotised by simply fixing the gaze, but we accept that through strong and skilful verbal suggestion and by intensely fixing the gaze, after the second or third, and more rarely after the sixth attempt, sleep is finally achieved. In fact, many neurasthenics display such resistance, that the first, second or third attempt can make the doctor despair. Suddenly, after the fourth attempt, all resistance falls away and neuropaths cannot avoid sleeping, which becomes a necessity for them. After repeated observations, we have come to explain this resistance in the following way:

Neurasthenics, due to their disease, are incapable of fixing their attention, because they are distracted by the slightest noise or loud sound. At times of complete stillness the idea of their illness occupies their brain, making it impossible to focus the mind on the suggested idea of sleep and their gaze roves from one place to another, avoiding the fatigue brought on by gazing fixedly. Indeed, all neurasthenics are obsessed by an idea (*idée fixe*), through which the disease, frequently, manifests. This idea forces neurasthenics to believe that they are sicker than they actually are and the idea of illness causes such anguish that their brain enters in a state of over-stimu-

lation, becoming initially incapable of receiving the outward impression of sleep and accomplishing it.

[...]

Other neurasthenics are very distrustful and their trust can be gained only after a great deal of effort. Certain neurasthenics, whose psychic centre (ed: without any anatomical correspondence) is most affected, believe that if they fall asleep, they will never wake up and assume that the slightest of causes could bring about their death, considering artificial sleep not to be a normal sleep and consequently fearing it. Doctors will regularly encounter, among their patients, neurasthenics who have tried to kill themselves two or three times, but, nevertheless, fear that sleep could provoke their death. Neurasthenics fear death and due to the fact they resist sleep strongly, frequently repeating words like: *I will not sleep; wasted effort; doctor, I know my constitution; you will not be able to prevail upon me; how will I be able to sleep in daytime, when I do not sleep at night*; and so forth. Usually in saying this, they slowly but surely start to fall asleep and before they have uttered their last opposing word, their eyes close and they surrender to a deep sleep.

[...]

When they feel the first symptoms of sleep, they rouse themselves by nervous movements, rubbing their eyes and making every effort in order to resist. If, nevertheless, they fall asleep, upon awakening from sleep they claim that although their mind was blank, they had not fallen asleep. Nonetheless, they didn't feel the deep pricks of the needle, nor any tiredness, although maintaining their limbs in catalepsy for half an hour and more, nor were they able to say how long they were

under clouding of consciousness. Frequently, they are the very spirit of opposition and it is possible to use therapeutic suggestion on them whilst they are in a state of awareness than during sleep, as they skilfully wrap this reversal in the raiment of willingness. The resistance of such individuals, is sometimes voluntary and at other times involuntary.

[...]

This treatise would become overly lengthy if we attempted to describe all categories of nervous disorders (as each neurasthenic may be a category unto himself) and particularly if we should consider resistance or yielding thereof from a therapeutic point of view. It is extremely rare to encounter two or three neurasthenics, whether simple or cerebral, presenting the same symptoms and the same moods, or the same resistance to accepting hypnotism or therapeutic suggestion. A particular symptom, as slight as it may be, places the neurasthenic into a special category requiring a particular type of suggestion. Nothing is more difficult than a psychological study of neurasthenics and degenerates in general. If the human spirit is difficult to explore when it is healthy, in neurasthenics the psychic centre is even more difficult to define and explore. In certain degenerates, one can find the most terrible faults, while in others the best of assets. Each fault, according to a sage, is a type of madness. Allow me to add that every asset, overcoming normality, may be considered as a particular type of disorder of the cerebral faculties, belonging to the higher class of degeneration. Neurasthenics belong to it, but we can not specify the appropriate subdivision (ed: of degeneration) they should be placed in. In other words, to be a coward is most certainly a fault, but to take extreme risks is a strength

greatly exceeding normal rules. Both conditions indicate that the brain is not functioning normally.

[...]

By saying that a neurasthenic has become susceptible to hypnotism, we refer to it as a means of treatment and not of experimentation. Unlike hysterical patients, neurasthenics cannot be used or can rarely be used as subjects of experimentation, because post-hypnotic actions are almost unattainable. We discussed this point at length with Mr. Berillon. After repeated attempts we contrived to bring about positive therapeutic results and upon informing Mr. Berillon of the success of our work, he contradicted us by saying that it was impossible for a neurasthenic to reach the degree of somnambulism and to perform the actions imposed thereon. However, repetition of these same attempts proved the truth of our claim, and our teacher finally accepted our opinion, that neurasthenics are susceptible to hypnotism to the point of accepting therapeutic suggestion, but they are inadequate subjects for performing experiments on hypnotism.



Nikolaos Pezopoulos (1859–1911)

On chronic progressive systematic delusions:

A clinical and medico-legal study

(Περὶ χρονίου προϊόντος συστηματικοῦ
παραληρήματος. Μελέτη κλινικὴ καὶ ἰατροδικαστικὴ)

Printing press of Alex. Papageorgiou, Athens, 1891

Introduction

Insanity, by attacking man in what is noble and great in him, by disturbing his intellect which is the instrument facilitating man to govern everything on earth, has attracted attention since time immemorial and became the object of serious study, not solely by physicians, but also by philosophers and all those who study the nature of man. However, instead of turning their attention to the study and analysis of the phenomena manifested by the sufferers and the research of their true causes, they were diverted into endless and, to a great extent, pointless discussions on the essence of intellect, of the soul and of the matter, because they acted under the influence

of predominant ideas of their times. These issues disconcerted everybody for many centuries and continue even now to disconcert some philosophers. Whatever the significance they may have from a philosophical or theological point of view, they cannot have the same importance for physicians like us, who consider insanity to be a disease, having, like all diseases, specific characteristics and its seat in a specific organ of the body, i.e. the brain. Nor is it possible to conceive some psychological disturbance without any injury, whether it is persistent or transient, visible or not to examination by means available to us, to the organ which has been proven by experiments and by clinical observations to be the seat of all psychological functions. Marcé said, "let us set aside the incorporeal soul, which cannot be diseased, and which should not be intermingled with the weaknesses of the body, and deal with vital qualities, which may, doubtlessly, be useful in covering our ignorance concerning the phenomena of life, but on which we can have endless debates without deriving any serious progress for science whatsoever. (...) The sole means, permitting us to derive conclusions that are truly useful, is to consider insanity as a disease, and to apply to its study those methods that are purely medical, in other words, complete and accurate observation, whose prudent generalisation permits us to deduce logical conclusions, starting from the partial events to the classification of diseases, to their seat and nature".

[...]

From the time of Pinel, new horizons are opening in front of the dazzled eyes of the initiates of science and everywhere it is a question of honour to support and nurse the insane and to study and investigate insanity under the fiery influence of Pinel's ideas and efforts. The work commenced by the teach-

er was completed by his great disciple Esquirol. This shrewd man, through careful and precise observation of the insane, sought to set the existing chaos into order. Although his efforts did not meet with complete success, he nevertheless set the foundations for more precise study and opened the path, which observers would have to follow in order to complete his work.

To the ancients' *Mania*, *Melancholia* and *Dementia* Esquirol already added *Monomania* willing to represent two different conditions, one characterised by delusions of *sorrow*, which he termed *lypomania*, and the other by a *light-hearted* delusion, mainly *Monomania*.

Monomania, in the sense given by Esquirol and his disciples, signifies a partial delusion limited to certain ideas or things alone, leaving all the other psychological functions intact. Esquirol's students and disciples, having observed that monomania does not manifest solely in disturbances within the sphere of mental conception, but also through perverse impulses and sentimental perversions, extended its meaning and defined a new form of monomania based on the prominent symptoms, without taking into consideration the foundations upon which these symptoms developed. *Kleptomania*, *pyromania*, etc. were designated in this way. Fairly soon, however, objections have been formulated to this view of monomania, based on the detailed observation of patients.

[...]

Yet monomania, as perceived by Esquirol, is not accepted, nowadays, almost by anybody[...]. However, an event that inaugurated a new era and constitutes one of the brightest achievements of medicine for the insane over the past

few years, is the mental disorder that Professor Lasègue has termed as *delusion of persecution*.

[...]

It should be noted, however, that this morbid form had already been observed several years ago and had been described in the works of observers of mental diseases. First of all, by E. Kant, in Koenigsberg, who described a precise picture of the symptoms of the disease that is characterised by ideas of persecution, auditory hallucinations, misunderstandings, a special vocabulary and, finally, all the characteristics of the disease. [...] However, the honour goes to Lasègue, who first described it as a separate form of disease.

[...]

Three years ago there was a great discussion in the Medico-Psychological Association (*Société Médico Psychologique*) in Paris, on the delusion of persecution. Magnan, one of the most distinguished contemporary alienists, and his disciples, having carried long-term observations on their patients who suffered from this delusion for extended periods of time, became convinced that this was not the entire disease, but simply the second period of a chronic disease which is divided into four periods. Magnan has named this *chronic delusion with progressive evolution* and his disciple Garnier *systematic progressive psychosis*. Those suffering from the disease appear uneasy and suspicious in the beginning, later on they become delusional and pursued, afterwards they seem to be ambitious and sooner or later they head towards dementia, which is the final outcome for all those with chronic mental diseases.

[...]

Against chronic delusion, as described by the wise doctor of Sainte Anne, three main objections have been raised. First, there are some persecuted, who never become megalomaniac; second, the delusion of grandeur may have a sudden onset, without being preceded by any idea of persecution; third, the delusion of persecution may lead to dementia, without passing through the stage of megalomania.

It is true that in certain cases, the delusion of persecution takes its course to the end, without being replaced by a delusion of grandeur; however, it does not mean that the type described by Magnan is without any substance. We don't go as far as to agree with Mr. Briand and accept that, if patients suffering from a delusion of persecution survive longer, the delusion of persecution will be replaced by a delusion of grandeur due to the fact that many other diseases showing and incomplete development?

[...]

Let us see, now, what the Germans think on this issue. Krafft-Ebing, according to Magnan, describes *Paranoia or primary systematic delusion of the degenerate* (primäre Verrücktheit), as belonging within the category of psychic degenerations, which he distinguishes into *inherent Paranoia* (originäre Paranoia), which develops from childhood, and tardy Paranoia (Paranoia tardive). In this latter category he includes the delusion of persecution and megalomania.

[...]

As Mr. Magnan correctly notes, Schülle's chronic systematic delusion (chronischer wahnsinn) and Krafft-Ebing's persecution paranoia are more inclusive than his own definition of chronic delusion and include –as do Lasègue's delusion of

persecution, Morel's persecuted and Foville's megalomania-clinical forms that differ greatly between them.

Having attended Mr. Magnan's department for an extended period of time, and being convinced by various cases we have observed, both in this department and in our own private practice, we accept the opinion of our teacher and consider that delusion of persecution, which is not connected to alcoholism, mental degeneration, hysteria etc., does not constitute a distinct form of disease, but is the second period of a delusion characterised by four periods, which come regularly one after the other, always in the same way, as we seek to describe further.

Chapter nine

Chronic delusion from a medico-legal point of view

Those suffering from chronic delusion are the most dangerous of sufferers. Convinced as they are to be the victims of heinous enmity, that they are reviled, harmed in many ways, they conceive the idea of seeking vengeance. When their patience has run out, they can hurt those they consider as the main causes of their sufferings. Instead of seeking to cover up their crimes, they appropriate outspokenly for themselves the right of self-defence. [...] Particularly dangerous are those sufferers who have a perfectly organised delusion and can pinpoint certain people as the main cause of their misfortunes.

However, not every patient with delusions of persecution react in the same way. Mr. Maret, in his doctoral thesis, divides those suffering delusions of persecution into three categories, depending on the risk they pose to themselves or to others.

In the first category he classifies those who are harmless to both themselves and to others. In the second category those who are dangerous to themselves, while in the third category, those who are dangerous to others.

[...]

According to Mr. Magnan, the sufferer reacts according to his own idiosyncrasy, and sometimes according to the phase of the disease and the intensity of the delusion, in the following three ways: (a) he emigrates, in order to escape these imaginary enemies; (b) he defends himself; (c) he attacks.

The reason of the insane

[...]

Concerning the insane whose main characteristic is considered, by most, to be the loss of reason, three qualities [*intellect* (νόησις), *judgement* (κρίσις), *spirit of behaviour* (πνεύμα συμπεριφοράς)], which constitute the *reason* (λόγος) or *logic* (λογικόν), are at least partly maintained. The patients retain the power through which healthy people are able to think, to speak and to act normally, namely their logic.

In order to prove that the insane are not lacking in logic, as is commonly admitted, provided that we had the appropriate space, we would have to analyse each of the consisting components and to seek them in the reasoning and the actions of the insane. It is, for example, known that *thinking* or *intellect* consists of *attention*, *memory* and of *combination of ideas*, to which we are also able to add *imagination*. But none of these intellectual functions is damaged or vanished totally in whatever form of insanity.

[...]

With the *word* logic we mean regular and normal continuity of ideas and actions. A logical person is consistent with himself and the ideas he has conceived. Sufferers are very often, equally, able to conform their ideas, their words and behaviour to certain principles and thus, from this point of view, we can say that many mental patients do not really differ from reasonable people. Just as the latter, so do the former know how to think using regular syllogisms. Of course, between them two deep and substantial differences exist, which constitute the condition of insanity. These differences consist of the fact that the insane, in contrast to people with sound mind, on the one hand base their delusional ideas on sensory disorders and false or misinterpreted sensory impressions, while on the other hand, they also are entirely unable to comprehend their fallacy and correct their false assumptions.

As a general rule, man forms his acquired ideas and concepts either by internal or by external impressions. He analyses both processes and takes them as a starting point for his actions. If the impression appear to be normal, the ideas and actions will be normal as well. If, however, they are abnormal and misinterpreted, the ideas and the actions undertaken will be abnormal as well. In this case, however, if the person has a sound mind, he can, either by himself or on the recommendation of someone else, correct his impressions, in such a way that his ideas and actions contain absolutely nothing that is abnormal (Victor Par-rant). This requires the brain and sensory inputs to be healthy and function normally, otherwise when the body is not in a condition to provide the brain with correct and precise knowledge, or when the latter is incapable of processing and judging these in a healthy way, the ideas formed will be false.

[...]

Thus the distinction between the healthy and the mentally ill mind lies in the starting point.

[...]

According to Parrant, “The law proclaims firstly, that an insane individual is not responsible for his actions. In principle, everybody, ethicists, judges and doctors accept that this lack of responsibility is in accordance with the laws of natural ethics, because, for somebody to be responsible for his actions, he should have full use of his intellect, and somebody who is insane is not entirely free to regulate fully his actions. However, this agreement is no longer so unanimous, when it comes to designate the extent of implementation of this lack of responsibility” (ed: “unfit to plea”). This lack of agreement is reduced almost exclusively to the following issue: is somebody who is insane and commits a criminal act always and entirely not responsible ?

There are two opinions on this issue: the majority admits on the whole the lack of responsibility, while the others believe that a degree of responsibility should be attributed, commensurate with individual circumstances, in other words the degree to which the delusion influencing the actions of a mentally ill person should be taken into consideration, as should be the conditions under which the actions were committed. Proponents of the second opinion, base this on the partial maintenance of intellect in insanity.

They claim that, if an insane individual is able to regulate his actions, to evaluate their significance and their value, to prepare their execution most artfully and in certain cases to conceal them, in order to elude justice and avoid punishment, he should bear a part of the responsibility.

While it is true that, although some insane individuals maintain a great part of their reason and are able to display exact knowledge of the act committed and to show obvious indications of will, yet, this is not sufficient, for them, to be declared responsible for their actions. The opposite would be erroneous, deriving from the confusion reason/logic with its perfect use and the confusion of the will with the freedom of will (*libre arbitre*). It is not sufficient to be rational, to have volition, one must also be master of himself in order to be responsible for his actions.

For this reason, persons suffering from chronic delusions, whose mental functions are deeply disturbed and who, therefore, are not masters of themselves, cannot be responsible for their actions, which, in any case, are not always the result of deluded thoughts, but also the outcome of hallucinations affecting them, so to speak, unconsciously.



Petros Apostolides (Pavlos Nirvanas) (1866–1937)

Physiological Psychology (Φυσιολογική Ψυχολογία)

*Lecture delivered at Parnassos Association
Published by Estia Press, Athens, 1893*

[...]

Allow me an attempt to present to you the incomplete outline of a most recent science –Physiological Psychology– and to act as its defender against prejudice, frequently leaving people reticent and daunted when dealing with modern trends. [...] Allow me to stand up for new ideas. [...] The objective science of research and experiment, which dissects the tissues of the human body, which examines the invisible texture of our internal organs under microscope, also investigates the phenomena of life, from the most elementary organic functions to those in the sphere of intellect and emotions; this science, studying the awe-inspiring variety of mental states, which have long been exploited by quacks and scorned by scholars, has revealed the mystery of states of hypnosis, thus giving rise to experimental psychology.

Today, faced with the amazing and paradoxical phenomena of telepathy and telesthesia, science zealously weighs observations collected from various sources in order to discover who knows which mental states in the future. If modern science and modern philosophy do not threaten to reverse prevalent psychological dispositions, which have been the most alluring points of appeal of human existence, they equally do not threaten to disrupt the social status, nor to undermine the terms of social solidarity, from which social virtues, as a sweet smelling incense, as the most pleasing flower of human civilisation, are derived. Social science, history, pedagogy, ethics are built on new, solid foundations and before the restless eyes of poets and artists new horizons open up, both radiant and infinite.

Modern science had to fight a long battle against a legion of prejudices and superstitions, in order to reach the point of studying nature and mankind freely, refuting one prejudice after the other, for three hundred years. Deluded beliefs on matter, and the elementary and erroneous understanding of its relationships, produced disjointed concepts which held sway over the spirit of humankind for centuries. Until the beginning of the present century, the theory of vital force prevailed in physiology and the mysterious source of the power which moved our organs was sought, up to the time of Bichat, Magendie and Claude Bernard, who proved the physicochemical nature of these elementary functions of the body.

[...]

The liberation of modern science from the common and dominating influence of these chimeric concepts permitted the birth of Modern Psychology. Physiological Psychology or, to use a more general term, Experimental Psychology, as

denoted by the term is the resulting fusion product of two distinct branches of biology, which had for a long time marched in opposite directions, those of Physiology and Psychology. [...] Thus, two sciences dealing with the same topic, the specific study of human life, had followed for centuries different paths, the former examining biological phenomena, as these are perceived by our senses, the latter seeking to use conscience alone, in order to interpret the relationship between events revealed by introspection. Wundt stated that, however different inner life may appear from the external one, they adjoin each other on most points, as internal experience is affected by external factors, whilst our inner state influences external phenomena. This led to the need for these two official branches of biology to come closer, together resulting in light being shed by each of these on the totality of biological phenomena occurring in human beings.

[...]

The more comprehensive experimental work on this issue has been presented recently in conferences on psychology, the first convened in Paris in 1889, the latest in London in August 1892. These studies come from the special laboratories of Physiological Psychology, which are constantly being established throughout Europe and America. [...] The usefulness of these laboratories is obvious: they contain complex instruments for accurately observing and measuring psychological phenomena. Kant's opinion, that these phenomena, by their nature, defy measurement, has proven to be unfounded. The simplest phenomena of sensation were measured in psychology laboratories (psychometry). Therefore, we can no longer say today that thought has the speed of lightning, whilst we can accurately state that it has the same speed as a fast train

or the flight of an eagle. It is obvious that such determinations require chronometers of the greatest accuracy, which can even indicate hundredths of a second. Moreover, Buccalla wrote that electricity is as necessary for measuring the speed of thought, as is the microscope to investigate the texture of a living cell and polarised light to determine the chemical composition of certain bodies.

[...]

Ebbinghaus reported on a new theory on the perception of colours, Miss Franklin, an American, explored the various aspects of this issue, Mendelssohn spoke of measuring the senses. M. von Tschisch investigated the reaction time and Goldschneider the sense of touch in the blind. The renowned psychologist Münsterberg, recently invited to direct one of the largest laboratories of psychology in America, based on the most elementary of these studies to the higher spheres of research, reported on the “psychophysical basis of feelings” and proved that measurement methods can be applied, not only on the simple phenomena of the senses, but also on the more complex and unstable phenomena of our emotions.

The edifice of psychology is being erected on such foundations, occupying a specific position among its sister sciences and standing apart, according to Alfred Binet, from the confused heap of knowledge, which has been named Philosophy.

[...]

In order to conceive in a more precise and comprehensive way the analysis of psychological phenomena and the conditions under which these occur, we need to dismiss the various fallacious concepts including our fallacious perception on matter. I would like to mention the beautiful and most scientific lines,

dedicated by one of the foremost French poets to the sound perception of matter. Sully Prudhomme, the philosophical poet of *Le bonheur* (Happiness) and *La Justice* (Justice), whose inspiration draws its force and insurmountable grace from the modern scientific revolution, in his introduction to the translation of Lucretius' poem *On the Nature of Things* (*De natura rerum*) stated with reference to the issue of matter in physiology: "In order to understand life we must attribute to the idea of matter all its wealth and breadth. We must understand that matter is not separate from force and that in nature only acting matter exists; the various ways in which it acts constitute its properties and forces. Force is this very matter acting with its properties. The essence of various forces is matter. From this point of view, great emphasis is put on matter which has been greatly undermined in favour of some imaginary intellectual concepts. [...] In distinguishing organic from inorganic matter, we are not identifying life as an element essentially different from matter, but rather as a higher degree of developing material forces".

[...]

The theatre of all phenomena of our psychic life, as these are manifested in the multifarious sum of our senses and movements, our intellectual faculties –memory, imagination, intellect– the psychic activity –sentiments and instincts– the theatre of all these phenomena, is located in our nervous centres, the brain, the spinal cord with its cerebral appendages of the medulla oblongata and the pons, as well as the minor nervous centres, the ganglia. [...] Physiology, with all its extensive research and knowledge, does not have a comprehensive picture of these mechanisms. Yet, the material contained therein is infinite and gives light to the dark penetralia of our psychic essence, to the same or an even greater extent than the philosophy of words.

[...]

According to Luys' mathematical calculations, the cortical matter of the brain contains approximately 500 million cells. Even though the nervous system is anatomically and physiologically very complex, the elements composing it are few: the nerve fibres and the cells. The configuration of these elements is also very simple, comprising of the cell with its two nerve fibres, the afferent and the efferent. The first transfers the vibration received at its final ending to the cell; the other transfers the vibration to its final ending, from the cell. This phenomenon was named reflex and it constitutes the simplest unit of the nervous system's specific function. Imagine this function on a greater, more complex scale and you will understand the mechanism of our nervous system.

[...]

All mental phenomena, from the simplest images formed within us by our senses, to the most complex orders of the intellect; from the most elementary specific or general emotions to the higher moral emotions, even sensations; from the simplest instincts to the most awe-inspiring manifestations of the will; all develop on the anatomical ground described previously. If they are to be reduced to their simplest anatomical forms: from an anatomical point of view the cell has two fibres; from a physiological point of view the reflex phenomenon can be observed. Therefore, two major currents constitute our mental life, the first progresses from the external to the internal and the other from the internal to the external. Currents, which never cease or rest, as long as we live and breathe.

[...]

What I would mainly like to praise is the method of modern psychological research, its positive and experimental nature and the wide-ranging scientific and social importance of modern psychology.

[...]

Michelet expressed a great scientific truth when he said: “Medicine must become Justice and Ethics, in other words the physician, an enlightened judge of our inner life, must enter into the study of moral causes, which bring about natural injury and attain its source, combating the habits that produce diseases.” Thus, Psychology, in our days, attempts to protect the still unaffected social elements, by demonstrating the ways of propagation of pathological states, either by heredity or by contagion or by lack of physical and moral hygiene (Féré).



Michael Katsaras (1860–1939)

1. The place of neurology and mental diseases in medicine and throughout science

(*Ἡ θέσις τῆς Νευρολογίας καὶ τῶν φρενιτίδων
νόσων ἐν τῇ Ἱατρικῇ καὶ ἐν τῇ ἐπιστήμῃ καθόλου*)

Inaugural lecture at Athens University.

Printed by the printers Passaris and Vergianitis, Athens, 1893

[...]

Medical knowledge is being based on increasingly more scientific evidence, in comparison to previous times, because it is supported not only by clinical observation, but also by new research into anatomy, physiology, experimentation and the various methods used in natural sciences, which have been applied in internal medicine and also in clinical practice. This new scientific spirit has been handled so well, and medical knowledge has increased to such a degree, that a division of the (ed: scientific) material has become inevitable and a division of labour is now also essential.

[...]

If this is true for all major branches of Medicine, I am sure there is no need to remind you that over the past four decades,

in no other field has the plough of progress brought to light so many unexplored areas, tilled as much fallow land and mined such hidden treasures of knowledge as in the field of Neurology and Mental Diseases. The cultivation, expanded along the entire line, of this broad-ranging neuropathological sector revealed in this way, has borne fruit along all its points, giving rise to the unfeigned admiration of the entire scientific world. The train of progress in this sector continues to accelerate; the number of special journals grows ever more, relevant scientific treatises are published one after the other and Medical Schools of the major universities are forced to increase the existing chairs in Neurology and Mental Diseases. It is only our own Medical School still lagging behind, despite its progress in other fields, but now this very significant shortcoming has been overcome even though belatedly.

A simple listing of the major discoveries, which took place over the past forty years in the various branches of this truly enviable field, is sufficient to indicate the significant position it has gained in the Medical Science.

[...]

A true renaissance has taken place in the field of Mental diseases. French alienists Calmeil and Bayle described general paralysis of the insane as a distinct disease; Falret, Lasègue and Baillarger completed the clinical picture and detailed the macroscopic alterations observed, whilst Magnan, Westphal, and their contemporaries described the histological alterations of this disease, constituting one of the major achievements in medical history. Pinel separated cataplexy from idiotism, confused as it was with it and Esquirol separated it for the same reason from acute dementia. The study of neuropsychic passions is presently being completed, for example with epileptic and hysterical mental

diseases. The influence of various toxic substances particularly alcohol, on the brain has been studied in detail and described most assiduously, thus establishing the order of toxic mental diseases. Baillarger and Falret père discovered cyclic or dual form insanity. Lasègue described the delusion of persecution and distinguished it from melancholia, while Magnan developed and clarified it further under the term of chronic systemic delusional state. Morel set the basis of degenerative mental diseases, along with an exquisitely profound analysis for each one of them, Magnan achieved to compose the broad, unfortunately, category of degenerate conditions. In consequence, degeneration is not something vague or abstract, something beyond recognition, but a disease clearly defined, with specific signs and features. Hence, degenerate people are most particular beings, abnormal in their usual condition, but also abnormal in the condition of their insanity, deviating in everything from the normal persons, whatever their present state might be, either normal or morbid. These deviations, anomalies, irregularities, having immense differences of their apparent guises and manifold forms, into which they are randomly divided, are nowadays well classified, perfectly organised, and subservient to distinct laws, which have been accepted almost unanimously by public medicine.

[...]

Our branch holds an important position in the science of medicine, not only due to its particular significance, but also due to knowledge acquired by physicians through neurology, useful for their overall medical education. It is really necessary for me to state that the action of the nervous system is generalized in a living organism and nothing is taking place in physiology or internal medicine without the intervention of the nervous system, in most cases acting

as the primary factor, while in other, rare cases, acting as a secondary factor.

Neurology and Psychiatry, having outpaced all the other medical branches, have set their sails proudly and float on the beautiful and immense sea of science. A precious and extremely new cargo, shedding light on various branches of science in general, which neurology carries within the holds of its vessels, having acquired incontrovertibly its rights, is experimental psychology.

The new psychology, having suffered for many centuries the anxious and heavy burden of metaphysics, declared a fierce revolt against its regressive master and after hard struggles, finally obtained complete independence over itself, becoming experimental psychology, physiological psychology, psychology proposing, as wonderfully stated by Ribot, "The exclusive study of mental phenomena following the method of natural sciences, independent of all metaphysical hypotheses". The definite victory of this fortunate revolt was obtained by the straight-shooting and most murderous weapons manufactured in the laboratories of psychiatry, i.e. brain's pathology, the studying of neuroses, particularly hysteria, and the conditions of hypnotism.

Research concerning the alterations of personality radically transformed the theory of ancient psychology, which considered every individual as an indivisible unit. By proving that some patients, in given circumstances, were capable of presenting many distinct personalities, it can be concluded that the ego is not something simple. An ordinary succession of two or more personalities in one and the same individual, in natural and induced somnambulism; the co-existence of multiple consciousnesses and multiple personalities, in con-

ditions of hysterical anaesthesia, of (hysterical) absences and post-hypnotic suggestions, proves the fallibility of the indivisible nature of the ego for the following simplest of reasons: everything that is divisible, must necessarily be composed of multiple parts; if a personality can be double and triple, the conclusion is that it cannot be simple, but must be a synthesis, an aggregate, composed of multiple elements.

[...]

In conditions of hysterical anaesthesia, beyond the main consciousness, beyond the main ego, there is a second consciousness, a second ego, a secondary self, as termed in English. Indeed, we can communicate with this secondary self, we can direct it, converse with it, measure the extent of its memory and the acuteness of its comprehension. Thus, despite the will and knowledge of the main consciousness, the main ego, we can provoke particularly clever movements in an anaesthetised extremity. After using a screen to render invisible the anaesthetised extremity of an hysterical individual and by placing a reed pen in their anaesthetised hand, it is sufficient to engrave thereon with a pointless instrument, any characters or numbers for the anaesthetised hand to reproduce them using its reed, having not only perceived the sensations on the skin, but also translated them into their written equivalents.

[...]

The coexistence of multiple consciousnesses and multiple personalities was proven by Pierre Janet, in his wonderful work on psychological automatism, existing in the so-called conditions of absence, in addition to hysterical anaesthesia, which we can produce by attracting the individual's attention by any means, either by reading an interesting book or by facilitating conversation of this individual with a third person. As it is

known, hysterical individuals are most easily absent minded and they were selected particularly for this purpose. Taking advantage of the abstraction of the main consciousness and by approaching from behind, we enunciate certain words in a low tone, in order to be in contact with the subconscious personality and we have an agreement with it (ed.: the subconscious personality of a hysterical woman) on the way of conveying its answers to us. Once we have completed this communication, we examine the comprehension of the subconscious ego, the extent of its memory, and the idea the subconscious has of the conscious ego, usually considering it as a stranger, as another person. If we insist on its identity, it frequently protests claiming to have nothing in common therewith. Finally we examine its degree of suggestibility.

Proofs beyond contestation prove the identity of subconscious and somnambulist ego, or the somnambulist nature of the unconscious ego.

1st proof: the state of memory. While the main consciousness ignores completely the ideas and orders given to the other consciousness, this individual placed into a state of induced somnambulism remembers and repeats everything that took place.

2nd proof: subconscious acts developing in a state of awareness can cause somnambulation.

The first and second consciousness, the conscious and subconscious ego, can enter into mutual relations under two specific forms, collaborative and antagonistic. The collaboration of multiple consciousnesses in particular in hysterical individuals becomes obvious in the so-called “automatic writing”, where the idea to be explained belongs to the conscious, but the movement of writing to the subconscious ego. Complete collaboration! Order an individual to think of certain words

for a defined period of time; while the conscious ego thinks, the subconscious writes the word being thought through the anesthetized hand. It need not be mentioned that the principal ego knows nothing on the word written by the second ego.

[...]

The coexistence of multiple consciousnesses and multiple personalities is also indicated by the so-called post-hypnotic suggestions, which the individual hypnotised and subjected to somnambulism, carries out upon being woken and aware. The dysjunction of personality is also indubitable in this case, where the suggestion is carried out not by conscious, but by subconscious or somnambulant ego. The proof thereof lies in the rapid forgetfulness subsequent to the execution of a post-hypnotic suggestion, the full absence of consciousness of the main personality through the period of execution of a suggestion induced by others and finally the fact that in certain cases the subconscious ego plays a leading part on stage, completely replacing the conscious ego, whereupon the individual falls into somnambulism.

[...]

These new pathological and hypnotic phenomena prove that the real unity of our ego lies in the assembly of its various consisting parts, a fact that fully confirms what was stated ten years ago by the wise Ribot, Professor of Experimental Psychology in Paris, based on personality disorders: "unity of ego, in the psychological sense of the word is, at any given time, a connection of a number of distinct conscious conditions, accompanied by others, which are less distinct and a group of normal conditions, which are not conscious, as their homogeneous, but act in the same way". Union lies in the assembly.

Amongst the elements that constitute the ego, the so-called total personality, the most important of all, as was clearly proven by Ribot, is the so-called physical personality; in other words the total sum of all somatic conditions, all those organic senses coming from all tissues, from all parts set into motion, from all special sensors [...], which are gathered in the *sensorium commune*, in the brain, where internal and organic life is summarised. [...] Something similar also happens concerning psychic life, which is maintained in constant tone, without any respite and suspension, by gathering in the brain the sum of all bodily sensations constituting organic life. Each of these single sensations is so indistinct that it is almost unconscious, however the total sum thereof constitutes the organic consciousness, in other words, the vague and pleasurable knowledge of our own existence.

[...]

Pathological misleading of the physical personality, proving it to be the most important element in overall personality, is what Bertrand called “delusions of somatic senses”. When a portion of the sum of the organic sensations, which compose physical personality, is perverted, for example one arising from fingertips, there is a partial perversion of personality and patients believe that their fingers are made of glass, wood, stone and so forth. If a portion of these organic sensations is removed, for example those coming from the stomach, bowels, teeth, mouth or the brain, then we have a partial destruction of the personality and insane individuals say that they have no stomach, no bowel, no teeth, no mouth or no brain. If muscular sensation is affected, patients feel themselves to be suspended in air and so forth. If a morbid, new and overall sum of organic sensations is born, then a new personality is also born alongside; if the new diseased ego does not replace

the normal organic ego, in other words if they do not merge, then both will co-exist and present together, with the sufferer thinking that he has two bodies.

[...]

Primacy of physical personality in the composition of the ego can be as well demonstrated negatively. Transformations of the ego, arising from mental disturbances, due to delusional ideas, for example, or even by suggestion in induced somnambulism are in fact neither perfect, nor constant or permanent.

Even under normal conditions, with constantly changing sensations and mnemonic pictures, the idea of personality is subjected to proportionate modifications, which are not rendered conscious, because they take place by degrees, little by little, and they are forgotten. But if we take into consideration various periods in an individual's life and observe some of these periods, possibly distant to each other, it is easy to discover many, frequently dissimilar, personalities.

[...]

By studying the way of divergence, of changing and disintegration (dissolution) of personality, we obtain a more comprehensive understanding of its way of construction. The morbidity of the ego is a true ball of Ariadne's yarn, permitting us to enter safely into the depths of the labyrinth of the normal ego, to conceive its true mechanisms of functioning. Indeed, the excessive development of intellectual faculties and emotions of man hid the true origin of his personality, the source of it, i.e. the natural ego, revealed by mental diseases and hypnotic experiments in all its importance, by removing the beautiful but deceptive veil.

[...]

A factor contributing to a mistaken perception of the great truth concerning the nature of the ego, was the fallacious idea held by ancient psychologists concerning the multiple and various conscious conditions constituting intellectual life. They attributed these (ed: the conscious conditions) to intellectual qualities, admitting the existence of certain unified and imaginary qualities, e.g. of one memory, one consciousness, one volition, one perception, one attention and so forth.

But who can be deceived nowadays by the use of these names? If, for example, we use the term memory, we do it simply for reason of facility. Studies on aphasias and morbidity of memory have proved that only in the use of *verbal forms* four kinds of memory exist: visual, auditory, motor articulating and motor graphic. Each one of these memories may be affected alone and cease to function, while all the rest remain intact; each of these memories is located in a specific area of the brain's cortex; each of these areas is served by the same branch of the Sylvian artery. The renowned Charcot, based on these data distinguished four categories of normal types of speech, depending on the category of mnemonic images, having a dominant role or, on the contrary, do not prevail at all. Thus we have people who are auditory, visual, kinetic or indifferent.

[...]

Concerning volition, which constitutes a fantastic and dark psychic quality, morbidity of volition proves to be the simple result of a specific psychophysiological process; a result only partially falling within the main consciousness of an individual, having the form of a final and judged decision, in a way that the ego, the expression of personal volition, "only views and confirms" the decision, "but does not form it". "Because", Cley stresses, "since man becomes conscious of actions produced

within himself and, in a way of speaking, sees them emerging, he is led to believe that he is their master and cause”.

[...]

The study of obsessions and ecstatic conditions shed copious light in understanding the function that we call “attention”. It contributed to prove that “the tendency to a singularity of consciousness” constitutes the main character, “the basis of attention”. Under normal circumstances intellectual life is full of ideas, i.e. an immense parade of sensations, sentiments, images and ideas, which are associated or repulsed, according to Ribot’s well-known combinatorial laws. Thus, attention is nothing else than “the instantaneous arrest or the instantaneous cessation of this incessant parade”, of this eternal multiplicity of ideas and the obligation of the brain’s energy to turn entirely to a single thought, to one single idea, i.e. “attention is a concentration in one idea (monoideasmos), and this concentration in one idea is relative, because an absolute singularity of idea, only a single idea existing in the field of consciousness is encountered only in pathological conditions, in extremely rare cases of ecstasy”.

[...]

The pathology of emotional conditions seeks to prove to us that something pleasant or unpleasant, pain or pleasure, depends on proclivities and proclivities depend on the organism. “Where a normal man with normal proclivities finds pleasure, a morbid man, who has pathological proclivities will encounter anguish”. Infinite events indicate the great psychological truth that abnormality, perversion, and alteration in an organism is accompanied by abnormal appetites, proclivities and general tendencies thereof and a similar abnormality, perversion and alteration in the position of pain and pleasure. “Proclivities are, basically, movements or cessation of movements”.

Hysterical individuals and those susceptible to hypnosis, are favoured by experimentalists, because they present dynamic manifestations under extremely magnifying lenses, due to their diseased excitability. They are, as Féré has so aptly characterized, the frogs of experimental psychology. On these hysterical hypnotised individuals Féré attempted to prove that stimulation of hysterogenic, dynamogenic and erogenous zones, stimulation caused by illusion, by sensory stimulation, either physical or chemical, even stimulation of anaesthetised organs, such as the cervix, in brief all stimulations exerted on the organs of general or specific sensibility increase the dynamic energy, which is externalised by manifestation of movements, movements rendered obvious with the use of a dynamometer; in other words “all senses have their motor equivalent”.

[...]

This law has naturally required the study and measuring of these equivalent movements and has given rise to a host of observations and experiments. The most important ones were reported at the psychology's congresses of Paris in 1889 and of London in 1891. Thus, the imperfection of psychology recognised by Bain (being unable to define quantities with any accuracy and thus to become an exact science) is being overcome and most phenomena of the psyche, in opposite to Kant's opinion, do not elude measurement. I regret that the pressures of time do not permit me to detail studies by Mendelssohn on the measurement of the senses, to go into the profound study undertaken by Ebbinghaus, director of the laboratory of psychology in Berlin, concerning the perception of colours; the treatise by Tschisch, on reaction time; into the wise research by the excellent American psychologist Münsterberg on the psychophysical basis of emotions, demonstrating that even emotional conditions are amenable to measurement and in particular the admi-

rable and most systematic studies undertaken under the direction of the renowned German psychologist Wundt.

[...]

The new experimental psychology has elucidated the genesis of the darker psychological phenomena, according to Spencer, of pain and pleasure, proving that agreeable sensations, agreeable sentiments, agreeable emotions are accompanied by an increase in dynamic energy, whilst unpleasant ones by a diminution of it.

[...]

A more material proof of the links between somatic phenomena and psychic ones of pleasure and pain, are provided by melancholic and excitable conditions of the insane (Féré). The depressive ideas, delusions and emotions of a melancholic person are accompanied by a parallel diminution in the dynamic energy of the organism, expressed throughout all its functions. In contrast, agreeable ideas, emotions and feelings of effusive situations are accompanied by a proportional increase in motility, sensitivity, circulation, and the general tone of the entire organism. Conversely, increases in the dynamic energy of the organism are accompanied by a similar increase in psychic energy.

[...]

The study of erotic diseases permits us to deduce, safely, its normal psychology. We can obviously conclude that normal love (eros) consists of the love of the sum of the bodily and psychic elements composing the loved person. (...) In pathological love, the part substitutes the whole (Binet). By developing the perversions of sexual urge, we can observe all degrees of such a (perverted) development, the minor fetishists of the eye, the hand, the hair, of the exhalations of the skin, to lovers

of some psychic quality, up to the major fetishists, the lovers of some soulless object, the underwear, the night cap, the white apron, the Italian vest, the nails, shoes and so forth.

[...]

Such erotic perversions, such fetishism we encountered in germ in normal love. Because, in addition to the love of the whole, there is always a tendency to prefer one part of the body or one psychic quality, or some erotic, pagan, worship of soulless material objects belonging to the beloved. (...) It is sufficient for the seed of fetishism existing in all normal love to increase, in order to have morbid phenomena.

[...]

To hypnotism besides the so many other psychic phenomena, we owe the wonderful experiments on the so-called *hallucinatory vision*, which can be summarised in the following statement: "the imaginary object which is depicted in the hallucination is perceived under the same conditions" and is subject to the same laws of optics "as if it were real".

[...]

This very general sketch has indicated the tremendous importance neurology and psychiatry have acquired in the field of science in general, due to normal and abnormal psychology. Is it really necessary for me to point out the major significance, both social and scientific, of this new experimental psychology and to what extent this has influenced Philosophy and its most important branches, Sociology, Ethics, Education and Aesthetics, the science of Justice and particularly Criminal Law, Linguistics and History. "History and Linguistics", says Taine most wisely, "are applications of Psychology, just as Meteorology is an application of Physics. Studying man and studying men have separate perspectives but a common subject".

Therefore we will pursue a dual scope in our teaching of Neurology and Psychiatry, because dual is the duty of a physician. First, as neurologists and psychiatrists, we aim to teach you nervous and mental diseases, so that you will be in a position, by relating symptoms to the disease, to diagnose, to offer prognoses and treatment, as this is one of your duties, in other words, to avert greater falls, to improve or perfect the rehabilitation of patients to the degree allowed by nature. Second, we seek to achieve a second purpose, which lies on the psychological analysis of each psychic function individually, to proceed to the direct study of symptoms; by the study of their formation and mechanism to gain sufficient knowledge of normal and pathological psychology, having hypnotism as our great ally, which is most effective in psychological studies.

In this way, dear sirs, you will be able to carry out your other duty, in other words to protect social elements that are as yet unaffected, by pointing out how diseased conditions spread, either by heredity, or by a lack of natural and moral hygiene.

Michelet praised this high purpose, which is your duty, in the following wonderful words: “medicine must develop into justice and morality, in other words the physician, an enlightened judge of our innermost life, must penetrate in the investigation and study of the moral causes that bring about natural evil and to dare reach up to its very source, pointing out the need to reform habits and constitutions, from which diseases arise”.

This latter part of our teaching interests students of all Departments, because nobody can be a true scientist without being a psychologist. If Plato inscribed over the Academy’s door “let no one ignorant of geometry enter”, the contemporary university should engrave in golden letters “let no one ignorant of psychology enter”.

2. On false catatonic dementias

(Περὶ ψευδῶν κατατονικῶν ἀνοιῶν)

*Lecture delivered in the great hall of the University,
Athens, 1908.*

[...]

Catatonia is a term coined by Kahlbaum and derived from Greek (kata-tonos). It should be noted here parenthetically that we term as catatonias all mental conditions, depressive or agitated alike, if they are characterised by the following three clinical elements:

First, negativism, consisting of the sufferer's resistance not only to movements of his body we initiate, but also to anything we may ask or instruct him to do. Such a refusal not based on delusions, the sufferer refusing without logical volition, without awareness, without any control, in an entirely automatic way, is not restricted to what others order him to do, but frequently concerns his own pleasures and natural needs. Certain catatonics not only refuse whatever we request of them, but do the exact opposite, a fact frequently used in patients' treatment. We can conclude that negativism clinically presents in two forms, *negativism towards others and self-negativism*.

A second clinical element of catatonia is stereotypy of the sufferer without good reason, independently of any causal paranoid ideas or delusions, endlessly staying in the same position and performing the same movements and actions; reiterating the same words and phrases emphatically, devoid of all meaning, frequently using the same articulation, rhythm, voice and tone, indeed frequently creating new words; writing repeatedly the same words, whether in the beginning, in the middle or at

the end of the phrases, sometimes interpolating other words, making characters similar to oral speech; sketching in a similarly detailed, but equally paradoxical and repetitive way. Thus, we have stereotypical positions, stereotypical movements and actions, stereotypical speech, stereotypical writing and so forth.

Third and last clinical sign of catatonia is *suggestibility* comprising the continuous and instinctive tendency of the sufferer to accept any external influence by keeping any position, even the most paradoxical and taxing, imposed by others on his body and carrying any action we order. This suggestibility is a result of complete elimination of volition, which may even lead to the sufferer automatically mimicking, aping and performing movements and acts, taking on postures and repeating the same songs and the same words and phrases that he hears (echopraxia, echolalia).

The phenomena of suggestibility and negativism, although opposite to each other, are frequently observed in the same sufferer, despite a paradoxical opposition easy to understand.

We would like to note that catatonic states, in our clinical practice, were not incomplete, elementary, did not have the character of a simple and temporary phenomenon, but comprised the entire clinical picture. The combination of these two classes of symptoms imposes the diagnosis of a catatonic form of precocious dementia and consequently a more ominous prognosis.

Nevertheless, a deep and extensive clinical examination repeated on timely occasions, reveals that apathy, lack of volition and loss of intellectual energy exist only in surface, that higher intellectual faculties have only been suspended, rather than destroyed. In brief, these are false catatonic dementias, as we call every morbid condition having the appearance of a true precocious dementia and the same relationship with it as paralytic syndromes or false total paralysis to the true general paralysis of the insane.

We observe that this is not only an issue of diagnosis, but also one of prognosis, as these cases can be treated, in fact they can often be cured, whilst precocious dementia cannot.

On this topic, Kraepelin, the wise clinician from Munich to whom contemporary psychiatry owes so much, because he established the foundations of precocious dementia, which is an achievement of equal importance with (ed: the study of) general paralysis, stated: "With respect to the cases really and definitively cured, the issue put forward is whether their pathological process is the same as the others, however these cases would be of the highest practical significance, if we were able to recognise them, from the very beginning".

This paragraph, from Kraepelin's most recently published work, attests that the author tends to reject the idea that these cured cases can be classified as *dementia praecox*.

This is exactly what we are trying to point out: we managed, mostly, to identify false catatonic dementias from the very outset, as proved by cured clinical cases, which we monitored in the neurology department under my direction. One can object that our clinical cases of cure are not definitive, as their duration is not long, ranging between few months and two or more years.

[...]

In our cases we have not perceived any intellectual deficit, and if some of these patients should suffer the recurrence of mental illness, for instance in two, five, ten or twenty years, we are entitled to contest the idea that this is the same morbid process, continuing to exist in a latent state for five, ten or twenty years, without manifesting obvious signs to a greater or lesser degree, disclosing intellectual, volitional, moral and emotional harm to mental life. If not, we can prove the com-

pletely different nature of false catatonic dementias or at least the possibility of their diagnosis from the very outset.

[...]

According to Klippel, dementias are divided into two categories on the basis of pathological anatomy and their genesis. In the first category fall the alterations occurring in all brain tissues that are contiguous to vessels and the neuroepithelium, while in the second one the alterations can be delineated and are located solely in components of the neuroepithelial tissue.

Precocious dementia belongs to the second category, according to the above mentioned authors. A. Marie, in his recently published important monograph, has correctly excluded adolescent dementia caused by focal changes in the brain from precocious dementia: for example, bleeding from head injuries, tumours, etc. and dementias due to dispersed alterations to vessels and neuro-epithelium of paralytic type, as in infant or juvenile generalised paralysis, for instance.

[...]

Our interest focuses on the following point: everybody admits that the anatomical process of precocious dementia is always *destructive and irremediable*, exactly like the processes of all dementias, whatever their nature. The evolution and advantageous outcome of false catatonic dementias manifestly proves that the process is *not destructive, or irremediable*, and consequently is *completely* different.

Let us see the processes of false catatonic dementias. These differ in nature and we distinguish four, as follows:

First is the *process of inhibition* of intellectual centres, caused either by hallucinatory delusions, as in some of our clinical cases, or delusions without hallucinations, that we observed in many other cases. Hallucinatory ideas and delusions inundating

the field of our patients' consciousness, exercised an inhibitory effect on the higher intellectual centres and by suspension of their functions released lower psychic centres and allowed them to function with no control, resulting in our patients being governed by lower psychism, entering in this way in a state of true automatism. Thus, we explain on the one hand the indifference to emotions, in other words apathy, lack of volition and lack of intellectual energy, and on the other hand catatonic phenomena, such as stereotypy, suggestibility and negativism.

Second, we distinguish the *infectious process*: Some of our clinical observations have cast doubt on the assumption that an anatomical process of infectious origin was under this state, which caused a false catatonic dementia by paralysing the energy of higher intellectual centres.

Third, a *toxic process*: Many writers and particularly Briesaud, Latron, Bauer, Regis and Lalane proved that a catatonic syndrome occurs in toxic delusions and mainly in uremic and overall in auto toxic delusions, where catatonia through its extensive development and persistence may dissimulate a catatonic precocious dementia, particularly in adolescents. All types of toxic substances, introduced into the body or produced by the body itself, affect neurons that are responsible for the higher intellectual functions, destroying them and thus resulting in the genesis of toxic false catatonic dementia.

Fourth, the *sleep process*: This process is useful as a proof of *hysterical false catatonic dementia*. According to the theory of the genesis of hysteria recently developed by Sollier –which we consider to be more reasonable, anatomically correct and in accordance with clinical events– the sleep of the higher mental centres, the centres of intellectual oversight can suspend intellectual energy, volition and affect as well as activate

the energy of the lower mental centres, producing the necessary conditions for the onset of catatonia.

[...]

What is presently missing is the solution of the following anatomical problem: where is the locus of false catatonic dementia?

Although the nature of false catatonic dementias differs completely from the anatomical process of precocious dementia, the localisation, however, is the same. Wundt accepts the existence of a mental apperceptive function, which we call mental oversight, a term coined by the late professor of philosophy Philippos Ioannou.

[...]

The anatomical organ, which presides over this higher function, in other words the seat of intellectual oversight, is located, according to Wundt, in the frontal gyri and, more specifically, according to De Buck, in their deeper layers. The *primitive destructive* alteration of this organ, according to Kraepelin, Weygandt, Nissl, Alzheimer, Klippel and many others, is fundamental in dementia praecox, constituting its anatomical substance.

However, the alteration of this anatomical organ, whatever its nature may be, according to the laws governing cerebral localisation, results perforce in a disorder of intellectual oversight and a subsequent apathy, lack of volition, lack of intellectual energy and a catatonic syndrome (phenomena of stereotypy, negativism and suggestibility). Thus, the seat of false catatonic and true precocious dementias is the same.

Hence, the following can be concluded:

Like aphasia, Bravais-Jackson's epilepsy and many other cerebral syndromes indicating the location of alterations in the centres of speech, in the tactile kinetic zone of the brain, etc. –without

however indicating the nature of alterations—catatonia, however manifest it may be, does not have objective characters permitting to diagnose the nature of the corresponding alteration. Only its anatomical seat is shown, its localisation in the centres of intellectual oversight. In order to diagnose whether it is the destructive and irreparable process of precocious dementia or false catatonic dementias occurring through curable inhibitory processes, infections, poisoning and hysterical sleep, we must take recourse in various diagnostic signs, with the main ones being:

First: *case history* [prior “attacks”]. Second: *aetiology* [e.g. “congenital syphilis”]. The third diagnostic element is the *way of onset* [e.g. “fever”, “hysterical sleep”]. The fourth diagnostic character is the *expression in the eyes* and the *appearance* of the patient. Fifth: The *psychopathological mechanism of catatonic symptoms*, playing a major role in differential diagnosis [e.g. “hallucinations” and “delusional ideas”, which suspended “the function of the intellectual oversight”]. The sixth diagnostic element of false catatonic dementias is the integrity of the intellect.

Hence, the following can be concluded:

- a. Apart from true precocious dementia, there is a plethora of mental conditions, which present as clinical syndromes consisting of, on the one hand, apathy, avolition and lack of intellectual energy, and on the other of negativism, suggestibility and stereotypy; in other words, catatonia has the features of precocious dementia or primitive dementia, without, however, this being the case.
- b. We call these mental conditions false catatonic dementias in contrast to true primitive or precocious catatonic dementia.
- c. The nature of morbid process of these false catatonic dementias is different from the nature of true primitive catatonic dementia, as concluded by its completely different evolution and favourable outcome.

3. Nerve Pathology and Psychiatry

(Textbook, 2nd edition)

(Παθολογία τῶν Νεύρων καὶ Ψυχιατρική)

Published by A. Vitsikounakis, Athens 1923

Preface

Over the past six decades, no other field of Medicine has seen the plough of progress bring to light as many unexplored areas, cultivate as much fallow land and dig such hidden treasures of knowledge as in the field of Nerve Pathology and Psychiatry. The cultivation of the revealed broad-ranging neuropathological field produced admirable fruit. Indeed, this truly enviable branch has now taken on a significant position in the Science of Medicine

In the prologue to the first edition, we wrote that Greek Medical Science was lacking, to its great detriment, a sound medical textbook, dealing with the Pathology of Nerves and Psychiatry.

The first volume contains the following: diseases of the Spinal Cord, Cauda Equina, Medulla oblongata, Pons and Cerebral Crura. The second volume: diseases of the Brain, Cerebellum and Psychiatry. The third volume: Hysteria, Epilepsy, Chorea, Neurasthenia, Parkinson's Disease, Graves-Basedow Disease, Radiculitis, Neuritis, all kinds of Neuralgia, and all types of Peripheral Paralyses, etc. Finally in the third volume of this edition, we have appended a small description of our "Clinical and experimental research on conditions arising

from eliminating air pressure”, which was published in French in Charcot’s *Archives de Neurologie*.

As the first edition of our book was sold out four years ago, we proceeded with this second edition, which has so many new additions that can be introduced as a new book. However, the foundations of our writing, giving it a particular originality, remain the same.

The book is based on our lectures made in the University classes and the clinical classes in “Eginiteion” hospital, permitting me to express freely my point of view in the arrangement of the material, both theoretical and clinical.

In dealing with diseases of each part of the cerebrospinal axis, I introduce in my teaching and consequently in this book, which is the most faithful depiction of my teaching method, the requisite anatomical, histological and physiological knowledge, without disregarding the close ties between these and the diseases of Nerves and Psychiatry.

[...]

The requisite anatomical, histological and histopathological knowledge of the cerebral cortex precedes Psychiatry, because it is impossible to understand mental diseases, without this knowledge. The anatomical clinical basis, which is the cornerstone of our teaching of Psychiatry, provides a real originality and a broader scientific understanding, proving that Psychiatry is a part of Brain Medicine and of Internal Medicine.

It is certain that the field of morbidity of the Cerebrospinal axis unveiled a number of areas hitherto unknown to Anatomy and Physiology. [...] However, we cannot contest that the field of Medicine of the Nervous system unstintingly reaped

the benefits of knowledge of the texture and physiology of organs. The most eminent proof thereof is the neuron theory.

Studies by Ramon y Cajal have shown that branches of nerve cells, in any area of the brain and of any type, whether these are Deiter's axons or neurites, cannot be dissected by an anatomist.

[...]

The new neuron theory offers a fresh understanding of physiology and pathology, the neuron representing the nervous system in miniature. Consequently, anatomy, physiology and morbidity of the neuron represent the texture, physiology and pathology of the nervous system in miniature.

[...]

We would like to note that all neurons have a similar texture. Differences in size, shape, length of axons do not change their fundamental composition, which is similar in all neurons, whether motor, sensory, connective, psychic, etc.

[...]

The synapses of a neuron to its neighbouring neurons form a chain of neurons, constituting physiological systems, thus creating the motor system composed of two neurons superimposed, the peripheral motor and the central motor neuron; the sensory system, which consists of the peripheral sensory and one or more central sensory neurons; the connective system, which consists of neurons that connect the two major physiological lines, i.e. sensory and motor in various parts of the spinal cord and the brain; and the psychic system or the chains of neurons in the cerebral cortex related to psychic (ed: mental) life.

[...]

In describing the symptomatology of the Nervous and Mental Diseases, we highlight the main symptoms or signs of each one. With the term “main” we are not referring to pathognomonic signs and symptoms, but rather to those necessary to diagnose the disease. In our clinical classes we underscore the clinical doctrine, that if we do not have at least one of the main symptoms or signs of a disease, we can only suspect its presence, but we cannot diagnose it.

[...]

We examine sufficiently in depth the aetiology of various nervous and mental diseases, which the progress in Internal Medicine has greatly influenced, in order to discover the appropriate treatment.

In compiling this book I consulted books of other authors, treatises and journals; however, in my classifications and descriptions I followed my own methodology, guided by my forty years of teaching and clinical classes, my years of experience in practice and long specific studies. In classifying and describing nervous and mental diseases, I did not limit myself to simply setting out the conclusions of the new researches, but I passed each one of these carefully step by step, without prejudice, without “theories”, through the scrutiny of clinical practice, as every reader can see in this second edition, thus providing physicians and our Medical School students with a preponderantly original textbook on the Diseases of Nerves and Psychiatry compiled in line with current progress.

[...]



Ioannis Foustanos (1856–1933)

Psychoses subsequent to operations.

Postpartum mental illness

(Ψυχώσεις κατόπιν ἐγχειρήσεων.

Ἐπιλόχειος παραφροσύνη)

Iatriki Proodos (Medical Progress) 285–289, 1898

[...]

An explanation of the underlying cause of the usually transient mental disturbances that follow operations, has not yet been sufficiently elucidated. Despite this, we should, from the very beginning say that amongst these disturbances we should distinguish and set apart acute delirium, which is due to the putrefying infection of the wound and is accompanied by fever, which will pass and disappear once the wound is cleaned and the fever has subsided. We should also distinguish and set apart the delirium occurring in individuals who are alcoholics, in which cases the causation of the delirium is easy to comprehend.

Mental disorders that follow operations were initially ascribed (when it was thought that only those surgeries taking

place in the sphere of genitalia carry the threat of such mental disorders) to the sympathetic influence on the organs being operated upon, when the nervous system is exhausted. Later it was thought that the reason for mental disturbances was the removal of organs important for the economy of the organism and the abrupt cessation, in this way, of the circulation of their anti-toxic humours. Others blamed the anaesthetic medications, like iodoform. Many attribute these disturbances to microbial infection or to self-poisoning.

Almost all these observers admitted that these mental disorders occurred mostly in individuals who were suffering from neurasthenia, neuropathy, hysteria and mainly in individuals who have an inherited or acquired predisposition. Indeed, the true cause of post-operative mental disturbances most often is an inherited or acquired predisposition and the operation is the circumstantial precipitating agent, setting the ground for mental disorders to manifest, on individuals already predisposed. The operation disrupts and weakens the nervous system when it has an inherited predisposition, or has been weakened by pre-existing neurasthenia or neurosis or by anaemia and the exhaustion of the operation. In other cases, however, in degenerate individuals who are afflicted with latent mental dysfunctions, the operation does no more than awaken this formerly latent diseased condition. In these cases, in fact, they seem to be deeper ingrained, rather more persistent and harder to cure. In these individuals it is not even necessary, as we have mentioned above, that surgery –the circumstantial agent– to be significant and major, because these disturbances may be brought on by even small and sometimes insignificant operations.

[...]

It is known that during pregnancy mental disturbances can be observed in certain women. These are brought on before childbirth, particularly during the 7th or 8th month of pregnancy and mostly pass following parturition. Other kinds of mental disturbances are brought on during childbirth in the form of acute mania, where the woman has no insight. This acute delirium usually passes following parturition or after 2–3 days.

These disturbances are usually expressed in the form of melancholia and only rarely in the form of acute manic agitation. They are usually reported in women who are hysterical, neurasthenic, neuropathic, or chloroanaemic and particularly those who have an inherited or acquired predisposition. In extremely rare cases these disturbances run so deep that they result in true insanity. In rare cases this condition may extend over many months subsequent to parturition, before a cure is usually, finally, achieved.

However, postpartum insanity is the most important disorder to be mentioned during the puerperal period. It mainly manifests in two forms, that of acute mania or that of melancholia and in rare cases in the form of monomania or a mental illness recurring on a cyclic basis or even simple paranoia.

The pathogenesis of these types of delirium is usually the same, because parturition constitutes a trauma for a woman. Women who have a predisposition for inherited or acquired neuropathy, whose mind seems strongly preoccupied and tortured with the fear of pregnancy and parturition, constitute fertile ground for the appearance of mental disturbances, during or after the trauma of parturition. Additionally, in these cases a very important role is played by postpartum miasma

(contamination), which brings on delirium and which, particularly in individuals with such a predisposition, is extended in time and subsequently takes the form of a mental disturbance.

The prognosis of such disturbances is good, as in most cases, sooner or later, they are fully cured.

Finally, there are also mental disturbances occurring during the period of lactation, brought on 6–7 weeks post-partum or even later. Obviously such disturbances are due to the exhaustion produced in patients by the secretion of milk and particularly in patients with predisposed organisms.



Michael Yianniris (1865–1956)

Mental diseases in Greece.

A study on statistical and clinical observations

(Αἱ φρενοπάθειαι ἐν Ἑλλάδι. Μελέτη ἐπὶ
στατιστικῶν καὶ κλινικῶν παρατηρήσεων)

Printezis printers, Syros, 1898

Part One:

On those who are seriously mentally ill in Greece

The types of mental diseases (*phrenitis nosos*) in all countries are certainly the same; however, differences can be observed pertaining to the proportion of mentally ill and the relative frequency of various nosological types. Degenerates, the unbalanced, those suffering from progressive paralysis, etc. are similar in all countries, however the proportions differ because, on the one hand, mental illnesses are created by various conditions and influences, which are not the same everywhere and, on the other hand, because races and individuals suffer from delusions according to their development and their natural tendencies.

It has been observed that in uncivilised countries, only the elemental forms of mental disease are encountered: mania, mel-

anchoia and certain degenerative delusions. In civilised countries and large urban centres, mania is rare whilst general paralysis of the insane and degenerative manifestations are frequent.

There is no doubt that progress of civilisation not only has altered the earlier elemental condition of mental diseases, but it has also increased the incidence of mental diseases in many countries. This conclusion can be drawn from statistics of various nations. There are countries in Europe where the proportion of mentally ill individuals has increased to 2.50–3 or more per thousand. In our country there has been no official study to date on this subject. One can hypothesize that since Greece follows European culture and Greeks have a high degree of nervous temperament it should have approximately the same proportion. However, it seems that in Greece the proportion of those mentally ill is far lower than in other nations. Our distinguished colleague, Mr Tsirigotis, utilising official statistics of the mental asylum of Corfu and of “Dromokaiteion” Mental Hospital in Athens, as well as additional information, calculated that in Greece there is one mentally ill individual for every 1000 inhabitants (Statistics from the “Dromokaiteion”, 1897). These conclusions seem to close with the truth. It may be true that the number of residents in mental asylums in Greece, which is currently 320 mental patients, cannot possibly indicate the prevalence of the mentally ill (ed: in the country), but other conclusions do convince us that mentally ill in Greece cannot be fewer than 2000 to 2500, neither many more. Mental illnesses in Greece are proportionately far fewer than in other European nations.

What is the reason for this disparity?

The cause must definitely be sought in the aetiology of mental diseases. It is known that the main factor underlying mental

diseases is predisposition, whether hereditary or due to other causes. Many alienists believe that nobody becomes mentally ill without being already predisposed. However, it is incontrovertible that specific factors also exist, i.e. alcoholic beverages can cause alcoholic delirium. Other forms of poisoning, e.g. by lead, and uraemia, give rise to the respective delirium. Self-poisoning in general and miasma diseases in particular can cause deliria. It has also been ascertained that syphilis, mental exhaustion, etc. may cause general paralysis of the insane.

[...]

Living conditions can also have a major influence on the development of mental diseases. Rural populations, whose life is quiet and without excessive toil and who live under relatively healthy conditions, give rise to fewer mentally ill individuals and most of those who became mentally ill are predisposed. External influences and subsequent causes are of only secondary importance. In these populations, whose physical and moral hygiene is on the rise, the number of mentally ill is decreasing.

In contrast, inhabitants of the cities who, due to their turbulent lives, are exposed and subject to mental strains, to competition and abuse, to alcoholism and syphilis, seem to have a much higher number of mentally ill individuals. The observed increase of mental diseases in many places is due to living conditions and mental stresses, to alcoholism and syphilis. [...]

In “Dromokaiteion” mental asylum, where mentally ill people from all social classes and all parts of Greece are treated, one can state that general paralysis of the insane is only observed in those who come from cities. Out of the 144

patients admitted into “Dromokaiteion” with a diagnosis of general paralysis, only 9 were women. In many countries of Europe, the number of mentally ill women is approximately the same as the number of men; however in Greece this is much lower. Of 718 inmates of “Dromokaiteion” Hospital, only 171 are of female gender.

All the aforementioned differences are naturally not due to reasons of heredity, as brothers and sisters have the same parents, but due to living conditions. Those who live a quiet life, who are not subject to excessive mental pursuits and addictions, usually count fewer victims. The major part of the Greek population falls under this category. On the one hand, many of the inhabitants of Greece are farmers and certainly live in healthy conditions –because hunger is not prevalent in our land– and on the other hand many of them live a quiet life, without many struggles. Those whose lives are turbulent and those exposed to addictions, etc. constitute the minority of the Greek population. Under these circumstances, it is obvious that the proportion of mentally ill individuals in our country would be far lower.

Can we claim that our climate has a certain benign influence?

We believe that it would have absolutely no benign influence, on the contrary it would be possible to think the opposite, as the climate in Greece is warmer than in other European countries –long drawn out heat waves have a bad influence on the brain– and in the summer there are more mentally ill than during any other season. During summer Greece may have an excessive number of heat waves, which may cause moral and physical apathy, but this condition has very little influence

on the manifestation of mental disorders. [...] Although heat waves definitely may weaken the brain, yet it is not the sole responsible factor. Such is also the case regarding suicides. It has frequently been observed that most suicides occur during the months of April and May. This is not solely due to the season of the year, but also to even more significant underlying causes. We believe that we are not able to assign any particular significance to the climate of Greece.

During the recent political unrest (ed: war of 1897) we have noticed serious outbreaks of mental illnesses under the influence of war-time conditions; however, these were outbreaks manifested by unbalanced individuals whose delusions were shaped by circumstances. Nonetheless all of these were the precipitating factors, they were not the causes producing the mental diseases.

[...]

We know that the island of Chios has a significant number of mentally ill patients, due to the fact that Chios has had, for many years, contact with the outside world.

The inhabitants of Chios travelled to various cities and proceeded to pay tribute to Bacchus and Aphrodite (ed: to enjoy the fruits of the wine and the pleasures of the flesh). Under these conditions, as one can understand, many of them were stricken by a disease or gave birth to degenerate children. The same can also be said about various other places in Greece. We must conclude that, if Greece does not have a large number of mentally ill or a proportion greater than 1 in 1000, this is due to the conditions of living of its inhabitants.

**Relative frequency of various nosological types
in “Dromokaiteion” Mental Asylum,
treated from 1887 to 1897**

In the classification of mental diseases, my respected colleague Mr. Tsirigotis accepted Magnan’s classification, with certain addenda. This classification seems to be the simplest to date and the most practical, as it incorporates all clinical cases.

This classification is as follows:

First Category

Organic brain diseases

1. General paralysis of the insane
2. Focused brain alterations.
3. Acute delirium

Second Category

Neuropsychoses

1. Hysterical mental disease
2. Epileptic mental disease

Third Category

Psychoneuroses

1. Mania
2. Melancholia
3. Chronic systematic delusional state
4. Acute systematic delusional state
5. Intermittent mental disease

Fourth Category

Toxic mental illnesses

1. Alcoholic mental disease
2. Mental disease due to pellagra

3. Various other forms of poisoning (morphine addiction, cocaine addiction)

Fifth Category

1. Stupidity
2. Moria
3. Feeble-mindedness
4. Superior degenerates

Since the first day of “Dromokaiteion” mental hospital (*φρενοκομείον*) in October 1887, 714 mentally ill patients have been admitted for treatment. The following table indicates the relative frequency of these various nosological types in both genders.

Table 1

| | Men | Women |
|---|-----|-------|
| Hereditary mental disease or mental disease due to degeneration | 245 | 92 |
| General paralysis of the insane | 135 | 9 |
| Melancholia | 60 | 29 |
| Acute systematic delusional state | 16 | 11 |
| Alcoholic mental disease | 24 | 1 |
| Chronic systematic delusional state | 10 | 6 |
| Intermittent mental disease | 10 | 1 |
| Epileptic mental disease | 10 | 6 |
| Hysterical mental disease | 0 | 7 |
| Mania | 4 | 3 |
| Secondary dementia | 25 | 6 |
| Doubtful diagnosis | 4 | 0 |
| Total | 543 | 171 |

We will deal with each of the aforementioned diseases from a clinical point of view, which is the main objective of this publication.

[...]

Telemachos Mitaftsis

The degenerates

(Οἱ ἔκφυλοι)

Reprinted from the dissertation for the degree of reader

With a prologue by Mr. Jean B. Charcot, and including 42 vignettes and other somatic stigmas of degeneracy.

Printed by Spyridon Kousoulinos company, Athens, 1899

[...]

The evolution of mankind has gradually progressed through centuries. The first man constituted the first point of proliferation of this lineage, disseminated here and there over the land. Subsequently, a great mechanical power for its conservation was developed. This progress was led by the precious treasure of his head, the central nervous system, where the greater the intensity and degree of functioning, the greater the damage imposed on this precious matter. If various conditions render it impossible to repair such damage, the destruction is complete. Man can act mainly through the nervous system and thus nations also develop by the development of their nervous faculties. It is rare to see deterioration to this precious material, when the intensity of its functions is minimal. Mental diseases and degeneration are commensurate of an individual's or a nation's development.

[...]

It is mostly the great nations that create the greatest social needs; large cities wear down individual spirit more than small towns, the struggle for life and progress being engaged more strongly there. For this reason, these two factors, namely great nations and large urban social centres give rise to the greatest number of mental illnesses. The psychic degeneration or rather the degeneration of the nervous system of individuals, is a disease which, as previously stated, leads the individual to intellectual destruction. When we face a degenerate we face an individual who is diseased; this disease may not have a generalised character, it may not concern all psychic faculties of an individual. This is the reason why degenerates only partially diseased also exist. This disease, in other words, may affect one of the manifold areas of the brain, which may differ functionally from each other, and here is the enormous difference between degenerate manifestations of different individuals. The disease is created in the brain, as is the case with every other disease in any organ of the body; its development may be exceedingly slow and is always preceded in a section of the brain or the entire brain, by a period of lesser or greater excitation, irritation or chronic hyperaemia. The overstimulated (ed: nervous) centre suffering hyperaemia, develops a most acute function, which later on will undoubtedly bring about its own damage and destruction. Degenerates, subjected to such acute stimulation and hyperaemia of one or the other functional centre of their brain, have created major works of genius and progress. The great mathematician, the great poet, the great engineer, the great inventor, the great musician, the great reformer and the outstanding minds in special fields, to whom humanity owes varying gratitude; these minds developed a mental illness for the sake of humanity and were subject to partial over-stimulation. Specific sectors of their brains manifested their function to

the greatest extent possible absorbing all the intellectual energy, leaving inactive all the remaining sectors of the brain, which atrophied and remained underdeveloped. These partial or general anomalies of the parents are inherited to their children, rendering them intellectually and psychologically abnormal and worthless. Thus, if some healthy conditions do not cut off or mend this inherited damage, the degeneracy proceeds from generation to generation until it brings about complete mental and somatic barrenness.

Degeneracy is a disease, which will never disappear from the catalogue of man-kind's diseases; it is also the only disease that will never be wiped out, as long as there are people acting and moving; indeed the more one moves and acts, the more one is rendered vulnerable to it. Degeneracy is the necessary consequence of mental stimulation of people, is the result of tendencies and struggles toward progress, development and conservation of mankind and societies. Amongst the causes of degeneracy various diseases are mentioned which also act on the central nervous system. Such influences cannot be disputed, but they are strong enough by themselves to produce full degeneration of an individual, but more often they produce mental prostration, in other words give rise to minor degenerates. The production of major degenerates is probably due to heredity or at least to causes which act upon the life of an individual while still in the womb, or during the first stages of infancy.

This is, more or less, a general overview of degeneracy. This topic is mainly new and it is due to the work of younger authors that this issue has acquired lucidity and perspicuity.



Elias Makris

1. New evidence on the aetiology and interpretation of mental illnesses

(Νέα στοιχεία ἐν τῇ αἰτιολογίᾳ καὶ ἐρμηνείᾳ
τῶν φρενοπαθειῶν)

Iatriki Proodos, (Medical progress) 312–314, 1901

The classical confusion reigning in the classification of mental illnesses is well known and this lack of a safe foundation in psychiatry is recognised by every one. Indeed, there is a large number of dissimilar and heterogeneous material of mental disorders. It would not be an exaggeration, if we were to assert that various systems of classification, which have emerged over time, are more or less equal to the number of renowned psychiatrists. But the chaos of these doctrines cannot endure forever. Systematic and unfaltering dedicated studies have put an end to this reigning outstanding issue and have given it a more specific, more characteristic and more scientific form.

There is already a common basis, whereon many western psychiatrists exchange opinions, that the aetiological basis. The system thus constructed, becomes ever larger, gaining

ground and imposing itself from day to day, due to its objective nature.

Recently, the causes have been grouped into three major categories, on the basis of which three major distinct groups of mental illnesses have been identified.

Morphological causes stemming from stunted cerebral development, due to various adverse conditions; *chemical* causes stemming from toxins of microbial origin or products of excessive denaturation of matter; destructive foci in the cerebral mass, all have been set as the foundations of aetiology at the disposal of psychiatric disciples.

From this entire body, we detach a selected group having a common aetiological element, which is stunted cerebral development in young age, including a broad collection of idiots, morons, simpletons, epileptics, degenerates and so forth, as well as, hysterical individuals, according to some researchers. The second group of mental illnesses to be distinguished, is due to chemical causes and includes neurasthenia, acute delirium, melancholia, various degrees of mania, etc.; self-intoxication caused by toxins; or nosogenic action of special parasites or other miasmatic diseases. The discovery by Leonardo Bianchi, the prominent psychiatrist and neuropathologist from Naples and a valued teacher of mine, of a special parasite in the blood of patients with acute delirium is quite well known. Perhaps the conclusions of other experiments in the laboratory of the same scientist, in the Salles mental asylum, may not have been broadly publicised. In them a particular toxin of influenza was perfectly isolated and very strong nervous phenomena of mania were induced when this was injected this in animals.

We know that every destruction of nervous tissue in the brain cannot be restored by creating new tissues, as it is possible with inferior tissues of our body. Therefore, the existence of destructive foci caused by inflammatory processes and so forth gives rise and shape to a third group of mental diseases. When the cerebral mass is deprived of a smaller or larger part thereof, which is the seat of one or another psychic presentation, its intellectual properties are diminished to a smaller or larger extent and through miscellaneous memory disorders give rise to various mental illnesses; when communication between the members of this “democratic state” of the brain is disrupted, the harmonious cooperation between various mental centres is also disrupted and fertile ground is provided for the manifestation of psychopathological phenomena and the key to their possible interpretation requires perfect knowledge of brain anatomy and brain physiology.

By defining objectively three categories of common aetiological factors, mental illnesses can be housed more permanently within three overlapping not completely independent circles. It is not difficult to find fertile grounds in the first group for causes of the second group and vice versa.

Nonetheless, more extensive knowledge is required. We put the question, whether histological causes can exist, abnormalities can be located in the fine texture of the nervous system, which could shed light on morphological abnormalities and chemical influences and inflammatory processes or whether they would be insufficient or unable to provide a solution to many problems that arise. So far research has drawn a blank, without however all hope being lost.

It is enough to consider the amazing progress brought about by the pathological anatomy of the nervous system

in recent years, in order to perceive the true revolution that has occurred in the theories on this fine texture of the brain, which progress greatly reinforces hope and with that hope the thought that the issue may simply have been an issue of technical means, microscopic technology and appropriate use of staining methods.

Many diseases are not classified within the content of neuroses. Why is that? Quite simply, because they escape the observer and Pathological Anatomy changes cannot be ascertained. Was it not only recently that the organic changes of multiple sclerosis became known? Or was it not only recently that Pansini, an Italian scientist, discovered changes in the brain and spinal cord in Parkinson's disease, which resulted in it being definitely deleted from the chapter of neuroses? How many and what kind of radical changes will occur in the perception of the fine texture of the nervous system, with respect to the very fundamental principle of the existence of an embryological, anatomical and physiological nervous unit and its relations to other units?

As the theory of the neuron postulated by Ramon y Cajal and van Gehuchten and Lenhossek and many others obtained support from important scientific centres and had been accepted by the most eminent psychiatrists and neuropathologists worldwide as a plausible anatomical basis for mental phenomena, suddenly the research of Apathy, Paladino, Bethe, Held and others, took central stage, bringing back to life, albeit in a different form, Golgi's theory of the nervous network, which had been considered no longer valid.

Whilst in Greece discussions about the denomination of this nerve unit are probably senseless, Apathy and Bethe proved that the neuron as a unit does not exist, either from an

anatomical or a functional, or even an embryological perspective. Before publications by neuropathologists and psychiatrists –even in Greece– on neuron fully came to light, Fagnito and Capobianco struck the final blow on the already fallen theory. What was difficult and impossible to achieve with Golgi's staining method, was easily done with Nissl's staining method. Fragnito was the first to demonstrate and Capobianco confirmed shortly afterwards, that the neuron cannot be the unit, nor can the nerve cell considered to be even as an embryological unit, but rather it is the result of merging of many embryonic cells, many neuroblasts, whose remains are so amenable to staining and appear as stained balls, aggregating around the cell nucleus.

This total reversal, in a short period of time, was justly termed a revolution.

[...]

2. On the pseudo-insane and Ganser's sign

(Περὶ ψευδοπαρὰφρόνων καὶ τοῦ σημείου Ganser)

Iatriki Proodos (Medical Progress) 20, 351–356, 1915

[...]

As pointed out by E. Regis, the renowned professor from Bordeaux in a recent medico – legal congress in France, “exaggeration in expressions, posture, and actions is one of the safest indications of pseudo-insanity”. Whilst a mental patient is, in a way, completely natural, even in his strangest fit of irrationality, the impostor gives an immediate impression of being artificial and false. He is obviously impersonating someone else. He enacts ideas and emotions, which are obviously not engrained and clearly not his own. He manifestly overdoes the part that he is playing. He oversteps the mark. It is impossible not to notice that he has completely gone over the line. One of the most important signs, indicating pseudo-insanity, is precisely the excessively strange and foolish answers, visibly the fruit of premeditation.” (E. Regis. *Simulation de la folie et syndrome de Ganser. Compte Rendu du 2ème Congrès de Médecine Légale*, Paris 1912).

[...]

It is imperative not to confuse Ganser's sign with Ganser's syndrome, although the former can constitute part of the latter, which in any case is a far more complex symptomatological concept. Ganser's syndrome, according to German physicians, incontestably constitutes a symptomatology of hysterical origin, classified amongst what they term dream-like states

(Dammerzustände, Traumwachen, Schlaftrunkenheit) and characterised, apart from the aforementioned sign of excessively foolish answers (Ganser sign), by various manifestations of hysteria, memory disorders and disorders of consciousness.

[...]

It must be taken into consideration that Ganser's sign, apart from its value in detection of fictitious insanity, can also appear as a symptom of a patient suffering from a real insanity.

[...]

Every year, an entire mosaic of hundreds of mentally ill patients passes through the Tzitzifies Mental Asylum (ed: a precursor in the 1910s of the Public Psychiatric Hospital of Athens). Where I have the medico-legal supervision for the last two years. The most prevalent mental disease, by far, is dementia praecox, whilst Ganser's sign is not uncommon, either through the homonymous syndrome or in the framework of other mental diseases, most frequently dementia praecox, as one of its manifestations.



Simonides Vlavianos (1873–1946)

1. Our programme*

Nevrologiki kai Psychiatriki Epitheorisis (Neurological and Psychiatric Review), Year A, Sept. 1902, issue A', pp. 1–3

The vehicle of Medical Science travels at a breathtaking speed, leaving us behind panting and surprised. However assiduous, nowadays, a scientist may be, it is impossible to follow the amazing day-to-day developments of science and particularly to follow the original sources. We barely receive an echo here (ed.: in Greece) of all this fresh intellectual activity, taking place throughout the world. Moreover, entirely new Sciences are created from day to day and frequently are known by most of us only by name. We are floating in the ocean of practicalities of living blithely insouciant of the giant steps of progress taking place elsewhere. The thirst for knowledge, has not yet overtaken us and the noble hunger of intellectual food is still many leagues away. In the midst of this situation –providing me with a most distressing impression– in the midst of a general fatal-

* This is the editorial announcing the agenda of the first Greek journal of psychiatry and neurology, published by S. Vlavianos from 1902 to 1911).

ism and status quo, we come, today, to open new horizons for Greek Science and through this Review we invite all our valued colleagues, the noble, eager for learning and hard-working physicians of Greece, to a feast of knowledge and collaboration.

We are simply making a start on the work, and each one with his personal contribution, shall complete and set a seal unto it. We need, first, to prepare the way and offer a form of indoctrination. For this reason the material, which our honourable colleagues and every simple reader of the present journal shall encounter in the beginning, will be carefully selected to be general enough, and by this way introductory. We seek to initiate our readers into sciences, born only recently. They are not taught at our University; no textbooks exist, either original or translated into Greek (ed: this is not accurate!); therefore our work becomes harder, because we are forced in choosing our material to carry out a double burden of work, by providing both education and journalistic information. Because we are talking of difficulties, please allow us to indicate certain difficulties not easy to overcome. We have to take into consideration that our Review, having such a broad and immense programme, exists nowhere, as far as we know.

Elsewhere, distribution of the material permits each branch to be represented by an expert in the field and every journal represents only mainly a single branch, while the others or a small part of them are represented in brief. The general process of publishing a journal is easy, because the publisher is separate from the editors and so is the director while the subscribers and the readers are countless. These conditions are, mostly, unfamiliar in our case, where the same person is obliged to be the publisher, undertaking great expenditures of thousands of drachmas, and the director, obliged to deal with

many of the difficulties of management and counting not a single true regular editor nor any permanent collaborator, as it is impossible to pay for one, as is the case elsewhere.

All these obstacles and many more that can be inferred... we shall bravely overcome. We consider ourselves proud to undertake such a worthy, fine and noble project, fully aware of the beneficial results it shall bring about after a few years. The present Review is just the beginning and the instrument of implementation of many plans. We are inspired by the highest and healthiest of principles, why shouldn't we say so? We do, however, have need of support, both moral and material, which we shall bravely request of our dear colleagues, for whom as well as for the general good, we intend to work with zeal and with all our strength.

Our publication can compete with the highest standard luxurious journals, as regards paper and cover, large shape, elegance and density of material, which is rich, varied, useful and enjoyable, adapted to requirements of this country and the mental needs of our scientists.

Finally, we thank all those noble colleagues who have rushed to assist us both with their good words and with their subscription... We are also grateful to the daily press and magazines for their sympathetic reception of our notice and their most favourable comments thereon and particularly "Iatriki Proodos" (Medical Progress) that is published on the island of Syros and the "Iatrikos Menytor" (Medical Messenger) of Athens, directed by two most gracious colleagues of ours, to whom we are offering a hand of collaboration and mutual assistance and would be happy if we could serve them in a unifying way.

In Athens, on the 15th September 1902
S.G. Vlavianos

2. Primary mental confusion

(Ἡ Διανοητικὴ πρωτοπαθὴς σύγχυσις)

Nevrologiki kai Psychiatriki Epitheorisis (Neurological and Psychiatric Review), issue B, 43–48, 1904

Designation and synonym

The designation of someone as a mental patient depends on the general definition of mental disorder and, to the extent that we are unable to have a perfect and clear definition of it, mental diseases will remain unclear and imperfect entities. Theories on mental disorders are inadequate, even though some of them are very brilliant, and the reason is primarily the lack of knowledge concerning the: aetiology just as was the case with nosology, before the work accomplished by the great Pasteur. Thus, we are unable to have an aetiological definition of mental confusion, at least presently, and we believe that the definition we do have, which is based on symptomatology alone, is neither serious nor complete.

For this reason, definitions given, to date, even by the most distinguished of alienists are so dissimilar that confusion results even from just listing them, probably because of the disagreement and differing descriptions, which various authors have undertaken of this disease.

Chaslin proposed the following provisional definition: “primary, idiopathic mental confusion is a disorder, usually acute, consequent to the influence of a cause, which we can often localise, generally induced by an infection and characterised by malnutrition of the body, as well as mental phenomena.

The essential basis of these, a first result of the condition of the body, consists of some form of mental enfeeblement and disintegration, mental confusion, which may or not be accompanied by delusions, hallucinations, agitation, or on the contrary by motor arrest, with or without perceptible variations of the emotional state”.

Seglas provides the same definition. Ballet and Faure avoid providing any definition and limit themselves to a concise exposition of the main elements constituting mental confusion. Schüle does approximately the same. It is not only the contemporary scientists, but also older ones who had even greater difficulty in defining the disease and we shall mention some of them, according to Chaslin, who has specifically studied all the relevant bibliography, as listed in detail in references to his textbook in our journal.

From the turn of the 19th century, Esquirol had defined it as a chronic brain disorder, feverless and accompanied by a decrease of sensibility, of intellect and volition, presenting incoherence of thinking and a remarked lack of initiative in the moral sphere and the overall mental sphere. The sufferer loses the power of understanding the mutual relationships of objects, of comparing these and of maintaining them in his memory. It is worth noting that Esquirol, along with all of his contemporaries, confused the nosological entity of mental confusion with stupidity and consequently the aforementioned definition was ascribed similarly to the latter, many of its traits perfectly corresponding to the former. Thus, Georget when speaking of stupidity, defined it as a random forfeiting of intellect, which in fact partially corresponded to mental confusion.

Delasiauve, who established (ed: the diagnosis of) mental confusion, defined the stupid individual through his external

appearance and physiognomy: “a stupid individual is one not using his intelligence, whose inability is betrayed by the external lack of movement, regressive characteristics of his face, his expressionless physiognomy and the lack of any expression of intellect”.

Wille defined mental confusion as a “functional disease of the brain, often acute, but not infrequently chronic, which commences almost always with a delusional stage, followed by mental confusion, unsystematic delusions, unexplained lack of quietude intermittently changing to intermediate states of excitation or cataplexy (stupor)”.

Meynert, attempting to provide a definition deriving from physiology, defined the disease as a disturbance of the consciousness due to exhaustion of the brain, accompanied by excitation phenomena either sensory or motor due to over-functioning of the central ganglia.

Krafft-Ebbing accomplished the distinction between mental confusion (wahnsinn) and stupidity, stating that the former displays phenomena of rebellion of an exhausted brain. He defined stupidity as a retardation of mental function, probably ending in perfect immobilisation, accompanied by a complete lack of emotion.

Ziehen defined stupidity as a psychosis, whose primary symptom is lack of all associations, to a greater or lesser extent. He classified cases accompanied by delusions in the incoherent form of acute paranoia, which is characterised by a primary incoherence of associations.

Kraepelin distinguished three forms of aesthetic psychosis – *delirium accompanied by collapse* (*délire de collapsus*), *mental confusion* and *acute dementia* (*démence aiguë*). Following

the example of Delasiauve and his contemporaries, we classify these forms within the framework of mental confusion, describing them as a single entity. Kraepelin also defines delirium accompanied by collapse as a deep confusion, developing exceedingly rapidly, the senses being disturbed as if in a dream, accompanied by logorrhea, intense motor excitation and interchanging emotions; acute dementia as a deep and rapid paralysis of all psychological functions, including the highest ones; and mental confusion as an intermediate form, where a condition of dream-like confusion is accompanied by delusions and hallucinations perverting perception; considering them as the product of an acute morbid external influence. As we can see, this definition is more improved, to the extent that on the one hand it indicates aetiology, while on the other hand the clinical picture is marvellously and concisely drawn, and this is an essential virtue of a good definition.



Euthymios Vardakoulas (1848–1923)

Phobopathy (Morbid Fear)

(Φοβοπάθεια)

Description of various forms of pathological fear

Printing press of Phoenix, Athens, 1904

History of the disease

With the term *phobopathy* we mean and intend to describe hereafter a disorder of the nervous system, a neurosis, having various causes, related to various forms of fear and affecting particularly people vulnerable to it.

The disorder was described approximately 30 years ago, by various neuropathologists of that time. Because the predominant symptom is the fear to cross freely a public square or a market place (“agora”), Westphal termed this disorder *agoraphobia*.

The disorder was known and it has been described by various distinguished practitioners of medical science, including Benedict, Professor of Neurology and Psychiatry in Vienna,

Webber and Williams in America, while in France by Brown-Séquard, Perroud and Cordes. The last one was himself suffering from a phobia and described this condition as “anxiety of squares” (*angoisse des places*).

In 1878, the renowned Parisian Neurologist Legrand de Saulle and, in 1879, the similarly distinguished Gélinau, described this disorder more systematically, the first under the name “*peur des espaces*” (fear of spaces), the second under the Greek term of “*kenophobie*” (ed: keno means void), referring to the sufferer’s fear of the void.

They gave these names to this disorder because the sufferer, in front of a large or void space or looking over a large distance separating the edges of a large space, is dominated, due to his idiosyncratic predisposition or specific disorder, by a very strong fear and feels all the phenomena that we will seek to describe below.

Unfortunately, I am aware of all the details of this disease, suffering from it for several years, and having studied it assiduously, due to its irksome developments and its effects on me. Having experienced the influence of almost all its forms, I have unfortunately acquired the specialisation in expressing an opinion most authentically on the most suitable name that must be given this disorder, but also on the explanation for many of its symptoms, which I will faithfully list herein below.

The names agoraphobia, fear of distance, fear of emptiness, are unfortunately not the only ones characterising this *phobopathy*, but they simply explain a single form of it. On the one hand, agoraphobia explains the fear of a marketplace or being in a marketplace, while with reference to the fear of distance or of emptiness, the sufferer experiences fear when fac-

ing these situations. Yet the unceasing scientific investigation has shown us many other forms of the disease.

Therefore, I think it appropriate to give this disease the title of “phobopathy”, as this term and its meaning include all various forms of manifestation of pathological fear, because some nervous patients suffer from a particular susceptibility to agoraphobia, while others a fear of spaces, others claustrophobia, others thalassophobia, while others in some different way. Nonetheless, in any case the main disorder is fear, therefore their disease is a “phobopathy”.



Miltiadis Economakis (?–1922)

Primitive dementia (Dementia Praecox). Clinical description followed by personal observations

[*Ἡ πρωτόγονος ἄνοια (dementia praecox). Κλινικὴ περιγραφή ἐν συνοδείᾳ ἰδίων παρατηρήσεων*]

*Archeia Iatrikis (Annals of Medicine), 1906, year B,
pp. 1–4, 63–68 and 396–402*

Psychiatry has been aware for many years of a large number of morbid conditions, whose classification, due to the very complicated and unstable nature of their clinical manifestation, was not always easy to accomplish. Affecting preferentially young people, they (ed: the morbid conditions) undergo an acute or very acute course, or a chronic or intermittent course, presenting a clinical picture sometimes similar to melancholia or cataplexy, at other times similar to manic excitation, to hallucinatory delirium and mental confusion; albeit so fainted and altered by the admixture of other elements that it is impossible to decide with certainty to which of the, well defined, clinical types they belong.

A variety of names were given to these conditions, mainly for the purpose of clinical communication. The intellectual

deterioration, whose early onset was fatal for the majority of cases, was considered to be a secondary phenomenon.

From this accumulation of hard to define cases of phrenitis (mental disease), in 1871 Haecker distinguished a group which was characterised by a common, more or less, severe outcome of intellectual degradation, which he described as a distinct disease: *hebephrenia or pubescent phrenitis*, a description significantly enriched by the contribution of Daraszkiewitz. In 1875 Kahlbaum distinguished another group, which he called *catatonia or phrenitis accompanied by muscle tension phenomena*, which are determined clinically, on the one hand by successive manifestations of states of melancholia, mania and cataplexy leading to intellectual degradation, and on the other hand by the presence of specific motor symptoms, which bore in general a convulsive character.

Finally, over the past few years Aschaffenburg and Kraepelin himself, pointing out the premature mental enfeeblement characteristic of both conditions, declared that these two forms of phrenitis were the same, while Kraepelin described these as simple forms of a particularly morbid syndrome, which he called premature dementia or dementia praecox and also classified within it a third, paranoid form, which is governed by delusional ideas.

The masterly clinical description offered by Kraepelin, permitted us to state that psychiatry has now defined to perfection the clinical autonomous existence of a large group of mental conditions, which manifest a common and most significant trait, from the point of view of diagnosis and prognosis: the rapid onset of a distinctive enfeeblement, which dominates very early the clinical picture, whose fundamental

psychological traits can be revealed, by a precise analysis, to an experienced eye, even at the beginning of the disease.

Clinical picture

The clinical picture of dementia praecox includes, on the one hand specific symptoms to each of its forms, *hebephrenic*, *catatonic* and *paranoid*, which can vary greatly and differ extensively from each other; on the other hand the general features, which constitute the permanent and fundamental physiognomy of the overall morbid syndrome, which links the various forms like a chain.

General symptomatology. The patients' consciousness remains, as a rule, intact, undergoing a temporary loss only during agitation or during an attack of cataplexy. Under these circumstances the *perception* of the surroundings and orientation may become altered, although in general they remain untouched. [...]

In contrast, the function of *attention* weakens to a great extent [...] but, most of all, what is lacking is *interest*: the spontaneous fixing of attention on what is going on in one's surroundings, as a consequence of an internal impetus. They perceive, but they are inattentive, they do not seek to be aware of the things surrounding them. Remote memory is entirely unaffected. [...] Recent memory and fixation through it of recent impressions also seems to be relatively complete, with the exception of certain lacunas, which correspond to severe fits of cataplexy. [...] It is true that, here, negativism often intervenes, impersonating lack of memory, but in this case it is possible by persistent questioning, despite negativism, to finally achieve the true response.

Another serious symptom is incoherence and disintegration of cognition and a marked weakening of *judgement*. A consequence thereof, on the one hand is the rapid leaping from one thought to the other without logical coherence, mixing unexpected thoughts and expressions –if the intensity is greater, we have a complete confusion of expression, creating new words or stringing together of a heap of similar sounding words– on the other hand is the lack of any precise awareness of their own condition. It is true that frequently some awareness of their morbid condition is maintained, but as a rule, there is no deeper comprehension of the seriousness of the disease and its calamitous consequences for the future.

Another characteristic symptom is the stereotypical nature of thinking, i.e. the persistent clinging to a certain mental image, which constitutes the sum total of the patient's thinking for an extended period of time, manifested by the use of a monotonous phrase. Finally, the tendency to foolish rhyming or risqué plays on words is particularly common.

Delusional ideas and hallucinations are almost never absent. The former are usually, in the beginning, of a depressive, hypochondriacal nature, focusing on persecution, guilt or self-blame, slowly revealing delusions of grandeur. Very swiftly all of them gain and most of them bear from the beginning, the seal of dementia, having under its influence an appearance of instability, incoherence and a liability to external influences. [...] Only in Kraepelin's paranoid forms the delusional ideas observed are more intense and last longer but here too, sooner or later, the fatal disintegration takes place.

Hallucinations, which usually constitute the first symptom in acute cases of the disease, are primarily auditory, and only secondarily are *visual* and *coenaesthetic* or organic.

[...]

The fundamental character of the overall clinical picture is, without exception, the observed intense bluntness of affect, which can extend to moral insensibility and the accompanying *binding or withdrawal of volition*, resulting in the characteristic behaviour of these patients. The moral blunting regularly constitutes the first sign of the disease, particularly in cases of slow onset, and it is never missing at the final stages. The patients are indifferent to their moral obligations, their affect is blunted, tenderness and friendship dry up; work, rest and recreation do not provide them with appropriate diversion. In general, various impressions of life are no longer accompanied by a corresponding change in the hue of sensibilities. Only food attracts them, often in excess and during visits of their family they greedily search their visitors' bags, seeking foodstuffs, while, in all else, they greet their family without the slightest expression of emotion.

[...]

The weakening of volition prepares the ground for the manifestation of particularly interesting motor symptoms. There is no question on deciding to act, but it seems that the brain image of an intended act is not stimulated enough, in order to become conscious, so that the actions of these patients, which they are incapable of choosing and of regulating, have an instinctive, automatic character. This is observed particularly during intermittent flares of excitement, characterised by increased mobility; even extended to blind agitation, deprived, however, of purposefulness in the movements, which have features of disorganised manifestations of an unconscious internal tendency. These patients are suddenly aroused and act violently in a flash. [...] When

questioned, they can not provide a rational explanation for these actions, or they explain themselves using rationalisations, which bear upon them the obvious hallmark of dementia.

This suspension of volition and lack of control of the connective centres in the brain, leaves patients to their instinctive urges, which, unbridled as they are, jumble with each other. When one or the other urge gets the upper hand in this struggle, it defines the various actions, which, however, bear a hesitant character; the constant prevalence of oppositional urges creates negativity (*negativismus*). The manifestations of this symptom, which is almost never absent, are most diverse and peculiar. These include an unwavering resistance to any passive movement of the limbs, a refusal of food, the cessation of salivation, urination, and excrement, alalia, persistent blinking, turning away of the head, farfetched and foolish answers to questions, a sudden interruption of movement already in action, or following of a movement by its opposite, refusal to walk, etc.

Some patients, being in a state of cataplexy or of negativism, are sometimes possessed by sudden urges for violent action and immediately after, lacking the urge to continue, they return to their initial position. They may become extremely dangerous to those around them. Often, instantaneous dominant urges return, persistently, following short or larger intermissions, producing another, most significant symptom, the *stereotypical movements and positions*.

[...]

The different changes in the handshake gesture are particularly typical, some of the patients offering only a single finger or the palm of the hand turned in, whilst others offer

their palm, instead of accepting the hand offered by the physician. The handwriting of these patients is characterised by a mannered style, the inclusion of imaginative decorations, the stereotypical repeating of the same words, or the setting out of riddles. A similar trend also appears in their drawings.

A consequence of this weakening of volition is an increased *suggestibility*, very common in dementia praecox, manifested in a way similar to hypnosis, through phenomena of *catalepsy* or *waxy flexibility* and the accompanying *echopraxia* and *echolalia*. The patients can hold even the most forced and extremely uncomfortable position, to which their limbs are placed for extended periods of time, or can repeat like an echo movements performed, or sounds pronounced in front of them.

These various manifestations of increased suggestibility are included by Kraepelin under the name *Befehlsautomatie* – *induced automatism*.

[...]

(*chapters on: hebephrenic, catatonic, paranoid forms*)

[...]

Course and prognosis

Phenomena of depression, restlessness, fears, distressing depression at the beginning of dementia praecox, as we shall see, are regularly observed. A short preliminary period with a silent installation of morbid phenomena is particularly characteristic of the hebephrenic form, while acute onset is observed more frequently in the catatonic form. Yet, the hebephrenic and even more the paranoid forms can also, in certain cases, have an acute onset through multiple hallucinations.

The course (ed: of the disease) can be acute, intermittent or chronic; the outcome is unfortunately an intellectual enfeeblement, varying from complete dementia to a slight blunting of affect, volition and judgement, which do not significantly obstruct an individual's restricted social activity in a limited circle and may elude an inexperienced eye. But this relatively favourable outcome is, unfortunately, not the usual final one, because irrevocable relapses are occurring with the passage of years. Therefore, these supposed cures are no more than remissions of varying duration.

The prognosis is ominous, because this terrible disease never leaves the patient entirely unaffected; yet, the varying intensity of each disability requires a relative gradation and distinction of the prognosis in severe, medium and relatively favourable.

[...]

Aetiology

Dementia praecox is a disease inflicting young people [...]. Both genders are equally affected by the disease. The hebephrenic form is observed mainly in men (64%), while the catatonic and paranoid forms affect mainly women (58–59%).

In approximately 70% of cases serious hereditary factors were observed, frequently atypical ones. In a fair proportion of patients, accounting to more than 20%, there were signs of degeneration, imbalance, i.e. lowered moral resistance, and very frequently signs of degeneration in their bodies. The intellectual development of those afflicted with the disease varies, mostly within the ordinary limits: 17% display excep-

tional or apparently exceptional development, while only 7% can be observed to be feeble-minded.

[...]

Kraepelin, taking into consideration the close relationship of the disease to the age of onset (the fact that important functions take place in the body at the age of onset of the illness) and its frequent manifestation during pregnancy or puerperium, the multiple disturbances of menses accompanying the disease, which are bringing about major alterations in the balance of tissues, even being within normal limits, based and on the histological changes brought about by the disease, which are very similar to those usually caused by toxic substances, accepted as very probable the aetiological influence of *self-poisoning*. [...] Heredity and degeneracy exacerbate the simple lessening of resistance.

[...]

Pathological anatomy

Significant non-reversible organic lesions constitute without doubt the anatomical basis of dementia praecox. However, we know nothing specific about these. There is also a question, concerning whether these anatomical changes are common to all its clinical forms or not.

[...]

Treatment

Treatment is purely symptomatic. The rapid confinement of patients in an appropriate treatment facility is absolutely necessary in the beginning, but once the acute phenomena

regress, what is most important is to maintain the remaining cognitive powers to the extent feasible. *A longerstay in the ward would be needless, in many cases would be harmful and some form of occupation is required.* Those having a mid-range mental enfeeblement can return to their families and take up some form of occupation, always under supervision. For those who have fallen further, because they are overtaken more regularly by intermittent attacks, it would be particularly beneficial to establish *colonies*, where they could be occupied with elementary work, mainly under medical supervision, using the remnants of their cognitive abilities appropriately and preserving them from complete destruction.

To supplement the exceptional clinical work of Kraepelin, as we have seen, the definitive results of detailed aetiological and pathological/anatomical research are required. Without these results, it is impossible to resolve in any positive way, the issue of whether (this illness) is a single disease or multiple diseases that are temporarily described under a common name.

Due to this deficiency, dementia praecox has been the object of very lively debate in the international psychiatric literature. It has, in fact, been subject to strong objections, particularly by Magnan's school, which, having incorporated since a long time many of the cases belonging to this category (ed: dementia praecox) into the common pot of *mental phrenitis of degenerates*, is most displeased to see its voluminous work undergoing fatal amputation.

[...]

Kraepelin was the first to supply us with a prognosis. Based on the specific changes of affect and volition rather than on

the delusional ideas, he stressed the diagnostic importance of essential clinical traits, which had previously received minimal attention. In this way he laid guidelines concerning the way to trace an outcome from the early marks of the disease, in other words how to diagnose dementia in *statu nascendi*. He also showed that, besides *paralytic, epileptic, senile* and *alcoholic* dementia, there is also another *specific* dementia, which manifests particular catatonic traits and which constitutes not only the outcome, but also the primary alteration in the clinical picture of an entire group of mental conditions. This form of dementia is so specific that we are able in most cases, solely on the basis of its outcome, to conclude safely on the nature of the preceding disease and this provides us, no less, with a remarkable scientific satisfaction.

[...]

Finally, concerning the denomination of the disease, due precisely to the premature nature of the cognitive enfeeblement and in order to avoid pointless discussions I believe that it is advisable instead of “premature” to use the word “primitive”, as I have done in the title of the present work, in order to create an analogue of the Italian “*demenza primitiva*”.



Dionysios Triantafyllos (1872–1945)

1. The pathological physiology of mental disorders

(Ἡ παθολογικὴ φυσιολογία τῶν διανοητικῶν
διαταράξεων)

Printing press of D.H. Terzopoulos, Athens, 1911

In my dissertation for the degree of Lecturer, published in 1903, I attempted to prove that various mental disorders and especially those giving, superficially, the impression of irritation, should no longer be considered to be a result of a process of *stimulation*, which favours an excessive increase of function in the brain matter, which is consumed in excess. I stated at that time that “I am not in agreement with those authors who explain the pathological physiology of mania, hallucinations, compulsions, etc. by (ed: the concept of) irritation. I would like to express the opinion that we cannot consider an increased function of the brain matter through some process, as the cause of the aforementioned pathological disorders, but rather the diminution or abolition of another brain function, which normally exercises an influence in securing

and controlling the function, which, superficially, seems to be increased” (D. Triantafyllos: *Schesis tis peri nevrnon theorias pros tin genikin pathologian tou nevrskou systimatos* – The relationship between the theory of neurons and the general pathology of the nervous system, 1903).

[...]

Having read the excellent monograph “La Psychose maniaque-dépressive” by G. Deny and Paul Camy, Paris 1907, we were pleased to see that, not only do these authors express precisely the same ideas, but they also refer to other authors who provide exactly the same explanations for the aetiology of many mental disorders. Up to now these had been considered mainly irritating in nature, as we can see in the relevant excerpts of this monograph.

We shall, however, first summarise the normal condition of the intellect and how we explain the development of a pathological one.

Intellect is the function of the so-called connective centres of the brain, which are formed, as is the entire nervous system, by successive layers of neurons. The function of these centres is to produce images through peripheral stimuli, which are transmitted by the so-called sensory organs. The function of the connective centres is not limited solely to the production of these images. They also have the power to preserve, recognise, recreate and combine images of objects and their qualities and to produce in this way what we call ideas. The sum of these qualities of the connective centres of the brain constitutes the intellectual function.

The development of the intellectual function follows various stages, before arriving at a steady point in each individual. The connective centres in the beginning receive solely images

of objects, in other words simple qualities thereof, and thus are able to combine these images and these elementary qualities into simple ideas and to carry out combinations of such ideas, whose nature varies at different periods of time and in different individuals. Finally, the individual manages to obtain ideas suitable to his abilities, proportionate to the individual structure of his intellectual centres and to those ideas, which were provided to him by his environment.

The final point in the development of the intellectual function, the carrying out and externalisation thereof, contains certain characteristics, which are useful in order to determine whether it is normal. These characteristics, which govern execution and externalisation of ideas, are *the logical consequence* and *the proper timing for expressing these ideas*.

Naturally, in the foundations of what is characterised as a normal intellect, countless combinations of ideas may be carried out, as many as one can imagine, existing separately in nature, but some of them, not accepted by others governing the externalisation of intellect, remain in a latent condition.

Based on these thoughts we formulated elsewhere the definition of normal intellect: "*Normal intellect is the sum of not contradictory ideas, which, in other words, are a rational consequence of each other; certain ideas contained within the intellect, which might not be reconciled with the others, remain in latent condition, without any combination beyond a certain point, without maintenance beyond a certain time limit and mostly without a proportionate reaction*".

According to Féré, scientists were never able to come to an understanding concerning the definition of either normal intellect or mental disease. As one can see, despite it, we attempted to provide a definition of normal intellect, so different in each

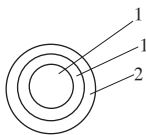
individual. We believe that our definition can be extended to all normal intellects and offer a basis to discern a pathological intellect, whose definition we shall provide herein below.

However, the following question arises: what is the purpose of a normal intellect? Each organ in the human body serves some purpose through its normal function, i.e. the preservation of the body in a healthy condition. What is the purpose of carrying out normally the combination of ideas on the basis of their rational coherence? We consider that the purpose of carrying out this combination of ideas is the felicity of human beings. But in this way, someone could note, the brain's physiology interferes in the privileges of philosophy. People's bliss is most certainly the object of philosophy. But this ordinary happiness would doubtlessly continue to be a chimera *ad infinitum*, if the normal intellect of man did not develop on the basis of those aforementioned qualities.

Philosophy, consequently, should have as its starting point the formulation of intellect on the basis of the logical coherence of ideas, in order to achieve its aim, which is to find the essence of human felicity and the way of realising it.

We will furthermore deal with the pathological physiology of mental disorders and we shall give an overall explanation thereof.

In order to facilitate the comprehension of the issue, we shall represent the sum of all ideas contained within a normal intellect as a series of concentric circles, which is a simplification of another schema we have published elsewhere [...].



The peripheral circle No 2 indicates the sum total of ideas, which we characterised as governing the logical consequence of combining ideas at the correct timing of their manifestation. The underlying concentric circles 1 indicate the sum total of ideas, which, even if they are combined to a certain point, they remain in a latent condition, as the ideas of the peripheral circle inhibit their manifestation, exerting a controlling force upon them.

If we should assume the influence of any morbid cause on the connective centres, the result thereof would be a diminution of the strength of these centres, in other words an extinction of ideas. Given, indeed, that ideas on the peripheral circle require the histological texture of the connective centres to be unimpaired, in order to further produce their own unimpaired function –this is why ideas are the most unstable possession of these centres– it therefore follows that ideas of the peripheral circle are fated to undergo *first* the influence of the morbid cause, and to be extinguished first. The result of the extinction of ideas on the peripheral circle is a diminution of the inhibitory and controlling force they exercise on the underlying ideas of the concentric circles, which were in a latent condition and now are freed to combine ideas and be externalised, no longer governed by logical consequence or the appropriate timing for expression. This is the disease.

It is obvious that we have localised within the peripheral circle the ideas that are governed by logical consequence for the purposes of communication, just as we could have localised these in the central circle. With this scheme we sought to say that the first ideas destined to be extinguished in any pathological condition are those which in order to be produced require an unimpaired histological texture of the connective centres, as well as their unimpaired function, being consequently the most unsta-

ble possession of those centres. The ideas of ethics, of conduct, for example, are far more unstable possessions of the intellectual centres, than knowledge of a certain object or some simple quality thereof. Of these, the former, belonging to the ideas of the peripheral centre and thus in particular pathological states, will be the first to be extinguished. It is easy to comprehend that we are not able to designate precisely, in which circle a certain idea belongs, as each idea is formed in a different way in the intellect of each individual. This differs in many ways depending on the final direction taken by the intellect of each individual. Historical knowledge, for example, in an individual whose profession requires acquisition of this knowledge, probably belongs to the central circles, so that a severe attack of dementia would be required for these to be extinguished, while in another intellect, where this knowledge is rarely renewed, it constitutes an unstable possession of the intellect and would be amongst the first to be extinguished even by a mild attack of dementia.

We formulated elsewhere the definition of pathological intellect: “A pathological intellect is produced by the organic or functional diminution –*brought about by heredity, at conception or through acquired causes*– of the power of the brain to possess or to form these ideas which govern the general expression of ideas on the basis of rational consequence, the timeliness of the expression, and also by the possible combination and expression of ideas, that the extinguished or diminished ideas would repulse”.

This is how, by extinguishing ideas in the peripheral circle, as we have schematically expressed, a morbid condition of the intellect is produced. How shall that be manifested? It is obvious that this depends on the nature of the immediately underlying ideas in the concentric circles, which now cease to be under the controlling power of the extinguished ideas, and are free to be externalised, on a random basis. In some cases we have a

manifestation of mania, while in other cases of melancholia, of delusions or even a mixture of all these.

Is there any reason explaining different clinical forms of pathological intellect in various individuals? To a certain extent we are able to grasp this difference by considering what occurs in normal condition. Certain individuals surround their intellectual manifestations with merriment, others with dysthymia. Merry ideas in the former, or sullen ideas in the others belong to the borders between the peripheral circles and those that lie underneath them and are ready, when the controlling ideas are missing, to be combined and externalised and be rid of all guidance provided by rational consequence and the timeliness of expression. We can understand (following this reasoning) that mania is manifested more in individuals with a merry character and the opposite for melancholia. In the depths of the intellect of these individuals there exists a sum of ideas. When these are left free, according to their content, the respective symptomatology is manifested.

[...]

According to established pathological physiology, all intellectual disorders, which superficially give the impression of an increased function, are due to a stimulating process, favouring an increased function of the affected organ beyond what is normal. Delusions, superficial hypermnesia, psychomotoric hyperactivity, euphoria, etc. can be ascribed to the stimulation of the connective centres beyond what is normal, i.e. an increase of their function. Logorrhoea is ascribed to the stimulation of Broca's gyrus. Some authors explain verbal hallucinations as a stimulation of the relevant centres for the image of words, in other words the centres of speech. General hallucinations are ascribed to stimulation of the cortical centres of various senses, namely

the projecting centres. A flippant evaluation of phenomena of abundance of ideas, hypermnesia, psychomotor hyperactivity, logorrhoea, the excessive merriment of a manic syndrome, contributed to consider them as a result of increased function of the connective centres. If one makes an effort to probe further, he will be convinced that it is not a manifestation of the function that these centres could be capable of manifesting in normal condition, but instead it is an apparent increase in function due to a diminution of function – if one is allowed to use such a paradox. Increase in function where normal components are missing, not only rational consequence and correct timing of manifestation, but also the full content.

I also, believe that localisation of hallucinations, proposed by some authors, in the centres of various mnemonic images of words and in projecting centres of the brain is unfounded.

The centres of various mnemonic images of words, i.e. the centres of speech, are, as we know, the foot of the third left frontal gyrus (Broca), concerning the motor structured images of words, the first left temporal gyrus, for the auditory images of words (Wernicke, Kussmaul), and the left curved lobe, for the visual images of words (Kussmaul). What, therefore, happens in any form of processing in these areas? In all cases, without exception, we will have a diminution or abolition of the relevant function of these centres, that is motor aphasia, deafness of words, blindness of words, but in no case has a lesion in these areas caused hallucinations. Furthermore, an ordinary form of hallucination has never been observed during any process affecting the cortical sensory centres, instead there is always a diminution or abolition of the corresponding function, in other words homonymous hemianopia, etc.

Indeed, these phenomena of apparent hyperactivity, are most frequently observed in diseases, which cause an aboli-

tion of cognitive forces, due either to their essentially destructive anatomical and pathological process or to their very nature, for example: general paralysis of the insane, cognitive disorders due to dementia, melancholic syndrome, mental confusion, etc. How, therefore, shall we be able to conceive delusions, psychomotor hyperactivity and hallucinations in these morbid conditions, on the basis of accepted pathological physiology? How, in other words, can we imagine an increase of function corresponding to anatomical/pathological processes which are by nature destructive, in senile dementia, in general paralysis of the insane, in a melancholic syndrome or in mental confusion?

The localisation of hallucinations in the centres of speech and in the cortical sensory centres has the following paradoxical, necessary, consequence from a semiology point of view, detaching them from the semiology of the connective centres. Accordingly, hallucinations should not belong to the semiology of cognitive disorders, being manifestations of a disorder of the speech centres and of the cortical sensory centres, and should be, rather, described alongside aphasias and hemianopia! The idea of localisation of hallucinations in these centres was not solely limited to theory, but instead there were also physicians who, faced with auditory hallucinations, considered that on the basis of established pathological physiology, they should intervene surgically and remove the irritated centre of the auditory images of words! Unfortunately, the results did not justify their hopes, but, even worse, these results have not helped to shake off the idea that hallucinations were localised in the above-mentioned centres.

However, we have the obligation to provide certain explanations. Cases do in fact exist, where hallucinations were observed, not only in lesions of these centres, but also in lesions at any point along the route taken by the sensory pathway; in fact we

have hallucinations coming from a very peripheral startpoint. Thus, auditory hallucinations have been observed due to injury of the ear, of the auditory nerve, and the cortical centre of hearing, while visual hallucinations due to injury of the eyeball, and the optic nerve: there are in fact two cases of hemianopia with hallucinations in the setting of an abolished visual field (Lamy, Fromhertz). It is easy to understand that these injuries, if they eventually cause the corresponding hallucination, do not do it by a stimulating process to the locus thereof, but due to the disturbance they produce to a specific sensation they direct the manifestation of the pathological intellect of the patient in the direction of this disturbed sensation.

Someone suffering from an injury of the ear may possibly present a hallucination, not because of the processing of the ear, which is not capable of bringing about an auditory hallucination, but rather because the knowledge of this injury turns the ideation of the pathological intellect of this patient towards the particular sensation which is disordered.

The fact that the content of hallucinations is in accordance with a pathological state of the intellect, proves that hallucinations derive from the connective centres. It follows that a hallucination should be considered as a delusional idea. It is therefore possible to observe auditory hallucinations in deaf and visual hallucinations in blind people. Under these circumstances, the lack of specific sensations (rather than stimulation), occupies the pathological intellect of the patient and points it towards the missing sensation, thus producing the relevant hallucination. Even these exceptional cases or rather coincidences, do not offer arguments (in favour of) localisation of hallucinations in the centres of speech or the projective centres or the periphery, but on the contrary greatly advocate in favour of their localisation in connective centres [...].

2. The essential disorder in schizophrenia.

(Le trouble essentiel de la schizophrénie)

L'Encéphale, Tome XXVI, Année 1931

Since Kraepelin undertook a synthetic description of dementia praecox, certain authors, observing that none of its symptoms could be considered to be the major one, started to search for such a symptom that might constitute a common basis for all symptoms of this disease. Impressed by the apparent preservation of certain parts of cognition and by the potential for cure of the disease, they conceived the idea that in dementia praecox there is no disorder of mental faculties themselves – cognition, affect, volition – but solely a dis-socialisation of these three faculties. Having it as a starting point, in order to describe the main disorder, they utilised expressions such as “psychic discordance” (Chaslin), “intrapsychic ataxia” (Stransky), “dissociation” (Anglade), “intrapsychic disharmony” (Urstein) and schizophrenia (Bleuler).

According to Kraepelin, the main disorder in dementia praecox consists of the enfeeblement of “general and abstract ideas, higher affects and the general directions of volition”, while the hierarchically lower functions of cognition are maintained. Weygand is consonant with Kraepelin when he talks about a weakening of the “perception of the object” (apperception), according to Wundt.

Kraepelin does not limit himself to these psychological explanations. He expresses the opinion that higher functions of the psychological triad (cognition, affect, volition) have their seat in the higher layers of brain's cortex, because, as he

says, the lesion of dementia praecox affects these higher layers almost exclusively. Kraepelin interprets the maintenance of the corresponding, hierarchically lower, functions of the psychological triad, through the maintenance of the deeper levels of the cortex.

E. Minkowski found these interpretations inadequate. He states that all these interpretations posit the idea that what is affected is not one function or the other, but far more their cohesion, their harmonious interplay. To use an image, the main disorder does not alter one or more capabilities, whatever their position might be in the hierarchy of the functions, but is located rather between them, in the interstitial space. He subsequently wonders under normal conditions “*which are those factors permitting the harmonisation of these capacities?*” This question has been asked and remains, for the time being, unanswered.

[...]

Finally, Minkowski uses Bergson's philosophical ideas (creative evolution) in order to resolve the problem. The concept of vital contact with reality is drawn from Bergson's philosophical ideas, which are summarised in the fundamental contrast between intellect and instinct. According to his point of view, vital contact with reality is related to irrational factors of life, in other words to the instinct; this loss of contact with reality constitutes the main dysfunction in dementia praecox. “Schizophrenics lose this contact, without their cognition being affected”.

Altogether, the above theoretical views can be summarized as follows: 1st intrapsychic ataxia; 2nd intrapsychic disharmony; 3rd psychic dissociation (schizophrenia); 4th psychic disharmony; 5th psychic discontinuity; 6th loss of internal psy-

chic unity accompanied by weakening of the higher functions of the psychological triad – cognition, affect and volition; 7th a weakening of the perception of the object (Wundt's apperception), similar to the previous; 8th disturbance of instinct and loss of contact with reality.

The first five of these views are based on the one hand on the existence of the psychological triad, i.e. cognition, affect and volition, as functions distinct from each other, and on the other hand on their maintenance, as the disorder does not concern one or more of these but is located *between them*. The sixth and seventh view, belonging to Kraepelin and the identical one of Weygand complement the previous ones, because they accept not solely that the main disorder in dementia praecox is loss of cohesion between cognition, affect and volition but, additionally, that there is weakening of the higher manifestations of each of these functions. The last of these views is based on the acceptance of the existence of the instinct, as a function different and oppositional and perhaps even higher than (the function) of intellect, since from the instinct is contact with reality derived, whose loss constitutes the main dysfunction in dementia praecox.

I shall attempt to find a solution to the issue of the main disorder in schizophrenia, on the basis of the ideas that I have exposed previously.

Beginning from the idea of the non-existence of mental localisations, I expressed the opinion that the mutual anatomical connection of the neurons in all directions was the only one possible.

On the other hand, I attempted to show that the psychological triad, the instinct and contact with reality do not exist as special functions different from cognition. In contrast I

claimed that the one and consequently indivisible mental function is cognition, while the other two components of the triad are nothing more than ways of existence of cognition. Cognition, both the higher and the lower, has its localisations in all psychic neurons, requiring the existence of histological and functional integrity of the sum of neurons and for this reason being their most unstable achievement. Furthermore, I claimed that the most essential character of the higher and more perfect mental function is that of rational association of ideas. To these points I must add one more, that the result of any disorder of mental neurons is a *hypofunction*, because, as I attempted to show elsewhere, disorders do not seem to be a consequence of *stimulation*, neither in the nervous nor in mental morbidity.

The conclusion can be drawn that as soon as any cause begins to disturb the function of the psychic neurons, the rational association of ideas will begin to weaken. It is obvious that the degree of this deficiency is related to the degree of the disorder.

I have reached the point where I can propose that *this insufficiency of rational association of ideas constitutes the fundamental disorder in schizophrenia*.

Any insufficiency in the rational association of ideas, concerning also consciousness and volition, allows the free expression of the remaining ideas, in other words, the ideas created by unaffected neurons and also by those affected, which continue to function even though imperfectly. The sequence and manifestation of ideas of still remaining functions constitute the symptoms of psychic morbidity. The remaining function is expressed clinically in various forms of mental disorder: in cases of limited deficiency in the rational association of ideas

(it is expressed) in the form of schizophrenia, manic-depressive psychosis, paranoia. When the degree of deficiency is more severe, the disorders are characterised by a deeper disturbance of cognition, such as states of confusion and dementia, which concern the more elementary forms of the psychism.

If we consider this gradation only from the point of view of pathological physiology, we shall not be surprised to observe states of confusion and dementia coexisting in the same group, whose difference in prognosis is due to other factors (in the former cases we have rectifiable procedures, in the latter cases not rectifiable and destructive procedures).

I believe that if we distinguish in schizophrenia, as professor Bleuler correctly proposed, the *physiogenic* (*physiogène*) from the psychogenic symptoms, the truly physical symptom (from which all these derive, including the decline of associations) is a deficiency in the rational association of ideas, which includes a deficiency in affect and volition. This is a *negative* symptom, in the sense given to the term by H. Jackson, or the deficient side of an affected personality. By accepting the term *physiogenic*, it would be useful to specify each of the remaining *positive* symptoms as *psychogenic*, because the remaining ability to create ideas produces positive symptoms and it is possible, at any given moment, to abandon one (positive symptom) and replace it with another. If, in another sense, we wish to consider the looseness of associations, the ambivalence, or autism as physical (*physiogène*), in the sense of loss of contact with the surrounding world, then, I think, that in specific cases we must consider all the other symptoms as physical. Setting aside the catatonic symptoms, which Bleuler names secondary symptoms, considering them at the same time to be *physiogenic*, I would say that even delusional ideas and hallucinations may be

considered as physiogenic symptoms, not solely because in certain cases they constitute the fundamental positive symptoms of schizophrenia, but also because they can persist for years as the apparently fundamental symptoms.

I think that it would be useful, concerning this question, to use an example from Neurology. In the case of a lesion in the pyramidal or extra-pyramidal pathway, the main symptom, the physical remnant symptom, is the inability to carry out normal movements, while the positive symptoms, i.e. the spastic syndrome and the hyperkinetic symptoms, are a manifestation of other untouched neurons, which are under the inhibitory control of affected neurons.

Besides the degree of a disorder, there is another reason explaining why the remaining ability to create ideas produces different clinical phenomena in different individuals. We should consider it the concept of the abnormal character; the concepts of Bleuler's schizoidia and Kretschmer's syntony, the active-affective dispositions and psychopathic complexes of Delmas and Boll.

E. Minkowski, speaking of the direction taken in research by contemporary psychiatry after Morel, by "reporting various clinical pictures to corresponding anomalies of temperament" cites Kraepelin (*Psychiatrie*, 8th ed, 1913), Sérieux et Capgras (*La folie raisonnée*, 1909), Dupré and Logr (*Les delires d'imagination*, 1911), Bleuler (*Mendelismus bei Psychosen, speziell bei der Schizophrenie*, 1917 and *Die Probleme der Schizoidie und der Syntonie*, 1922), Delmas and Boll (*La personnalité humaine*, 1922), Kretschmer (*Der Sensitive Beziehungsahn, Ein Beitrag zur Paranoifrage und zur psychiatrischen Charakterlehre*, 1918). I expressed my opinion on this issue in 1906.

[...]

Therefore, the diversity of clinical pictures can not be attributed to differences in pathogenic factors or differences in the nature of an injury, whether aggravating or destructive, not even to any difference in localisation in one or the other specific area, but to individual differences in the quality or quantity of erased ideas and the individual differences in the quality and quantity of production of the remaining ideas. On the basis of non-existence of aggravating injury and procedures, I had proposed the equivalence of manic and melancholic conditions.

From the point of view of pathological physiology, clinical entities are not, in and of themselves, real entities, but are instead syndromes. We do not want through this view to propose a vain attempt of extreme clinical synthesis. We must, first of all, remain clinicians, and must find, through analysis, the points differentiating the various forms of mental illnesses. We must keep in mind that all these mental illnesses are clinical manifestations of a single organ, with one function. Abnormal fluctuations of this function express, on the one hand the degree of its failure, and on the other hand the quality of its psychological content, i.e. of abnormal temperaments. If much has been said against synthetic concepts, as much can also be argued against “the tendency to drive the classification of mental disorders to extremes, which frequently leads to frighteningly sterile results” (Bleuler).

These syndromes are easily expressed as concepts, but sometimes are hard to distinguish in clinical practice. We have seen that we can diagnose these syndromes in two ways: on the basis of the degree of intellectual insufficiency and on the basis of pathological temperaments. If the psychological content of schizophrenia, manic-depressive psychosis, paranoia

is determined by the production of ideas of the corresponding temperament, this doesn't happen with the psychological content of conditions with a greater degree of intellectual deficiency, i.e. states of confusion and dementia. In these conditions, which affect the most elementary functions, including perception, memory, orientation, the production of ideas stemming from the previously existing personality disappears, to a degree that we can only contrive to find its traces in the present clinical picture, whose content is composed of incoherent ideas deriving from complexes, which in the past ran through lower layers of idea production, or through instantaneous impressions of the surrounding world.

Considering that neither the issue of the degree of insufficiency, nor that of temperaments have been clearly elucidated from a point of view of practice, we will set out the potential difficulties of this diagnosis. With reference to the diagnosis of schizophrenia (as a concept), Bleuler says that "it does not allow us to confuse it with any other mental disorder", but recognises "the manifestation of manic-depressive attacks with schizophrenic tones, the manifestation of schizophrenia presenting certain manic-depressive signs and the simultaneous co-occurrence of these two disorders".

Bleuler explains these cases through the *co-occurrence* of schizoid and manic-depressive factors of a constitutional character (Kretschmer's "alloys"). It would be more sound to consider these cases not through the co-occurrence of two temperaments and the disorders "of an entirely different nature", but as transient, intermediate conditions having the same clinical value with typical disorders. I think that Claude's schizomania, for example, can be considered an intermediate form between schizophrenia and schizoidia from the point of

view of degree of the disorder; it may also be considered as an intermediate form between schizophrenia and manic-depressive psychosis from the point of view of temperament and psychological content. Furthermore, I think, that if it is easy to say about a schizophrenic that he previously had a schizoid temperament, it is not so easy to foresee the form of psychosis that an individual of a given temperament will manifest. The remaining production of ideas may change, within certain limits, the texture of the pre-existing temperament.

Bleuler also stresses that: "It is even possible for certain manic and mainly melancholic states to be a direct manifestation of a schizophrenic process". On my behalf, I cannot but fully accept this proposal, but it will be difficult to reconcile this with Bleuler's other well-known aphorism: "schizophrenia is not solely a clinical entity; it is also an anatomical - pathological entity".

I have used without any distinction the terms schizophrenia and precocious dementia (*démence précoce*), due precisely to their physio-pathological origins and their common constitution. Having defended the common physiopathological origins of all forms of morbid production of ideas, I must furthermore accept the physiopathological identity of psychical phenomena belonging to the group of Bleulerian schizophrenia, not distinguishing amongst them anything but the degree of the disorder. However, from a clinical point of view, we must praise the efforts of clinical thinkers attempting to differentiate, within this conception of schizophrenia, clinical pictures probably useful to us (Claude). Kraepelin had already separated his *Dementia praecox* from the group of *paraphrenias*, which are characterised by minor affective and volitional disorders; the fact that two thirds of these patients became schizophrenic within a peri-

od of nine years, is not a sufficient reason to follow the proposal of W. Meyer to stop this distinction. Bleuler himself accepts that on the one hand “the clinical pictures of French psychiatry equally merit the name of clinical entities as schizophrenia and manic-depressive psychosis” and on the other hand he states that “we can maintain the previous concepts, such as catatonia, mental confusion, paranoia, delusional misinterpretation, etc., however, we have to consider them as sub-divisions of the new entity”. We agree with Bleuler’s critical comment to Claude, who, although supporting the duality of schizoses (schizophrenia, schizomania, schizoidia) vs dementia praecox, claims at the same time that “we do not refuse to accept that there exists a very large number of intermediate states and the main form of dementia praecox and schizophrenia may be considered as extreme forms of a single disorder”, it seems excessive, on the other hand to include in the clinical framework of schizophrenia, as Bleuler would like to, the delusional misinterpretation of Sérieux and Capgras or Kraepelin’s paranoia.

We can draw the following general conclusions from this treatise:

1. The only possible association of the mental neurons is their mutual association in all directions.
2. The only function of mental neurons is cognitive. The other capacities of the triad, namely affect and volition, are not separate capacities but modalities of the cognition.
3. The most perfected expression of cognition, its highest function in the cognitive hierarchy is the rational association of ideas.
4. The fundamental and substantial dysfunction in schizophrenia is the disorder in rational consequence of ideas, with its components arising from affect and volition.

5. The same disorder of the rational consequence of ideas is at the basis of manic-depressive psychosis and paranoid conditions. In its less severe forms, this disorder constitutes the basis of psychasthenic conditions.
6. The physio-pathological character of this disorder always diminishes a function, both in schizophrenia, and in any other clinical symptom in psychiatry.
7. Schizophrenia is the group of clinical syndromes characterised by the orientation of the remaining production of ideas, in accordance with the direction of the temperamental psychic characteristics, which are grouped together under the name of schizoid temperament. Manic-depressive conditions are characterised by the orientation of the remaining production of ideas in accordance with the direction of the cyclothymic temperament. Paranoid conditions are characterised by the orientation of the remaining production of ideas in accordance with the direction of the paranoid temperament.
8. Schizophrenia/precocious dementia, as well as every other clinical condition, is not due to a localisation of a lesion in a specific region. The change (material or functional) of any area or layer of the mental anatomical elements may cause one or the other clinical syndrome.
9. If we intend to distinguish physiogenic from psychogenic symptoms in schizophrenia (I believe that we can make this distinction in all mental disorders) the only truly physiogenic symptom, all others arising from it, is the inadequate rational association of ideas (which also contains the insufficiency of the affective and of the volitional ideas).

[...]



Constantin (von) Economo (1877-1931)

1. On a new perspective concerning the pathogenesis, diagnosis and treatment of progressive paralysis *Über eine neuere Gesichtspunkte zur Pathogenese, Diagnostik und Therapie der progressiven Paralyse**

Wiener Medizinische Wochenschrift, 34, 2094–2100, 1913

[...] Schaudinn's discovery of *Spirocheta pallida* made it necessary to reconsider all old views concerning the pathogenesis of progressive paralysis. While previously [...] it was generally accepted that (this paralysis) was not a syphilitic, but a post-syphilitic disease (i.e. its manifestations were not ascribed directly to the supposed syphilis microbe, but to the toxic substances that are produced by it, or to the tissue damage and chronic disruption of metabolism it causes) the eventuality has once more begun to be investigated [...] that these Spirochetes are the direct cause of general paralysis. The regular positive Wassermann's reaction in the blood of paralytics advocates for this view. [...] However, despite the fact that spirochetes are sometimes found in neurosyphilis, up to now research for spirochetes in general paralysis was futile.

* Translation in English from the Greek translation of the text.

In February of this year, a report was made that Noguchi [...] had located, both in paralysis and in tabes dorsalis, spirochetes within the parenchyma of the central nervous system (not in spiral form, but) in the form of small granules. [...] These new findings, if verified by later studies, propel us ever more towards accepting [...] a cycle of the syphilis microbe, that would explain its fluctuations, both concerning the clinical pictures produced by it as well as its response, to medication. We are led to similar results by experiments in vaccination with extracts of dead spirochetes or organs rich in dead spirochetes, producing so different reactions (*on syphilitic patients*) in various stages of their disease [...].

(Concerning diagnosis) one can conclude, with great probability and in fact relatively early, the existence of paralysis, by a positive result in [...] four reactions (*Wassermann reaction in the blood, Wasserman reaction in the cerebrospinal fluid (CSF), increase of globulins and polycytosis in the CSF*). (However) the intensity of the result [...] does not indicate any steady proportional correlation with the gravity of the disease, and their quantitative evaluation during therapeutic interventions does not allow safe conclusions concerning the general effectiveness of these interventions. Moreover, treatment seems to affect these reactions and specifically the three CSF reactions. (*In contrast to the Wasserman reaction in the blood*) treatment applied for paralysis generally lessens the reactions in the CSF. These results were achieved with methods introduced [...] by Wagner von Jauregg (tuberculin, treatment with staphylococci and streptococci).

It is now rather well known that Wagner von Jauregg commenced from the observation that fever and abscesses in paralytics sometimes led to remissions, to arrest of its progress, and even, in some cases, to the cure of the disease. Using this therapeutic method, paralytics were treated with injections of

tuberculin in order to induce fever. [...] Treatment with tuberculin, and in particular a combined treatment with tuberculin and mercury, induces a decline of the disease in approximately 50–60% of cases, even though these are usually well selected cases. [...] The degree of fever induced seems to have had some correlation to the improvement. [...] Somatic symptoms such as non-responding pupils and abnormal reflexes in general do not present any amelioration [...]. Speech disturbances, however, often improve amazingly and may disappear entirely. [...] In some cases, a form of anaphylaxis appears, as patients develop an ever-increasing sensitivity after each injection, manifesting a higher fever. These cases indicate a somewhat better prognosis concerning the success of treatment. [...]

Starting from the idea that it is not the fever leading to an abatement of the progress of the paralysis, but rather the leucocytosis of the blood, methods causing leucocytosis are being tested. [...] Reports indicate the results to be quite good. Reports on using this method show that 50 to 60% of cases show a remission. [...]

More recently, Wagner von Jauregg experimented with injections of inactivated staphylococci and streptococci, based on the idea that in those cases of paralysis cured by erysipelas or abscess, the beneficial influence may be carried out by toxins from the pyogenic bacteria or by antitoxins. [...] The older view that only manic paralytics improve with this method of treatment has been abandoned. However, these patients have better prognosis, even though we have achieved very good results with other patients as well. Some of them became sociable again, while others relapsed. One case treated with streptococci showed a remission for two years, during which although a slight dementia has remained; yet the disease has never since progressed at all.

2. Sleep as a problem of localisation

The Journal of Nervous and Mental Disease,
vol. 71, 3, 1–5, March 1930

The search for a so-called sleep centre seems to be a paradoxical idea. [...] Our entire life takes place in the alternating course of two biological conditions, the waking state and the sleeping state, and in this way the problem may appear primarily of the same category as the problem of the centre of life itself. [...] However, if we agree that the expression “nervous centre” signifies only an accumulation of nervous grey matter, the action of which is of direct, primary importance for the production of a definite function, we might nowadays again discuss the possibility of locating sleep regulation in a specific part of the nervous system, since we know that even a so complicated biological function as our body’s temperature has got a very definite and localised regulating centre in the diencephalon.

The extinction of consciousness, the most striking symptom of sleep of man and of higher animals, appeared until recently as the essential characteristic of sleep and as the only one which demanded explanation. [...]

All these theories of sleep which assume an interruption or a blockage of conduction of stimuli to the cerebral cortex as the essential character of sleep, can be grouped together under the name “Theory of Lack of Stimuli”. [...]

However important the clouding of consciousness might be, theories of lack of stimuli did not offer, either in the past or in the present, a satisfactory explanation for the following reasons: (1) In cases of sopor, a disturbance of sensation and

of tonus cannot be demonstrated, so that in these patients the interpretation of conduction to and from the brain cannot be, in itself, the cause of the change of their conscious state. (2) If the blockage of conduction was brought about by the periodic change of a congestion or an anemia of the central ganglia or by recurrent sleep edema or by the retraction of dendrites of the cells, the very cause of this periodical daily return of these phenomena would still have to be explained. (3) The inter-change of consciousness and unconsciousness is not the essential character of sleep but only one of its important symptoms.... (4) Animals without cerebrum and anencephalic monsters lack not only the cerebrum but, to a large part also the periodic change of sleeping and waking. (5) More recent evidence indicate that sleep changes most of the organic functions in some way or other, not only by affording them rest, but also in a qualitative manner, a fact suggested by the change of the sugar and calcium content in blood, the narrowing of the pupils, the Babinski phenomenon and other symptoms.

[...]

Many other attempts of finding an explanation for sleep in one or the other of its important symptoms are afflicted with the same one-sidedness, for instance the vasomotor theory of Mosso, the anemia theory and other. They again do not first of all explain the essential character of sleep and its periodic change but only one symptom although we agree that vasomotor symptoms surely play a very important role in the production of sleep.

[...]

Others have been able to prove that nerve cells after exhaustion have a changed histological appearance, especially with reference to their tigroid discs and nuclei. It is therefore

very plausible that the absorption of cell substance by activity during the waking state leads to a progressive decrease of the excitability of the cells and finally to sleep. [...] The best of the chemical theories is that of French physiologist Piéron. [...] The blood serum of dogs, which had over-exercised for several days and were not allowed to sleep, produced prompt sleep when injected into healthy dogs, which had had sufficient sleep. That proved that fatigue produces substances in the blood which may provoke sleep. [...] They are nerve toxins which the author called “Hypnotoxins”.

[...]

This fact can be deduce from many considerations of which I shall mention only the two most apparent: (1) Sleep is initiated in many cases without fatigue as we may assume from the naps after meals. (2) Furthermore, the most striking characteristic of sleep, the possibility of being aroused (we call it reversibility of sleep), shows that sleep does not represent a mere narcotic action. [...] During the action of narcotics, for instance during narcosis, this complete reversibility does not exist. [...] Also the other pathological conditions of unconsciousness which may be very similar to sleep, for instance, fainting, coma, cerebral concussion, agony, etc., do not show this reversibility, a characteristic only of normal sleep.

[...].

To explain the periodicity of sleep, two Italian authors, Mingazzini and Barbara assumed that this change is brought about not so much by fatigue substances as by endocrine processes and their action on the vegetative system.

[...] While all the other theories previously referred to tend to seek the cause, as well as, the essential character of sleep in

the elimination of the activity of the nervous system –which is not right as we can see by the fact that sleep is occurring also in plants that lack any nervous system– Mingazzini's quite original thought of explaining the periodicity by a balancing change of activity of two groups of endocrine glands, represents really the first attempt of showing sleep to be a state not solely concerning the central nervous system.

[...]

In fact, most scientists, both physiologists and internists, are fully satisfied with these explanations of sleep. The original attempts to locate sleep function were looked at as obvious. Though some curious clinical facts were known, for instance, the occurrence of sleep as a frequent symptom in cases of tumor of the infundibulum and were specifically mentioned by Claude and Lhermitte, yet Lhermitte himself stated in 1910, during the discussion of narcolepsy, "We absolutely object to the thought of the existence of a specific nerve centre for the function of sleeping". [...] and Dejerine stated in 1914: "Sleep cannot be localised".

So stood the facts when two years later the appearance of lethargic encephalitis, which I first described in 1916–1917, refuted all these statements, however well founded they appeared to be. Lethargic encephalitis, in its most common somnolent-ophthalmoplegic form, manifests as its most striking symptom, in addition to the disturbance of the eye muscles a sopor of varying degree, ranging from simple somnolence to the deepest sopor in which the patients may sleep for weeks and months, but from which, in the majority of cases, it is possible to arouse them. The disease is produced by an inflammation of the central grey matter localised mainly in the cap of the *interbrain (diencephalon)* at its junction with the thalamus.

The inflammation may spread frontally and caudally to other parts of the nervous system and produce other symptoms.

[...]

Lethargic encephalitis produces, furthermore, in addition to insomnia and sopor, a great number of other disturbances of sleep, for instance, the inversion of sleep, i.e. the reversal of the periodicity of sleeping and waking, patients sleeping in the day time and being awake at night. Another very frequent sleep disturbance in encephalitis is what I call the dissociation of cerebral and bodily sleep.

[...].

The consideration that diseases of such diverse nature can always be productive of sleep if they occur in this region of the nervous system, proves the correctness of the statement that not the individuality of the diseases as such, but its localization at this very definite area of the nervous system is decisive for the occurrence of sleep. Inasmuch as furthermore in lethargic encephalitis sleep is disturbed in such various ways as somnolence, insomnia, inversion of sleep, interruption of sleep, etc. we have additional proof that we must consider this region of the grey matter as the site from which sleep can be primarily and directly influenced. This area is therefore selective for the function of sleep and as in more than 85% of the cases of encephalitis several troubles of the sleep function occur, we must suppose that the virus of encephalitis has a special affinity to these accumulations of grey matter which are of special importance for sleep and which I designate as the “center for regulation of sleep”.

We must insist on the anatomical detail that the centre for the regulation of sleep is in the immediate vicinity of the

other important vegetative centres located in the infundibular region and we can suppose that it forms with them a larger physiological entity. Yet, it is distinctly separated from the other vegetative centres (not only) by its localization but also by its chemical affinity, as its affinity to the virus of encephalitis proves.

[...] The action of this centre for sleep regulation probably consists in a co-ordination of the different changes which occur in sleep in our vegetative, animal and psychic system. As to the psychic system, the centre for regulation of sleep has the role of initiating the cerebral sleep, which, as we know, is characterised by partial extinction of consciousness and by the difficulty of conduction in the brain.

[...] (*Pavlov's experiments*) suggest that normal cerebral sleep may be considered as an inhibitory action brought about by the centre of sleep regulation upon the cerebral hemispheres and the thalamus. [...] This way of action by nervous inhibition explains also the capability of arousal from sleep, as well as many other particularities of normal sleep much better than the theories of anaemia or the chemical theories because in chemical and vasomotor states such sudden changes do not occur.

In addition to its effects on cerebral functions, the centre of sleep certainly exerts a regulatory influence, as previously mentioned, on the other vegetative and biological components of sleep, which we can call "bodily sleep", for instance the change of respiration, perspiration, metabolism, etc. This influence is exerted directly on the neighbouring vegetative centres, as for instance the centre of temperature, the centres for sugar and calcium content of the blood, the centre for regulation of water metabolism, etc. the centres of (these func-

tions) are located in the subthalamic region and in the wall of the third ventricle and they all change during sleep.

[...]

Now we must put forward the question of “what sets the regulation centre (of sleep) in action?” It seems most plausible to admit that this centre is ordinarily and normally set into action by fatigue substances which circulate into the blood, yet in amounts insufficient to bring about intoxication... In this sense, the statement of Claparède that we sleep not because we are intoxicated by hypno-toxins but in order to prevent intoxication by them, is probably quite correct.

[...]

We may then assume that the localized mechanism we postulate, for the supervision of sleep really exists and we must find the best way to localize it. Our experience with cases of lethargic encephalitis and other infundibular processes shows that somnolence may occur in these diseases as an isolated symptom and that it is associated mainly with paralysis of the eye muscles, especially with ptosis. This corresponds to the most frontal part of the nucleus oculomotorius, so we must place the posterior border of the centre for sleep regulation immediately in front of the nuclei of the eye muscles in the grey junction of the interbrain and the thalamus where the aqueduct of Sylvius opens into the third ventricle.

[...]

The problem of more exact localization could only be solved in a conductive way by physiological experiments. [...] Hess in Zurich succeeded in making cats fall asleep normally with all symptoms of fatigue, of yawning and position of rest, by electrical stimulations with very fine electrodes introduced

into the brain and by very weak currents which acted upon the anterior region of the aqueduct and the posterior wall of the third ventricle. If these results are verified in the future, irrefutable proof is furnished for the correctness of our conception of a centre for the supervision of sleep situated at the junction of the thalamus and the interbrain from which sleep is actively initiated.

[...]

Now you may think that what I have stated about the existence of such a regulating centre for sleep is a very interesting physiological fact, but you will ask for the practical consequence of such a statement. I will first point out to you that all knowledge of localization has a practical effect inasmuch as it helps us to localize different diseases, for instance tumors, and helps us to get at them practically in a curative way. You know that we are ardently seeking to find methods to stimulate externally either by electricity or by rays or by diathermy through the skull, the centers of our nervous system with the intention of producing a therapeutic effect. Some initial results have already been obtained in that direction by diathermy. Imagine that sometime in the future we may have an effective method of influencing deep lying centers. In this case, the exact knowledge of the localization of the center for sleep regulation which I have attempted to give you, would make it possible to treat insomnia and other sleep disorders in a better and more active way than hydrotherapy and psychotherapy. Let us hope that we shall soon be able to have such results.



Constantinos K. Tsiminakis (1875–1942)

Contribution to diagnostics of epilepsy (Συμβολή εις τήν διαγνωστικήν τῆς ἐπιληψίας)

Presented at the Athens Medical Society, in April 1914

Published by ed: I. Vartsos, Athens, 1915

In scientific research related to the pathogenesis of epilepsy, there are widespread references to vasculomotor disturbances in the brain, either as a cause of epileptic paroxysm or as a precursor of such an attack, or as a syndrome or a sequel thereof.

[...] Hughlings Jackson considers that, in most cases, the first functional alteration in epilepsy is of a circulatory nature and that cellular excitability is the result of occlusion of very small arterial branches.

[...] Kussmaul and Tenner drew the following conclusions from their research on experimental anaemia of the brain:

1st. The cause of epileptic attacks lies in a transient functional dysfunction and not in an anatomical change.

2nd. This functional disorder of central innervation is potentially a result of stimulation of vasculo-motor centres of

the medulla oblongata. This pathological stimulation causes anaemia in the cerebral cortex (loss of consciousness) and the motor centres of the midbrain (convulsions).

Northnagel [...] considered that the starting point for loss of consciousness and convulsions is in the medulla oblongata and the pons and that during an epileptic attack the vasculomotor centre is stimulated, resulting in cerebral anaemia (loss of consciousness and concomitant stimulation of the spastic centre)

Bechterew [...] concluded that: circulatory dysfunction of the brain resulting in the stimulation of its cortical centres are the primary cause for an epileptic seizure [...].

By reviewing the above experimental, clinical and other research, which was summarily outlined, indicating vasculomotor dysfunctions during epileptic attacks, we cannot draw a positive conclusion concerning the state of cerebral vessels before an epileptic seizure and during convulsions. [...]

From the experimental and clinical research conducted to date [...], it becomes obvious that neither instantaneous hyperaemia, nor cerebral anaemia can be the cause of epilepsy, but rather an epileptogenic alteration located at any point of the brain (possibly in its cortex). [...] Random stimulation, external or internal, may cause the onset of an epileptic seizure, producing of course instantaneous dysfunction in the epileptic focus. Circulatory dysfunctions are usually the causes of these functional dysfunctions. This idea led me to conduct this research: by causing sudden anaemia of the brain and a consequent circulatory dysfunction, would an epileptic patient be subject of an epileptic seizure? [...]

We applied pressure on the carotid arteries in thirty, selected, healthy subjects aged from 18 to 30 years of age. We never prolonged the pressure beyond one minute; always relieving

it as soon as consciousness was lost, both in healthy and subjects suffering from epilepsy. All healthy subjects took a time period longer than half a minute to lose consciousness, returning to their previous condition immediately after pressure was relieved, without leaving any remnant of confusion, only dizziness of short duration. Once the person was unconscious, no convulsion was observed, only complete relaxation of the entire muscular system, with the head falling suddenly onto the shoulders and the body falling sideward or backward. [...] Some years back, we conducted a research where we applied pressure on the carotids of 86 epileptic patients, who suffered from various types of seizures. [...] All patients, whose carotid was pressed, lost consciousness more rapidly than healthy subjects. [...] The loss of consciousness was followed in some patients by a general state of convulsions, in others convulsions affected half the body, in some cases a larger or smaller portion of the facial muscles was involved, whilst in others these were not involved. [...] This state of convulsions lasted for approximately ten seconds to thirty or, at the most, forty seconds, followed by confusion and a characteristic vacant expression, as observed in many cases of attacks of epileptic absence.

[...]

To what extent the results of our observations can contribute to the research on the circulatory dysfunctions occurring in the brain ... will be confirmed solely by experimental research on epileptic animals (dogs, etc.). [...] From a diagnostic point of view, I believe that these results undoubtedly contribute both to forensic medicine and to army enlistment (as they may help) to distinguish true epileptics from persons feigning epilepsy.

[...]

Manolis Triantafyllides (1883–1959)

The origin of language and Freudian psychology (*Ἡ ἀρχὴ τῆς γλώσσας καὶ ἡ φροϊδιανὴ ψυχολογία*)

*Δελτίο Εκπαιδευτικού Ομίλου (Educational Group
Bulletin), vol. 5, 1915, Nr 3–4, 219–231*

(i) Theories on the creation of language. (ii) Freud's System of Psychology. (iii) The beginnings of language according to Freudian psychology

[...]

For a long time the main subject of “language philosophy” has been how language was born among primitive people, how the first words were used and how were these formed. This problem, albeit dismissed as idle metaphysical research by the positive and fructuous work in the field of linguistics over the last forty years, always remains as one of the most attractive topics to be discovered through studying language, for both experts and laymen who seek to lift a corner of the dark veil shrouding the problems of human life. From the depths of

history, comes the naive narration of Herodotus on Psamtik, who, in order to ascertain which language was spoken first, gave two newborns to a shepherd to be raised far away from human speech, until their first word –*vekos*– was heard and the Egyptian king verified that this was the word for bread in Phoenician language. Equally, in recent years a language researcher shut himself in a cage with monkeys, in Africa, in order to study the first traces of human language in these backward brothers of mankind.

In Plato's *Cratylus*, viewpoints on the origin of language were succinctly postulated, articulated later with respect to the origin of language, in the discussion on whether language exists by nature or nurture (*φύσει ἢ θέσει*), in other words whether language came naturally or was an arbitrary invention of mankind. In recent years the following theories have been formulated on the origin of language:

A. Language was *given* to man by *God*. This explanation was based on a literal interpretation of the Old Testament, although in plumbing its depths one realizes that it is not an explanation, but rather the negation of all explanation, and simply transposes the problem outside of human consciousness to metaphysics.

B. Language is a human *invention*: Some outstanding people discovered and utilised symbolic sounds. This was a favourite theory in the 17th and 18th century, but this theory also contains a miracle: God is substituted by a few people, who in the absence of language initially, suddenly decided arbitrarily to create the first words in order to communicate.

C. At the end of the 18th century, Herder's treatise was published on the origin of language (1772) and thereby a

more convincing theory was put forward, known since the Stoics, the theory of *onomatopoeia*, the preferred explanation with the greatest number of proponents: The first vocabulary was a collection of sounds abounding in nature; the first language was an imitation, direct or indirect of the impressions produced on our senses (termed *similarity and proportionality* by the Stoics). Even today, we can see a simple man identify the object by the word expressing such object –i.e. the dog is *called* dog because *it is* one– and onomatopoeia is a phenomenon which continues to exist in modern languages for concepts that signify noise or motion. Thus, in the Greek language we have: *hahanizo* (cackle), *kakarizo* (crow), *tsitsirizo* (sizzle), *tsirizo* (squeal), *mougrizo* (moo), *gavgizo* (yap), *tour-tourizo* (shudder), *houhounizomai* (cuddle), *gourgourizo* (gurgle), *gargara* (gargle), *kritsanizo* (crunch), *houhoulizizo* (breath on), *boubounito* (boom of thunder), *bakakas* (frog), *gargaros* (gurgling), *fapa* (whack), *katrapakia* (wallop). New onomatopoeia can likewise be found in baby language.

D. Finally, the *exclamatory* theory, whose first advocates were the epicureans and Lucretius: Language was born from involuntary reflexive phonemes enunciated by natural man on seeing various objects, when experiencing passionate feelings, without intention to announce something specific – at least not in the beginning. A dog cries out differently if we hit it and differently when it is happy; this theory, according to the phylogenetic principle of Haeckel, is confirmed by the cries that babies utter before talking (Rousseau). According to this theory, the first words were verb roots signifying action or conditions, though, of course, their phonemes were not asso-

ciated to their meaning by an innate need (Geiger 1868), as for instance tears or laughter express our psychic state.

Critics expressed many reservations on the last two theories, which are in fact the sole theories with any merit today. Although Paul recognises the significant position of exclamatory *onomatopoeia*, Wundt raised significant objections. Wundt considered that sound is not a primitive function of consciousness, but rather a secondary phenomenon and consequently, as sound necessarily precedes the motor function of the vocal organs, thus, for example, the concept of thunder cannot be directly correlated to the motions made in pronouncing the word. Indeed, the *exclamatory* theory presupposes that initially language was born from random cries while performing work together (Noire), therefore reason existed before language. Even *children's language* can be used as a proof, for instance it is important that children's representations are still vague and the words employed by children have a restricted and a broader meaning, e.g. quack=duck (in water), as well as water (without the duck), or a specific duck. We should not forget that a child learns a language mainly from the mother, nanny and others, adapting the vocal faculties to whatever, imperfectly, sees and hears.

The general conclusions to be drawn are more or less the following:

1. In order to find an explanation we can only use the linguistic and psychological preconditions of modern man, without assuming that in those bygone times the entity of man was different.
2. Linguistic creation has never been absent until present times.

3. The first language was born without any intention to make pronouncements. This was added subsequently, although without the intention of making language the permanent instrument of communication.
4. The first words were uttered in an emotional state and expressed the desire for something.
5. The origin of language will be better comprehended –according, mainly, to Wundt– if, in line with the evolutionary perception, we understand that language is an expressive movement, and if we examine language in conjunction with other similar movements expressing the state of man’s psyche (as in Wundt’s view, expressive movement and affect constitute the same physiological phenomenon). Every feeling abates through its impact on the body-reddening, paling, pulse, hand motions, facial mimetic motions. The instinct of transmission was slowly born in conjunction with mimetic motion.

For this reason, there are no distinct borders between linguistic and pre-linguistic times. The evolution of human consciousness is mirrored in the evolution of expressive movements, mimicry and language; and at all levels it expresses representations, feelings, thoughts through appropriate expressions. Language, “an expressive movement at all levels of its evolution, stems from the totality of expressive movements, as a part thereof, distinguishing every vital impulse”. Consequently, the problem of its initial creation is limited to the following: how did those expressive movements available to humans, given the level of consciousness they possessed at that time, become the phonemes and symbols of our thought content. Apparently, the precursor to the language of phonemes was mimetic lan-

guage, which, even at present times, can sometimes accompany our language or is even the exclusive instrument of expression. Therefore, we must assume that the main aspect of the first era of phonemic language was not sounds, but rather the vocal motions that gave rise to sound, which were part of the mimetic movements of the hands and the rest of the body. These motions were simply *indicative* (e.g. a hand on the ear, eye=hearing, seeing) or mimetic and *descriptive* (e.g. moving lips=eating, talking) or, in a more advanced evolution, *symbolic* (e.g. showing my heart=loving). Subsequently, the disjunction between phonemic and mimetic languages occurred, phonemic language became independent and phoneme became directly related to the representation – whilst in the beginning the phoneme was part of the mimetic expressive motion, and the corresponding affect consisted of representation and feeling. Thus, with its aforementioned intent, the language of sound triumphed in the end and the first words had the meaning of entire sentences, similarly to mimetic configurations. What we presently term as “words” is the product of an even longer evolution.

This was a short overview of the ideas predominating in the circles of specialists on the origin of language. A new research, *psychoanalysis*, established by professor S. Freud, attempts to shed new light on this problem. Needless to say it would be too much to give here a comprehensive account of the Viennese professor’s psychoanalytical theories as these were formulated over the last twenty years (1895–1914); nonetheless, I consider it propitious to say a few words about them, because the Greek public is not familiar with them.

Freud, by studying and treating certain nervous diseases, psychoneuroses, slowly but surely established a system of psy-

chology that seeks to explain, out of psychopathological considerations, the psychological mechanism of man. Indeed, recently an increasing number of scientists have joined the Freudian school, which seeks, in accordance with Freud's method, to shed new light on all intellectual sciences, folklore and law, art and religion, pedagogy and language.

The first premise of psychoanalytical theory is that in every person's psyche various subconscious representations and emotions are hidden below the consciousness, not with the meaning attributed to the subconscious by other systems and philosophies, but rather as a content that is inaccessible to us, that we ourselves resist to it should we by chance try to see inside us or come face to face with it, since it appears strange to us and cannot be reconciled with our conscious being.

The key to the subconscious was found by psychoanalysis, driven by the burdensome and invective symptoms of neuroses, which frequently contrast greatly with the conscious part of the sick psyche. The key is –the same as for healthy people– dreams, artistic creations, parapraxes of everyday life (e.g. saying one thing instead of another, remembering something incorrectly, forgetting what is correct, becoming distracted and doing one thing instead of another, etc.) All these symptomatic manifestations of the unconscious –which the conscious cannot explain– are correlated by psychoanalysis (“psychology of depth”) with inner subconscious volition and with remote motives, which, according to an unavoidable psychological determinism, link every manifestation of our psyche. Thus, Freud sought to shed light on the most intimate texture of the human psyche by defining hidden *complexes*, which in his view constitute the main motives for every psychological

action. These are the most important elements of representations that were joined into groups over the first years of the child's psyche, and they have been superconstructed therein with great amounts of affects (love and hate).

Thus, our psychological being, since its shaping as consciousness, undergoes a *repression* (Verdrängung): a part of our first impressions and first contents of consciousness is forgotten and lost. According to Freud, repression is due to the fact that at the beginning of our psychological life we encounter a world of confrontations – our world and the outer world, the egotistical and the familial-social, the natural and the civilized world. Every desire of a young child comes into conflict with the child's other desires and moral and aesthetic domains gives rise to discomfort, while the representation, associated to it, is repressed under the conscious. Indeed, the stronger the first egotistical and anti-social impulses are in the psyche of a child, the more intense is the initial appetite for life (*libido*), the greater the demands of obedience and ethics, imposed by familial education in the name of society and civilization, the harder the adaptation of the child to the demands of the outer world, the more radically every representation and every emotion incompatible with conscience of a civilized person, in educational process, is erased from memory –hereditary temperament is not taken into consideration here– and the greater the *resistance* that will appear if some of them are to become conscious again.

The repression of these primitive drives, which remain forever hidden and undisclosed, but continue to exist and to seek manifestation, is a great source of our entire civilization. The repressed animal drives, transformed by education, civilized,

sublimated (sublimiert), will be used in spheres where conscience can accept them without conflict, in art and science or –if their “sublimation” is not achieved– will drive a person to illness.

According to Freud’s theory, exceptional importance is placed on the repression occurring in children’s upbringing during infancy and mainly the repression of *sexual* drives, as these are the first ones channelled and limited by civilisation and a large portion of its power is based thereon. Naturally, in the first years of childhood the term of sexual life must be understood in the broadest sense, like something encapsulated in a germ, on which further development depends and when manifested in a young child has an autoerotic character –as posited and proven by Freud– in contrast to what happens later on. Thus, contradictions of life causing conflicts and psychological splitting in a person from early on, also provide him with the most important sediment in the depths of his psyche, that will enrich his life.

If we were to consider that the character of a person is only the “façade” of something much more complex, that we can unveil and study with the help of psychoanalysis, like impressions and affects hidden in the deepest layers of the backstage of the psyche, then we will understand the great assistance that this research is called upon to give to pedagogy.

These ideas of Freud have not yet really overcome the stage of polemics, nor are they interpreted in a similar way by numerous proponents of the Freudian school. Nonetheless, even if we do not attribute to them an absolute value aspired by the Viennese professor, they contain truth and importance. Their application in pedagogical issues was frequently under-

taken in Germany and Switzerland. First, the series of the new Meumann-Messmer pedagogical collection was inaugurated with a work dedicated to the systematic description of this method. In order to “aid the application of psychoanalysis to intellectual sciences” *Imago* was established, a German journal having Freud as editor. It was in this journal that were published, among many other studies shedding light on the folklore and linguistic issues, two studies on the first linguistic creation, which inspired this treatise.

The ideas of Sperber, a philologist, on the origin of language can be summarised as follows:

To say that a language is born, it is not sufficient to have a voice, but this voice must be useful for a person in order to express some psychical content to another. A cry upon being heard is nothing more than a cry of pain, nonetheless, it becomes a language upon the moment that we cry out for help. Almost all those persons who have investigated the problem of the origin of language, have sought to discover the way the ancient vocabulary was formed, the first words, e.g. how certain phonemes were associated with certain concepts. Yet, we would come closer to the truth, if we were able to experience *the terms that helped in creating language*.

Language was born, according to Sperber, since the moment that a person ignorant of language, who possessed a voice, noticed that sounds he made in moments of passion (emotion) without any particular purpose, could affect the actions of persons around him. From that moment forward that person possessed a language: he would shout in order to cause other people to react. To do it, the following conditions were necessary: at least two persons were required –one of them

experiencing an outburst, an affective state; there needed to be certain conditions that made the second person react normally to the voice of the former— this would be the desired reaction on behalf of the first one; a similar scene would have to be played out often; it would have to remain always the same and would have to be simple.

Of all the scenes that could be presented to the primitive people, or rather the beast people of antediluvian times (e.g. while hunting or when attacked by a wild beast), two correspond better to the above conditions, particularly the latter: a hungry infant crying for his mother to give him food and the impulse of a man seeking a woman. The mother-child relationship naturally explains the origin of language in a person, although it cannot explain the first beginnings of human language; in fact, children learn their language from adults. Therefore, it is in sexual life that we will find the origin of language, as well as so many acquisitions of civilisation, and the first word was related to sexual invitation.

Thus, the known linguistic maxim that a language reflects the civilisation of the race and concurrently makes it richer, would have been applicable in those prehistoric times. The first word evolved only after families were formed, continuous coexistence and a certain civilisation were established. The absence of a specific season for orgasms, the establishment of families and many other restrictions associated with animal impulses, occurred in parallel with the invention of the first tools for the first tasks. The imagination of those people, who started becoming civilized and created civilisation, was charged, in parallel with “sublimation” of primitive impulses, with “repressed” prohibited representations. Accordingly, they

sought to relieve these by working at tasks hitherto unknown. While working, they accompanied their work with exclamatory expressions, which were the first words of civilisation, as the result of their familiar use, offering also a counterbalance to their imagination.

Even today, we can see that this theory is justified, as many words in known languages are related to tasks of primitive people (ploughing, making tools out of hard material, lighting fire) or to names of relevant tools. We must think on the fact that primitive people lived in nature and thus it was easier to draw parallels with life in nature. These exclamatory words uttered during work with dual meaning, were used subsequently to exclusively denote the task.

Why did they not use the same sexually related word for all types of tasks, but rather invented so many different words? We must dwell on the fact that for a new task, a new tool to be invented, hundreds or even thousands of years were required. Meanwhile, the first word was related to the first task, which even prepubescent youngsters would use; and having to assume some psychological orgasm for the invention of each new task, much stronger than orgasm necessary for the old and familiar one, it is natural that they did not “transfer” the known word to the new task, but rather that they used, like the first time, a new exclamation, known from the life of love. Thus the first roots, for various primitive tasks, with different phonemic composition –born in various parts of the world– all had the same first meaning.

This theory explains better than all others the birth of language, correlating it to the first tools and their use, presenting first people labouring at a common task and having the

opportunity to frequently re-use these first linguistic elements. Moreover, it sheds copious light on a folklore phenomenon, which is otherwise difficult to explain: the faith in the magical force of language which is sufficient to give power to a person by pronouncing his name. This is easier to comprehend if we embrace this theory in studying those ancient times.

Concerning the type of first words, Sperber traces them back to the verbal roots, which signified mainly, even if rather vaguely, an action. Gradually the noun became separate and subsequently other parts of speech –adjectives and adverbs of place– which were hidden in the initial root, like a germ. When, gradually, the initial language started to accompany psychic excitation, no longer referring to concrete incidents, then thinking became faster and wording more complex: hitherto “bark” signified a present dog or “dog” (i.e. “there is the dog”), which later on was followed by: “barking”, now signifying “dog barking”. The faster thoughts and speech were shaped, more words became joined in a phrase. Depending on the meaning, words started having diverse intonations, with principal and secondary accents. This changed the phonetic and semantic value of some of the first words, which were demoted to endings and prefixes. Thus, conjugation was born.

This theory, articulated by Sperber, as well as so many new theories that saw the light for the first time, are not as new as one would believe initially. Since 1877, Noiré had underscored the great importance of the first tasks of primitive man and the utterances that accompanied them in the genesis of language and later in 1894 the Danish linguist Jespersen pondered the importance that sexual life must have had in the birth of language. But Noiré had not yet demon-

strated that these voices were an integral part of group work –he considered mental intensity only in extraordinary circumstances, such as when soldiers make an assault or try to save a sinking ship from shore– that Sperber achieved, by showing the relationship of work and sexual life. Jespersen could not yet exploit his idea and use the fruitful psychological elements and conclusions presently supplied by Freud's school. In fact, the ultimate acquisitions of human mind, art, science, civilisation, are directly linked to the primitive sexual urges, that are "repressed" and remain unmanifested, in their original form. Is it not possible that language, man's instrument of expression par excellence, was brought to life because its roots were drawing water from the same inexhaustible source of life, the primordial need of man to *express* himself? In fact, we can assume that in bygone times of mankind's first steps into "civilisation", this source possessed even greater power and significance, as in those times higher instincts were taken so little into account.

Sperber does not consider his theory to be a "complete theory", but rather as a set of unfinished thoughts, providing the opportunity to re-discuss the issue of initial linguistic creation, from this new point of view. Of course, these ideas have to be associated more closely to previous evidence and this issue will have to be reconsidered in accordance with the fruitful views opened up by Freudian psychology. Sperber himself accepted that he doesn't actually diverge completely from onomatopoeia or other existing explanations, he believes, though, that only his theory explains the first linguistic creation in a satisfactory way. Indeed, however difficult it is for someone not accustomed to it, to espouse these Freudian positions of

the Swedish philologist, for those persons accustomed to the psychoanalytical method, Sperber's theory sheds new light on the first period of humanisation [...].

As a supplement to these ideas, an article by Berny, from Vienna, was published in one of the subsequent issues of the journal that I mentioned above. Berny used Steyer's purely philological work as his starting point, as well as his conclusions on the first sounds used by prehistoric Europeans, and then attempted to go further and supplement the linguistic point of departure postulated in Sperber's theory. (Sperber's first word was the symphonic *oa*, *hurra* of Steyer, which is the simplest set of vowels).

That is all we can say in order to explain how language was born, according to Freud's psychoanalytical theories. I would like to note at this point that psychoanalysis, through the study of the subconscious and of archaic language presented in dreams, provided many conclusions and shed light on the language and thinking of people in prehistoric times. It further confirmed the importance of thinking in terms of symbols (when people couldn't even think in abstract terms and with concepts) which are also directed by the subconscious being able to accept and reconcile the most obdurate opposites, which is something impossible for a rational human being) and explained in a better way the well-known observation that in many older languages the same word frequently signifies two opposite concepts.



Yiannis Imvriotis (1898–1979)

Psychoanalysis. An overview of the theories of S. Freud

(Ψυχανάλυση. Έκθεση τῶν θεωριῶν τοῦ S. Freud)

*Reprinted from the Deltio Ekpaideftikou Omilou
(Educational Group Bulletin), v. 11, 1923
Publishing House “Athina”, A.I. Rallis, Athens 1923*

[...]

Dreams

Dreams, as well as slips, are a difficult problem to interpret; indeed those persons attempting to approach it outside psychoanalysis, have not achieved a comprehensive interpretation, nor have provided interpretations devoid of a corresponding scientific substantiation.

Some (ed: dreams) are simple, short, easily understood and rational; others are lengthy and lavish like romances, which, nevertheless, reanimate scenes and episodes of everyday life; others are irrational, incomprehensible, enigmatic and unre-

lated to daily events, leaving us clueless as to the implicated aetiological factors.

Only simple dreams and those of children can be explained through observation, without the help of psychoanalysis. We only need to know the event occurred during the previous day in order to interpret a child's dream. As an example always helps to illustrate theory we will mention one dream. Freud's young nephew dreamt that he was eating cherries and in the morning, upon awakening, shouted with joy: "Hermann", this was his name, "ate all the cherries!" This dream is easy to understand, upon learning that on the previous day the child was given a basket of cherries to offer to his uncle and the young boy did so with great difficulty, exclaiming "There are cherries inside!" So, young Hermann, in offering the cherries to his uncle, experienced great trouble at not eating them all himself and his dream appeared as a reaction to this sadness, to this unconsummated desire.

Similarly, by studying many other children's dreams, the conclusion can be drawn that they constitute reactions to everyday events, which leave some traces of sadness, an unfulfilled wish, which serves as a stimulus triggering the dream and the wish fulfilment is the content of the dream. Hence, children's dreams have always to do with wish fulfilment and this is one of their most fundamental traits. Another characteristic is that this desire, upon being realised, appears in the guise of a hallucinatory mental function. In addition, as children's dreams are a reaction to a mental stimulus, this stimulus must be set aside, in order for sleep to continue.

What is sleep? It is still debated if it is a physiological or biological phenomenon. However, from a psychological point of view, it seems to be a condition where we periodi-

cally withdraw from the outside world and sink into a state similar to the foetal state, at least recreating similar conditions of warmth, darkness, absence of stimuli. But the psyche does not sleep entirely and stimuli do act upon it, stimuli to which it must react. These stimuli can be external or biological and studying children's dreams proves that these can be psychological internal stimuli.

Under this view, a dream looks like a guard protecting us from anything that would disturb our sleep. Worth noting is that sometimes the dream itself can disturb our sleep, like a night watchman who is forced to make some noise when chasing those who would disturb us much more. Also, in dreams we observe the desire, which is the disturbing agent, while sleep is the disturbed one. So dreams, like slips, are born from a compromise, i.e. the person sleeping attempts to fulfil his wish and by fulfilling it continues sleeping.

A similar wish fulfilment exists in ruminating, reveries, daydreams, however these may be named. These are products of our imagination and their contents are scenes and episodes, where a person's egotism, ambition, need for power, and sexual desires are fulfilled. Indeed, in these daydreams, an unprocessed material of artistic creation is also processed, transformed and shortened by artists, thus creating conditions where the artist's work can be placed. Nevertheless, although daydreams may be played out in a vivid way, they only exist in thought and cannot take on a hallucinatory form of events of mental life. Similarly, language, which encompasses so much accumulated wisdom and observation, expresses itself in a way indicating daydreams as consummation of unfulfilled wishes: "The hungry man dreams of bakeries with loaves of bread" and similar turns of phrase.

Such wish fulfilment is also obvious in another group of dreams, as easy to understand as those of children, stemming from urgent biological needs, such as thirst, hunger, even sexual needs, etc.

Therefore, by studying children's dreams and other similar dreams, important conclusions can be drawn, i.e. that *a dream is a mental action with its own meaning, whose main features are wish fulfilment and hallucinatory mental life. Born from two competitive opposing tendencies, the need to sleep and the need to satisfy a psychological stimulus.*

Herein arises the question: are these conclusions drawn from children's dreams, also valid for other more complex and incomprehensible dreams? Only through observation, as used in studying children's dreams, it is impossible to study complex dreams that seem both enigmatic and strange. Neither a mental stimulus is apparent in them, nor do they represent the fulfilment of an unconsummated desire. Here, observation is not enough and the technique of psychoanalytical interpretation can intervene, always unveiling the particular meaning lying beneath and which was expressed in such a distorted and complex, dream-like, way. We name as manifest dream whatever a dream narrates and as latent representations whatever underlies the manifest elements like a substratum, as it were, uncovered by psychoanalysis.

By applying this technical interpretation to complex dreams, not only does their hidden meaning become unveiled, but also the substrata are transformed into manifest elements, i.e. distortions and their mechanism. The opinions to be outlined with respect to these distortions are not a theoretical conjecture, but rather conclusions drawn from observation of psychoanalytical interpretation of many

dreams, from correlation and comparison of dream substrata to its manifest elements.

Let us cite a specific example. A lady, married for a number of years, dreams that she is in the theatre, that many of the front stalls are empty and her husband is recounting that a friend of hers, Eliza, and her fiancé, who were supposedly coming to the theatre, did not come because they had bought three bad seats, for 1.50 florins. She thought, in fact, that it was not a bad thing. The dream seems irrational, completely far-fetched and trivial, devoid of meaning. The lady upon being psychoanalysed remembered that her husband had informed her that Eliza, her friend, only three months younger than herself, was engaged to be married. Concerning empty seats in the theatre she recounted, how, just a week ago, determined to go to the theatre, she had bought the tickets *beforehand*, so as to make certain she found seats, but upon reaching the theatre she noticed that she had *rushed* unnecessarily, as a large number of seats were empty. Concerning the amount of 1.50 florins, this acts as an allusion to a different incident, i.e. her sister-in-law received a gift of 150 florins just the day before, and she rushed, "*what foolishness!*", to buy some jewellery.

In the light of this information, the manifest elements of the dream seem to refer, either clearly or allusively, to everyday events and episodes. But what does the number 3 mean? How can three tickets for two persons be explained? Here the person undergoing psychoanalysis refused to force her memory, putting up systematic and persistent resistance.

However, what is striking and is underscored greatly in the explanations of the lady undergoing psychoanalysis is that all explanations have a common trait: haste. She was hasty in purchasing the tickets and consequently paid more for them, her

sister-in law was hasty in purchasing the jewellery, as if afraid of losing it. If we take into account the incident used as pre-text in the dream, i.e. the engagement of Elisa and the fact that although she is only three months younger, managed to catch a good man and the characteristic expression “what foolishness!”, the latent representations of the dream are unveiled and become apparent, i.e. its hidden meaning. “I was foolish to get married in haste. Eliza didn’t lose anything by waiting and she managed to get married.” So the dream expresses the lack of esteem that the lady holds for her husband and her sorrow at being so hasty to marry. But how distorted and hidden these ideas appeared in the manifest content of the dream. Whilst the dream refers to the marriage of the dreamer, nonetheless, the centre is transferred in the manifest dream and seems to pertain to Elisa’s marriage. Marriage is expressed by the theatre, and tickets and jewellery represent the husband. There remain some dark points, such as why Elisa didn’t go to the theatre, but these will be explained only upon the comprehensive interpretation of the dream.

All these distortions, appearing in this dream, must have their aetiological factors. The question emerges: What are the distorting factors of the dreams?

The first is *censorship* and then comes *symbolism*. Censorship, of course, should not be construed in an anthropomorphic sense. It is simply a tendency characterised in such a way, i.e. tendencies recognised by an individual as his own, in daily waking life, confessed tendencies with which he agrees, attempting to repudiate, to repress, to censor in a way other condemnable and indecent tendencies from the standpoint of morality, aesthetics and society. What is distorted in a dream is these indecent desires, by repression and censorship. These

are manifestations of unrepessed egotism and in any dream the ego of the dreamer plays the main role, even though well hidden in the manifest content.

This egotism of the dream is certainly associated to our disposition during sleep, our interest withdrawing from the external world. Thus, ego liberated from all moral ties surrenders to all its sexual desires and the sexual instinct chooses its objects freely and indeed from those prohibited: not only another person's wife, but also the mother and sister of the dreamer. All this should not be amazing, as mental life appears as a battle field, where opposing forces are in struggle and made up of contrasts and paradoxes, which exist in parallel. If one tendency dominates, its opposite is repressed into the unconscious.

Censoring gives rise to various distortions. *Condensations* occur, i.e. the manifest dream is always smaller than its substrate, because some hidden elements are rejected, others are fragmented and only some pieces are included in the manifest content, whilst others, with common characteristics, become merged. This means that a person in a dream can correspond to many other persons, which, however, share a common characteristic. Nonetheless, it is not only similar elements that are merged, but frequently opposing elements. This phenomenon is not so strange, if we take into consideration that such merged contrasts also exist in language. Thus, in ancient Egyptian the word *ken* initially signified the strong and the weak alike, the Latin word *altus* means tall and deep, whilst the English word "with" means together, but "withdraw" means to recede.

Apart from condensation, *displacement* frequently occurs in distortions. In other words, a hidden object is replaced not by something related to its components, but rather by some-

thing remote, acting like a hint. Even the accent is transferred from the important and main element to another one, modifying the centre of the dream, which becomes strange, as we have seen in the example. Something similar is observed in daily life, in plays on the word, but there the double hint is easily understood. Another significant method of distortion is that some concepts are transformed in the dream into visual images. As the starting points for all meanings and representations are specific images, the latent representations of the dream, those verbally acquired, in order to be distorted will be processed backwards and will be expressed in the manifest content through these old, archaic, mnemonic images. Thus, we can see how many mental phenomena are present in the transformation of the dream substratum into manifest elements, like condensation, displacement, allusion, reversal in relations or situations, so that the hare may chase the hunter and, in addition, something not mentioned so far, the *symbolic expression*.

Freud considers symbolism as a particular distorting factor, because symbolic expression, however closely related to censorship, and performed under its influence, is somewhat independent. Frequently, a technical interpretation with free associations does not work, as the person in psychoanalysis knows nothing on certain elements of his dream (such as number 3 of our example), due to their symbolic expression. Therefore, this technique of interpretation based on symbols is complementary to the other one based on free association. In a dream, various objects and actions are symbolically expressed, such as a man represented as an upright house; a woman as a house with vergers; parents as royalty; small children as animals or worms; death as travelling; birth as actions including

essentially water, one falling into or coming out of water; but most of all, sexual objects have an abundant and rich symbolism. Most symbols in the dream are sexual whilst here the objects are few their symbols are numerous. Thus man, in his sexual aspect is symbolised with the number 3 or with long objects, such as trees, canes, guns, and so forth, while women are symbolised with hollow objects, such as vases, galleries of mines and other similar items.

A question arises at this point. A person undergoing analysis is unaware of these symbols and is unable to explain them. How does psychoanalysis contrive to interpret these, where does it gather the information on their significance? By studying and researching the corresponding symbolisms in the thinking process of everyday life. Myths, stories, proverbs, current language and poetic license use the same symbolism. By examining these sources one draws a parallel with symbolism of dreams, thus attesting to the legitimacy and accuracy of psychoanalytical interpretations. In consequence, Jewish sacred books are full of expressions with sexual symbolism, as indeed the Song of Solomon, and women are often symbolised as a table, both in dreams and in Jewish literature. Similarly, the number 3, a sexual symbol in dreams, can be found in many insignia, using the three leafed clover, the fleur-de-lis, and other similar. There are many other talismans with similar shapes that are used as "warding amulets". Thus, the horseshoe, sexually representing a woman, can be used as a warding talisman and is frequently found in various houses in order to protect from evil, not only in our days but, in ancient peoples, as well.

If one should consider all those things said on symbols, the conclusion is drawn that the dreamer did not make any individual comparison and correlation in order to symboli-

cally express a specific representation, but rather used A or B stereotypical manifest symbolic expression, which he doesn't know nor indeed recognise whilst awake. There is proof for this, arising from the fact that the same symbols can be found in the most diverse persons, in spite of linguistic differences, i.e. a specific symbol expresses a specific representation in a permanent and steadfast way and not another representation. An overall observation, concerning symbols, is that many symbols found in language, myths and other sources do not appear at all or rarely in dreams and the opposite. Thus, it seems that we are facing an archaic way of expression, which disappeared, with the exception of some relics scattered here and there. Certainly, symbolism belongs to phylogenetic inheritance.

Psychoanalytical research proves that in dreams not only do individuals relive recent personal incidents, but even archaic personal ones, that is of their early childhood, as well as of our phylogenetic prehistory, because a person, most certainly, reproduces a short version of mankind's evolution during infancy. By reliving ancient situations through dreams quite a few mysteries are interpreted, i.e. many dreams are interpreted as expressing sexual desires so indecent and uninhibited, that the person in psychoanalysis protests against the explanation given. What happens then? These bad desires are frequently rooted in the past and it is possible to prove that they were once conscious and familiar. Freud mentions the example of an affectionate mother, whose dream expressed the wish that her child should die, which finally proved to be a real wish of death, but an ancient one, during her pregnancy, when she had fought with her husband and wanted to avenge herself by not having a child.

Indecent desires frequently manifested in dreams have no hold in reality, they do not correspond to any incident, either remote or recent. The reason runs deeper and, in fact, if it is related to enmity among persons of the same family and gender, it is caused by erotic competition. The son, in childhood, felt great tenderness towards his mother, considering her to be his possession and his father to be a rival, encroaching on his possession. Likewise, the daughter turns to her father and adopts a hostile stance concerning her mother. This stance of children towards their parents is what Freud terms the *Oedipus complex*, which many opponents of psychoanalysis might want to dismiss, but in fact it is used in tradition and poetry. However, we shall approach further the Oedipus complex later on, discussing neuroses. In general, if we have such indecent and immoral desires in our dreams, this is indicative of regressive dreams, returning us to our childhood. This backward turn refers not only to forgotten childhood incidents, but also to the childish psyche, with all its particular attributes, egotism, incestuous tendencies, etc. It is not only *formal*, i.e. does not solely provide a primitive way to express our ideas, given that it provides a symbolism, but is also *material*, because it awakens properties of our primitive psychic life. All this ancient infantilism, which predominated in the past, should now be in the unconscious.

After elucidating all these points of view, the unconscious has been proven to be clearly delineated, something real and specific. In other words the *unconscious is a specific mental area with its specific tendencies, special modality of expression (special psychic function) and has a dual substance, i.e. it is composed of (a) elements of our daily life suppressed, for a*

shorter or longer time; and (b) archaic elements, both infantile and hereditary, suppressed and pushed therein.

Before we finish the chapter on dreams, a question still remains. Do distorted complex dreams have to be interpreted in order to prove that they are the realisation of unfulfilled wishes? But the previously mentioned dream of the Lady, who dreamt of going to the theatre, expressed her lack of appreciation for her husband and a regret for her hasted marriage. Similarly, many other dreams have the appearance of expressing just a regret or preparing for some work or something ordinary of daily life.

Therefore, where is the famous fulfilment of an unfulfilled wish? Freud insists in affirming that a dream may express regret or preparation for work or any other aspect of current daily life, but all of these refer to daily incidents and belong to the first group of elements of the unconscious. Yet, there is also the unconscious desire, which is the main locomotive power of the dream, which stems from the second group, i.e. archaic infantile and hereditary elements alike, and mostly sexual desire. Thus, if the dream of the theatre expresses regret, its locomotive power is sexual desire. The lady hears about her friend's engagement. This trivial incident awakens a long-buried thought, that she was hasty and her marriage was a failure, but simultaneously awakens old sexual desires from her life as a young girl. It is well known that sexual curiosity in girlhood is particularly striking.

Therefore, her dream expresses the satisfaction of this sexual curiosity. The fact that she dreamt of going to the theatre signifies that she is getting married, because a wedding is a spectacle in the eyes of a girl, which intrigues her curiosity. The fact that she, herself, is going to the theatre, whilst her

friend Elisa is absent, expresses the dreamer's past triumph over her friend. It is as if she is saying: "Yes, I am going to the theatre, whilst you are not yet doing so!". We know how women can pride themselves on getting married with respect to their unmarried friends. However, in going to the theatre, a part of the front stalls was empty, a detail associated to the failure of her marriage. Therefore, her dream, in addition to transferring to a previous psychological state, the era prior to her marriage, apart from making her relive an element of the infantile and archaic unconscious, simultaneously expresses regret for her marriage, which belongs to the first group of elements of the unconscious, in other words something related to her current daily life. All these unmentioned desires and improper representations, that are repressed and censored whilst awake, are expressed in the dream, when censorship is more relaxed.

Freud, with his unique acuity, mentions yet another difficulty related to the point of view that considers dreams as a fulfilment of wishes. His detractors may well ask how is it possible to consider dreams as the accomplishment of an unfulfilled wish, as so many dreams have an unpleasant content, even anguish, or torments. The realisation of desires should always give rise to a pleasant and not an unpleasant content. Freud's response is that it is possible, either that the transformation of the substrata into manifest elements not to have been fully achieved, in order to produce fulfilment of a wish, and a part of the unpleasant feelings to enter the manifest content, or the substrata to have been transformed into a fulfilled wish, but the accompanying painful affect, passing intact into the manifest content, to produce, naturally, an asymmetry between the manifest dream and the accompanying emotion.

And something more: Wish fulfilment should normally cause a pleasant feeling on the dreamer, but we know that the dreamer's attitude regarding his desire is very peculiar, he suppresses it and censors it and its realisation unavoidably gives rise to an unpleasant affect. Experience shows that this unpleasant affect is manifested through dreams in the form of anguish, in the form of a nightmare. Furthermore, experience shows that the content of dreams with nightmares is undistorted, often escaping censorship, i.e. those dreams frequently unveil the consummation of a repulsive, repressed wish, and the accompanying nightmare takes the place of censorship. Thus, Freud believes that pleasant and unpleasant dreams alike express the consummation of an unfulfilled desire.

Nonetheless, repressed desires do not find expression only in dreams, but also in neurotic symptoms. We must elaborate more on Freud's relevant research, as the conclusions stemming from dreams are further confirmed and enriched, and because psychoanalysis, as we have said in the beginning, can not be outlined schematically and dogmatically, as theory and practice cannot be separated but proceed in parallel.

[...]



Georgios Koskinas (1876–1975)

On the influence of malaria-induced fever treatment of Progressive Paralysis on the histological process of the disease

*Über den Malariabehandlung der progressive
Paralyse auf den histologische Prozess*

*Von Professor Ernst Sträussler und Dr. Georg Koskinas,
Wiener Medizinische Wochenschrift 1923, 17, 783–787*

It has already been verified, beyond doubt, that amongst the efforts introduced by Wagner-Jauregg and continued by his disciples Pilcz, Schacher and Gerstmann, in order to render possible the effective treatment of progressive paralysis, which for so long had been considered untreatable concerning its malignant course and fatal outcome, the method of induced tertiary malaria achieved exceedingly impressive therapeutic results.

In the results communicated by Gerstmann [...] we can observe a significant percentage of complete [...] remissions, which, according to Gerstmann, show unusual stability. From

other sources also [...] there are positive therapeutic results reported on tertiary malaria.

In his classical study on progressive paralysis, Alzheimer had expressed –based on the results of examination of the brain of a paralytic [...], which (*despite the relatively complete remission*) had significant paralytic lesions [...]- the view that even the most complete remission of paralysis does not correspond to a cure on the level of histological findings. Paralytic remission simply constitutes a languishing of the disease with all the inflammatory symptoms diminishing. For this reason, recoveries that appear like cures are observed solely after lightning-fast onset and intense inflammation, i.e. after attacks of illness characterised, almost entirely, by inflammatory manifestations.

Previously known spontaneous remissions mainly concerned cases belonging to the manic form of paralysis. The successes of malaria fever treatment, however, are not linked to any specific form of the disease, and exceedingly long remissions can be observed, particularly in cases in which the disease appears to have an insidious development, as a simple form of dementia.

Under these circumstances, it is advisable to ascertain the effect of malaria fever treatment on the histopathology process of the paralysis. The question whether remissions are sufficiently present, qualitatively or quantitatively, in histological findings, raises a great clinical and pathological interest.

The most suitable material for this research, i.e. cases with full and long-term remissions, eludes the attention of psychiatric facilities, even when the patients die during a remission from associated diseases – particularly when they die either

at home, or in non-psychiatric treatment facilities. Due to this, we have not yet managed to obtain a histological examination of even a single brain from the large group of patients who seem cured from their paralytic disease by malaria fever treatment and who have practiced their previous professional activities for many years. We had to be satisfied only with the material offered for post-mortem examination by the psychiatric department.

They mostly concern patients that passed away [...] during the period of malaria attacks. Yet, we have additionally managed to acquire some material that seems suitable to allow response to the question concerning the histological findings of a remission. [...]

The histological findings of the first case, where the patient had a decisive remission subsequent to malaria fever treatment, seem [...] to permit very specific conclusions concerning the histological changes that constitute the substrate of the remissions [...]. Specifically, the findings reflect, in an impressive way, a variation of the picture of a typical paralysis, initially described by Alzheimer as “static paralysis”, which is characterised by the particularly small intensity of anatomical changes. [...]

(*In another case*) histological findings are characterised [...] by the presence of an impressive disproportion between alterations in parenchyma and inflammatory manifestations. The picture by no means corresponds to the progressive paralytic process. [...] An impressive contrast (*to the aforementioned cases*) are the findings of four patients who passed away during the malaria fever treatment or immediately after it – before the usual treatment with quinine and salvarsan was completed and before signs of remission had manifested.

[...] In the three cases the paralytic process can be found in the greatest development one can imagine, from the point of view of inflammatory components and prolific manifestations in the vessels and the neuroglia [...]. Regarding the fourth case usual histological picture of an acute paralysis appears.

Due to these findings the effectiveness of the malarial fever treatment can be approximately described as follows: Falling ill with malaria results in an intensification of inflammation [...]; all immune forces of the central nervous system are activated against the damage caused by syphilis. The result of the battle, which is now in full flow, if everything goes well, is expressed with a retreat of inflammation to a lesser degree; the histoproliferating manifestations regress and the degenerative components of paralytic process remain stationary.

When speaking of syphilitic “harmful components”, this corresponds to both spirochetes and the toxic substances they produce. Because, as Hauptmann recently underlined once more, the anatomical and clinical manifestations of paralysis cannot be explained solely by the local effect of spirochetes. The biological process taking place in successful treatment must consequently comprise the annihilation or at least a significant destruction of spirochetes not only in the brain, but throughout the entire body, which will be associated with a removal or a weakening of the toxins as well. The Hauptmann hypothesis, that “acquisition of immunity” plays a role in the successes of malaria fever treatment [...], cannot be rejected. To this we must add, as our findings appear to indicate, the local defensive response of the central nervous system itself. [...]

The question concerning whether paralysis can be cured was the object of intense debate, particularly over the past few years. Schulze, Spielmeyer, Nonne and Jakob all argued in

favour of a potential cure of general paralysis. It is fairly obvious that once the loss in nerve substance due to the process of the disease is established, it cannot be reversed. From our results too, it seems that a complete anatomical cure of paralytic disease process has not taken place. It could be possible, however [...] *that treatment of progressive paralysis may affect the histological process in such a way, that the anatomical picture of "static paralysis" may appear*, which is typical of the long-term cases, with ten to thirty two years duration, which were partially "cured" in the clinical sense of the term.

From the above findings it seems that it is possible to convert, in a significant proportion of cases, the *progressive* histological process to a *static* one, and in this way to influence for the better the condition of a paralytic patient, as well as the course of the disease, in cases where the destruction of the nerve tissue implicated in mental faculties, has not yet progressed.

Principal works

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Constantinos Papastratigakis (1891–1929)

The mentally ill in the army
(Οἱ ψυχοπαθεῖς ἐν τῷ Στρατῷ)

Printed by K.G. Makridis & I. L. Alevropoulos, Athens, 1924

Prologue

This study, which is not addressed solely to medical officers but to non-medical officers as well, intends to render everybody more cautious in order to evaluate certain events, involving very mistaken commonly held views, which can have very painful consequences. It is irrefutable that, on the one hand everybody considers themselves capable of recognising insanity wherever encountered, and on the other hand, according to current opinion, the actions of the insane can by no means be similar to actions of other people.

A direct consequence of these views, of these convictions, or even better of these beliefs, is the lack of recognition of those who are mentally ill. When this lack of recognition takes place within a social environment, where every paradoxical statement finds a listener and every insane individual has his admirers, there is no risk for those who failed to recognise nor for the one who has not been recognised, so long as the latter does not proceed with

acts prohibited by common criminal law. However, things are very different in a military environment, where regulations leave no room for aberrations, any tolerance of which would weaken the major strength of the Army, which is discipline. If a mentally ill person acts in a way which does not immediately give the impression of a mental disorder governing his actions, he will fatally expose himself to consequences of actions contrary to regulations. Consequences are frequently serious, as the action, which he has committed, may also be serious.

Old traditions force man to believe that he is entirely free to choose between one act or another and must therefore bear full responsibility for it. For those who do not possess any experience of psychiatric facts, volition constitutes a force which each of us can use, independently of questions of mental nature.

It is true that the majority of human actions is based on false prejudices, from which it is difficult, if not impossible, to separate the beliefs of simplistic spirits. Because, there is nothing easier for a frivolous intellect than to acquire beliefs or prejudices.

In view of the above, it becomes clear that familiarity with the mentally ill is not a luxury for an army officer, but is most conducive, on the one hand to the prohibition to enter the Army, of anyone who does not possess the required mental faculties the number of which increases constantly, following the perfection of martial arts; and on the other hand to improve the condition of mentally ill soldiers in the army, who are at risk, because they are not recognised for what they are, of falling foul of various martial courts and military prisons, charged as they are with various actions contrary to military discipline. Even more, the identification of mentally ill soldiers by their line commanders will constitute the first step in

organising mentally sound troops, something that is not sufficiently appreciated till now, everything being limited to some elementary knowledge of somatic hygiene, even if the body has no value without the intellect.

Knowledge of some elements of psychology would be useful to officers, besides all other benefits, because it will greatly contribute to studying the soldiers' character. The knowledge of an individual's character constitutes the main factor of utilising him better, as well as of understanding various irregularities in his conduct. Officers will also be able to comprehend far better the character of a soldier who suffers from a mental disease and they will also be in a better position to help him. It is not possible to uncover the feelings of a person if this person does not consent to it, facilitating the work with spontaneous confessions and honest responses. However, each one of us trusts only people he loves, or people that he is disposed to love, and this will never happen with an army officer who does not offer understanding.

Let us see now in what way does the study of mentally ill in the Army differ from their study in a different environment. Is there a particular branch of science especially dealing with the mental disturbances of a soldier? Of course the pathological psychology of a soldier is governed by the same general laws as those governing the pathological psychology of other people. Nonetheless, setting aside the consequences of failing to recognise someone who is mentally ill, if we take into consideration the fact that in the Army the life of a soldier is circumscribed by specific age limitations, that life conditions differ significantly from the previous life of an individual, as well as the fact that opportunities to disturb a person's mental equilibrium not only appear differently in the army, but are highly multiplied during military action; if

we take all these into consideration, by no means should one be surprised by a special study on mentally ill soldiers.

Our work, having no pattern upon which to draw, is almost entirely based on personal observations, which we have collected since 1918, by directing successively the Military Neurological Centres in Athens, Thessaloniki and Komotini. For this reason we had to overcome many difficulties, in order to complete this work. The greatest difficulty, in each of our steps, came from the necessity to provide explanations on certain issues in order to be understood. For this reason we finally decided to set out some introductory general knowledge, required to enable further understanding of our work. In describing the various types of mentally ill, we have taken into consideration solely what is observed in our own Army, which without doubt constitutes an advantage of this study, given that each country has its own morbidity, to which the varying conditions of life and the differences in character of individuals, give rise to. We have in fact studied the forms of these mentally ill people, as manifested in barracks, when they were exposed to everybody's eyes, and we have insisted on each of these cases, depending on their frequency. In order to count percentages, we based our opinion on statistics we performed ourselves, mainly for reasons of unification of diagnoses. In the area of Forensic Medicine we have given priority to, and mainly studied, the issue of mentally ill not identified in the Army, having observed how a mental disease can occur under circumstances where nothing makes us suspect it. Cases that can escape recognition are those of insubordination, voluntary enlistment, lack of discipline and simulation of sickness.

Beyond these medico-legal issues we shall undertake a short discourse on protecting the mentally ill in the army,

drawing attention particularly to those points which should make anyone coming into contact with soldiers suspicious of a potential underlying mental abnormality.

Whenever we thought that we could easily transmit the current views on certain psychological issues, we did not hesitate to do it. But, we have carefully avoided to lead the reader into any inaccessible psychological regions, requiring a very particular preparation.

[...]

This is our work. It was by no means our intention to present within the narrow confines of a book the issue of insanity in the Army, at its real size. As we did not hold in our hands a magic wand but a writing implement, we never imagined that we could transform our readers into psychiatrists, which, in any case, would not be to many people's liking. With this study we shall attempt simply and solely to draw back slightly the curtain, behind which an entire host of mentally ill is hidden dressed in army uniform who will shortly march past the reader in the next parade. We will guide the reader, sequentially, from the barracks to the battlefield and to the gaol, always attentively removing any thorn capable of rendering this tour ever more painful. If through our efforts we would be able to change mistaken perceptions on the mentally ill in the army and to show the reader the wealth, interest and extent of a soldier's psychology, including real and hidden treasures, on which all people are indifferent and unaware, our purpose will have been achieved. For the rest we believe in the good judgement and leniency of our readers.



Dimitrios Kouretas (1901–1984)

1. Psychoanalysis (psychology of the unconscious) [*Ἡ Ψυχανάλυσις, (Ψυχολογία τοῦ ἀσυνειδήτου)*]

Helliniki Iatriki (Hellenic Medicine), March, 1928, 200–222

A century ago, Psychiatry was still a chaotic and stagnant science, under the influence of metaphysical beliefs of the psychology of that period, considering psyche as an immaterial entity, independent of the body. No systematic classification of mental illnesses based on objective observation had been achieved until the last decades. Such classification has been achieved on the basis of the study of affects; considering mental illness as a disorder of affects rather than a disorder of intellect. Despite the significant progress achieved in a relatively short time span, most experts were unable to grasp the more remote motives of our actions and emotions, to attain the causes from the results. Freud, as a messiah of science, attempted to lift the veil of mystery through his teaching.

The method employed first by Freud, has flourished unexpectedly over recent years under the name of psychoanalysis; used initially in medicine it was gradually expanded through all facets of human thought. Psychology, pedagogy, ethnolo-

gy, sociology started to feel its influence. In the world of theatre, literature, art, a sudden wave of enthusiasm followed a period of unjustified disparagement of the discoverer's work.

Dr Sigmund Freud, nominated recently professor of psychiatry in Vienna, is presently the head of a flourishing school, with proponents in all intellectual circles, as his teaching transcended the initial small circle, originally restricted to the study of the mechanism of neuroses and particularly of hysteria.

Upon completing his medical studies in his homeland, in 1895, Freud travelled to Paris, where he attended the lectures delivered by Charcot at Salpêtrière and later those of Professor Bernheim at Nancy. From his French teachers he retained the habit of fine clinical analysis, which he employed with masterly acumen and great perspicacity. Nevertheless, from the outset Freud's theories met with severe reaction and caused great animosity against this wise scientist, for reasons related to his theories, which we will explore herein below.

It is needless to note that through this treatise our only ambition is to give a broad synthetic outline of the theory. Moreover, we should warn the reader that the issue is of an extremely delicate nature: psychoanalysis systematically attempts to bring to light the most intimate and thorny details of sexual life, hidden in the unconscious. Psychoanalysis can be defined as a method of investigation and treatment of psychoneuroses, inspired by an extremely broad system of interpretation of most forms of normal and pathological human psychic energy. Moreover, it is characterised by the analysis of affectivity in general and its results, mostly considered as stemming from the sexual instinct.

[...]

Genesis and psychoanalytic approach of neuroses

We have presented, above, the basis of the pathogenetic views of psychoanalysis on neuroses and we have to recall that this was the first objective of Freud's psychological researches. It was only later that his method was gradually employed to study all mental conditions.

According to Freud, *neuroses are divided into two groups*: The first group, less important from a psychological point of view, includes *current neuroses*, i.e. due to the presence of a nervous disorder in the function of the genitals. Thus, Neurasthenia, the illness of nerves, is not associated with overworking of nerves, but more commonly with sexual excesses and in particular, according to Freud, to masturbation, which is frequently not revealed. Similarly, *anxiety neurosis* described by Freud in 1895, comprises a perpetual state of anxiety radiating to the heart, the digestive tract, respiration, etc., anxiety during which sudden paroxysmal attacks of anguish occur, without reason.

Anxiety neurosis is rather common. Its cause lies supposedly in the non-satisfaction of sexual arousal, developing, for example, in individuals who masturbate and who suddenly discontinue their annoying habit, in those affianced who are in perpetual excitation without fulfilment of desire, in those widowed, in married individuals who perform practices in order to avoid pregnancy and oblige themselves to discontinue intercourse (known with the Roman term *coitus interruptus*).

The second group is that of *pure neuroses*, i.e. those originating from the abnormal development of psychogenetic function during childhood and puberty. The most important thereof is *hysteria*. Indeed, hysterical individuals, more often hysterical women, suffer from sexual repression to a greater degree than normal, from excessive and sudden release of

forces strongly opposing the sexual urge (prudishness, revulsion, moral inhibitions).

The existing opposition between these needs and the revulsion caused by repression, explains the contradictory and enigmatic nature of hysteria. Obviously, this neurosis can affect all organs and disturb all functions, as all parts of the body may constitute erotogenic zones and in these perverted urges the genitals may be substituted by other organs, whose stimulation is sufficient in order to elicit pleasure. Hysterogenic and erotogenic zones are one and the same. Thus, the conclusion can be drawn that bodily organs, in addition to their physiological function (e.g. chewing with the mouth, seeing with the eyes) also take on a sexual function (kissing, visual pleasure) and, should the latter prevail, physiological function may be disturbed or hindered. Only through the mechanism of substitution one can interpret the hazardous and complex symptomatology of hysteria, which includes pharyngeal spasms, temporary blindness, convulsions and paralyses, anaesthesia and fugues. For this reason, the aforementioned hysterical fit is, in fact, the imaginary and pliant equivalent of intercourse, a type of sexual dream, in which the hysterical female experiences sexual stimulation in the form of a fit brought on by (genital) memories or bodily genital excitation.

[...]

An interesting point of view introduced by Freud into the study of psychoneuroses is *seeking recourse in disease*. Persons of a weak character incapable or unaware of positively resisting the stronger volition of their spouse, kin, friend, without however wanting to surrender thereto, take recourse more or less unconsciously in neurosis, thus providing asylum to their psychic freedom. Morbid fears, fixations, even psychoses are produced through similar processes; the symbolic realisation of suppressed desires plays a primary role.

Treatment methods

Cure of psychoneuroses is possible only after analysis reveals all suppressed thoughts distressing a sufferer, no matter how disgusting and immoral they may be. Once the sufferer knows himself and understands the shame of his hidden desires, success is possible. Only then will he find the necessary power within himself to channel all the energy used in a flawed way towards a normal fulfilment of desire and absorbing occupations.

Four kinds of treatment are applied, as follows:

1. *Denigration.* The patient must condemn and express a categorical and definitive denigration of the morbid proclivities, discovered in him and brought to light. The patient will soon start to detest them under the influence of the physician, who will then achieve complete moral reconstruction.
2. *The sexual act.* Certain neuropaths have strong sexual needs, but their resistance makes them withstand gratification of these needs, hence their revulsion towards anything related to sex. However, in the measure that this resistance withdraws, we must advise moderation in normal and regular use of the sexual act. This instruction is hindered by great difficulties and frequently fails to bring about the desired results due to the impediment of social decorum. Therefore attentive sexual supervision of children and circumspect sexual education of adolescents, constitute measures of prevention of a particular interest to psychoanalysts.
3. *Sublimation.* Applied to intelligent, idealistic and educated people. It consists of diverting all misused affective power for noble, constructive and interesting purposes, by channelling

of purely selfish affective instincts to altruistic purposes. The direction of this channelling depends on the character and the ability of a person, in other words is subject to the individual's temperament. Some individuals can do it on their own and these are the artists and the mystics. In most cases the physician should intervene by transferring the redemptive emotional force to an ideal, familial, professional, scientific, charitable or social. Practicing sports is extremely beneficial. Achieving sublimation presupposes acuity, good judgment and trust in the efficacy of the method.

4. *Devotional transference.* Neuropaths, due to their imperfect use of affectivity have a surplus of energy to consume. They need to love, to devote themselves. They feel intensely sorrows and emotions of their brethren. Their emotional transference to others should be facilitated. The best advice to give to a patient in order to treat him is to express his emotions, to come out of himself and his humiliating thoughts on his condition and to immerse himself in the manly joy of devotion and self-sacrifice. During treatment this phenomenon of devotional transference usually occurs in the person of the physician. Affects are normally focused on him. The sufferer is open to suggestions and moral influence from the person to whom he has given his trust and preference, thus enabling successful channelling and virtuous use of irregular affects. We should add that the clientele of a psychoanalyst does not comprise only neuropaths. The moral crises of a normal affective life, especially during the period of adolescent anxiety also require psychoanalysis, especially since they usually have decisive importance on the entirety of an individual's moral life. The role of a psychoanalyst is confused in many cases with the role of a spiritual father.

2. Principles and directions of modern psychiatry

(Ερείσματα καὶ κατευθύνσεις τῆς σύγχρονης
Ψυχιατρικῆς)

Iatriki Proodos (Medical Progress) 1934, 24, 369–378

[...]

Historical knowledge concerning mental diseases provides criteria for assessing the current state of our science and constitutes a starting point for further research. From an ethnographic viewpoint, it contributes to an understanding of the relationship that prevailing social and secular beliefs, as well as general views in a certain era and country have with delusional ideas produced in the brain of the mentally ill. For example, those suffering from a delusion of persecution in the middle ages, affected by the superstitious ideas of that time, considered that their persecutor could be the devil. Today they believe that spirits are persecuting them or that organised groups are using electricity or Hertz's waves in order to torture them.

[...]

How did science face these outdated beliefs on mental illnesses? It is noteworthy that until the French revolution, with the exception of humanitarian philosophers, only Greek thinking, emancipated by Hippocrates and the Hippocratic physicians, stated that mentally ill persons suffered from a disease of the brain: “by the same organ (i.e. the brain) we become mad and delirious and fears and terrors assail us...”, we read in the treatise attributed to Hippocrates on the “Sacred Disease”, describing epilepsy. Unfortunately, the positive viewpoint of the father of Medicine was only a shooting star, which illuminated the darkness of many centuries of ignorance and superstition.

Certain psychiatrists, from the beginning of the previous century recognised that mental illness is a disease, but as they fostered a purely idealistic ethical-philosophical perception, they considered it to be a disease of the soul, which was independent of the body and they tried to reconcile the irreconcilable, namely the material concept of a disease with the concept of immaterial soul.

The German spiritualist school, whose founder was Stahl and whose disciples were Heinroth and Ideler, proceeded further: in their opinion, mental disease was the result of sin and deviation from the rules of morality and religion. They did not distinguish mental disease into types, but its symptoms were considered as indications of a single psychological disorder. Incapable to conceive its essence, they were forced to recognise that treating psychological disorders was impossible with the available means –an opinion held by many people even to this day– recommending repentance and compliance with the precepts of Christian religion.

Despite these ideocratic convictions, “thymocratic” positions, focusing on affectivity developed, implicating the influence of an excessive psychic passion in the genesis of mental illness, its suppression having the same effect on it. In this second case we can discern the core of Freud’s psychoanalysis.

The clinical and the somatocratic School reacted to the beliefs of spiritualists and thymocratics. Without refuting the mystery surrounding the higher psychological functions, clinicians focused on describing and classifying symptoms –through which these (ed: higher psychological functions) are manifested under the influence of a disease– and managed to distinguish major clinical entities. Thus, Pinel and Esquirol in the chapter on mania, included alongside this disease, as

we perceive it today, other states of excitation, manifested in mental confusion, epilepsy and toxic psychoses.

The followers of the somatocratic conception, represented mainly by Nasse, Friedreich, Vering and Jacobi, flourished and advanced through the generalisation of pathological anatomical research, furthered by Virchow and its application to the pathology of the brain. The investigators pursued with enthusiasm the discovery of histological alterations corresponding, as they assumed, to psychological diseases. Wernicke, on discovering the pathological anatomical substratum of aphasia, which bears his name, came to believe that all mental diseases are diseases of the brain. However, this one-sided tendency, of trying to discover localisations of all mental illnesses in the brain, could end up in neglecting the research concerning the mechanism producing these symptoms. This would have been the case if –along with the progress of medicine– the concept of causality was not introduced, by virtue of Pasteur’s discovery on microbes and Bouchard’s autointoxication theory. The discovery of the cause of general paralysis of the insane (syphilis) and of the syndrome of mental confusion are the most eloquent examples of this direction in research.

Even though the purpose of this short historical introduction to psychiatry is more an overview of major lines of thinking than a listing of names, we couldn’t enter the modern period without mentioning the name of the great German psychiatrist Kraepelin, whose death in 1926, “caused great pain to psychiatrists over the world (Halberstadt)”

[...]

Many definitions were given to the area that psychiatry deals with. However comprehensive or expansive these may be, they fail to include the entire set of psychopathological phenomena, from the simplest character abnormality per-

taining to people who live freely amongst us, to the manifest mania, which asks for urgent commitment of the sufferer to a special treatment facility.

Here we put forward the following definition: “mental illness is a disorder of the psychic-intellectual faculties, which hinders, temporarily or permanently, the adaptation of the sufferer to the environment”.

According to this definition the centre of gravity is placed on the relations of the person with the outer world and society. The above definition was imposed, on the one hand by the mission of practitioners in psychiatry to protect society from harmful and dangerous individuals. On the other hand one of the main objects of our branch is to study pathological phenomena, such as agitation, aggression, incoherence of thought and so forth, related to their social significance, whilst other branches of internal medicine investigate diseases of kidneys, liver, heart and so forth in correlation to pathologically altered organs and their negative impact on the life of an individual. Moreover, mental disorders, even in their milder forms, have an impact on the co-existence of affected individuals with other people and social activities, with infinitely greater consequences than those resulting from an equally mild (somatic) disorder.

[...]

Psychiatry, compared to internal medicine, studies under a different perspective the various phenomena belonging to the jurisdiction of the latter. Is it reasonable to say that each of the two disciplines follows its own way and they have nothing in common? Most certainly not. Apart from their common purpose, which is to treat diseases, they have other points of contact which are more essential.

First, the influence of morals and emotions are manifested particularly on the body by functional dysfunctions of the circulatory system, the gastrointestinal tract and other systems, as well as biochemical changes, proven experimentally beyond a shadow of a doubt. Ignorance of the fact that psychological factors, as causative contributors in disorders, may possibly lead physicians to a false diagnosis, particularly in cases where pathogenic emotions –through their intensity and repetition and according to the mechanism of Pavlov’s conditioned reflexes– constitute the onset of a functional disorder that becomes permanent over time or causes the exacerbation of an existing organic disease.

The physician should also be aware of the temperament of the sufferer, in order to judge precisely the patient’s complaints, as well as to assess their value, depending on the possible exaggeration or distortion they can undergo under the influence of an emotional, fanciful or perverted character, or the exigencies of some patients, usually characterised as hypochondriacs.

All these testify in favour of the valuable assistance provided by Psychiatry to internal medicine. In Plato’s dialogue “Charmides”, says Socrates “as you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul; and this”, he said “is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also; for the part can never be well unless the whole is well. For all good and evil, whether in the body or in human nature, originates, as he declared, in the soul and over flows from thence, as from the head into the eyes”.

[...]

Neurology is close to psychiatry, indeed it could be said that it acts as its bulwark. Before we expand on this issue, we

consider it expedient to previously look into the differences between various methods from the point of view of research.

A neurological symptom is primarily partial and localized, usually related to a damage in a specific centre or system of nerve fibres. Paralysis of the lower part of the facial nerve, for example, always corresponds in classical textbooks to a central lesion.

Psychiatric symptoms, on the other hand, take on primordial importance by their reference and integration in overall psychic manifestation and behaviour of an individual. For example, forgetting one's name is not enough to result in a diagnosis of pathological amnesia. Indeed, it has been correctly stated that the strangest idea of an inmate in a mental asylum, can correspond to an equally strange idea that, nonetheless is considered wise when expressed at a certain time and place, in correlation to prevailing ideas and prejudices.

In neurology, the most important progress was made upon ascertaining, owing to pathological anatomy and experimental research, that a specific symptom was associated with a lesion in a specific part of the nervous tissue, and that a specific phenomenon, such as a pain or a convulsion is produced through the direct mechanical or electrical stimulation of a specific part of the brain.

Conversely, in psychiatry, apart from general paralysis of the insane, congenital abnormalities, organic dementia and certain other conditions with a proven organic substratum, pathological anatomy hitherto had very little to offer.

[...]

We acknowledge that psychiatry without neurology would be a one-sided science, but we do not agree with those considering the former as a simple branch of the latter. The method of psychiatry and its way of thinking are completely differ-

ent. The morbid psychological symptom and its expression through speech and mimicry, in other words the raw material of psychiatry, represents the final result of an entire series of previous psychological processes and include the contribution of the psychological past of an individual. Psychopathological symptoms are incomprehensible without knowledge of normal psychology and, in particular, of the psychology of elements which lends denominations of symptoms to psychiatry –despite the monist tendencies of morphological psychology– which is useful mainly in the semiotic classification of symptoms (dysfunctions of memory, judgment, imagination, etc.). Even if, in the far future, psychiatric illnesses will be divided into independent morbid entities, each one corresponding to a specific pathological anatomical alteration, knowledge of psychology will continue to be necessary to a psychiatrist, just as knowledge of anatomy is necessary to a surgeon. We are obliged to think psychologically in order to understand and interpret most psychopathological phenomena. For example, a hallucination and a dreamlike delirium are differentiated by knowledge of the psychological mechanism of affects and dreams. Symptomatology of senile dementia is better understood, if considered as an exacerbation of the temperament of the elderly who are usually characterized by egocentric behaviour, reduced emotionality, fear of change, fixation on the past, suspicion and avarice. Symptoms of aphasia, including signs of intellectual decline, presuppose knowledge of psychology of articulated speech. Of course this has nothing to do with psychological interpretations, which common sense arbitrarily applies in every day life, but rather with the science of psychopathology, a topic that we will not deal with now.

Professor G. Pamboukis considers psychopathological knowledge equal to neurological knowledge. From his very first

classes following description of the histological texture and of the centres of cerebral cortex, where mental functions are performed, he dealt with each of these functions separately, in accordance with data of normal psychology and in conjunction with their corresponding pathological manifestations.

Finally, we will counter those postulating that psychology is useless for psychiatrists, by saying that it is impossible to differentiate between common sense and mental illness –in those cases where the limits between them are vague– without reference to the psychology of a healthy person. This allows us to distinguish autism, associated with schizophrenia –which is a passive internalisation, a thought maladjusted to life, an inability to communicate, an intellectual encapsulation– from the tendency to day-dream and the creative imagination of an adolescent or a poet, the intense dedication of a researcher to solving a problem, etc.

Permit us to cite here the characterisation of poetic creativity given by (ed: the literary) D. Tagopoulos (in 1919), in a lecture on the “Prophecy” written by our great poet K. Palamas: “the poet, during a creative period, concentrates, withdrawn completely into the solitude of his thoughts and carried away by his dream, lives an isolated private life –as he wants and as he makes it– a life dispelling reality and giving life to his dreams”. If Tagopoulos had ended this description here, poetic creation would be similar to autism as defined by Bleuler, however as an eminent psychologist he added: “whatever (the poet) may say cannot be construed as alien or raving. Everything he says is life itself, reality itself, but free of the superfluous burden put on life by each of us, distorting it according to our views, our character, even our material interests...”. Bumke, professor of psychiatry in Munich and Kraepelin’s successor, wrote, on similar observations of men of letters:

“there is not a shadow of doubt that every true poet promotes psychology more than one thousand experimenters!”

When Archimedes, absorbed in solving his problem, responded to the Marcellus’ soldier intruding upon him with his famous: “do not disturb my circles”, he did not suffer from autism, but rather he had freely turned inwards, in order to serve an active and productive mental life, whose invaluable products would be important for the future of geometry and mechanics. [...] In exchange for what psychology has offered to it, psychiatry offers abundant material for observation and research, as illnesses in general and mental illnesses in particular represent some kind of experiment on man, shedding copious light on his psychology.

Over the recent years, the use of questionnaires and elementary psychological analysis, in clinical examination, has been enriched by Freud’s method, which penetrates into the depths of the individual subconscious and unconscious psychic world and determines the innermost mechanism producing psychoneurotic disorders and conditions, by displacing instinctive impulses incompatible with dictates of morality and decorum (ed: in the unconscious psychic world). Many psychiatrists have contested or rejected some findings of psychoanalysis, concerning mainly the omnipotence of the sexual instinct and exaggerations stemming from the generalisation of this theory; in a similar way, they have received with doubt and mistrust the psychological theories of P. Janet. Nevertheless, it should be noted that most of them, as seen in cases published over recent years focusing on psychological interpretation of symptoms and seeking their moral causes, have changed their minds and have been influenced imperceptibly by psychoanalysis, even if they do not recognize it. We believe that, at least, the content of psychoneurotic symptoms is greatly elucidated by this way of investigating the unconscious. We

have examined exhaustively a schizophrenic patient, who presented, among other neologisms, the following: seeking to express how his imaginary persecutors were torturing him (by poisoning), he said that they were “delivoring” him. By analysing his dreams and associations, emerged a forgotten, probably disagreeable representation of a boy of his age named “Delivorias”, who had tortured him during childhood.

Without doubt, psychoanalysis provides us with the key to open the door leading to the unconscious and frees the pathogenic complexes therein; however, these should be attributed solely not only to sexual urges, but also to aggressive tendencies, both producing intra psychic conflict, feelings of guilt and manifestations of anxiety.

In the primordial region of psychic conflict, i.e. psychoneuroses, in certain cases secondary biological, endocrine and vegetative alterations occur, clinically, pharmaco-dynamically and chemically controlled, pertaining to basic metabolism, levels of cholesterol, calcium, potassium and alkaline reserves in the blood. We will not insist in this issue of capital importance, which is increasingly gaining ground in psychiatry. We will only mention that Laignel-Lavastine recently utilised biochemical methods to isolate, on the basis of clinical observations, a special form of psychoneurosis, which he termed “anxiety neurosis from alkalisation”.

Knowledge on endocrine-sympathetic changes and those in the composition of humours, which occur not only in psychoneuroses but also in most psychoses, such as mania, melancholia, mental confusion and others, provide us with arguments permitting to catch in the act perpetrators of the above mentioned diseases and to identify them, either as directly responsible or as instigators of other changes occurring in tissues, which will probably come to light after further research.

We have already spoken of the mutual relationship between psychiatry, on the one hand and internal medicine, neurology, psychology, biology on the other hand, noting that a practitioner of psychiatry should always keep his antennae turned towards these branches, leaving no issue of psychopathology uninvestigated. In order to have a comprehensive concept of a mentally ill person, we must consider him as an integrated psycho-organic entity, as Pierre Janet stated “we think with our entire body”.

We would have the impression of not having exhausted the topic under discussion, if we were to overlook the relationship between psychiatry and philosophy. Indeed, not only do we admit it, but we consider it to be useful.

The opposite opinion of those thinking that, probably, any philosophical involvement takes a psychiatrist away from a clinical approach and diverts his thought to more metaphysical considerations –which are dangerous waters, according to detractors– is only justified in the case where a psychiatrist abandons his post at the patient’s bedside, throws down his weapons, i.e. observation and positive thinking, and turns to theoretical and fruitless consideration of philosophical issues.

What Hippocrates said (according to Pr. A. Kouzis): “(*an*) excellent physician (*is also an excellent*) philosopher”, is particularly true of psychiatrists, if they philosophise without becoming philosophers. In other words, a psychiatrist must attempt, on the one hand a methodical analysis and synthesis in order to achieve an overview of all psychiatric issues and avoid a simple registration of phenomena unrelated to each other; on the other hand, he must pay close attention to the conclusions of philosophical systems, particularly those whose source and basis is the introspective psychology, in order to draw a better understanding of psychopathological phenomena.

The relationship between philosophy and psychiatry is presented under a dual aspect. What do philosophers believe regarding mental illness and which philosophical systems are useful for psychiatry?

We will not answer the first question in detail but we will list some names. Plato in *Timaeus*, as well as Aristotle in “Problems” lay down their doctrine on mental illness. Subsequent philosophers were Locke, Voltaire, Condillac, Hegel, Maine de Biran and others. Kant attributed mental diseases to morbid conditions of the brain: in *Anthropology* he says that rather a philosopher than a doctor should evaluate the responsibility of a mental patient for his acts. Erasmus wrote a witty essay entitled *The Praise of Folly*. Schopenhauer developed his own theory on mental illness in his treatises: *The World as volition and representation* and *Parerga and Paralipomena*.

Concerning philosophy’s influence on psychiatry, we would like to remind you that it was very marked in Greek antiquity and up to the middle of the previous century. Daquin, a psychiatrist, wrote “*The philosophy of madness or a philosophical essay on persons affected by madness*”, his most important work, in 1792. Amongst contemporary psychiatrists, Binswanger was influenced by Husserl (phenomenology) and Adler was inspired by Nietzsche’s philosophy. Adler rendered humane the German philosopher’s teaching on the superman, by discerning the innate feeling of weakness and insecurity, behind the mask of neurosis produced by transfiguration of domination’s tendency. The point of view of individual psychology, whereby a neurotic person arbitrarily attributes real value to tricks or figments of his imagination, attempting to exalt his ego, is justified by the theory of Vaihinger, a philosopher, on “as if (als ob)”.

Amongst various philosophical systems, Bergson’s approach is most closely associated to psychiatry. Before publishing, 40 years

ago, the invaluable to psychology and psychopathology treatise of the French philosopher, entitled "Matter and Memory", psychiatrists would take recourse in certain issues of associational psychology and they would be satisfied to consider delusions as a product of alteration of a nervous centre producing ideas; or they would imagine that a pathological process affecting a cell or a group of cells was sufficient in order to produce the corresponding disorders, as if it was a set of drawers containing a memory or an affect. Indeed, Taine compared the infinite autonomous centres of the brain with the image of a polypod.

Bergson struck a timely blow to this hyper-localisationist pseudo-anatomical phraseology by introducing nervous dynamism and psychic unity, on the dysfunction of which lay the foundations of Mignard's theory on the mechanism of all mental illnesses. Concerning application of Bergsonian philosophy to psychiatry, we would like to refer to Minkowski, who considered an elimination of vital contact with reality as the fundamental disorder of schizophrenia; basing this theory on the concepts of vital impulse and the difference between instinct and intellect, in Bergson's teachings.

Von Monakow and Mourgue used the concepts of the same philosopher, on the co-efficient of "time" and vital impulse in the "*Biological introduction in the study of neurology and psychopathology*". Indeed Mourgue, in his theory on perception and recognition by the senses in combination with a nascent movement, attempted to formulate a version concerning the pathogenic mechanism of hallucinations.

Unfortunately Bergson, apart from his treatise "Memory and matter" and another study on the "Memory through false recognition", does not focus on psychiatric issues. A careful study of his theory, from a psychopathological viewpoint, can conclude that psychosis is the result of loosening of active psychological

adaptation to external circumstances, as a result of which the sufferer becomes unable to have active experiences, although he retains the ability to develop a dream-like inner mental life.

Philosophy does not only enlarge the theoretical education of a psychiatrist, but may also prove to be useful in practice. There are cases of mental illness and attritional forms of schizophrenia “wealthy in autism”, in educated patients whose philosophical interests determine the content of their thoughts. We must be able, first to understand and subsequently to argue on the idealistic and absolute thinking paralysing action and then to adapt them to experiential reality. In cases of depression, bordering melancholia, which is brought on subsequently to all types of disenchantment and failure, we must prove to the sufferer that this abnormal psychological state is a consequence of his special tendency to exaggerate, a tendency which is linked to excessive value attributed to things and events. Depending on situations and individuals, we can draw examples from philosophical systems –we can draw freely from Epicurus and the Stoics to Kant and Berkeley– to prove the relativity of human affects, views and desires, in order to achieve reconciliation of the individual with the outer world.

Psychiatrists can combine the remedial influence on reason, whose efficacy is indubitable in certain cases, with the beneficial influence on affect. This is accomplished by manifesting sympathy and an open mind towards the sufferer, depends on the personality and character of the psychotherapist and on the enrichment and acquired cultivation of his affective world, which is provided by social and family experience and knowledge of the human psyche, as achieved by ancient Greek tragedians, Shakespeare, Racine, Balzac, Flaubert, Dostoyevsky and many others.

Constantinos T. Manthos

Schizophrenia

(*Ἡ σχιζοφρενία*)

*“Ephemeris ton Valkanion” (Newspaper of the Balkans),
Thessaloniki, 1929*

[...]

Clinical picture

Schizophrenia is a major manifestation of a schizoid constitution, often appearing in young age, particularly in adolescence, potentially developing further in adulthood and mature age. Its progression can be arrested by education, insight and various inhibitory influences.

Schizoid constitution is characterised by a tendency for splitting of the personality (insufficient contact with the external world and reality) along with the development of an inner life characterised by idiomatic thinking and symbolism.

In many individuals with schizoid constitution, this tendency can exist in an elementary form, manifest episodically and easily inhibited by external influences or self-criticism.

In some cases it exists in a latent state and can be revealed on the occasion of certain events or under certain conditions. In other cases, this tendency for splitting, appears to a rather marked degree and is revealed in the behaviour, the way of living of these individuals and in some of their actions, but they are still adapting, to a certain degree, to reality. The life of these individuals is only partially directed to the surrounding world, limited as it is to certain forms of activity (art, philosophical concepts, religion, etc.).

These individuals are usually considered to be eccentric or unbalanced, but they can lead a normal life in society, adapting to a greater or lesser degree to its fluctuations. However, in certain cases they can not adapt anymore, as is the case with intermittent phrenitis, where under the sway of various influences a manic or melancholic state is manifested. In higher degrees of schizosis, called schizopathy, the rupture with reality is more extended. The sufferer abandons his usual activities, turning to other activities, becoming suspicious, distant, aggressive, revealing certain proclivities, presenting either a frenzy of activity or meditating and concentrating on his private thoughts, which under normal circumstances he would never externalise.

The usual tendency of the sufferer to autism, in many ways restrained, is manifested through a partial and transient break with the external world, leading occasionally to a crisis, where contact with reality is lost and autism dominates the intellect of the sufferer. Many sufferers do not overcome these stages of schizoid and schizopathic conditions.

In further major degrees of schizosis, schizophrenia invades the picture, characterised by a complete break with reality and contact with the external world. The sufferer ceases to care for

his family, professional and social life, replacing reality with autism (inner life).

In primary autism, there is loss of contact with reality. The elementary mental functions are carried out properly, in contrast with the patient suffering from progressive paralysis, whose rupture with the external world is a direct consequence of weakening of the various mental functions (memory, judgement).

The patient with schizophrenia, due to defective direction of his mental activity, is isolated from reality, limiting himself to an intense inner life (autism), living in his abnormal, peculiar thoughts, contrary to reality. Any form of useful guiding idea disappears and the patients suffer sometimes passively the influence of the external world (giving rise to an excessive suggestibility, echolalia, etc.) and at other times do not react to any form of verbal stimulus, falling into absolute mutism.

The sphere of affect is particularly disturbed. The sufferer rapidly becomes indifferent, becomes a “spectator” and is not “in tune” with his environment; in certain cases he refutes and at the same time confirms the very same thing (Bleuler’s ambivalence). He also manifests a contradictory variety of erotic reactions and a discord of his affectivity, i.e. parathymia (M. Katsaras). Psychologically, this rupture of mental activity corresponds to the cognition of autism, presenting purely subjective tendencies, coming into conflict with “realistic” thinking which adapts the demands of reality and seeks to achieve the maximum of the real value.

The evolution of this syndrome leads to disruption of the personality, which ends up in “schizophrenic dementia”, characterised by a great change in affect, interest and spontaneity, in contrast to the relative integrity of the intellect.

Pathological psychology

As we have seen, the main disorder of schizophrenia is loss of connection with the environment and with reality. It has been observed that none of the cognitive functions is affected in the beginning, the disorder affecting to a greater extent their mutual functional relationships.

The main disorder exists *between* cognitive functions, *in the interstitial space* (Minkowski), producing the concept of “intrapsychic dysharmony” (Urstein), “psychic arrhythmia” or “discordance” (Chaslin), “intrapsychic ataxia” (Stransky), “loss of inner unity” (Kraepelin), “schizophrenia” (Bleuler).

Anglade, in attempting to characterise the psychological synthesis of schizophrenics, likens them to a book, which is not bound, and whose pages are not in order, and thus cannot be read, although not a single page is missing; which is completely different from a book whose pages have been torn.

Concerning the difference between dementia and schizophrenia, in dementia there is loss of judgement and memory, while in schizophrenia, even in the more advanced stages, all elementary psychic functions remain untouched.

The symptomatology of schizophrenia rapidly reminds one of dementia and unstructured delusions, accompanied by activation of lower psychological order, cataplexy with paradoxical positions, etc. Despite this, most commonly there is no observable point of real cognitive weakening, nor any loss of memory or faulty judgement. In contrast to organic dementia, it seems that nothing is irrevocably harmed in a patient, who frequently looks limited to an automatic and vegetative life.

[...]

From a psychopathology point of view, the processing of autism has some aspects in common with daydreaming conditions, which confirms certain of Freud's views. In some cases particular events of a sufferer's life, which have heavily burdened his sensibility and have been repressed in the "subconscious ego", take over the inner life, the mental action of the patient, and feed his autism. These complexes in certain cases can explain the significance of certain incoherent manifestations of the sufferer.

Because of autism, the sufferer is isolated from reality more than a blind or a deaf mute person, etc. All the sufferer's actions are inhibited on the very moment that they are planned and never lead to execution.

As to intensity, autism takes on two forms: (a) it can be profuse, fed by daydreams, where complexes oftentimes hold the major part; (b) it can be meagre, observed only in patients with an inferior imagination: this is the most common in schizophrenia.

Concerning daydreaming, in a normal psychological condition, one can instantly forget reality, yet reality never entirely disappears and daydreaming seeks an entrance into reality. Normal daydreaming is always subjugated to a latent awareness of reality. In schizophrenia, the latent awareness of reality is missing.

Pathological daydreaming in schizophrenia oftentimes narrows down, as it were, the sufferer ruminating on one or two fixed ideas/desires in a repetitive way. Sometimes, in fact, the sufferer is unable to say what he is daydreaming of.

Another characteristic of the schizophrenic condition is sometimes a *morbid rage* (bad temper, cruelty). From a young

age the patient presents egotism, pride, usually bad mood, irritability, and intolerance of the slightest of objections; the sufferer manifests, thus, from a young age the reaction of rage, in an excessive way and abnormal duration. Under the influence, for example, of some moral injury, these inherent traits give rise to mental disorders, in the basis of which the mechanism of morbid rage can be detected, the individual being furiously preoccupied with (what he considers as) the cause of his distress.

Pathological daydreaming and rage are secondary manifestations, added to the fundamental primordial morbid process, which consists of loss of contact with reality and a pointless inner life.

[...]

Differential diagnosis from dementia praecox

Rapid and early degradation of cognitive functions has been observed in dementia praecox, with dominant disorders those of affectivity, energy and volition. The sufferer expresses no curiosity, no initiative, no interest, has no awareness of the decline of his cognitive functions and has no insight, becoming a victim of automatism, displaying certain proclivities, being unable to adapt to the environment; due to a weakening of the higher cognitive functions (judgement, attention) and to lack of initiative. We are indebted to Kraepelin for the classification and the description of the various forms of dementia praecox: hebephrenic, catatonic, paranoid.

Cases similar to dementia praecox exist, presenting a less rapid and less extensive degradation of cognitive functions. The suffering adolescent or adult manifests a primary disorder of the intellect, rendering him unable to adapt to occupations

he was performing previously, indifferent to family and social life, suggestible or manifesting resistance. There is also a tendency to manifest certain characterised by unjustifiable affective reactions, agitation or depression. Sometimes the sufferer is possessed by hallucinations. This syndrome differs from dementia praecox, to the extent that cognitive enfeeblement is less extensive and certain cognitive functions are maintained, in contrast to others suffering degradation.

Although, through their apathy, inactivity, suggestibility, emotional indifference, unjustifiable reactions, paucity of association of ideas, they manifest an obviously affected mentality, yet, sometimes, they have the ability to undertake a fine work, to carry out calculations, or to compose a written text. Sometimes their memory is in good condition, but a diminution of normal tone is obvious: the sufferer manifests sometimes stereotypic behavior, incoherences between regular phrases, and proclivities opposite to his previous behaviour.

The most prominent characteristic of the syndrome of schizophrenia is a deep alteration of inner life in its relations to the external world. The inner life takes over in a morbid way (autism). The sufferer, in a way of speaking, becomes secluded within himself, perceives his desires as if they had already been accomplished, limiting to the minimum his contact with the external world. For the sufferer, autism is equivalent to reality, or rather becomes another form of reality.

The most prominent characteristic of dementia praecox is a primary and complete dissolution of psychological functions. In schizophrenia, the irrevocable, final dissolution of cognitive functions is secondary to the primary dissolution of psychism, the first manifestation of this dissolution being autism.

Pathological anatomy

The pathological anatomy alterations are neuroepithelial and angioconnective, with lesions in parallel of the tangential fibres. According to Bleuler these are localised in the fifth cortical layer. The intensity and variety of symptoms is due to the extent and nature of the anatomical lesion, in the evolution thereof, in the previous intellectual condition of the sufferer, his education, profession and heredity. Besides the aforementioned alterations, disorders of glands of internal secretion greatly contribute to the manifestation of this syndrome. Autism, negativism, etc. are due to the break in continuity, i.e. the fragmentation of the psychism in an altered brain.

Treatment

Therapeutic indications originate from the very definition of schizophrenia, which is mainly characterised by autism. A long stay in an asylum is by no means indicated, because the sufferer, in this case, is adapting and settling into his condition. Placement in farming families combats this tendency. Work, depending on the habits and preferences of the sufferer, constitutes the most suitable means.

It is also indicated to combat schizophrenic reactions with appropriate psychotherapy – at least as long as there is no complete decline in cognitive functions.

It goes without saying that a biological and chemical examination of blood, urine and all the organic systems is necessary.

By transforming a mental patient into a physical patient by inducing fever (malaria), by recommending a change of environment, by intensive psychotherapy we can achieve unexpected results.

Sometimes treatment is assisted by the psychoanalytical method, wherever this is possible (in absence of agitation or negativism).

Without an appropriate treatment, it is easy to understand that a patient with schizophrenia will drown ever more in his own autism, and will descend into a complete degradation, which is frequently induced artificially, by an extended isolation in an asylum or elsewhere (Minkowski).



Phocion Kopanaris **(1883–1975)**

Public Health in Greece
(*Δημόσια Υγεία ἐν Ἑλλάδι*)

Printed in Athens, 1933

CHAPTER 7: Preventing and combating acute and chronic diseases

B. Chronic Diseases **Mental Diseases and Addiction**

For many centuries, lack of systematic care for indigent and mentally ill patients in Greece has led to a full abandon of these groups of people, living without care amongst healthy members of their families and wandering in the streets. The influence of these mentally ill individuals, living and remaining in close contact with society, on the overall evolution of the race is patently obvious. The only attention and care the mentally ill received was their confinement to certain monasteries, where they were kept confined and bound in specific cells.

The first law in Greece concerning mentally ill was Law ΨΜΒ of 1862, providing for the establishment and the maintenance by the state, at the public expense, of one or more mental

asylums, depending on existing needs, in order to segregate and treat the mentally ill. The Mental Asylum of Corfu is considered to be the first Public Mental Hospital: established by the British, when the Ionian Islands were governed by them. It has been adopted at the time of the Union (1864) by the Greek government and according to the law of September 13th 1866 continued to operate under the supervision of the state, through a local committee, until it was entirely taken over by the (Greek) state. With a later law, of April 1922, the rules of functioning of this institution –which now (1933) is caring for approximately 600 mental patients– were designated in greater detail.

In 1882, a Decree incorporated a private philanthropic institution in Athens under the name “The Zorzi and Tarsi Dromokaitou Mental Asylum” (“Dromokaiteion”), legated by the late Dromokaitis. It is under the direct supervision of the state and operated by a five-member directory board. Since its establishment (ed: 1887), this institution received payment for admitting mental patients and is one of the best philanthropic institutions of this branch of care in Greece, caring approximately for 550 mental patients, under the supervision of a staff of approximately 150 individuals.

A similar foundation is “Eginiteion” Psychiatric Hospital, directed by the Greek National University and provides training for its medical students receive training in it. Legated by the late prof. D. Eginitis, it was established in Athens, in 1905. Approximately 100 mental patients receive treatment in it, all upon payment.

In 1910, an asylum was established in Suda, on the island of Crete, intended to treat itinerant indigent mental patients. A similar institution was also established in Thessaloniki in 1914.

In addition, a number of small annexes, attached to community or charitable hospitals, is gathering and nursing a number of mental patients. “Skylitseion” hospital on Chios island, “Vallianeion” hospital in Argostoli (Cephalonia island), where 20 mental patients are currently receiving treatment. A charitable association on Syros island run a similar foundation, as in Thessaloniki, where a unit for indigent Jewish insane was established and operates in the hospital legated by the Jewish Baron Hirsch. A similar asylum was established in 1913 in Athens, the Police Asylum at *Tzitzifies*, near *Phaleron* (ed: suburbs of Athens), in order to gather all psychopaths, alcoholics and vagrants wandering around Athens. This asylum moved, a little later, to a residence in the district of *Agia Eleousa*.

Established in 1924, the Direction of Hygiene (ed: the author has been the first director) has taken some series of measures in order to improve the condition of those mental patients treated in public asylums and mental hospitals, to extend and improve these facilities, as well as to create new psychiatric hospitals, in order to gather in all those mental patients who are wandering freely about and to assure the necessary care and treatment for them.

In 1925, a Decree was published “On the organisation of public psychiatric hospitals of Athens, Thessaloniki and Chania”, aiming to convert these casually organised asylums for the insane into psychiatric hospitals and modernise their way of functioning, according to up-to-date ideas on nursing and treating mental patients.

Through this Decree, the asylum located in the district of Agia Eleousa in Athens evolved into the current Public Psychiatric Hospital. Due to deficiencies of the unsuitable building

of the asylum of Agia Eleousa and the fact that a large number of mental patients had been gathered within, the state allotted a ground of over 20 hectares in a suitable green area near the Monastery of Daphni. Initially, temporary facilities were established, housing, by 1926, approximately 250 mental patients. This Psychiatric Hospital in time developed into a very active foundation, which is constantly undergoing improvements and progress, and may soon become the largest relative establishment in the Balkans. Four large buildings are almost finished, constructed in simplicity but in accordance with rules of hygiene. These will be, shortly, able to house easily 500 mental patients. The asylum at Agia Eleousa has improved to the extent possible, and is still functioning as an annexe of the Public Psychiatric Hospital of Athens; it should move to central facilities as soon as finances permit the construction of a new building, whose plans and preliminary studies are already finished.

The following table indicates the number of patients in the Public Psychiatric Hospital of Athens (along with the asylum of Agia Eleousa) from 1925 to 1931, showing a rapid increase of those treated therein, who make up half of all psychiatric patients cared in various institutions in Greece.

Table 1

| Year | 1925 | Admissions and pre-existing mental patients | 575 |
|------|------|---|------|
| » | 1926 | » | 564 |
| » | 1927 | » | 610 |
| » | 1928 | » | 742 |
| » | 1929 | » | 756 |
| » | 1930 | » | 1015 |
| » | 1931 | » | 1103 |

The efforts of our service in order to establish suitable new facilities in Thessaloniki's Asylum for the Insane (which was renamed as Public Psychiatric Hospital of Thessaloniki) were

not successful. However, conditions have much improved by moving from an old building in the Jewish section of Thessaloniki to appropriately arranged pavilions (ed: tolls) used by refugees in *Lembet* quarter. The operation of this institution has improved greatly, since its direction was placed in the hands of an experienced psychiatrist. The following table indicates the increasing population of this psychiatric hospital.

Table 2

| | | |
|--|------|-----|
| Mental patients receiving care in the year | 1925 | 50 |
| » | 1926 | 56 |
| » | 1927 | 84 |
| » | 1928 | 187 |
| » | 1929 | 192 |
| » | 1930 | 127 |
| » | 1931 | 146 |

The Asylum for the Insane of Souda (Crete), (renamed as Public Psychiatric Hospital of Chania, by the Decree of 26/7/1925) developed quite normally and since 1931 has been housed in a quite appropriate facility, in a fully renovated and suitably arranged large public building, which is located in the area of Souda. The patients' population changed as follows:

Table 3

| | | |
|--|------|-----|
| Mental patients receiving care in the year | 1925 | 101 |
| » | 1926 | 97 |
| » | 1927 | 119 |
| » | 1928 | 133 |
| » | 1929 | 132 |
| » | 1930 | 154 |
| » | 1931 | 151 |

Finally, from 1925 to 1931, many repairs, modifications and extensions were carried out in the Public Psychiatric Hospital of Corfu, in order to develop it to one of the best institutions of its kind. The population of the Public Psychiatric Hospital of Corfu for the period 1925–1931 was as follows:

Table 4

| | | |
|--|------|-----|
| Mental patients receiving care in the year | 1925 | 402 |
| » | 1926 | 433 |
| » | 1927 | 425 |
| » | 1928 | 478 |
| » | 1929 | 479 |
| » | 1930 | 542 |
| » | 1931 | 601 |

Statistics of Public Psychiatric Hospitals make it clear that it is psychiatric disorders associated with individual idiosyncrasy that fill up our psychiatric institutions and to a lesser degree psychiatric disorders due to external factors (syphilis, alcoholism, narcotics, infectious diseases, etc.).

The proportion of women confined, compared to men, was 1:3. The difference is sufficiently elucidated by the fact that, in our society, women are to a great extent confined to their home and are far less likely to be exposed to external causes of psychiatric disorders, or to suffer worries and daily inconveniences of overall life, as men do.

Treatment implemented on mental patients in Public Psychiatric Hospitals.

In these institutions mental patients received systematically the most recent and recommended treatments. Since 1925, Agia Eleousa's asylum has begun to implement, on a large scale, malaria therapy on general paralysis of the insane. On the other mental patients, those with dementia, schizophrenia, and cyclothymia, almost all forms of fever therapy were implemented: in other words, by Ducrey vaccination, by dengue fever treatment, by virus of Marseille fever (fever de Marseille or fever exanthématique), by antityphoid vaccination, by sulfosine and finally by fever therapy using extract of bees.

Table 5. Number of cases of main diseases, in Public Psychiatric Hospitals 1925–1931

| <i>Year</i> | <i>Dementia and Schizophrenia</i> | <i>Cyclothymia</i> | <i>Epilepsy</i> | <i>General Paralysis (syphilis)</i> | <i>Alcoholism</i> |
|---|---------------------------------------|--------------------|-----------------|---|-------------------|
| A. Public Psychiatric Hospital of Athens | | | | | |
| 1925 | 115 | 94 | 31 | 28 | 49 |
| 1926 | 170 | 194 | 23 | 32 | 28 |
| 1927 | 210 | 148 | 34 | 36 | 51 |
| 1928 | 344 | 219 | 53 | 69 | 43 |
| 1929 | 381 | 174 | 55 | 44 | 21 |
| 1930 | 299 | 231 | 53 | 65 | 45 |
| 1931 | 283 | 268 | 48 | 51 | 60 |
| B. Public Psychiatric Hospital of Corfu | | | | | |
| 1925 | - | - | - | - | - |
| 1926 | 179 | 31 | 33 | 7 | 9 |
| 1927 | 224 | 23 | 29 | 6 | 6 |
| 1928 | 225 | 26 | 30 | 7 | 4 |
| 1929 | 217 | 29 | 40 | 8 | 6 |
| 1930 | 266 | 29 | 43 | 9 | 5 |
| 1931 | 301 | 33 | 45 | 6 | 7 |

Table 6. Number of cases of main diseases, in Public Psychiatric Hospitals 1925–1931

| <i>Year</i> | <i>Dementia and Schizophrenia</i> | <i>Cyclothymia</i> | <i>Epilepsy</i> | <i>General Paralysis (syphilis)</i> | <i>Alcoholism</i> |
|---|---------------------------------------|--------------------|-----------------|---|-------------------|
| C. Public Psychiatric Hospital of Chania | | | | | |
| 1925 | 6 | 37 | 8 | 1 | 4 |
| 1926 | 11 | 22 | 14 | - | - |
| 1927 | 13 | 24 | 16 | - | 3 |
| 1928 | 19 | 29 | 15 | 3 | 3 |
| 1929 | 17 | 27 | 13 | 1 | 4 |
| 1930 | 16 | 26 | 9 | 1 | 3 |
| 1931 | - | - | - | - | - |
| D. Public Psychiatric Hospital of Thessaloniki | | | | | |
| 1925 | - | - | - | - | - |
| 1926 | 25 | 10 | 3 | 2 | - |
| 1927 | 31 | 20 | 6 | 1 | 3 |
| 1928 | 70 | 45 | 18 | 2 | 5 |
| 1929 | 74 | 32 | 24 | 7 | 6 |
| 1930 | - | - | - | - | - |
| 1931 | 98 | 30 | 16 | 12 | 10 |

The number of patients vaccinated in the Public Psychiatric Hospital of Athens is as follows:

Table 7

| | |
|------------------------------------|-----|
| 1. By malaria's plasmodium | 60 |
| 2. By Ducrey vaccination | 1 |
| 3. By the virus of Dengue fever | 200 |
| 4. By the virus of Marseille fever | 500 |
| 5. By the sulfosine virus | 200 |
| 6. By anti-typhus vaccination | 350 |
| 7. By extract of bees | 8 |

The conclusion drawn from this wide-ranging implementation of various forms of fever therapy is that malaria therapy implemented, particularly on patients with general paralysis of the insane, is preferable to all others. To a lesser degree came the action of Marseille's fever and to a similar extent that of sulfosine, the latter having the advantage of being entirely harmless and without side-effects, the fever subsiding spontaneously after 1–3 days.

In addition to the aforementioned treatment, the so-called work therapy was equally implemented, particularly in the Public Psychiatric Hospital of Athens. Inpatients are systematically involved in various productive work, either by cultivating the large fields surrounding the psychiatric hospital, gardening, or by sewing clothes, ironing, embroidering, doing fine-work, etc. These work groups are enriched and perfected over time. The influence of liberty connected to work on the overall condition of mental patients was truly most beneficial. First and foremost the work acts by suppressing agitation, and consequently, the use of isolation chambers, in this psychiatric hospital, has been almost entirely wiped out, as has the use of all usually implemented restraining means.

The establishment of additional psychiatric hospitals, similar to the Public Psychiatric Hospital of Athens, at suitable rural areas of the country, following the system of (ed: internal organisation) of small departments, for 20–25 psychiatric patients, will complement the work we have already begun in receiving, nursing and treating mental patients in Greece to the extent possible. We estimate that ten of these institutions, each one admitting 250–300 mental patients, will be sufficient to care for the totality of psychiatric cases, thus preventing their (possible) criminal activity and the degenerative influence on the race.

By elaborating the system of care and completing our statistics on mental patients, which we have already begun; by building departments, independent of the main psychiatric hospitals, for less severe cases of mental disorders and for mentally abnormal epileptic and nervous patients, by establishing consultations for mental hygiene, in particular to indigent people, in order to obtain medical assistance and advice on everything concerning nervous and mental diseases and, finally, by a detailed and vigilant monitoring of children in their intellectual and psychological development, we will complete the work of the State Hygiene Service.

The obligatory application (in Greece) of a premarital health certificate, would, without doubt, have a most beneficial effect on the issue of suppression of mental disorders.

Measures taken against drug addiction

The attention of Society in general, and of the State Hygiene Service in particular, has over the past few years turned to the risk from drug addiction, in view of the devastating effect it has over the mental state of its victims. Drug addiction, this

post-war global menace, and particularly heroin addiction, has also had an effect on our country and particularly on the working classes and most particularly on young individuals. The danger from alcoholism has been almost entirely wiped out compared to the hazard presented by drug addiction and catastrophic heroin addiction. Concerning heroin addiction in particular, we should note that over the past few years this has significantly replaced morphine, cocaine and marijuana addiction.

Therefore the Greek State, with its leading Hygiene Service, considered drug addiction and particularly heroin addiction as a National Hazard. The measures taken to combat narcotic drugs, used for hedonistic purposes, are set out in detail in the chapter “measures of protection against the use of hedonistic pharmaceuticals” of the present study. Here we shall note only that such importance has been placed on drug addiction to heroin, as to prohibit its use in general and not to include it amongst narcotic pharmaceuticals, which are available through narcotic pharmaceuticals monopoly and are procured and imported by the state for purely therapeutic purposes. It should be reiterated that only the establishment of state monopolies on narcotic pharmaceuticals in all countries, in accordance with our own legislative system, will truly prevent the illicit production and spreading of narcotic pharmaceuticals [...].

Of course we do not dispose of precise statistics on the number of heroin addicts in Greece, however the numbers of drug addicts (heroin addicts) who have received treatment over the past four years in the Public Psychiatric Hospital of Athens are indicative of the increase of drug abuse victims and fully justify the extremely harsh measures recently insti-

tuted by the Greek State in order to combat the spreading of hedonistic drugs.

The number of heroin addicts who received treatment at the Public Psychiatric Hospital of Athens was as follows:

Table 8

| | | |
|--|------|-----|
| Heroin addicts treated during the year | 1928 | 10 |
| » | 1929 | 51 |
| » | 1930 | 99 |
| » | 1931 | 113 |

Alcoholism

Research conducted by medical officers in various prefectures of the state over the last few years, concerning alcoholism, permits us to draw the conclusion that the problem of alcoholism, existing also in other European countries, does not exist in Greece, to the extent and in the form manifested there. The alcoholic beverages consumed in Greece by the working classes are mainly various domestically produced wines, usually containing 12–13% alcohol by volume, while table and desert wines contain 14–16% of alcohol. Locally produced, tsipouro, ouzo, masticha and other spirits are the products of distillation of fermented juice of the pomace (the residues of the wine press) after the addition of mastic or seeds of aniseed or fennel and most frequently anethol, containing 30–40% alcohol by volume. Pure alcohol, from European markets, which is not derived from grape products but from starches, is not utilised in Greece for the production of alcoholic beverages. In urban centres beer is extensively consumed, usually containing 5–6% of alcohol.

In the northern regions of the country, the use of strong alcoholic beverages (tsipouro, ouzo) is quite extensive. However, the use of alcoholic beverages cannot be considered

excessive, with the amount of alcohol consumed per capita and per annum not exceeding 1,500–2,000 grams and this not in its pure form.

These projected observations go together with clinical observations concerning disorders caused by alcoholism to the entire body and particularly to the nervous system. A review of tables, in the chapter on mental diseases and psychiatric hospitals, on the distribution of individuals treated in the Public Psychiatric Hospitals for mental diseases during period 1925–1931 indicates that the proportion of mental disorders due to alcoholism was small (did not exceed 3%) compared to other causes of mental disorders and particularly those of an idiopathic nature. This is contrary to the rate of alcoholism observed in psychiatric hospitals of other European countries, for example in Switzerland where the percentage of mental disorders due to alcoholism is as high as 25%. However, even in Greece, enlightening and educating the public as to the dangers of excessive alcohol consumption and campaigns against alcoholism in general should become more systematic, not only in order to decrease the abuse observed particularly in provinces, but also to avoid any potential future diffusion thereof.



Constantinos Mitaftsis (1893–1965)

Bleuler's theory on schizophrenia and the group of schizophrenias

(*Ἡ θεωρία τοῦ Bleuler περὶ σχιζοφρενίας
καὶ σχιζοφρενικοῦ πλέγματος*)

Iatrika Chronika (Medical Chronicles) 1933,
4, 275–282 & 5, 385–398

Surveying the evolution of the names given to the classic psychosis of schizophrenia, we observe that this is the only one that has undergone so many changes in denomination, out of all psychoses known and described in psychiatry.

First of all, in 1843, Spurzheim and Esquirol described this disease under the name “acquired idiocy”. Later on, Morel has described distinct traits of this disease, first introducing the term “*démence précoce*” (precocious dementia) and the term “juvenile dementia”, characterising the cognitive condition of young individuals, whose development of mental functions had stopped and was deteriorating towards mental disintegration. However, Morel, through investigation of various mental diseases and being convinced of their hereditary nature,

considered this disease also, whether precocious or not, to be a secondary one, coming either as a complication or as a consequence of the evolution of various psychoses, whose course could not be interrupted. Indeed, in his classification of mental diseases, he conferred the stigma of degeneration on the disease, under the term “final symptom of hereditary insanity or insanity of the degenerate” (*folies des dégénérés*). Some time later, Magnan, adopting the same denomination as Morel, extended, as is already known, the aetiological significance of degeneration in the development of mental diseases. However, towards the end of the 19th century, despite noteworthy studies by Ball and Christian, this disease had fallen into absolute oblivion.

In contrast to French authors, German psychiatrists, over the same period, had created another theory on primitive dementia (*dementia praecox*) that was introduced by Kraepelin. Alongside his name it is essential to mention also the names of Kahlbaun and Hecker.

In 1863, Kahlbaum and later, in 1871, his student Hecker used the term “hebephrenia” to describe a nosological entity oncoming during puberty, characterised by a suspended development of the inner mental world, rapidly leading to an intellectual decline of mental functions of the higher psychism, through successive phases of excitation and depression.

A little later (1874) Kahlbaum focused his attention to a specific psychosis, with cyclical course, which successively impersonated the picture of melancholia, mania, cataplexy, etc. [...] occurring, usually, in a slightly more advanced age than hebephrenia and not leading, as the latter did, to complete prostration, to a greater or lesser degree, of all mental functions.

Based on these two syndromes, on their rapid onset during puberty and on the typical gravity of their outcome, Kraepelin proposed in 1893 that these should be classified together with hallucinatory delusions, which developed into paranoid dementia and paraphrenia, under the term of dementia praecox. All (the aforementioned entities) were promoted by Kraepelin to the order of a specific clinical entity, including three sub-divisions (hebephrenic, catatonic and delusional), characterised from the beginning by the existence of a primary and rapid deterioration of cognitive energy, possibly caused by self-poisoning, from an endocrine source. One can understand that this nosological synthesis, which overturned all previous ideas and which furthermore was described in various ways by its author, had a small number of fervent partisans and many more opponents, upon the formulation of its definition.

In the first rank of opponents was Regis, as for many years and even recently he attempted to limit the framework of Kraepelin's primitive dementia, in favour of the term mental confusion. He distinguishes two, substantially different forms of primitive dementia: (1) one type, that constitutes a *primary systematic early dementia*, being systematic and produced by degeneration, affecting young individuals with a heredity burden and more or less subject to the acquired cause of self-poisoning by the factor of puberty and which includes a limited number of cases of the three forms of Kraepelin's primitive dementia, mainly cases of the hebephrenic form, thus forming the *primary systematic precocious dementia* and (2) another type, the *secondary precocious or post-confusional dementia*, that is secondary, caused by contagion or toxins, always occurring at the end of an attack of acute mental confusion, which becomes chronic, acquiring

the features of catatonia, ending in the destruction of mental functions.

[...]

The affinity of precocious dementia with mental confusion has been ruled out also by Chaslin, the person who created the term mental confusion, considering that these diseases are rather incompatible, especially with reference to dysfunction of disorders of the higher psychism. [...] Chaslin fully rebutted the distinction established by Regis and he was opposed to the term “dementia praecox”, considering it inaccurate and inappropriate. Concerning Kraepelin’s form (of dementia praecox) produced by self-poisoning, he claimed that it is not caused by deterioration of mental functions of lower and higher psychism, but rather by discordance between these, i.e. dysfunctions belonging to each of these psychisms are unrelated and consequently symptoms are independent and free of any connective links, in contrast to all other psychoses, where all symptoms are dependent on and resulting from the interconnection of both psychisms. Therefore, according to Chaslin’s view, this situation of disharmony, which has also been noted by Ziehen (hebephrenic paramimia) and by Stransky (intrapsychic ataxia), is not a sign of dementia, but rather a phenomenon preceding dementia, no one being able to predict the time of emergence of dementia. Based on this view, Chaslin proposed the term “discordant insanity” (*folie discordante*), instead of Kraepelin’s “dementia praecox” including, in any case, all its forms (hebephrenic, catatonic, delusional).

These were the views held by various psychiatrists and authors, concerning the nosological autonomy of schizophrenia and especially its denomination, up to the beginning of the second decade of this century.

In 1912, E. Bleuler, professor of psychiatry at the University of Zurich, described in G. Aschaffenburg's *Psychiatry* a nosological entity under the name of primitive dementia or *group of schizophrenias*. Bleuler did not follow either the views of Morel, or the views of more recent authors, such as Hecker, Kahlbaum, Glouston, Kraepelin –who studied and denominated precocious dementia, thinking that, from a psychopathological point of view, it was a nosological entity produced by the weakening of psychic functions of the higher and lower psychism– or the views of Regis [...]. One could say that Bleuler's theory approaches the theory of Chaslin, who thinks that precocious dementia is not a weakening of psychic functions but an intrapsychic discordance with the higher psychism; this is why Chaslin named it “disharmonic phrenitis”. According to Bleuler, however, this is no longer a discordance, but is a splitting, literally a schism of the tracks connecting psychisms and the various psychic functions, a schism which constitutes a precursor sign and the fundamental character of primitive dementia, preferring for this reason to use the term “schizophrenia”. In order to enact this new nosological entity, Bleuler based his clinical and psychopathological ideas on the following irrefutable, to this day, points:

1. *Clinically*, the main characteristics of this psychosis are: (a) autism (autismus) i.e. the loss of cohesion of the individual to reality and the double or bipolar intellectual condition thereof; (b) the weakening of affectivity; (c) the maintenance or rather the hypertrophy of certain functions of the higher psychism (memory, conception, automatic attention and the perception of time and space); (d) the disorder of ideation (paucity of ideas, ideas that are foolish, contradictory, capricious, incoherent); (e) the ambivalent state of the three qualities of psychism.

2. *Psychologically*. The views held by various psychiatrists and authors (Dide and Guiraud, Kraepelin, Bleuler, Delmas) and clinical observations necessitate that our psychism, which is a complex energy centre, consists of three qualities: (a) the higher conscious psychism, which includes the mental functions (cognition, memory, attention, logical judgement, ideation, conception); (b) the lower psychism, intrapsychic subconscious psychism, which contains psychic functions (emotional and moral affect, neuropsychic disposition, passions, instincts); (c) the volition which received the products of the higher and lower psychism and externalises them, some in the form of voluntary or conscious acts and ideas and others in the form of subconscious or reflex acts and ideas.

In order to obtain a psychopathological correspondence of clinical features of schizophrenia with the above mentioned characteristics of psychism, Bleuler claimed that links or connections between the higher and lower psychism and volition, on the one hand, and between various mental functions, on the other hand, are torn apart or rather undergo a schism and that each psychism becomes free of all continuity with the others and each one is divided into many fragments. Thus: (1) From the higher or cognitive psychism we obtain products that have no affective coloration, are incoherent, contradictory and entirely contrary to the affective condition, i.e. a poor, foolish, incoherent ideation, existing but unutilised memory, perception and attention and finally an ambivalent intellect [...] (*Ambivalenz intellektuele*); (2) From the intrapsychic or affective psychism (we have products) that are also autonomous and independent of any participation of the higher psychism, namely autism, daydreaming and affective ambivalence, e.g. the patient loving and hating simultaneously regardless of any cause and interaction; (3) From the volition

we have products that are autonomous and have no cohesion with the higher and the lower psychism, such as volitional ambivalence (Ambivalenz den Willens), the patient seeking, simultaneously, to eat and yet not to eat.

This is Bleuler's schizophrenia, from a clinical and psychopathological point of view. Aetiologically, he considers it to develop on a special ground of ascendance, the "schizoidia", erupting into schizophrenia under the influence of some exogenous factors (infectious diseases, moral shocks, head injuries, etc.). One might say that Bleuler's aetiology is in accord with the views of Regis.

Bleuler's theory was embraced by almost all psychiatrists and authors, both German and French (with the exception of Claude, Regis, Lavastine, Barbe), because the term of primitive or precocious dementia –whose psychopathological and clinical substance was differently formulated by each author– had the imperfection of incorporating psychic forms, which had not really developed fully or would develop at a later stage into dementia praecox.

However, Bleuler, as we already know (Bleuler, "Dementia praecox oder Gruppenschizophrenien", *Aschaffenburg Handbuch Psychiatrie* 1912 Literatur), not only introduced this new nosological entity under the name of "schizophrenia", but also used the term group of schizophrenias; i.e. according to him schizophrenia constitutes the common basis for many psychoses which belong to this group: (1) many atypical melancholias and manias; (2) Kraepelin's dementia praecox; (3) paraphrenia; (4) some forms of paranoia; (5) mental confusion and particularly the hallucinatory form; (6) the majority of Magnan's degenerates; (7) the form of litigious delusion of senile dementia; and (8) psychoses of prison.

Concerning the group of schizophrenias, the purpose of the present dissertation and the following clinical cases is to set some limits to the broad framework and broad entity given by Bleuler to this new nosological entity of schizophrenia and not to deny its existence .

(ed: *There follows a description of six clinical cases, which all concluded in a negative "judgement", concerning criteria of inclusion of these clinical entities in the group of schizophrenias*): (a) and (b) "...this case refutes Bleuler's view on paraphrenia, as having a similar basis to schizophrenia"; (c) "this case refutes Bleuler's view on paranoia being a basically schizophrenic disease"; (d) "Paranoia or chronic systematic delusion of persecution evolving into a megalomaniac and erotic delusion (...), having no schizophrenic features"; (e) this case (...) contests Bleuler's view on the schizophrenic character of Ganser's syndrome"; (f) "our patient (...) permits us to refute Bleuler's view on the schizophrenic character of hysterical melancholia".

Conclusion: It is known that almost all French psychiatrists and authors are arguing against Bleuler's theory. The majority, including Barbe, Laignel-Lavastine, Deny, Delmas, Nathan, Regis and mainly the students of Dupré, Devaut and Logre, refute entirely the existence of this nosological entity, named schizophrenia. They promote the idea that, neither discordance in the psychism (according to Chaslin), nor a splitting or schism of the connections linking psychic functions (according to Bleuler), could be considered as criteria of schizophrenia, as this fragmentation of consciousness can be found in various conditions, either in psychasthenia, where the fragmented pieces of the personality deliver a difficult battle (psychasthenic anxiety), or in hysteria where the patho-

logical synthesis of the subconscious is isolated, or rather kept at a distance from the conscious personality, like a comedy or tragedy art or playing his part and forgetting or ignoring his own true personality. Similarly and by other means, Devaux et Logre refute the existence of schizophrenia on the issues of intellectual enfeeblement, outbreak etc., admitting, in its place, the (diagnostic concept of) hebephrenic-catatonic psychosis. Other authors, such as Claude and his disciples, Robin, Minkowski, and partially Pierre and Kahn, admitted that Bleuler's schizophrenia should be divided into two distinct illnesses: (1) primitive dementia (an exogenous disease) and (2) schizoses (a group of mental diseases developing along the special psychopathic constitution of schizoidia).

Our own position is as follows: we accept, on the one hand, Bleuler's view on the existence of this new nosological entity (schizophrenia), whose psychopathological basis –having a better scientific foundation– is more solid than the clinical one, reflecting better its clinical traits. On the other hand, we do not accept the broader sense attributed by Bleuler to schizophrenia, as none of the six clinical cases we have already described, presented any clinical characteristic of schizophrenia and particularly the major and basic sign of autism. Consequently, we must classify these psychoses as separate nosological entities under their own recognised name and definition and not in accordance with Bleuler's schizophrenia.



Georgios Pamboukis (1885–1959)

The functions of language or speech. Intellect and right-handedness

(Αἱ λειτουργίαι τοῦ λόγου ἢ τῆς λαλιᾶς.

Ἡ διανόησις καὶ ἡ δεξιοχειρία)

*Inaugural Lecture (14th November 1934),
Reprinted by Iatriki Proodos (Medical Progress)*

The theme that we are going to deal with today has many facets and is amongst the hardest to approach. This theme is the relationship between the functions of language or speech, intellect and right-handedness. We will attempt in the broadest and most general terms, to address the psychological and particularly the anatomical and functional aspects of this topic, in order to provide a broad idea, a generally accepted contemporary scientific view, on the relationship between these functions, and first and foremost the relationships of the functions of speech or language to thinking or intellect (Denken).

Thinking or intellect, in the most general sense of the term and according to various views, as Bühler states, is not only to compose, analyse and judge, to receive representations, to perceive, to form abstract concepts, to compare and correlate,

but also to undertake the appropriate action and volitional process to this end.

[....]

Scientists of our specialty have attempted to study the problem of speech by combining conclusions of psychologists/linguists with those concerning aphasia. These are mainly Isserlin, Goldstein, and particularly Pick, and some others, such as Finkenburg and H. Jackson. In fact, almost all who have addressed the problems of aphasia (Broca, Wernicke, Pierre Marie, Head, Déjerine, Lichtheim, von Monakow, Liepmann, Herschen, Kroll, Niessl, von Mayendorf, Pötzl, Bonvicini, etc.) have more or less approached the topic of speech.

The older specialists, linguists, psychologists and philosophers, generally founded their relative studies on the opinion first expressed by Aristotle, that speaking is one and the same with thinking. Aristotle, in his work on *Psyche*, in Book III, chapter 7, paragraph 6 (ed: Bekker) wrote: “to perceive, then, is like bare asserting or knowing”, and in part 2, paragraph 22 he writes that: “Therefore, as one speaks, so does one know and perceive”. Aristotle’s opinion was widely accepted up to the last century, and this opinion on the *equivalence* of these two functions held sway to such an extent, that Steinthal would say: “To speak is the same as to think, the word is the same as the concept, the verbal sentence is the same as the judgement; all these are expressed verbally, perception can approach them through the voice and they are incorporated into something unified”. Yet, this opinion is no longer accepted today, with certain isolated exceptions. That this theory of identity of these two functions is mistaken was not only deduced by studying them in-depth in savage and primitive people, the development of speech in children and even in higher animals

(where, as is generally accepted, certain mental functions exist without verbal function), the study of the deaf-mutes, the study of talking birds (parrots – where no corresponding cognition to mechanical, mimetic and verbal functions exists); but also from the pathology of aphasias and their analysis in the form of an experiment of nature, where the relationship of the two functions is disrupted in such a way that while one function, that of speech, is removed, the other one, of intellect, remains almost untouched.

[...]

We must accept a close and, in fact, the very closest relationship between intellect and speech, but not that these two functions are identical.

Concerning this relationship, special attention was drawn to the *pathway connecting thought and speech* (der Weg vom Denken zum Sprechen), particularly by Pick, who focused his research on this issue, in normal and pathological conditions (aphasias). In parallel, with relevant conclusions drawn by linguists/psychologists, he studied the various stages of development of this pathway in relation to the phenomena of illiteracy, verbal forms of telegraphic expression (Telegrammen-styl), the childish way of expression, the language serving the requisite need to communicate (Sprachnot), etc. These phenomena are also observed frequently in aphasic conditions, in which often disturbance and dissolution of this pathway from thinking to speaking takes place *in the reverse direction*, to the way in which this pathway was originally formed, in other words in the opposite way to its normal phylogenetic and ontogenetic development. A regression takes place to inferior, older ways of expression as, for example, the way of speaking of primitive and savage people, of children and the communication of deaf-mute people.

[...]

The anatomical and functional study of this topic encounters greater difficulties because, whilst we do have certain rough data concerning the functions of speech, when it comes to thinking we are still very far from determining it either functionally and more so anatomically. Anatomy of normal people hides most zealously the secrets of this problem and may conceal them for a very long or infinite time; at least until the time that advances in technical progress will permit us to distinguish the various qualitative and quantitative functional correspondence to histological changes...

Histological alterations observed in the form of destruction of adjoining fibres of the outer zone of the molecular layer and of nerve cells of the cortex in general paralysis of the insane, and histological changes in the form of a decrease of cells or a ravaging of third and fifth layer of the cortex in schizophrenia, that is to say in two diseases leading particularly to dementia provide the suitable ground for study, yet (these studies) are not sufficient at least to date in order to permit some conclusions concerning the relationship between such lesions and the functions of intellect. Also, dysfunctions of attention, volition, affect and logic, as well as dysfunctions observed in lesions of the area between the parietal, temporal and occipital lobes, such as disorders of perception, knowledge (and action), can inform us only of non-specific dysfunctions, possibly related to the communication between the parts, rather than a lesion of the specific centres of these functions; and even less of the mode and the nature of the relationship between anatomical substrate and functioning.

The most prevalent contemporary opinion is that intellectual functions are performed by the cortex as a whole in both hemispheres of the brain. If something is better localised, to a

greater or lesser degree, as to anatomy and function, this is the sensory impressions and particularly their cerebral recordings, i.e. the remaining memory traces, no matter whether we accept these to be produced in material, physico-chemical, or dynamic ways. These are considered to constitute the simplest psychic elements, whose countless and varied combinations permit to weave the representations, to accomplish their association with each other and, in general, to compose the extremely complex mechanism of intellectual functions. If it was permitted, one could compare these simplest mental elements to typographical movable letters, which although so tiny may achieve an infinite combination of words and sentences. What intellectual force is we do not know, and possibly we will never know what its essence is. Perhaps this problem is connected to the more general problem of the relationship between energy and matter, or is even more complex. This unknown (intellectual) force, as Wahle states in his work on the mechanism of intellectual life, makes use of the brain as an homunculus, without us knowing how it acts beyond it. Perhaps only memory traces coming from the senses, what is *written* in the brain, can help us to achieve a very limited comprehension of the elementary functions of intellectual life.

[...]

Concerning the functions of speech, we can distinguish these into centripetal and centrifugal. Of the centripetal functions, which are mainly two, *auditory* and visual, the auditory is utilised to conduct auditory impressions of words (verbal symbols) and the visual, which is a special achievement of those who are literate, is utilised to conduct to the brain the visual impressions of words (by reading). Here again, for those who are not specialists, we must note that we distinguish the sensory impres-

sions of words, auditory or visual, from the sensory impressions created by objects e.g. a *bell* produces an auditory impression of sound, while *the word "bell"* produces the auditory impression of *the word "bell"*, which is something entirely different.

Here we are dealing with the auditory and visual impressions of *the words*, which constitute an integrated system of functions of language and of mnemonic images engraved by the words in the brain. It is obvious that the impressions of the words, usually bring forth in the brain the images of the objects connected to them; this entire psycho-physiological mechanism is very complex and in many aspects still impermeable to research. The only thing we know through morbid conditions is that mnemonic records of auditory images of words are localised near the posterior section of the left superior temporal gyrus, the so-called Wernicke's area, the auditory centre of words, while the visual images of words are localised in the angular gyrus, which is the centre of visual images of words. It is obvious that the above mentioned centres should not be conceived as a concentration in definite parts of the brain, as in a single address, as in a form of geographic table of these various functions, but as parts of the brain wherein a function is manifested to a greater, clearer degree and consequently it is harmed to a greater extent in pathological states of these parts. That is what we have to say concerning what we mean by centres.

[...]

It is impressive, that what we have described as centres for the function of speech one of the two hemispheres of the brain. In 90% of people in the left hemisphere, in 5–6% in the right hemisphere and in 4–5% in both [...]. One other noteworthy phenomenon also exists: 90% of people who have their speech centres to the left are also right-handed, the 5–6% who have their

speech centres to the right are also left-handed, and the rest, in their majority are ambidextrous (or perform with both hands).

We can therefore postulate that with reference to the functions of speech, a counter-lateralisation or mono-lateralisation (Lateralisierung) exists one hemisphere having an apparently commanding position over the other one, notwithstanding the fact that it participates equally in the neurological mechanisms of these functions, while in the mnemonic and connective functions the opposite hemisphere has a subordinate role. We also observe, as stated above, that this lateralisation of functions of speech exists in such a way, that in right-handed individuals this is localised in the left (opposite) hemisphere, while in left-handed individuals it is localised in the right hemisphere of the brain.

Besides the possibility of localisation of the functions of speech, in certain people on the one or the other hemisphere [...] clinical, patho-anatomical and comparative anatomical-physiological studies carried out by von Niessl Mayendorf – which have revealed that, e.g. the so-called speech cells (Die Sprachzellen) exist also in the brain of the monkey, which are unable to speak, justify the conclusions of this specialist investigator of functions of language, that these functions, and in our case, the kinetic articulating function of language, the speech, are not connected with a pre-formed anatomical structure. He writes: “The ability of humans to speak cannot in any way be based upon the presence of specific cell forms or on specific cortical cellular-architecture, but is based solely on a *purely functional combination* of certain cell groups, which can never agglomerate (sich verkörpern) into a single anatomical texture”. In another part of his relevant study he adds “The human faculty of speaking is not a requisite physi-

ological consequence of an anatomically *pre-formed* centre of speech, but instead this quality (the functions of speech) is the product of over a millennium-long *practice*, which solely by the influence of social living *on each individual is constantly renewed and continues to exist*".

On the basis of this justified opinion expressed by von Niessl Mayendorf, if we accept that the various functions of speech constitute the cardinal means of communication of this intellect with the environment, we must necessarily accept that intellectual functions also, *at least as far as their relationships with the functions of speech* is concerned, are not stably linked to a pre-formed anatomical substrate, as the purely neurological functions are. The intellect can draw its verbal material by centripetal paths and project through words the elaborated material, via centrifugal paths *sometimes by the use of the left hemisphere and at other times by the right one*; we must accept, however that the closer link of these two aforementioned functions, the development of the *pathway* from intellectual functions to speaking, as well as of the other functions of speech, is also (as are the functions of speech) the result, mainly, of *one or the other functional practice and layout* (path making). In other words, the function does not necessarily grow alongside an anatomical substrate preformed for this purpose, but is a quality, which is mainly gained functionally in each individual. Basic anatomical prerequisites naturally exist in each of the two hemispheres, but these particular paths develop in their further individual evolution either in the left or in the right hemisphere, by *particular functional lay out and practice*. Both of these functions (of speech and of communication pathways with the intellect) can confirm the principle that *function creates the organ* (la fonction crée l'organe).

Through his aforementioned views, von Niessl Mayendorf draws the conclusion that *the material substrate of thinking* is the product of the functional path-layout, arising from the action of one hemisphere, usually the left one; and along with this of the conscious functions of speech, that is to say the result of functional practice, which depends on this or the other path layout within the brain cortex.

It is obvious then that lateralisation, i.e. the concentration of very fine functions of speech in one hemisphere and consequently a much closer connection and relationship of these to thinking constitutes a rule or a principle, according to which concentration of energy, in a way of speaking, of a mental wave on a specific area of the brain, is potentially the necessary prerequisite for these extremely complex and multifarious cortical functions.

This principle, i.e. of concentration, excellence and hegemony of one of the two hemispheres of the brain, may potentially constitute the continuity, i.e. the further evolution, of two other principles that govern the anatomical and functional evolution of the entire nervous system and particularly the brain in the ascending zoological scale. One principle was formulated by J. Steiner and particularly by our unforgettable late teacher von Monakow, as a constantly evolving migration of functions *from the lower and older (sub-cortical) areas towards the higher and newer areas of the brain (cortex)*. The second principle was formulated by the other late great researcher, von Economo, the principle of progressive cerebation and consequently cognitive development as a *principle of nature* (Die progressive Zerebration ist ein Naturprinzip. Med. Wochenschr, 1928, No 28)

According to the principle of von Monakow –the migration of functions towards the cortex– the various different func-

tions, which in the lower animals are located in sub-cortical parts of the brain, as we ascend the zoological scale migrate towards the higher and newer parts, the cortex. In this way, for example, the function of vision in lower animals (in sandy bottom animals like the sea lamprey *Petromyzon* and crustaceans) ends below the cortex in the so-called visual lobe, but little by little we can observe that in the immediately superior animals a *new anatomical/histological path* develops that leads to the cortex (in the occipital lobe) and creates therein a new centre for visual function. Similar is the case with auditory function, sensibility, mobility, etc. where this so-called migration of various functions to the cortex is also observed.

Von Economo's principle, of a *progressive "cerebration"*, consists of the fact that as we ascend the zoological scale, the areas of the brain between the sensory and motor areas (the centres of the sensory and motor functions, the so-called projective centres), what Flechsig calls cognitive or connective areas, *expand anatomically* and particularly those located in the anterior frontal, parietal, temporal and occipital lobes. These areas increase *quantitatively* and are *differentiated qualitatively*, as von Economo underlines, and constitute new acquisitions of man connected to his higher intellectual evolution and the related development of the functions of speech. Von Economo drew the conclusion that in humans the brain cortex has not simply expanded quantitatively compared to that of animals, but also presents qualitative differences, due to its cortical cerebration, its more detailed differentiation and the new brain organs it has developed. Similarly, he concluded that progressive cerebration in man, as observed particularly in his evolution after the appearance of Neanderthal's man, does not mean, biologically, a simple increase of certain intellectual faculties, existing since previous periods in phyloge-

netic evolution, but proves the *capacity to gain* constantly new brain organs, meaning that in the cortex already exists and will exist in the future the *capacity to gain ever new and yet not suspected mental capacities*, a fact that creates new prospects for the future evolution of the human intellect.

At this point we should note that, these opinions expressed by von Economo, who admits the principle of cortical cerebation and differentiation from an anatomical point of view, seem contrary to the opinion of von Niessl Mayendorf, who underlines most notably the significance of path-building and functional practice. We believe, however, that these two views can be reconciled, in the sense that phylogenetically speaking progressive cortical cerebation may in fact take place (anatomically speaking) and thus the *fertile ground increases* anatomically, in order to be used in ontogeny (in each individual). The constantly (anatomically) increasing intellectual ground *always requires special cultivation, i.e. the action of each individual*, in order to open up the pathways. Without this action the intellectual substrate can not, on itself, develop its functional specificity, namely, the creation of special functions of thinking and speech.

It seems therefore that as a consequence of a more advanced evolution there is the principle of concentration, or at least the closer linking of the two aforementioned functions, those of speech and cognition in a single hemisphere, in right-handers in the left hemisphere and in left-handers in the right hemisphere, with some exceptions that can be explained through amphoterity.

[...]

We have to admit that, according to the phylogenetic and ontogenetic weaving plan for various functions, motor abil-

ity comes first and particularly that of the *upper limbs* and the *major* development of one of two arms, *the right or the left*, into finer, more complex, organised and purposeful actions, ex. motion melodies. It therefore follows that the function of speech appears as a further evolution of motion melodies of a *higher order*, in other words actions of a finer and more complex form, which create the most appropriate and easy-to-use way through which the intellect can promote its content to the environment. Because of this, the intellect is connected to the pathways that have been functionally set out and built. The result of this is that *the functional path-layout* for right-handedness or left-handedness, which comes earlier in the developmental sequence (approximately in the 7th month following parturition), prepares more propitious functional conditions, possibly due to the concentration of greater functional energy in one hemisphere, or by the greater circulation of *blood*, etc., which permit to the contiguous field of the brain, in the same hemisphere, to develop also the finer and more complex functions of speech. Finally, these *neurofunctionally* produced contiguous fields, either by right-handedness or by left-handedness, are utilised by the intellect in order to open up the aforementioned pathways for its purposes of expression.

Another necessary phase of phylogenetic evolution must take place, namely that of shifting from *quadrupedal* to a *bipedal* stance and gait, before permitting the above mentioned processes. A basic change in the function of the brain is taking place in this phase of evolution, particularly that of the frontal lobe, and of the functions of the upper limbs that are dependent thereon.

In quadrupedal stance and gait in animals, the frontal lobes of the brain govern mobility, all four limbs collaborating to this

end, and consequently they are limited to directing this simplest mechanism of standing and walking. Through the evolution to a bipedal stance and gait, the collaboration of forelimbs and back limbs in the frontal lobes *was raven*, in such a way that, although the centres for the back limbs maintained the old function of standing and walking with all the static and motion amendments required by the new conditions (standing upright brought about more difficult conditions for standing and walking, because they greatly decreased the surface on which the centre of gravity falls, and this is why a number of various regulatory mechanisms were added, relating to the functions of the cerebellum), at the same time, the cortical centres for the forelimbs (which now became the *upper limbs*) underwent a functional differentiation, permitting to these limbs their new functions, e.g. finer and more dexterous gathering of food, use for finer functions more and more increasingly technical, more complex ways of defence, attack, etc., the construction of primitive clothing or primitive works of art, in a way that through functions of the upper limbs these brain centres advanced somewhat in carrying out *organised, purposeful actions*... *This differentiation* of functions of the *upper limb* led to further development of expressive movements, having on the top the functions of speech. Attempts have been made and are still underway, so that monkeys who can be made by practice to understand many words, can contrive to express words. This not only has proven unachievable, to date, but from what we can conclude from the above, is impossible to achieve, because the monkey has to pass through all phylogenetic phases of movement differentiations, of standing upright, and particularly though differentiation of the upper limbs, as this has happened to man. Man owes, precisely, the higher functional gain of speaking to *this differentiation*, first

of both the upper limbs, and then of one of them, to the *right-handedness*.

This differentiation, however, due to particular environmental conditions or pathological conditions, did not develop to the same extent in all individuals and in both limbs, but in some of them one limb differentiated somewhat more and in others the other. In fact, some scientists, and particularly Richard Kobler in his study “Der Weg des Menschen von Links- zum Rechtsänder, 1932”, admit that initially men were in their majority left-handed, as can be seen from the study of works of art of that time (the various tools which men utilised at that time led this researcher to the conclusion that most of these could be used by the left hand) and it was with the *discovery* and use of various kinds of *weapons* (i.e. the discovery of primitive means of defence, such as the later-discovered use of a shield to protect the heart and a spear to attack an enemy) that men started becoming more and more right-handed.

With the exception of certain pathological conditions, both hemispheres up to the 7th month post-parturition, have the same probability and the same anatomical prerequisites to develop right-handedness or left-handedness, and it depends later on the individual adaptation to the environment if, in any further development, either the right or the left hand will be leading (this takes place, as we have mentioned around the 7th month post parturition). However, in keeping with present environmental conditions, the required adaptation to various means of use by hands and the overall regulation of movement *is now adapted to the use of the right hand*. All these environmental influences for further differentiation exist, having as consequence the majority of people to undergo further functional differentiation in the left hemisphere and raise it above

the right as far as the localisation of the functions of speech and all the pathways of cognition connected to it are concerned. From all this, one may conclude that the functioning, the functional practice carried out, neuro-functionally speaking by the hand, is the primary factor which lays out, prepares and finally localises the functions of speech, carrying along with this the concentration in one of the two hemispheres and the closer linkage of those functions to cognition, leading thus to the lateralisation of these functions.

Led by the aforementioned view, based on theoretical and clinical arguments, which maintains that right-handedness is the primary factor channeling and localising the function of speech in Broca's gyrus, we thought that the pathway from the centre of movement of the right hand (for right-handed individuals) in the left hemisphere, to Broca's gyrus on the same side (the manual motion's pathway of Broca), would have to be represented anatomically-histologically. To this end, we attempted during our studies in Zurich, under the enlightened collaboration of our revered late professor von Monakow, to work in the direction of locating such a pathway. This work was interrupted for a long period of time, due to the invitation to serve our country, and since then, to our knowledge, no relevant study has been undertaken. Nonetheless, from our further interest and study on this problem and particularly through von Niessl Mayendorf, focusing on the *functional rather than the anatomical* components of these functions, it is possible that our efforts in that direction would not have led to any particular results, as they would have had to distinguish, in amongst a host of connective bundles in this area, which cannot be distinguished histologically from the rest, at least with the technical methods currently in use, concerning their quantitative but mainly their *qualitative special* function.

Furthermore, it seems that it is mainly through functional practice that the intellect lays out the greatest part of its connections to the environment and particularly by the most important pathways for its development, those of the functions of speech. The more these various paths broaden, the more adaptation to reality is achieved and mental development occurs. From all the above, we can draw as the most likely conclusion that functions of speech and the important pathways *relating* them to the intellect, do not grow together and they are not, initially, related to a previously formed anatomical substrate, because if such was the case they would have to be stably and exclusively connected to this substrate and they could not be carried out *in some cases in the left and in other cases in the right hemisphere*. Or, at least, they are not stably connected to the anatomical substrate, as are the pure neurological functions (ex. the nucleus of the facial nerve, or various other nuclei, containing inherently, without any particularly active practice, the movement functions of those muscles that are enervated by them and, subsequently, their function is tightly, insolubly and more than likely inherently connected with their anatomical, cellular substrate). It seems likely that some, probably neurological functions of the cortex, are not also stably linked with the anatomical substrate, as indicated in cases of injuries of the brain, where some functions, mainly pertaining to movement, can be replaced, *again by functional practice*, by other parts of the brain, thus taking up the impaired functions. However, in the aforementioned functions of speech and the intellect, it is mainly the *functional layout and practice* by each individual which adapts and *finally localises these pathways and functions*, within certain limiting anatomical constraints, of course. In other words, what is required is a *special cultivation*, permitting to the initially

deprived of function cerebral, intellectual ground to become, by *functioning, utilisable and productive*.

[...]

All of these, namely “the localisation of biological mechanisms”, “the ease to use them”, “the laying out and in general the practice of functions”, can be carried out solely by individual *active action*. Teachers are useful only because they place that seed in your cognitive ground and they supply the general lines of mental guidance; while you are called upon, using your own personal mental hoe, and that alone, to cultivate the seed tossed into your brain field in the best possible way, taking care not only to purge this of all the thorns and weeds that are constantly growing, due to the purely bodily, lower animal functions, and to maintain a healthy body in order also to have a healthy spirit (because *mens sana in corpore sano*), but also by regulating in the aforementioned way, anything having to do with your intellectual cultivation, in an attempt to obtain the greatest degree of productivity.

[...]

However, your mission (ed: medical doctors) does not consist solely of this. You are the intellectual breeding ground and you are not called upon solely to receive the intellectual material, to engrave this in our brain and to cultivate it. You are also called upon to carry out the important mission of evolution, which is *progressive cerebration*, and that can be promoted and mobilised to a greater pace, by active action. According to von Economo, it is a principle of nature that gradually and slowly the cultivable intellectual ground will increase for the better, even anatomically. Of course this takes place over a period of thousands of years. An initially fallow cultivatable ground is handed over from generation to generation, but by constant

practice and path layout it increases and is differentiated anatomically, thanks to this principle of nature (progressive cerebration), without a visible end. Thus, as will be repeated all over the world to every new generation, you are similarly called upon not solely to take over the mental material that has been conquered up to this day and to spread the heavenly light, the *Himmelslicht*, as Goethe called the intellect, to future generations, but you are *now the invited and select precursors of phylogenetic cerebration*, and consequently you are the contemporary representatives of a constantly evolving intellect that is becoming ever-greater; thus you are called upon to fulfil that part of the phylogenetic mission that falls to your lot.

It is precisely due to this higher, faster mobilisation and the more perfect discharge of this great phylogenetic mission, for the evolution of mankind, that our great ancestors excelled. Cicero wrote on the *most perfect type* of that great Greek generation in the flow of centuries, on the incomparable Socrates, who primarily utilised in *the dialectic method* of his teaching the *functions of speech* for the expressions of the highest creations of *the human intellect* that he *was the first* to bring philosophy down from heaven and establish it in the cities and furthermore to introduce it even into the home of each person, contributing through his life and death to the research of good and evil. “*Socrates primus philosophiam evocavit a coelo, et in urbibus collocavit, et in domos etiam introduxit et coegit de vita et moribus rebusque bonis et malis quaerere*”.



Constantinos D. Constantinides (1902–1981)

1. On the personal and impersonal –collective–
unconscious. Jung's Analytical psychology
(Περὶ τοῦ προσωπικοῦ καὶ ἀπροσώπου
–ἀθροιστικοῦ– ἀσυνειδήτου. Ἡ ἀναλυτικὴ
ψυχολογία τοῦ Jung)

*Reprint from the journal Ekpaideftika Chronika
(Education Annals), Athens, 1936*

Never before such a true understanding of the psychic world of the human being has been accomplished as in our times psychological research having acquired an analytical nature, investigating all aspects of the psyche in a most detailed way, ascertaining the cause and the formation of many psychic manifestations and thus the texture of the psychic constitution of individuals. This great progress is due to analytical psychology, used as a research method by three researchers of the psychic life of humans: the genius Freud, Adler and Jung. Using psychiatry as their point of departure, each has created his own psychological teaching and school. First Freud instituted psychoanalysis, Adler individual psychology and Jung the analytical psychology that bears his name. As the subject of all these teachings is the unconscious, these teachings could

be termed psychology of the unconscious, even though one differs from the other in its approach: Freud posits that the prime force of psychic life is the energy of the sexual instinct, whilst Adler gives emphasis to the energy of the instinct to rule and Jung highlights all psychic energy, which he calls Libido (Freud refers to this term to denote sexual psychic energy).

In Greece, psychology as articulated by Freud and Adler alike is sufficiently well known; Jung's psychology has not really been promulgated (recently Mr. Kaliafas published an excellent study entitled "Characters or psychological types", which sets out one part of Jung's teachings on psychological types). Paradoxically, the dissemination of Jung's ideas has been delayed in other countries as well.

Jung's psychology, as the one of Freud and Adler, originated from observing subjects both healthy and mentally ill. Moreover, he performed research on primitive people, with whom Jung lived for a certain period of time. His work is more comprehensive and general than that of the others and has more philosophical overtones.

[...]

Jung postulated that the individual psyche contains the so-called impersonal or collective unconscious. The impersonal unconscious pertains to psychical elements and events not stemming from individual life but from the history of human race, including "all remnants of primordial human nature and of past millennia, which are a common possession of the evolution, presented to the mankind, like sunlight and air" (*Jung: Wandlungen und Symbole der Libido*, 1930). In other words, the impersonal unconscious contains everything that the human race has undergone as psychic life and experienced in its evolution, from lower beings to human beings.

All events, throughout many centuries of evolution, have left traces retained through memory, which have been transmitted from generation to generation, either as a predisposition for the development of psychic abilities, or as a clearly formed psychosomatic manifestation and ability, e.g. as an instinctive tendency. Hence, a person recently born is not devoid of psychological properties, but has infinite types of predispositions within him, coming from the psychic heritage of his infinite ancestry. Consequently, the psyche of a newborn is not a *tabula rasa*, but is prepared and charged with a myriad of psychological potentials, remnants of the psychic life of bygone eras. All these, in their totality, constitute the content of the impersonal unconscious, meaning a state of multi potent predisposition of the organism, permitting the development of one or another psychic capacity, e.g. the predisposition for rational thinking, permitting the development of intellect according to the laws of logical reasoning. The example of somatic capacities is more concrete and specific, e.g. instinctive tendencies, developed through endless repetition of the same function, throughout evolution.

Jung observed that primitive man, in constant interaction with the environment, formed certain specific representations of the outer world, which pertained to all elements thereof. The content of these representations is diverse, for example rage, demons, supernatural monsters; these contents are expressed in the form of myths, transmitted from generation to generation and, paradoxically, retained in this way in all peoples, to our days, e.g. myths concerning the Moon, Sun, vegetation, death, etc. Jung considers these to be more than a simple predisposition or undetermined proclivities of the psyche, positing that specific representations and images constitute their content, which he terms *archetypes* or *archetypal images*.

[...]

Jung suggested four main mental functions, i.e. *thinking*, *affectivity*, *sensation* (the impression from senses) and *intuition*. [...] One of these four main functions is in the majority of cases the most developed, and takes hold of one's consciousness, therefore it becomes conscious, constituting simultaneously an agent of adaptation to the environment. The other functions are blunted and therefore are more or less unconscious. However, the aforementioned functions and generally the various psychic elements are relatively proportionate to each other in evolution. In this case we have a normal temperament. When the development of one function is disproportionate to the others we have an aberrant temperament, on the substrate of which mental disorders occur easily.

The excessive development of one function takes place to the detriment of the others, as they lose energy due to the exceptionally developed conscious function. Therefore these become unconscious.

As long as the undeveloped functions do not become completely unconscious, they act as surrogates and compensate the predominantly developed conscious function, so as to hinder the one-sided and excessive development thereof. However, when the conscious function is the most intensely developed, the others are completely unconscious and consequently, due to the known opposition between the conscious and unconscious, the latter act opposite to the conscious function and against it.

Under these circumstances, the so-called conflict may arise, whose emergence signifies that the sphere of the psyche is partly experiencing a conflict between two different psychic tendencies and functions. [...] Conflict in the psyche may be conscious or unconscious. When this conflict is not resolved,

then, provided that it is conscious, it is repressed in the unconscious. When the conflict becomes unconscious or is unconscious from the beginning, the so-called regression can ensue.

We propose the following conception of regression: the opposite psychic tendencies, in conflict, cannot find a smooth resolution in order to overcome the impasse, to make their energy available for the implementation of a specific psychosomatic function. Therefore, the energy is made available to another psychosomatic function offering an apparent solution to the conflict, whose character is usually archaic and infantile. Psychic energy available and used for a psychosomatic function other than the appropriate one, which is the normal psychosomatic function, constitutes a disadvantageous way of resolving psychic conflict and consequently an abnormal and morbid psychic manifestation. Such a manifestation is termed neurosis.

[...]

However, in order to create a psycho-nervous disorder, a repression of psychic elements and the so-called regression must occur. When a group of ideas and representations with a pronounced affective coloring is repressed in the unconscious, this is termed a *complex* [...]. Generally, the repressed complex causes pathological conditions, e.g. fear, obsession and impulsive actions, i.e. neurosis.

Neurosis, which is also a creation of the unconscious, may conquer any man of any personality, previously normal and sound, if within him an excessive and unbearable conflict is created. In other words, the creation of a neurosis depends on the intensity of mental conflict and the person's resilience. [...] The ensuing neurosis is nothing more than a "failed act of adaptation".

[...]

2. Relationships between the brain and civilisation

(Σχέσεις ἐγκεφάλου καὶ πολιτισμοῦ)

*Reprinted from Nea Iatriki (New Medicine),
February-March 1938*

[...]

The study of the relationship between culture and the brain brings to light the harmful effects of civilisation to the brain. It appears that latter has suffered and continues to suffer certain damage due to civilisation, influence which is its functions and consequently the mental and intellectual life of individuals.

As we know, the more complex a machine is, the more precise is its performance. However it is also more often subject to disorders and damage.

The brain of advanced people has become very fine-tuned, and this is why it is so easily subject to damage. There is evidence that many disorders and damages of the nervous system may be ascribed to the influence of civilisation. The most important is that civilised people very often display nervous and mental disorders, yet unknown or extremely rare in primitive people.

Statistics in England, the United States and Germany since 1860, have shown a progressive increase in the proportion of mental diseases [...]. Statistics pertaining to mental diseases in Greece show a similar progressive increase as well.

Usually the average number of those suffering from mental diseases in civilised countries ranges from 1–4%. The more civilised a country is the greater is the number of the mentally ill.

Black people of North America constitute a typical example of the effects of civilisation on the brain. Before their liberation, when their life was simple and natural, i.e. before 1860, there were 69 mentally ill individuals in a million. In 1890, i.e. a few decades after their liberation, the mentally ill amounted to 886 in a million. This event may be used as an experimental indication of damage of the central nervous system due to civilisation (Bumke: *Kultur und Entartung*, 1922).

The frequency of people affected by general paralysis of the insane, having a syphilitic origin but rarely manifested in nations without culture, is presented as evidence of the damage inflicted to the brain by civilisation. According to Kraepelin, the increase of general paralysis of the insane in civilised people is due to the decrease in the resistance of the nervous system as a consequence of civilisation.

Examples of damage caused by civilisation include, inter alia, the decrease in population and the extinction of many primitive tribes, consecutive to their contact with civilisation, as Tasmanians, inhabitants of New Zealand, Oceania and Sumatra can provide an example. The harmful effect of civilisation is, also, manifested in the larger percentage of inhabitants of big cities suffering from mental diseases in comparison to inhabitants of the countryside.

Concerning the harmful effect of civilisation, we have to accept that it harms the nervous system more than a simple or primitive life, because life within civilisation is based on the function of the brain, as a civilised society has, mainly, intellectual demands.

In our time constant unrest, uncertainty about tomorrow, trends for social reforms keep the human nervous system in constant tension. Therefore, life in civilisation entails greater

consumption of nervous energy that wears down the nervous system. We have to add two significant pathogenic factors: alcoholism and syphilis, affecting preferentially the nervous system.

Many scientists claim that civilisation has a harmful influence on the brain and decreases its resistance, due to the way of living and the various pathogenic factors it entails. In consequence, disorders and injuries occur, entailing mental anomalies and diseases [...].

The lesser resistance and the greater vulnerability of the nervous system was considered to be a phenomenon of degeneration, manifested to the advanced man by civilisation. Degeneration consists of the degradation of mental life, expressed through the frequent occurrence of mental diseases or mental abnormalities, the neurasthenic phenomena, by the increase of delinquency and suicide, as well as moral and intellectual prostration (damage of the biological constituents of an individual, under the influence of pathogenic factors, causes degeneration and transmission of these alterations from generation to generation. In this way descendants are born disadvantaged both in their nervous and their psychic health. Transmission takes place through their reproductive cells).

Not only individuals, but entire nations can be destroyed by degeneration, as we can see in the history of nations. In our times, many voices are heard about damage to mental health and degeneration of the European race (Carrel, Spengler). There is no consensus on this as some scientists refute a harmful influence of civilisation and do not admit the existence of signs of degeneration in our age. Some of them exaggerate in one direction and others in a different direction. The truth, as usual, lies in the middle. In other words, civilisation can produce damage but a real threat against the European race and its culture does not seem to exist. [...]

3. Cerebral localisation of normal and morbid mental functions

(*Ἡ ἐγκεφαλικὴ ἐντόπισις τῶν ὀμαλῶν καὶ νοσηρῶν ψυχικῶν λειτουργιῶν*)

*Docent's inaugural speech delivered at the amphitheatre of the University of Athens, on the 28th of April 1939.
Reprint, Athens 1939*

Research into morbid mental and neurological phenomena can be carried out by using pathological anatomy and pathological physiology of the nervous system; through pathological anatomy the correspondence and consequently the aetiological connection between histopathological lesions in certain parts of the nervous system and morbid psychological or neurological process is determined.

Pathological Anatomy research in psychiatry investigates lesions in the brain and attempts to explain the psychopathological symptoms by means of these lesions. Cerebral lesions found in many mental illnesses, e.g. progressive general paralysis, senile dementia, infectious psychoses and other mental states rendered histopathological research of the brain necessary in psychiatry. The abundant material produced by brain injuries during the Great War, contributed greatly to the advancement of the so-called neurological research, one of the most prevalent forms of research in Psychiatry today (ed: references to Kleist's: *Die gegenwärtigen Störungen in der Psychiatrie*, 1925, noting that the existing methods of research in psychiatry are: philosophical, psychological, constitutional and neurological). From this point of view, psychiatry is iden-

tical to brain pathology and psychiatric diseases are considered to be diseases of the brain.

The historical review of correlations of psychiatric diseases to histopathological lesions of the brain, shows, if we set aside suppositions and vague formulations of bygone eras, that this research essentially commenced in Virchow's time, with the development of pathological anatomy in general. It was further reinforced by the work of Hitzig and Fritsch on the physiological functions of the brain and followed by Griesinger, Broca, Meynert and Wernicke, who correlated psychiatric disorders to brain lesions, the latter (ed: Wernicke) treating psychiatry as brain's morbidity. In our times, systematic research is being conducted with respect to brain lesions in psychiatric diseases.

Brain lesions pertain both to general psychopathology and to specific psychiatric nosology. I will not focus on lesions of the brain, which are characteristic of specific psychiatric disorders, but rather on lesions related to general psychopathology. Only the localisation of lesions will be examined and neither their type, i.e. neither if the lesion was due to injury, atrophy, tumour and so forth, nor the fine texture of the altered part.

I will set out on the one hand the links between psychopathology and the lesions of the brain and their localisation; and on the other hand the current knowledge on the relationship between normal mental process and the mode of function of various parts of the brain. In other words what we know and what we accept with reference to the normal or abnormal psychological life, in relation to the brain and its faculties.

[...]

Consciousness is affected in conditions like clouding of consciousness (in epileptic phrenitis and hysterical psychosis), during a state of confusion (in infectious psychoses) and in the loss of consciousness (fainting, coma). Disorders of consciousness are attributed to lesions of the central grey matter of the third ventricle of the brain, in particular its posterior part and the initial part of the aqueduct (Kretschmer: *Merizinische Psychologie*, 1926). Pathological Anatomy lesions found in these parts of the brain in lethargic encephalitis, which produces loss of consciousness (oscillating between the states of sleep and wakefulness) confirms the dependence of the aforementioned disorder from these lesions. Moreover, it is known that an increase of pressure in the 3rd ventricle dims consciousness.

Disorders of volition and mental urges (*Antrieb*) consist in either lack or diminution of them, with retardation of mental manifestations and psycho motor activity or increase of these faculties with corresponding acceleration. We know that volition depends on the endocrine glands, and any dysfunction of them can cause serious disorders of volition, as is the case, among others, with myxoedema, Addison's disease and hyperthyroidism.

Among brain lesions, those located in the globus pallidus and the corpus striatum, or in the frontal lobe cause disorders of volition and of psychic urges. According to Hartman, lesions of the thalamus also bring about disorders of volition.

More specifically, in lesions of the globus pallidus in Parkinson's disease, loss of willpower and psychic urges are observed with a concomitant reduction of psycho-motor activity and affectivity. The diminution of volition in the said aforementioned disorder also causes inertia of the intellect.

In lesions of the caudate nucleus in chorea, there is excessive expression and possibly increase of psychic urges, psychomotor activity and affectivity.

The disorder of volition in Parkinson's disease is considered to be similar to volition disorders present in catatonia of schizophrenics. In both conditions, volition is diminished and is manifested in bouts.

We know that disorders of psychic urges occur after juvenile lethargic encephalitis, where impulses are unleashed, with impulsive acts of violence and emotional outbursts.

Reference has been made above to disorders of volition and psychic urges in frontal lobe lesions.

It is accepted by some scientists that disorders of affectivity are located in the optic thalamus, while for others it is situated in the central grey matter of the 3rd ventricle, which is the superior centre of the neurovegetative system, directly and closely correlated to affectivity. The lesions of lethargic encephalitis, which are located in the above areas, cause concurrent neurovegetative and emotional disorders.

The so-called affective psychoses, such as mania with an increase in animal energy and affectivity and melancholia with a reduction thereof, are considered as functional disorders of these parts of the brain trunk.

With respect to disorders of the ego, it should be stated initially that the ego (ed: references in Reichardt's: *Theoretisches über die Psychose, Journal of Psych. Und Neur, Bd. 24*) is an extremely complex psychic construction, containing diverse elements, such as instincts and common feelings, constituting the so-called somatic or physical ego; emotions and volition constituting the affective ego. Furthermore, intellectual

abilities, social and moral principles, the sum of all memories, experience and so forth constitute the proper or superior ego. These elements are part of an unified continuum, to which the idea of the ego derived from the intellect should be added. Whenever there is a dysfunction, the idea of the ego or its intellectual elements in general, its origin must be sought in the locus of ideas, that is in the cortex, as is the case with the alteration of the ego occurring in thought disorders of schizophrenia.

Conversely, the main constituents of the ego, i.e. affectivity, volition, the instincts, as analyzed below, are related to the brain trunk and primarily to the diencephalon and are affected by lesions produced in these parts. The consequences of juvenile lethargic encephalitis located in various parts of the diencephalon provide relevant examples and produce severe disorders of character and personality of an individual (reference to K. Bonhöffer's: *Psychische residualzustände nach encephalitis epidemica bei kindern*, *Klinische Wochenschrift*, 29, 1922).

Concerning the dysfunction of psycho motility, I will not consider the dysfunctions associated with the disorders of the cortex, but I will mention only those related to the brain trunk and the frontal lobe, as these are the ones of psychopathological importance.

Lesions in the nuclei of the diencephalon (corpus striatum and globus pallidus) cause psychomotor disorders, either in the form of akinesia (with hypertonia or not) or in the form of hyperkinesia. The state of akinesia also occurs in the case of frontal lobe lesions, as mentioned above. The above psychomotor disorders are accompanied, in their majority, by disorders of volition, psychic urges, affectivity and intellect.

It is worth noting that most psychomotor symptoms in catatonic schizophrenia are considered identical to the psychomotor phenomena originating from the corpus striatum and the globus pallidus (Kleist, Bonhöffer, Stertz). A parallel is drawn between catalepsy, negativism, waxy flexibility, stereotypic movements, echopraxia, grimaces and so forth in catatonia, on the one hand, and the symptoms of mobility disorder caused by lesions of the diencephalon, as in Parkinson's disease, chorea and so forth, on the other.

The great similarity of many catatonic pictures to Parkinson's syndromes, led many (authors) to associate catatonia with lesions of the diencephalon.

Anatomical and histological research in schizophrenia has revealed lesions not only in the third cortical layer (Josephy, Fünfgeld), but also in the nuclei of the diencephalon (Lange, Spatz).

It appears that a psychomotor disorder is caused either by an organic lesion (encephalitis, arteriosclerosis) or by a psychosis (catatonia, agitation) and its localisation must include the same parts of the brain and particularly the diencephalon, with an additional smaller or bigger variation due to a greater cortical involvement in psychosis, as is the case in schizophrenia.

Kleist admits that there is an association between motility and thought. He characteristically mentions the co-existence of flight of ideas with mobility. According to his opinion the morphological disorders of ideas must be associated not only with lesions in the cortex, but also in the brain trunk. Indeed, Goldstein's observations on the dysfunctions of ideas in disorders of the diencephalon speak in favor of the above

(Goldstein: Über den einfluss motorischer Stömungen auf die psyche. Deutsch. *Zeitschrift fur Nervenheilk*, 1924, 83)

[...]

Even though psychopathological phenomena should not be considered as strictly isolated manifestations of the affected part of the brain, but rather as resulting from the dysfunction of the brain as a whole, nevertheless, the separation of cortical and sub-cortical disorders is justified and results in distinguishing not only the symptoms, but also the relevant syndromes. Thus, dementia, amnesic dementia, hallucinatory dementia, and thought disorder dysfunctions referring to the cortex of the brain. Psychopathological states with disorders of the ego, affectivity (mania or melancholia) or psychomotor syndrome are caused by dysfunction of the brain trunk.

What has been examined above concerning general psychopathology, constitutes a concise review of prevailing the opinions. Psychopathology as related to brain pathology has not been clarified sufficiently, either in its totality or in particular entities. Consequently, there still is a broad field for study and research.

Over the recent years, Kleist advanced the existing knowledge on the relationship between psychopathology and brain pathology. In his treatise “Die gegenwärtigen Strömungen der Psychiatrie”, he reports his research and opinions on psychopathological problems, based on observations of 290 cases of brain injuries and 16 cases of focal lesions. In these cases, he studied and compared the psychopathological manifestations with respect to the brain lesions in each individual case. He retained the main distinction between cortical and sub-corti-

cal mental disorders. In fact, his opinions on various points of psychopathology have been quoted above.

[...]

Psyche, in its psychological and psychiatric sense, is the sum of mental processes, i.e. thought, affects, perceptions and, in general, the content of a person's consciousness. We can not say or discuss if the psyche is composed of energy or matter. It seems that the psyche is similar to what we call life. Just like the phenomenon of life is founded on biochemical processes, without being possible to explain or comprehend life by these biochemical processes, thus the brain is the substrate of the psyche, without being possible to understand the inner and real relationship between psychic and cerebral processes.

It is in dispute that cerebral function is closely linked to mental life. However, it remains to be clarified whether the brain produces the psyche or if it is the organ through which the psyche manifests its self. For brain physiology, the first seems to be the most probable. Nevertheless, there are opposing views and theories on this subject, constituting various philosophical systems.

In the past, mental (psychic) processes were separated from somatic processes; the psyche was considered as an immaterial essence, different from the body, co-existing with the body and influencing it. The belief which gave rise to the differentiation between soul and body, i.e. mental and bodily processes, was the theory of dualism (diarchy). Antithetical to this was the theory of monism, either in the form of idealism (ideocracy), which attributed material phenomena to psychic ones, or in the form of materialistic monism (unitarianism), according to which the soul (spirit) is attributed to matter. Those are the

three main theories on the psyche. None of the three can be considered to fully resolve the problem of the soul, but they have certain points in their favor and certain points against them, so that none actually prevails over the other. This is also true in the case of the neo-vitalist biological theory (Dreisch's vitalism) that may also be considered as a dualistic theory. Therefore the problem of the soul still remains unsolved. Perhaps, no theory, whether biological or philosophical will find a solution thereto, as possibly this problem is outside the limits of human knowledge.

The most satisfactory approach in terms of psychophysiological research and philosophical thought is the theory of idealistic (ideocratic) monism, recognising the prevalence of psychological elements over material ones, both constituting the forms of one and the same substance (identity theory).

The problem of the relationship between mental and somatic functions and particularly those of the brain is considered in the same way. If the brain and the entire body are the substrates of the soul, given that psychic constitution depends on the structure and humors of the body, the generalisation of the correlation between soul and body, i.e. soul and living matter, validates the neo-vitalistic perspective on a psychological component of all living matter and renders the close correlation and co-existence of psychological and material elements in living organisms comprehensible, to the point that one cannot exist without the other in living beings.

From this point of view, the absolute separation of psychic processes from somatic ones, in other words those of the psyche from those of the mater, is unfounded and unjustifiable. Bleuler's theory on the so-called "psychoïd" functions gives an answer that seems to correspond to reality (E. Bleul-

er: *Die Psychoide*, 1932). According to this theory, psychoid functions are a property of all living matter (pan psychism, pan psychiatry of living matter) and the psychic life of humans is a manifestation of this.

This perspective is not only beneficial in the research of the brain's psychobiology, but also bridges the gap between soul and body, soul and brain.

[...]

In conclusion, I would like to underscore that brain pathology constitutes one of the most important methods of psychiatric research. In the context of the research endeavor it greatly contributes, along with brain physiology, in some cases, to a deeper understanding and in other cases to the complete resolution of the manifold problems in the fields of neurology and psychiatry.



Nikolaos Arkalides (1901–1972)

Treatment of schizophrenia by induced epilepsy according to the method of L. von Meduna

(*Ἡ διὰ προκλητῆς ἐπιληψίας κατὰ τὴν μέθοδον
τοῦ L. von Meduna θεραπεία τῆς σχιζοφρενίας*)

Helliniki Iatriki (Hellenic Medicine) 1937, 9, 777–795

The method introduced in 1934 by Ladislaus von Meduna to treat schizophrenia by inducing epilepsy through the use of Cardiazol had its origins in observations made by various authors, concluding to the following two facts: first, the coexistence of schizophrenia and epilepsy was exceedingly rare; and second the manifestation of epileptic seizures in schizophrenic patients resulted in improvement or recovery of their mental illness. Conversely, the complication of schizophrenia in epileptic patients brought about a cure of epilepsy.

[...]

These observations led Ladislaus von Meduna to think that epilepsy and schizophrenia are biologically antagonistic and, consequently, that by inducing epileptic seizures in schizo-

phrenic patients, he would be able to alter in such a way the chemical and haematological components of the body, that a remission of schizophrenia could be achieved.

[...]

Von Meduna is of the opinion that the perspectives of improvement are better if the patient reacts with an epileptic seizure to small doses of Cardiazol. He considered that the body's readiness to react to small doses was an indication of non-chronic schizophrenic process. From this relevant experience he concluded that the beneficial or malign result of the treatment could be prejudged, in a way, by the result of the first injections. If the injections, containing a small quantity of Cardiazol, bring about an intense seizure and consequently it is not necessary to increase the dosage, then the result will be beneficial; on the contrary, if small doses are not accompanied by epileptic seizures, the result will be negative. Our own experience, although significantly more limited than that of the investigator, does not agree with this view. We have had cases in which it was not necessary in all injections (sometimes exceeding 20) to increase the dosage of Cardiazol more than 5 or 6 cc (=0.50–0.60 g), because with such doses we achieved intense epileptic seizures whose therapeutic result was negligible. In contrast, cases where we utilised large doses of Cardiazol had a transient or permanent improvement. Systematic monitoring has convinced us that it is not the large quantities of Cardiazol administered or the severity of schizophrenic process that play the greater role in the manifestation of epileptic seizure, but mainly the speed of administration of the injection.

[...]

Concerning the number of epileptic seizures required in order to achieve a remission, there are no rules. The number is different in each case. Certain cases showed a complete improvement with only 2 to 5 seizures, while in other cases this occurred after 25 to 30 seizures. Continuing treatment past the twentieth seizure was considered pointless, if no improvement at all had been observed. We observed improvement in certain cases from the very first seizures; an amazing remission, equalling recovery, on a very long-term case of paranoid schizophrenia, following the second relapse, which was unfortunately not stable. Furthermore, a catatonic catalepsy (stupor) was fully eradicated after the third seizure, and a case of simple schizophrenia was stably and permanently improved after the second seizure. According to von Meduna, once remission is achieved, it is necessary to proceed to three additional epileptic seizures, in order to stabilise the beneficial result and avoid a relapse. Unfortunately in our cases even this measure did not make it possible to avoid relapses.

[...]

This method is carried out in the “Dromokaiteion” Psychiatric Hospital since 10 months already. This period of time is, certainly, still far too short for us to be able, on the basis of our own experience, to draw specific conclusions concerning the therapeutic value of the method. Both, the number of cases is limited and the time of observation and monitoring of the patients showing improvement is still short.

[...]

L. von Meduna interprets the mode of action of his method on the basis of the hypothesis of a biological antagonism between epilepsy and schizophrenia. The changes in

the body's composition achieved chemically, serologically and haematologically by the epileptic seizures constitute an environment that is not favourable for the development of schizophrenia and can offer the possibility of a biological remission of this morbid mental process. As we do not have precise knowledge of this type of biological antagonism, according to the aforementioned hypothesis, we are entitled to talk simply and solely of treatment by bodily and biological shock. We are not entitled to consider a psychological shock, as this does not occur in these patients, who experience retrograde amnesia. The action is therefore purely biological, distinct from psychological phenomena. As von Meduna himself states, the aforementioned hypothesis is partially satisfactory and subject to both discussion and dispute. Further research must bring to light the nature of alterations in the fluids of the body and other possible contributory factors, which are released by the shocks in their therapeutic action. If we accept the view of Professor G. Pamboukis concerning idiopathic or general epilepsy, according to which the disease is "due to the accumulation of toxic substances in the brain cells, thus provoking an overactive, excitable state of these cells, aiming to increase metabolism and consequently a more intense burning, dissipation and in general ridding of these accumulated toxic substances" – we can accept, by analogy, that during these induced epileptic seizures brain cells are, similarly, stimulated to overactivity. Consequently, metabolism is enhanced, thus removing, temporarily or permanently, toxic substances which have inundated the cerebral cortex and other areas of the brain, with resulting beneficial effects of the treatment, transient or stable. We can interpret, always hypothetically, the most ben-

eficial effect of this treatment on acute cases, by postulating that the physical alterations in the acute cases are still rectifiable and consequently the removal of deleterious substances through epileptic seizures (and possibly the multiplication of other defensive factors in the body), contributes to a rapid restoration of the disturbed function of the brain cells. Anyway, we believe that although a precise explanation of the mechanism of action of the method in question is still missing, as is the case with other methods which to a greater or lesser extent are similarly empirical (malaria therapy, insulin therapy according to Sakel), any result must be ascribed to physical-chemical and biological changes in the brain cells.

Closing this study and not being able to reach any final conclusions for the reasons we have exposed above, we are only able to draw the following general conclusions:

1. The method is simple and safe, as there is no counter-indication for the heart function. We have noted no complications.
2. The possibility of induction of epileptic attacks by the injections increases proportionately to the speed of administration. To date, we have performed 77.5% of successful injections; and we are certain that this will increase in the future. In our opinion, the acuteness of the schizophrenic process does not play a major role in the appearance of seizures.
3. The effect of the treatment is certainly greater in acute than chronic cases. As far as the most sensible form (of schizophrenia) is concerned, we have not drawn definite conclusions yet. In chronic cases we have not observed a completely stable remission. However, we have observed temporary but most marked remissions, giving the impression of a full

remission. In any case, this immediate, even if temporary, effect proves the value of the method.

4. Relapses were generally frequent. A new remission, following again Cardiazol treatment, was only achieved in acute cases.

Although the excessive enthusiasm dominating the published work of von Meduna, the results obtained by him are not fully shared by everyone, yet nobody of those who have, to date, used this method doubts that it represents a valuable step in the treatment of schizophrenia. If we take into consideration, how many hopes were dashed after being raised, at various times, by other attempts to treat this exceedingly frequent mental disease (fever therapy, humour therapy, gold therapy according to Claude, etc.), no doubt should remain that the method of von Meduna, with the hypoglycemic shocks of Sakel, will be the most effective methods in our possession, concerning the treatment of schizophrenia. When these methods will be perfected and implemented in rotation or combination on the same cases, when we will have, finally, found the true therapeutic indication, along with an exact differentiation of therapeutic action of each of them, on various clinical forms, they will constitute particularly worthwhile methods, which will safely open up new therapeutic ways in the future psychiatry.



Fotis Skouras (1903–1953)

Psychogenesis and automatism (Ψυχογένεια καὶ αὐτοματισμὸς)

Helliniki Iatriki (Hellenic Medicine) 1937, 11, 261–274

To begin with I would like to define the concept of automatism and outline the field of its application with reference to the morbid manifestations of the intellect. Every author, who has studied this topic, conceives the notion of automatism in a different meaning and significance, frequently purely individualised (Grasset, Janet, Hesnard, Guiraud, De Clerambault). Grasset, Hesnard and Mignard, call automatic any psychic phenomenon associated with the liberation of the deep psyche from the inhibitory influence of the higher psychic centres, following a temporary or permanent suppression of their function. In other words, it consists of the liberation of existing mechanisms, which are set in motion, once the aforementioned opportunity arises (ex. epilepsy). According to P. Janet, a necessary condition for the appearance of automatism is the narrowing of consciousness and the subsequent crystallisation, in the form of motion, of various emotional tendencies and desires of the patient (hysteria). In order to avoid confusion between normal automatism (which is acquired over time and habit) and pathological automatism (epileptic

automatism, ambulatory automatism, fugue) de Clerambault uses the term: “S syndrome”, meaning a syndrome having no attachment to the ego, syndrome of captivation, in order to determine the main and essential symptom of psychosis, precisely the unexpected incubation of a parasitic thought, inundating suddenly the area of consciousness. Therefore, if we analyse the constitutional attributes of automatism, according to existing theories, we will observe that the concept of automatism includes many phenomena, abnormal or normal. According to the first point, automatism is attributed to the effect of preformed mechanisms, ready to be set in motion, as soon as the function of the higher centres is suspended. Consequently, the release of the dynamics of neuropsychic formations, constitutes one of the main manifestations of automatism. The existence of an organic damage (even hypothetical) is necessary, for instance in epilepsy and dementia praecox. Automatic motion phenomena, in these two diseases, are caused either by inhibition or by stimulation; in essence, these are caused by the aforementioned neuro-psychic mechanisms, released whenever the appropriate opportunity arises.

The second point considers things differently. According to that, automatism acts under its psychological form, mobilising a rich reserve of subconscious psychic forces. The release of stored emotional reserves becomes synonymous to automatism, as previously the sudden release of activity of the lower neuropsychic formations. In this second case the organic damage facilitates the appearance of the emotional manifestations of automatism. Bleuler, admitting that the disorder of thought associations as the direct linear consequence of the initial organic damage of schizophrenia, considers the secondary symptoms of schizophrenia, as well as all its automatic manifestations as stemming from the surreptitious action of

subconscious complexes of the sufferer. Thus, despite its initial organic origin, emotional automatism explains the secondary symptoms of schizophrenia.

As outlined above, it becomes obvious, that we can distinguish two major categories of automatic phenomena, which are totally opposed to each other.

The first category contains manifestations caused by automatism, which stem from the automatic succession of reflexive phenomena that are more or less composite, their pathogenic character is mechanical in nature and they vibrate in succession due to the initial organic damage (as pathways of the above-mentioned reflexes are pre-formed and engraved in the texture of the nervous system). The second category includes phenomenally, that are only superficially mechanical, but in essence originate from the very depth of the psychical personality and betray the devious action of various complexes of the subconscious psychic world.

On the basis of this dual nature of automatism (organic and emotional), some authors, like H. Ey, deny to this term any form of precision, and simultaneously condemn it, as including dissimilar phenomena having nothing in common. This author rejects the theory of automatism, because it considers the symptom as stemming from a mechanical stimulation of certain neuropsychical formations. This is not only erroneous, but also dangerous, because if we accept this theory, then the distinction between pathological and normal, between voluntary and automatic collapses. Indeed, if we reject the concept of determinism, as bordering on metaphysics, then we must equally and for similar reasons reject the theory of automatism. He considers that we must replace the organic psychogenesis with a dynamic one, yet within an organic context.

Instead of admitting the automatic release of pre-formed neuropsychical mechanisms, we must admit that in psychoses, normal thought regresses to lower levels, down to its archaic emotional forms.

H. Ey's objections are not unfounded. It is obvious that this dual nature of automatism cannot satisfy the intellect. In a most elementary way, organic and emotional automatism become synonymous to the old dualism that opposed the matter to the power and vice versa. Recent trends in psychiatry, as well as the totality of the biological sciences, are irreconcilable with such badly postulated issues, indicative of philosophical prejudice. The contrast between organic and dynamic is not as radical as previously believed. This traditional contrast between organic and dynamic, between neurological and psychic, is obviously erroneous, as the area of action of each of them is not completely independent of the other. Under this light Pichon is justified to burst out against this traditional prejudice, opposing to it new clinical and laboratory evidence.

Organic disorders cause mental disorders and vice versa, in a way rendering the discovery of their causal relationship problematic. The recent knowledge on the inner mechanism of emotion, implicating the intervention of the endocrine/sympathetic system, renders the still cultivated opposition between organic and psychic unjustified. The study of hysteroid conditions (Marinesco, Draganesco, Tinel), provides us with another argument against this deceptive contrast, as the rich clinical symptomatology of these patients is caused by subtle histological changes to the midbrain, whose ensuing functional dynamic dysfunctions can be induced by a strong emotion, such as fear. Also, the cases of emotional Parkinsonism observed during the Great War with a full group of organ-

ic symptoms, contribute to the understanding of the organic character of many other neuropsychic syndromes, having exclusively psychical or emotional origins (e.g. goitre).

Of course, if we limit ourselves within the framework of automatism, as outlined above, we will observe that only by extension, by analogy, we have the right to use this term in order to define phenomena occurring during psychosis. Because, in the strictest meaning of the term, neither organic nor emotional automatism apply unreservedly on psychoses, as both depend on pre-existing neuropsychic formations –in certain cases mechanical, in other cases emotional– and consequently fail to include the newly formed parasitic thoughts of a mental patient within their competence. Only certain characteristics of automatism, such as the involuntary and subconscious nature of idiomatic verbal expressions, their autonomy and progressive organisation, beyond the voluntary participation of the sufferer, may find complete implementation therein. For these reasons, in order to be more precise, De Clerambault uses the aforementioned terms, which can serve his theory better than automatism. In our view however, we are obliged to retain the term of automatism for reasons of practical expedience, apart from other reasons, e.g. historical reasons (as Baillarger was the first to use the term of automatism in the description of psychical hallucinations). To date, the concept of automatism has resisted time in denoting those mental phenomena that have developed outside the usual conscious mental activity of the patients, and on be known to them like invaders aim to conquer the totality of his psychic personality.

[...]



Michael Striggaris (1903–1996)

Elementary trends for the formation of delusional ideas under the influence of hashish

(Στοιχειώδεις τάσεις πρὸς σχηματισμὸν
παραληρητικῶν ἰδεῶν ὑπὸ τὴν ἐπίδρασιν τοῦ χασις)

Elliniki Iatriki (Hellenic Medicine) 1937, 100–126

In the past, it was believed that the so-called poisons of the central nervous system constituted the cause of certain psychopathological phenomena, a cause possible to calculate with the greatest precision: how many grams of alcohol, for example, produce a particular symptom.

In our days, we no longer go along with this conviction, as we have ascertained its inaccuracy concerning the psychoses resulting from long-term toxic substance abuse, but also in experimental use, where specific quantities of poison are used. From the time of Kraepelin, who was the main representative of this new direction of experimental research in contemporary psychiatry, to this day, many experiments have been conducted by Wernicke, Hoche, Knauer, Gutmann, Joel, Frankel, Kant, Krapf, Beringer, etc., with alcohol, mescaline, Narcylen,

Cawa-Cawa, hashish and so forth. The conclusions drawn from these experiments limited the initial hypothesis.

Each one of these experiments raised the following questions: What is a typical symptom arising from a specific poison and what is the response of the individual temperament to any stimulation, including a response to the poison of the experiment. Experience in such cases taught us that, as a rule, each poison produces certain psychopathological symptoms with specific characteristics. Mescaline and hashish cause visual hallucinations, however, hallucinations caused by mescaline have a different colour than those produced by hashish. Thus, we are able to distinguish, totally, one type of intoxication from another.

Yet, quantitative differences in doses of the same poison, as well as the same quantities (doses) applied on the same person in varying biological and mental conditions, do not only give rise to differing intensity of symptoms, but also to a qualitative difference in the psychopathological phenomena produced and the overall intoxication.

This diversity of contributors, such as the qualitative and quantitative difference in the effects of poisons during each intoxication, the alternating biological and mental states and the readiness to manifest different reactions, when the same quantity of a poison is administered to the same individual, render it impossible, according to Beringer, to distinguish the special effect of a poison from the individual's temperament.

The importance and significance of these experiments cannot be limited only to artificially induced psychoses and to the conclusions drawn from studying toxically altered mental faculties. Experiments are, also, valuable, more than the most

thoroughly objective examinations, because they enable us to probe further into psychopathological phenomena, by virtue of self-observation and self-description, furnished by the subjects of the experiment. Indeed, in some cases we are able to draw analogies and parallels between the special symptoms of intoxication and the corresponding phenomena of psychoses (e.g. schizophrenia), provided that we diligently avoid viewing them as one and the same thing.

According to Beringer, for this experimental purpose a poison should have the following properties not to eliminate the individual's ability to observe himself, to permit the examination of the personality on which the poison acts, and not to alter consciousness to a degree producing its deepest darkening. For this reason, scopolamine, used by Mannheim and Kappes to perform self-observations, proved to be unsuitable for this purpose, as doses producing the interesting psychopathological phenomena are very close to those having a profound effect on consciousness. Mescaline and hashish are always considered to produce states of intoxication with most abundant psychopathological phenomena. We are referring to the well-known Beringer's study on the effect of mescaline and the hashish experiments by Joel-Frankel and Kant-Krapf.

[...]

With these few examples of self-observations I attempted to present, very succinctly and schematically, the main and fundamental psychopathological phenomena of intoxication with hashish. Moreau (de Tours), in his treatise published in 1845, focused his attention on these phenomena, which he characterised as "dissociation des idées" (dissociation of ideas), in our days partially classified in the alterations of function of thought (Denkstorung). These conditions create secondarily an inner

uncertainty, doubts and a feeling of lack of self-control, which are easily perceived in the following self-description:

“When I was asked to leave the room, where the experiment had been conducted, in order to walk around the ward, I refused obstinately to proceed. I felt as if I was suddenly exposed, open, vulnerable and fully unprotected. Uncertainty, doubt and worry pervaded me. I felt that I was safer where I was sitting before. ‘Where should I go?’ I wondered. ‘What else do they want? I’m fine here.’ I thought that I was in a pitiful state, that others around me could see and make fun of me and if I were to leave that room, everything would take a turn for the worse. I had the impression that I would lose myself. This bothered me and I was consumed by shame. Only when B.E. told me that we were not playing, but instead were conducting a scientific experiment, did I decide to give in. Thus the great interest I had initially for this experimental inebriation and self-observation, came back. Afterwards, when I was coming down the stairs and was passing through the wide entrance, I thought that everyone was watching me and even the walls had something to do with me, as if they were staring at me. I thought that people were looking at me with an undetermined calmness. I was so ashamed that I looked straight ahead and I don’t remember having met anyone during the entire course. I had the idea that those watching me would be amused and this thought appeared so funny that I burst out in laughter. Nevertheless, I felt the strong desire for this test to come to an end, as soon as possible, and get rid of this state, which was unpleasant overall. Meanwhile, I had the feeling that coming down the stairs and passing through the exit were endless”.

In this fragment of auto-analysis we have information on the paranoid disposition due to the influence of hashish.

There is a tendency to form delusional ideas, however the delusional contents are missing, only their direction is apparent. If the subject under examination, were to add that everything was happening in order to make him look ridiculous or that indeed he was being hoodwinked, we would have a complete delusional idea. This mental disposition and readiness to experience delusions appears more clearly in the following excerpt:

“When I mentioned my first subjective observations on the oncoming intoxication to B.A., I remember that he laughed and got up in order to telephone B. and invite him over. As he did not tell me whom he was calling, I formed the idea that he avoided mentioning the name for a particular reason. Later I thought that he intentionally avoided mentioning the names in order to protect me from paranoid ideas. Subsequently, upon examining this condition, I believe that thinking in this way constitutes a type of idea of correlation (*Beziehungsideoe*)”.

In the shorthand transcripts, we encounter the following episode: The person being examined says that he prefers to keep his eyes open. One examiner says to the other without addressing the subject, who is under the influence of hashish: “Strange, when I was intoxicated with hashish, I always wanted to keep my eyes shut.” Then the subject says: “An examination of suggestibility”. In the self-description he explains that he believed, at that moment, that the examiner’s phrase was intentional to suggest to him the idea to maintain the eyes closed. This is an obvious example of paranoid disposition, even containing the onset of a delusional interpretive process. Let us examine the same problem with respect to those who are long-term hashish users. Obviously the repeated use of hashish causes a change in the way of action of the poison; to

say the least, the subjective symptoms of intoxication of hashish addicts are distinct from those in experimental use. On this point, all habitual users agree and affirm that only those familiar with the repeated use of hashish are able to perceive its real effect, or as they call it the "trip". Concerning the main symptoms of the immediate action of Indian cannabis, no substantial difference could be found, on the contrary I was able to certify in the "trip", both the fast alternating states of consciousness and the objective alteration of thought in long-term hashish users.

A characteristic trait of people with a hashish use habit is their constant suspicious mood and their readiness to "misunderstand". Their capricious character is well known. Therefore, we are able to form the opinion that the property of the poison in question, which we encountered regularly in our experiments, plays a major role in shaping the character of those persons with a hashish use habit. This was confirmed by the fact that three days after hashish was consumed, there are still traces of its ongoing action on the body (a vivid example of such traces is the episode of colleague R., which occurred three days after an acute intoxication in the lecture hall, during clinic courses and during a presentation delivered by a visiting professor from overseas. He suddenly burst out laughing and was forced to leave the hall; indeed, he continued laughing outside because he considered hilarious an insignificant observation during the lecture).

What addicts seek in the pleasure induced by hashish is joviality free of cares. The euphoric influence of intoxication seems to occur more frequently during the time of familiarisation to this habit. During this period, as addicts themselves state, there is a tendency to laugh and a feeling of exceedingly

good spirits. Some of them find the greatest pleasure when they are in perpetual motion, when they are dancing or even walking, while others prefer to taste calmly their pleasure. In this state of intoxication they begin lengthy discussions, narrate various imaginary and adventurous stories, boast and present themselves as heroes in make-believe events or they attribute colossal importance on ideas inspired by the hashish. The subjective feeling of high spirits leads them to greatly overestimate themselves: "I am everything and everything else is nothing".

They frequently repeat these "axioms". However, once the intoxication is over, they know very well that these ideas and feelings are caused by the direct influence of hashish. One of them was very sorry to be unable to remember the full details of the exceptional ideas inspired by the intoxication and to record them in order to preserve them. This example illustrates, on the one hand the recognition of the causal origin of these ideas, and on the other hand, the prolongation of the conviction concerning the importance of these ideas, in other words a delusional remnant (*Restwahn*). Generally, we can see that people under the direct influence of hashish are easily carried away by abstract ideas. Suddenly, a simple idea can occupy their intellect without a real cause and dominates their entire mental world: "When you have an aim, you will follow it to your dying breath" said an addict. This explains why these people are very easily swayed into superficial acts, frequently dangerous. It could be said that ideas, as psychological formations, take on a morbid intensity due to hashish abuse. A result whereof is the inability to communicate with people under the influence of hashish. They don't accept either advice or objections; indeed they react to any objection disproportionately,

with excessive rage, because they are, also, sensitive and short tempered.

As a general rule, people inebriated with hashish manifest delusional ideas. A hashish addict, for example, correlates to himself a stranger passing close to him. He distinguishes intent and calculation in the most insignificant event, believing that somebody is acting against him. Two strangers are talking at a neighbouring table in a pub, while others, sitting a bit further away, are laughing; the hashish addict considers that talking and laughing refer to him. Some children are playing on the street; he starts pursuing them and throws stones at them, thinking that they are laughing behind his back. Everyone knows that he abuses hashish, and moreover, that he is in a "trip" at that moment. Sometimes fear is added under the influence of hashish, the addict believing that the threat of death lays everywhere around him. Footsteps heard far away in the middle of the night, or even the faintest whisper are sufficient to make him panic. If he meets a stranger, who will address a simple question to him, the addict is capable of drawing the most implausible conclusions regarding the other's intentions, to show signs of fear and flee or to turn against the stranger with uncontrolled aggression.

Some of them say that the starting point for these paranoid ideas is a feeling of shame, which overtakes them during intoxication. Their innermost thought is: "How do I look to others, who are not in a state of hashish-induced intoxication?" During their intoxication they have the impression that their entire existence is exposed to everyone. For this reason, they try not to be seen, as much as possible, in order to hide in some way their mental nakedness. They avoid people, they smoke in secret (not only because they are persecuted by the police, but also from an

inner psychic need). They focus their attention on their appearance and their clothes, always trying to be well dressed, yet according to their special taste [...] However, even this feeling of shame, particularly in the case of hashish addicts represents a specific paranoid disposition disguised as shame.

By way of summarising our observations with hashish administration experiments, self-observation, as well as by monitoring and examining hashish addicts, we identified alteration of consciousness and thought to be the main symptoms of the direct effect of cannabis. We have observed a tendency to misconstrue, misunderstand, and misinterpret the environment. This tendency is interpreted by one of our colleagues who was an experimental subject in the following way: this tendency is caused by the ability of the individual to observe his proper state and in parallel combine and unify it with what he can see around him, in order to evaluate them according to reality. Thus, he is obliged to depend on an instantaneous arbitrary interpretation, which he manages to form between two positions of consciousness and which is intended to fill in existing gaps. Therefore, paranoid interpretations, during experimental intoxication, as well as during recreational intoxication, are a way of filling in subjective blanks, left behind by alternations in states of consciousness and the discontinuation in thought associations.



Georgios Pamboukis (1885–1959) & Georgios Anastasopoulos (1906–1977)

Treatment of schizophrenia by insulin at the Eginiteion Hospital

(*Ἡ διὰ τῆς ἰνσουλίνης θεραπεία τῆς σχιζοφρενίας
ἐν τῷ Αἰγινιτείῳ Νοσοκομείῳ*)

Reprint from the journal Hippocrates, 1938, issue 7–8

The treatment of schizophrenia by insulin coma introduced in 1933 by Sakel, was applied with unusual swiftness in almost all civilised countries. The causes for this rapid expansion must be sought, naturally, in the relative ineffectiveness of the treatments at our disposal to that date, but is mainly due to the hope engendered by the amazing number of successes reported by the Viennese School, concerning the cures and improvements achieved by insulin therapy. Up to this date, a large number of cases of schizophrenia treated with insulin, has been reported. However, what intrude in many people's minds, are diametrically opposing opinions of authors concerning the therapeu-

tic value of insulin treatment. Most authors cite truly amazing therapeutic results. For example, Sakel and Dusik achieved remission with full ability to work in 88% of recent cases, i.e. in those cases where the duration of the disease did not exceed a period of 6 months. Müller, in data derived from Swiss hospitals, draws the conclusion that in 78.8% of recent cases there was a complete remission, and Berglas and Susic mention for the same category 70% of stable remissions. Statistics of clinics at Wilna and Oslo refute these results, the number of remissions achieved by insulin not exceeding those brought about spontaneously. Von Pap from the hospital of Debrecen adopts an intermediate position; taking into consideration the duration and form of the disease, were reported in 38.6% of cases.

This difference in the results achieved is doubtlessly due in part to the varying views concerning the concept of schizophrenia in various hospitals. Indeed, this divergence of views is most obvious in the recent cases. If one includes amongst schizophrenia cases of chronic confusion of infectious or toxic origin (amentia), psychoses due to degeneration, conjectural cases, which all have a greater tendency to spontaneous remission than schizophrenia proper, then, this may lead to much better statistics compared to those, taking into account only schizophrenias. Another reason for these contradictions stems from the differing views concerning the definition of the concept of full remission (vollremission) or simple remission (remission) etc. Dussik and Sakel, Müller and Angyal and Gyárfás defined some criteria, which everyone should have in mind, when drawing up statistics, in order to reach a more general consensus.

In any case, even if one achieves to prove that insulin treatment is not much more effective than spontaneous remissions,

we believe that it would not necessarily prove that its implementation is unreasonable. Teenestra thinks that it should be examined whether insulin, amongst other factors, may at least shorten the duration of a schizophrenic attack. It should further be examined whether the duration of remissions achieved by insulin treatment is longer than that of a spontaneous remission (Horanyi-Hechst and Szatmári).

We are implementing Sakel's method at Eginitieion Hospital since June 1937. It has been applied in 13 cases – two of them will not be taken into consideration, because the necessary number of comas was not reached. This number of cases is of course small, but lack of sufficient time, the relatively high expense of the method, the long duration of treatment, the great number of nurses who have to be involved throughout day time and other secondary reasons are sufficient to justify it. However, we hope to overcome obstacles and increase the number of patients undergoing insulin treatment.

We shall not expose extensively the technical part of this treatment. We attempted to maintain the guidelines provided by Sakel and to follow the instructions set out by Frostig. Treatment is always preceded by a detailed examination of the candidate, liver function testings, taking an orthodiagram of the heart, an electrocardiogram and a chest X-ray. We commence at 7:00 am by injecting 20 units of Bayer's insulin and continue on the following days, increasing by 10 units each day, unless special reasons impose smaller increments. Coma was achieved with a number of units that ranged from 60 to 200. Hypoglycemic phenomena appeared with much lower units of insulin.

[...]

We usually fix the duration of a coma at 1½ hours and we interrupt it rarely by administering glucose by intravenous

injection or more frequently by the digestive path. Comas of long duration did not occur and only in one patient we did observe a slow recovery taking half an hour or more beyond what was usual. This patient fell into coma more swiftly than usual and no change in the technique contrived to alter this reaction. In two other patients we observed that, sometimes, half an hour to an hour after complete recovery, they reverted into a coma, which was once more interrupted by administering sugar and an adrenalin injection. Finally, one patient presented an akinetic condition a quarter of an hour after recovery, which lasted a few seconds and remitted spontaneously. The patient described how he could hear and see everything around him, but was, however, unable to react.

The number of comas differed for each patient. The lowest number of comas was 15, with 30 days of insulin's administration. Many patients underwent 90 comas and the treatment lasted for up to 110 days. Our experience indicated that positive results were achieved after the first 30 comas.

[...]

In four patients with hebephrenic and hebephrenic/catatonic forms, a greater or lesser change in the clinical picture was achieved. In one case the unmoving cataleptic condition was resolved, however the patient rebounded in the opposite direction developing excessive eating, reaching the point of greed, he became animated, manifested sexual motivation, however remaining as incoherent as he had previously been. After the end of treatment he was taken to his birthplace, where shortly thereafter the district attorney was forced to order his commitment to the local Mental Hospital, as he had attempted to rape a young girl. The other two patients showed a slight improvement during their treatment, which

pleased their relatives, more than it did us. However, even this slight improvement slowly disappeared and the patients once more reverted to their previous condition. The fourth patient showed no change whatsoever. We did not hope for better results, because all four patients were suffering from chronic, established conditions for many years. In one of the three cases of paranoid schizophrenia a series of thirty comas produced significant improvement, despite the fact that the disease was established three years ago, enabling the patient to return to social life. The patient got rid of his delusional ideas; however, this wasn't because he recognised them as delusional, but rather because he became indifferent to them and, in general, he became less active. [...] In two other cases no definite improvement was achieved.

In another case [...], there was a significant improvement, the patient achieved full contact with his environment, he commenced, in part, to obtain insight in his delusional ideas, and in part to be indifferent to them. However, we observed the manifestation of new delusional ideas, having the form of revelations, as well as auditory hallucinations. When the patient left the clinic, his personality was more stable, however, he did not achieve a harmonious cohabitation with his environment. Pathological behaviour and delusional ideas kept him in the margins of social life.

In the following case we have a typical schizophrenic bout. [...] After the tenth insulin injection and before we had even reached the dose necessary for a coma, we observed an exacerbation of the auditory hallucinations, which surpassed all the other phenomena. [...] Despite the continuing presence of auditory hallucinations, the patient was not bothered by them, the delusions were indifferent and alien to him and at the same

time we observed a relative and unstable insight. Before the end of treatment the patient recognised fully the morbidity of his previous condition and –something more significant– he did not hesitate to speak about it and judge it objectively.

Two next cases of acute states, however, cannot be considered to be pure cases of schizophrenia. [...] Both patients were unmoving and cataleptic, with some symptoms of melancholia. [...] After the fifteenth coma (one patient) was transferred to the Public Psychiatric Hospital, where she improved rapidly and was discharged, fully recovered. [...] The other patient was also discharged fully recovered, but retained his melancholic idiosyncrasy, as previously. [...] In his case the treatment began five months after the onset of the mental illness and in the case of the female patient after ten months.

The data naturally, are not sufficient, in order to permit any reliable conclusions. However, we must underline that in those cases where we expected positive results through the application of insulin treatment, according to the experience gained to that date, we did in fact achieve satisfactory results. This fact strengthens our efforts, despite the financial burden and multiple exigencies of this treatment, in order to continue in the future, to the degree that various difficulties permit us to do and particularly the necessary permission by the relatives in order to submit schizophrenic patients to this treatment during the initial acute phase of their illness.



Isaac Tastsoglou (1880–1959) & Panagiotis Karambateas (1904–?)

Aetiological link between dementia praecox and tuberculosis

(Αιτιολογική σχέση της πρωτογόνου άνοίας
πρὸς τὴν φυματίωσιν)

Elliniki Iatriki (Hellenic Medicine) 1938, 190–208

In Psychiatry, despite the recent clinical progress, deep ignorance still exists concerning the aetiology, the pathological-anatomical alterations and the physiology of most mental diseases. This is why treatment has so poor results.

The aetiology of many mental diseases is known, such as the post-infectious and toxic, endogenous or exogenous, diseases. The pathogenesis and physiological origin of most of them has not been precisely determined, nor have the pathological alterations been investigated in detail. Despite this, antitoxic and anti-infectious therapeutic means act remarkably well upon these, at least at the initial stages.

However, there is an entire group of mental diseases, perhaps the largest one, characterised by indeterminate patho-

logical and physiological substratum, and also complete ignorance on their aetiology. These are dementia praecox (schizophrenia), paranoid psychoses, paraphrenia, melancholia, manic excitation and so forth. Faced with these diseases, the treating psychiatrist becomes a simple observer, who can act only in order to relieve symptoms, mostly ineffectively, in the absence of other therapeutic means. This therapeutic incapacity is due primarily to the aetiological ignorance surrounding these diseases and additionally is due to the unclear designation of pathological alterations and the lack of knowledge on their altered physiology.

The spontaneous evolution of these diseases is diverse. Certain illnesses, such as melancholia, manic excitation and other conditions related to these, in most cases can be cured rapidly, but of course, the risk of relapse is always there. Paranoid psychoses persist for long periods of time and, with very few exceptions, have negative prognosis. Finally, dementia praecox and various forms of schizophrenia, after different periods of time lead to complete mental devastation of the sufferers.

The difference in the evolution of the disease depends on the extent and nature of the damage and its localisation in the nervous tissue (cells, fibres, neuroglia), which constitute the various areas of the psychic sphere of the brain. It is, also, dependent on the extent of action of aetiological factors (if one assumes that these factors exist) and on the degree of tolerance and reaction of the nervous elements.

Regarding the diseases in question, the extent, nature and localisation of the damage has not yet been ascertained. The fact, however, that some of these diseases can be cured, some remain static and many others have a rapid deterioration,

indicates that the damages can be reversible or not. It has been established by Marinesco that in cases where an alteration concerns a partial dissolution of the stained protoplasm material and a simple migration of the nucleus (Nissl's degeneration phase) rehabilitation is possible to a certain extent. If the unstained protoplasm material, the main component of the cell (Hayem-Forel's degeneration phase) has become atrophic, then the damage is beyond repair. This observation is valid for nerve cells carrying out vegetative functions, but not for nerve cells carrying out functions of the mental sphere, as in various mental diseases no specific alteration of nerve cells has been identified.

In spite of this, we have to note that similar conclusions can be drawn with reference to mental disorders on the basis of their differences among them. The variability of clinical pictures in the mental diseases should be ascribed to different actions of aetiological factors, varying reaction and tolerance of the nervous elements comprising the mental sphere and the varying localisation and nature of alterations involved. Previous knowledge on properties of those elements that constitute the mental sphere (intellectual development, knowledge of grammar, professional occupation, social life, individual habits, tendencies, proclivities, etc.) is contributing greatly to enrich the clinical picture of the various diseases, but all these elements contain basic symptoms, observed in all patients, referring probably to similar cell disorders.

In melancholia, manic excitement and related cyclothymic psychoses, the supposed disorder creates an intense affective and volitional morbidity, which is fully disproportionate to that of higher cognitive functions. In paranoid psychoses, however, disorders mainly concern certain higher mental

functions, in a restrictive and distinctive way, with a commensurate impact on affect and volition, while most of the other higher functions remaining untouched. Finally, in dementia praecox and various forms of schizophrenia, most of the higher functions are highly afflicted, as are affect and volition, following morbidity of the former. These basic clinical observations are incontrovertible. If different patients presenting the same disease develop a variety of symptoms of secondary importance, this is not inexplicable, given that this is most frequent in almost all diseases of the human body, and particularly in the case of contagious diseases.

These clinical data allow us to observe that the nature of pathogenetic factors must differ in each of these mental diseases, or, at least, must act in a different way, depending on the conditions they encounter, thus creating different alterations, which also bring about a different clinical picture. It therefore becomes easy to comprehend from the aforementioned clinical observations that the alterations created are certainly minor in cyclothymic psychoses, increase in intensity in the paranoid psychoses and are greatest in dementia praecox and the schizophrenias. This might be the reason why improvements and cures are most frequent amongst the first group, rarer in the second group and exceedingly rare for dementia praecox and other forms of schizophrenia.

The question definitely arises: do these mental diseases, of unknown aetiology to date, owe their genesis to factors that are infectious, toxic or toxic, endogenous or exogenous, due to an improper formation of the various components of the mental sphere, in the sense of an inherited or acquired predisposition, or to both of these causes, the first serving as the occasion for their manifestation?

Hereditary or acquired predisposition, as perceived by us today, would fully explain all mental disabilities, such as idiocy, cretinism, feeble-mindedness and so forth, as well as the existence of various specific mental qualities and anomalies, but not, however, the genesis of these aforementioned mental diseases (i.e. cyclothymic, paranoid psychoses, dementia praecox and schizophrenia). They certainly contribute, greatly, to their manifestation, preparing the ground and making it vulnerable to those pathogenic factors that remain unknown to us. It is, however, doubtful whether they can be their sole causes, because in that case, there would be no reason for them to leave the brain undisturbed to develop normally until a young or mature age, and only then to reveal their destructive action. It is a fact that many people affected by these mental diseases had manifested during their development various character anomalies or they come from mentally ill or otherwise burdened parents. However, predisposition can not be the sole cause for the genesis of these diseases, but in all likelihood strengthens the view attributing to it the role of *locus minoris resistentia* (the site of least resistance), offering a suitable ground for the unremitting action of other pathogenetic factors, to which the manifestation of these diseases is mainly due. Moreover, cases exist where these diseases manifest in individuals who do not have a burdened heredity and who had a normal development through their childhood and youth, therefore it would be extremely arbitrary to lay the blame on a non-existent or at least obscure hereditary or acquired predisposition. Furthermore, there are many cases of mentally ill parents giving birth to children who are perfectly healthy, throughout their lives [...].

All these facts, for the time being, render as most justified the opinion that a hereditary or acquired predisposition may play a significant role in the creation of these mental diseases, however, other factors have a role to play in order for these to be manifested and remain active. The importance of action of acquired pathogenic factors is also reinforced by the fact that in infectious and toxic psychoses, the clinical picture is the same or similar to the picture of these mental diseases. Toxic substances retained in the body can manifest manic, melancholic, confusional, paranoid, schizoid and dementia psychoses (Toulouse, Marchand, Shiff and others) or various neurotropic infections (Claude, Targowla, Lamache, Tixier, etc.). In the genesis of these psychoses there is without doubt contribution of organic, bio-somatic and infectious factors; therefore they were correctly named psychosomatic syndromes (Targowla). Consequently, it would be incorrect to reject the idea that factors of a similar nature could contribute to the manifestation of the so-called idiopathic mental diseases.

[...]

Finally, wide-ranging clinical observations on dementia praecox have given cause to turn the research to the investigation of tuberculosis as its underlying cause.

[...]

Having in mind all the abovementioned, we considered it expedient to work on this topic, aware of the difficulties that we would encounter and the doubtful result of our efforts. In this case we followed all the ways of observation and research, which include clinical, statistical, laboratory, experimental and post mortem dissection.

[...]

In conclusion, we would like to articulate the opinion that the sum of our studies did not bring to light anything clear-cut in relation to a tubercular aetiology for dementia praecox. Nevertheless, our clinical observations, statistical data, few laboratory findings at our disposal, minor experiments we undertook (ed: vaccination of laboratory animals with cerebrospinal fluid from mental patients) and post-mortem examinations, as these mentioned above, sustain, to a certain extent, the opinion that Koch's bacillus may potentially be involved in the manifestation of dementia praecox and justify our further investigations. This was, after all, our intent, when we decided to carry out the aforementioned laboratory research.



Ioannis Patrikios (1895–1977)

Migration as a psychopathological factor

(*Ἡ μετανάστευσις ὡς ψυχοπαθολογικὸς παράγων*)

*Reprint from the journal Iatrikai Athinai
(Medical Athens), 1939, vol. 131*

The study of psychopathological conditions that occurred during the Great War provided the opportunity to observe, once more, the etiological significance of emotional factors in the genesis of mental diseases. The organisation of neuro-psychiatric centres, not only in the countries at war, but also in those close to the front, permitted the observation of these psychopathological manifestations, from their first appearance to their ultimate outcome. Finally, the presence of psychiatrists in the expeditionary forces often permitted the study of the origin of these manifestations, i.e. the trials and tribulations of the souls of the soldiers.

Adverse war conditions combined with this propitious scientific organisation allowed a fair evaluation of the importance of emotional factors for the origin of mental illnesses. The life of a migrant is yet another situation, where emotional factors appear to have a substantial contribution to the onset of mental illnesses.

In a migrant's life (with the exception of violent emotional shocks caused by war events, as bombings, scenes of slaughter, etc.) similarities can be drawn to the life of a soldier (as seen during the Great War) regarding the frequency and duration of painful emotional events, as a migrant has also been exiled from his country of origin and has to fight an arduous struggle to make a living under untoward psychological conditions.

Migration has of course already been studied by psychiatrists. However, it has been studied particularly in host countries, especially from the point of view of increased morbidity caused by migration.

Obviously, the study of a frequently turbulent life is of greater interest to those countries which are linked emotionally to their children who have moved away due to the harsh necessities of life.

Classical psychiatry, with some exceptions, has been absorbed mainly with nosological classification, and tends to quickly bypass this significant factor, even though some references to emotional factors when discussing the aetiology of mental diseases have been made.

Yet, a relatively recent development in psychology, namely the fact that it has ceased to be absorbed almost exclusively with the study of pure cognitive issues and was turned to the emotional part of the human psyche has had a beneficial impact on how psychiatrists perceive mental diseases.

Two researchers in particular initiated this development. The first was Ribot, a venerable teacher, through his studies on human emotions, human passions and their effect on the way of thinking; and subsequently Freud, whose work has shed copious light on the dynamics of the affective subconscious, which governs human acts in an obscure albeit decisive way.

Indeed, more than anything else, to live is to feel. But an emotion is not simply a psychological sensation, it cannot be reduced to a psychological aesthesia, similar to skin aesthesia (cutaneous sensation). It contains, in its consistency, a factor which is clearly sensory and indeed we could say it contains a somatic sensation (sadness, fear, happiness), a muscular sensation (sensation of flaccidity, sensation of vigour) and possibly a vascular sensation.

However, this sensory factor is not everything. An additional factor, which is most important, is the purely psychological colouring of such "sensation" as being pleasant or unpleasant, colouring being experienced by the ego according to whether the external events serving as stimuli of this "sensation" (in the way that a pinprick, hot and cold, etc. serve as stimuli for cutaneous sensation or dilatation for visceral sensation) are in accordance or discordance with our impulses (drives), are in line or opposed to our "sacred ego".

What is pleasant or unpleasant stems from the meeting point of two forces. The first force is "the event", which is external and temporary. The second force is the impulse (or drive), which is internal, continuous and eternal, one could say as life itself; primitive, rooted in the subconscious, and in some cases having a life latent to the conscious. The emotional condition of a person depends on the meeting of these two forces. If the first is favourable to the second, the effect on the totality of somatic and psychological functioning is beneficial. Conversely, if it is unfavourable, if it is opposed to the continuous tendency for achievement and domination of the second, all these functions suffer.

The result of such congruence or incongruence, which subjectively gives rise to a pleasant or unpleasant sensation,

may be subject to a rational, comprehensible rule, however, it is completely independent of the conscious intellect of a being, of this most recent –from the standpoint of evolution– functional perfection of the central nervous system. What is pleasant or unpleasant has a substantial effect on our distinct somatic functions, our actions themselves and, even more, on our intellectual mechanism.

[...]

The affective event, which naturally influences human thought, through its repetition and by virtue of a more or less predisposed ground, upon exceeding physiological limits may result in mental disorders of a clearly pathological nature.

How could the mechanism of such a pathological process be conceived? Let us consider, as an example, the most straightforward cases of mental disorders caused by a violent and sudden emotion, an emotional shock. In daily life, many states of confusion have been observed under the shock of an emotional blow, e.g. the sudden and unexpected death of a beloved person, and similar cases having occurred, even more frequently, during the Great War. Clinical pictures classically viewed as the result of intoxication, whether infectious or not, that is to say due to a chemical effect, were also observed in purely psychological traumas. Of course, it is possible that a chemical factor is also found in these cases, and indeed high levels of adrenaline in the blood have been found to be a substantial factor. Nevertheless, we believe that this is neither the sole factor nor the predominant one. Over and above this, the abrupt disruption of the dynamic equilibrium of the nerve centres is observed upon a violent emotional blow; in fact, recent research on the functioning of the nervous system has shown the perpetual fluctuation of this dynamic equilibrium.

The results of an emotional shock can be compared to those of a painful injury, suddenly occurring on a part of the body. In this case, the sensory vibration, upon reaching the thalamus, radiates to the centres of the third ventricle, giving rise to the familiar somatic reactions (vasomotility, secretions, muscular tone and so forth), while on the other hand, upon reaching the sensory cortex, pain invades consciousness. The violence of the injury, upon reaching the higher level of the nerve centres, may have an inhibitory effect on them.

A violent emotional shock will have the same inhibitory effect, as we know from our clinical practice. A complete and total inhibitory effect would be expressed as a coma; suspension to a lesser degree would cause sedation; and to a still smaller degree, as is normally the case in emotional shocks, could temporarily or permanently disrupt only the process of making pathways (frayage, Bahnung) that ensures the higher level of integration of mental life, the intellect. On the contrary, it will allow the pathways of a lower level to remain intact. If these (ed: pathways) function only through a quite anarchic mechanism, an irregular thought organisation will be manifested, which is observed in intense intellectual confusion. If the normal mechanism is fully substituted by a purely sub-cognitive mechanism, delusional ideas may emerge, which are more or less constant, governed by the subconscious urges released in such a way.

These morbid consequences of a sudden emotional shock are more or less reversible depending on the strength of the shock, on the condition of the suffering organism at the time of the shock, finally, on its stronger or weaker congenital constitution. In most cases, intellectual function is restored gradually. In other cases, such restoration may be impossible, because of weak ground from birth, or weaker congenital capacities of restoration of the brain's full integration (e.g. schizoid con-

stitution), or because the mechanism itself has been distorted in one way or another by successive traumas. Then, the intellect will continue to function in an erroneous way, organised according to the lower functional level's mechanism (post-confusional delusions, post-confusional dementia).

[...]

The first emotional vibration of the migrant is that of the departure, i.e. separation from the environment in which he has lived so far. Sometimes consequences are manifested even in the days prior to departure, becoming exacerbated as separation approaches. We all know cases, whereby a plan to emigrate, which had been prepared in detail over a long period of time, was cancelled at the last minute due to a mechanism of emotional raptus, which was frequently followed by a secondary depression. In some cases the affective vibration is generated at the moment of farewell, increasing progressively in the following days. In other cases the person, engrossed in preparing for the journey and dreaming of future success, is not "awakened" until the departure is effective, whereupon suddenly the emotional factor, which had not been tackled up to that point appears. In this case, the psychological pain of separation is added to sadness that had not been anticipated, as well as to doubts about the success of an endeavour that had not been calculated well. Under the influence of this psychological state, the person, anticipating the future, views the environment awaiting him to be coloured in black, he is filled with anxiety, seized by a feeling of "jumping into the unknown". In most cases, the details of the journey, meeting with fellow countrymen, involvement in finding a new job or the satisfaction of first earnings, serve as a compensatory mechanism, and gradually alleviate the pain of separation, which emerges only occasionally, at times of leisure, occurring even more rarely over time. Conditions of adapting to the new environment are

slowly created and the psychological transformation of the person is gradually accomplished. Nevertheless, not everyone can achieve the same successful outcome and we know cases whereby a person incapable of overcoming these first tests, unable to focus on his work, with a depressed affect and his intellectual function suppressed, enters into a state of intellectual decline and can be saved only by returning quickly to his homeland.

This is the first emotional adventure of the migrant. Let us, now, follow the migrant in his new environment. Those who have adapted only partially, present a condition characterised by a sustained emotional tone of depressive colour, exacerbated by almost daily small emotionally-laden events; the person is trying to counteract these injurious results by small accomplishments and great hope. The most essential part of this displeasing emotional atmosphere is nostalgia, which is well known in countries with immigrants, and has been extensively cited in poetry. This is a state of psychic pain, which is latent but bitter, poignant and continuous. In persons of strong temperament this elevates the person's activity, however, in others causes depression, hindering their actions, hampering performance, reducing their "economic worth" and, hence, laying the groundwork for failure.

Thus, a migrant's sensitivity increases with respect to everyday adversities. These unpleasant events are not rare in the life of a migrant, and it wouldn't be an exaggeration to say that the first condition for success is his ability to endure them.

Let us first consider the physical conditions of the migrant's life, which are almost always full of hardship. Usually, a farmer who, up to that date, has always lived in the countryside, finds himself suddenly cooped up in a factory or a small cramped workshop, he rarely sees the light of day, sleeps in closed quarters and even saves on food. In this way, through extreme parsimony,

which is even more difficult as the initial earnings of an unskilled worker are negligible, he tries to set aside some “savings”, as the first step of a desired return to his country of origin or, alternatively, to send these savings to those waiting back home.

Let us now have a look at the psychological conditions. The farmer who has always lived in freedom, even though poor, is suddenly forced to bow to the yoke of regular work imposed on the working masses. There, he feels a conscious diminution of his ego to a greater or lesser degree. This is a feeling that some of the older migrants have never been able to erase from their memory. We have to add the fear concerning the employer, the rebukes by the foreman who is usually of different ethnic origin, whose behaviour can sometimes make the migrant feel belittled to the lowest human level. Furthermore, sorrow caused by being dismissed and the anguish of seeking a new job can be added. How many times have we heard stories describing this sorrowful period, with the person striving and begging, wandering through the big city, taking refuge in night shelters; in fact, this is a period that reinforces nostalgia, weakening the resiliency of the migrant who develops the psychology of a shipwrecked person.

Let us now consider the usual migrant, who has been relatively favoured by luck, managed to put aside some money and is self-employed. In this case, life returns to some balance, the person establishes connections to the new country, which he starts to feel as a second homeland. In these cases, mental traumas occur rarely, although there is one that we have encountered as a psychopathological factor: when a small business, which the migrant established so industriously goes bankrupt, or his laboriously acquired capital is lost due to a general economic crisis. The great hope that pushed him onwards and which he strived to fulfil, begins to fade, and the migrant must adapt once again to the harsh conditions of the

outset. We have encountered such cases of breakdown, after the recent global economic depression, which resulted in psychopathological states without remission.

This was a broad outline of the hazards caused by migration to emotional life. So far we have included the emotional adventures of a person, which stem from the environment of transplantation. What remains is to familiarize ourselves with those originating from the homeland. [...]

The migrant leaves with a heavy heart, but with the radiant hope of acquiring the Golden Fleece and returning home. Those remaining at home, in the midst of the sorrow of separation, expect and anticipate material support, in order to have a better perspective, perhaps future wealth, a hope possibly stoked by the case of a joyous neighbour.

As time passes, the absence of the missing person becomes less pressing, assisted by the material improvement in their life. The “missing” child or brother is transformed slowly but surely into the provider of an income. Their demands become increasingly frequent, as if this is the most natural thing in the world. The emigrant belatedly perceives this change, and his indignation and sorrow gradually become intense when he sees the emotional grounds of his endeavour collapsing, like a spouse who suddenly discovers that he has been cuckolded. The disappointment is bitter and this is not the smallest of emotional wounds that the overseas expedition has in hold for the migrant.

We should add yet another category, the young women, who have been “placed” abroad through their overseas marriages. The marriage would be either arranged during a short trip of the migrant, the future spouses barely seeing each other, or arranged by correspondence and exchange of pho-

tographs, the spouses being complete strangers, the affective factor being always absent in these marriages. These latter cases represent even more risky situations, the woman uprooted from her familial environment with the hope of finding a “good fortune”, is exposed, as every other migrant, to the aforementioned mental traumas: of separation, nostalgia, anxiety, material difficulties - the wealth of the spouse not being as described to her - and family accidents eventually occurring. There is, however, an additional trauma in this case: a frequently great difference in age, the not uncommon difference in intellectual development, whereby a young lady from a good family with some education, but no dowry, meets a man having good financial means, but primitive, uneducated and frequently hardened by toil. Under these conditions, these people never become a real couple, mental contact never exists, and discord becomes chronic. Then the disappointment and bitterness of this forced but unbearable situation will take root in this woman, who remains at home alone, without the emotional support of relatives. She will take “recourse” in neurosis or will end up suffering from a more or less severe psychosis, as we repeatedly have had the opportunity to observe.

[...]

Out of these psychopathological cases, many reversible ones occur in the host country and are either neurotic or melancholic or confusional syndromes in character. Some of the other cases become chronic, sometimes remain in the host country, increasing the number of chronic cases committed to the psychiatric hospitals found there, while others return to the homeland, thus permitting us to observe them. In practice, the majority of these patients (if we set aside long-term neuroses, almost all organised through a mechanism of repression) are cases of schizophrenia, seen at a very advanced stage of their evolution.

Agapitos Diakoyiannis (1915–1999)

Hyperkinetic psychoses (Αἱ ὑπερκινητικαὶ ψυχώσεις)

Doctoral Thesis, Athens, 1942

Introduction

German authors use the term “hyperkinetic psychoses” (Hyperkinessen) or the general term “motility psychoses” (Motilitätpsychosen) to describe psychoses with predominant psychomotor symptoms. The term hyperkinesia can be traced back to Wernicke, who was the first to describe these conditions, underscoring the dysfunction of psychomotility, so that he should be considered as the father of the recently described nosological entity, even though he did not classify it as a separate one, but rather as a psychopathological syndrome. Attributing paternity to Wernicke is more than justified, as he was the one who pointed out, that these states occur in mental diseases that are usually cured without leaving any residual symptoms, that they have a tendency to recur periodically, that they are observed mainly in women, being associated

with menstruation and postpartum conditions, and that they are difficult to distinguish from confusional mania. Lastly, Wernicke underlined the observed predisposition to degeneration of these persons. These are the main characteristics of this nosological entity, with which more recent researchers have also dealt.

The term “hyperkinesia” (Hyperkiness) mainly seeks to denote the excessive mobility observed in these patients and to place this symptom at the forefront of the clinical picture, in accordance with Wernicke’s beliefs on the central position held by motility disorder in the psychotic event. Wernicke considered the dysfunction of psychomotility to be a primary one, with the other dysfunctions stemming from it. To be more precise, he postulated that this motility dysfunction is a psychomotility disorder and identified the corresponding lesion at the point of transition from the sensory to the motor part (psychomotor reflex arc). These have been named more recently motility psychoses, also incorporating akinetic states. Similar states have been described by Stransky, as well as Schröder and Kleist, Pohlisch, Ilse Graf, Herz Lange Klieneberger, V.D. Torren, Schmidt and finally Fünfgeld. Hitherto literature on those psychoses, by those who were actively engaged thereon, was relatively sparse, as observed by Fünfgeld.

The effort to place these psychoses in a separate nosological framework was the work of Wernicke’s disciples and of their own disciples.

Since some decades, Bonhöffer is teaching in his clinical courses that there is an independent group of hyperkinetic psychoses, distinct from schizophrenia. His disciple Pohlisch dealt extensively with this nosological type in a monography, containing a large number of cases. Kleist paid particular

attention to various motility disorders in repeated publications and, following Wernicke's footsteps, he attempted to locate these disorders in areas of the brain. He also postulated that motility disorders hold a central position in psychotic events. This author distinguished in those psychoses that develop in phases: (1) *confusional psychoses* (confusional agitation and stupor); (2) *Hyperkinetic and akinetic psychoses* (Motilitätspsychosen); (3) *Psychoses of the ego* (Ichpsychosen); (4) *Expansive confabulations* (Expansive Konfabulose) and hypochondria; (5) *Peripheral paranoid psychoses* (Acute Expansive Eingebungspsychosen and Acute persecutorische Halluzinose) and finally (6) *Psychoses of correlation and alienation*. Recently added to this list are psychoses that occur once and are subsequently cured, as well as periodic anxiety psychoses, to which Leonhard recently dedicated a monograph. Finally, Fünfgeld, his disciple, published an extensive monograph in 1931 on both hyperkinetic and confusional psychoses.

In addition to those cases of hyperkinesia, classified as specific nosological entities, we have to classify the hyperkinetic states observed either in manic depressive illness or more frequently in schizophrenic or exogenous psychoses, or finally constituting a syndrome following brain injuries. Schröder described a case of hyperkinesia related to a tumour in the pituitary gland. Kleist postulated that psychomotor disorder was localised in the central ganglia of the brain, considering it to be an advanced form of the hyperkinetic phenomena observed in diseases of the brain, i.e. the athetotic movements, choreal movements and so forth. He described hyperkinetic states in brain injuries corresponding to the central ganglia. A very small but interesting group is the initial hyperkinetic psychosis in lethargic encephalitis described by Stern. From a

pathogenetic point of view, this psychosis borders other forms of lethargic encephalitis. The disease is of sudden onset with obsessive and repetitive anxiety, presenting sometimes emotional hypo-manic features. In our own department, the doctoral thesis of Dr. Photopoulos described a case of hyperkinetic psychosis linked to a tumour in the lucidum.

In addition, Pr G. Pamboukis and Dr G. Anastasopoulos presented a case of recurrent hyperkinesia in ependymitis of the lateral ventricles of the brain, where a hereditary tendency to hyperkinetic psychosis was triggered by an extrinsic factor. [...]

The cases we have described presented features of periodic hyperkinesia, belonging to the nosological entity described as hyperkinetic psychosis by Bonhöffer and Kleist.

The nosological base of hyperkinetic psychoses

As already mentioned, Wernicke underlined the greater frequency of hyperkinetic syndromes in women, the frequent links to menstruation, as well as the degenerative predisposition. All these have been confirmed by those who have subsequently dealt with hyperkinetic psychoses.

Pohlisch drew attention to the fact that these cases are frequently preceded by extrinsic causes, pulmonary processes, various infections, mostly deliveries, with an ensuing hyperkinetic state occurring approximately ten days later. Pohlisch found that similar psychoses in family members of the patients were rare and this was confirmed by subsequent research. Lange underscored that these cases occur only in close relatives. Pohlisch, based on the fact that hyperkinetic syndromes may occur without any other type of straightforward manifes-

tations, in manic depressive psychoses, schizophrenic illnesses and extrinsic processes alike, concluded that hyperkinetic syndromes are not related to a specific nosological cycle.

Lange, criticising Pohlisch's work, explained the correlation of extrinsic and intrinsic factors, as follows: Even in Pohlisch's cases, one could observe that manic depressive disorders and simple recurrent hyperkinesias occurred simultaneously and therefore the cases without any possible relationship are rare. In addition, on average the patients are very young. Therefore, we have to admit, according to Lange, that in simple, recurrent and periodic kinetic psychoses, besides the elements of a cyclical constitution, a possible hereditary tendency for manifestation of a hyperkinetic syndrome also exists. This tendency was more or less immobilised previously and is now mobilized. Finally, we have to admit a differing tendency of the hyperkinetic syndrome to respond to extrinsic causes. Generally, we have to accept the major differences regarding the propensity of hyperkinetic syndromes to manifest. The propensity to manifest is small in cases where the hyperkinetic syndrome occurs once, during the manic phase in the course of a cyclical illness, possibly under the influence of an extrinsic cause. Conversely, where this is reiterated in cyclical phases and the intrinsic fluctuations are sufficient to trigger hyperkinesia, the existence of a greater instability must be accepted, possibly hereditary in nature. Generally, due to physiological reasons, the propensity to hyperkinesias is higher in younger people. We have to add that cyclical symptoms have also a different propensity to manifest. Finally, Lange admits that patients with manic depressive disease can have morbid cerebral contributions, which act, by patho-plasticity, to modify manifestations of cyclic psychosis. These abnormal

predispositions of the brain are, as mentioned above, purely hereditary and independent of the hereditary propensity for manic depressive psychosis. Lange considers that hyperkinetic psychoses essentially belong to the cycle of manic depressive psychoses; however a cyclothymic propensity is not sufficient for their manifestation, but instead a complex combination of factors is required to a greater or lesser degree. The fact that these hyperkinetic psychoses recur in the same person without alternation with purely manic depressive psychoses, in addition to the fact that similar psychoses are observed in the family of a patient, is not considered sufficient to refute the relationship with manic depressive psychoses.

[...]

Bonhöffer, in his latest study, pointed out that the existence of extrinsic factors is not characteristic of hyperkinesia. He drew particular attention to the fact that patients in excitatory states easily develop infections due to injuries, catching cold, having bad oral hygiene, etc. This should make us particularly careful about those cases of hyperkinetic psychoses characterized by sudden hyperkinetic restlessness, which become greatly exacerbated and develop into non-specific hyperkinesia, with slight but marked cyanosis, ending in death. Histopathological findings indicate venal hyperaemia of the brain and of all the organs in general. These cases, according to Bonhöffer, are caused by infectious or toxic influences, which are accumulated resulting in the intrinsically triggered hyperkinesia, without, however, being connected to the hyperkinetic psychoses. Therefore, Bonhöffer considers hyperkinetic psychoses to be endogenous and distinguishes them not from manic depressive psychoses, but rather from schizophrenias, whose clinical picture they can be confused with.

[...]

According to Schulte, hyperkinetic psychoses constitute, not only by their evolution and heredity, but also by their psychopathological constitution, an intermediate group between cyclothymic and schizophrenic psychoses, given that the psychotic event occupies a more central position over the ego than in schizophrenia. Schulte's view should not be accepted as indicating that hyperkinetic psychoses constitute mixed psychoses, in the sense of the Tübingen School, where manic-depressive and schizophrenic contributions collaborate together.

Fünfgeld starts out studying motor and confusional psychoses from Kleist's standpoint, who, as is well known, separated from the cycle of manic depressive psychoses an entire set of psychoses, among them the two mentioned above. Schröder had already separated degenerative psychoses from manic depressive psychoses, without distinguishing a particular group amongst them. In contrast, Kleist describes clearly the distinguished entities. Their common traits are the autonomous onset, their course in phases and the fact that they are curable. Despite their kinship they must be considered distinctly and are possibly related to various primary genotypes. These initial genotypes, of the entire nosological group, possibly tend to join each other, becoming part of more complex genotypes and this may explain the mutual tolerance of each of these forms on the hereditary sequence, as well as the occurrence of many transient and mixed forms, difficult to separate. Fünfgeld, using Kleist's views as a starting point, concludes that these psychoses, whose clinical manifestations are common, have diverse co-existing hereditary roots. In the manic depressive psychoses, the clinical formation of the manic and melancholic syndrome is pre-eminent and these are strong

arguments for the hereditary-genetic diversity (of these two syndromes). Thus, Fünfgeld admits that there is no common hereditary predisposition, only a close relationship. We have to note that this view held by Kleist's School, separating mania and melancholia was attacked fiercely. [...]

Therefore, these syndromes are encountered in constitutional mixtures that are strongly related, with great hereditary/biological forces. To consider them as a single disease does not draw objections, provided that their complex hereditary-biological nature is taken into account. If a quality from the epileptic cycle is combined with another of the cyclic one, then such a mixture of biological roots, so little related, may give rise to a new clinical entity entitled to exist, as are classical mixtures. Clinical experience shows that personalities which are not syntonetic in accordance with Bleuler's use of the term, can manifest diseases progressing in phases, whose symptoms are distinct from manic depressive psychoses, yet their course is similar to them. According to Fünfgeld, hyperkinetic psychoses are hereditary-biological compound complexes, wherein one of the factors is that of evolving in phases, a factor that links them to manic depressive psychoses.

Kleist and Driest in their work on catatonia came back to the issue of separating hyperkinetic psychoses, and more generally degenerative psychoses, from catatonias and the schizophrenias. They underscored that differential diagnosis is predominantly relevant to the above illnesses, but from the standpoint of their tendency towards repeated attacks and predominance in the female sex, they are akin to manic depressive psychoses. According to these authors, the causation of degenerative psychoses may have a major hereditary component and a corresponding burden. This burden

of similar or other psychoses is not so frequent, as in manic depressive psychoses, nor as intense as in schizophrenic psychoses. Therefore, other components must play a role. Perhaps the hereditary factors of degenerative psychoses are less dynamic than those in manic depressive and schizophrenic diseases, the variance in their manifestation is smaller, and so far undefined corporal (endocrine?), extrinsic, partially psychic factors, must act synergistically, in the emergence of the psychosis. The greater frequency of the disease in women and young persons favours this theory. Degenerative psychosis syndromes may appear without hereditary predisposition, only upon bodily or external cerebral lesions, as observed in symptomatic psychoses and in twilight conditions after skull injury. Therefore, we cannot preclude that atypical psychoses behave in a way similar to epilepsy and oligophrenia, which are partially hereditary, while in some cases are brought on by external and somatic causes, and finally in other cases they originate from the collaboration of hereditary and bodily or external components.

Finally, we would like to draw your attention to the fact that hyperkinetic psychoses are mentioned either rarely or not at all in the psychiatry textbooks of Mayer-Gross and Gruhle. In Bumke's textbook, in the chapter on schizophrenia, the existence of degenerative psychoses is not accepted.



Nikolaos Drakoulidis (1900–1988)

The inferiority complex.

New views on aetiology and interpretation

(Τὸ συναίσθημα τῆς κατωτερότητας.

Ἐπὶ νέων ἀπόψεων αἰτιολογίας καὶ ἐρμηνείας)

Korydalos Publications, Athens, 1945

The feeling of being disadvantaged or inferior (in French: *complexe d'infériorité*, English: inferiority complex, in German: *Minerwertigkeits gefühl*) is a complex, an abnormal mental manifestation, which is so common, albeit mostly disguised, indeed so closely linked to sexual function and with such severe consequences on the social life of all people, that it merits careful examination.

However, some other intentions have motivated us in this endeavour, such as our individual points of view on the feeling of inferiority that places the entire issue on a new interpretive basis, aiming: (a) to reconcile the conflicting views of Adler and Freud; (b) to prove that the feeling of inferiority is a consequence of an affliction of two basic instincts (the instinct for

self preservation and the sexual instinct); (c) to determine two different basic and opposing types of inferiority, the oppressive one on the one hand and the reactive on the other; (d) to prove that femininity of those with such feelings of inferiority is linked to childhood remnants, rather than to feminine proclivity; (e) to clarify the issue of female inferiority; (f) to study the feeling of inferiority in ethnic groups.

Definition and description according to Adler

The feeling of inferiority was studied extensively by Adler (who broke away from Freud's theory, which he initially followed and finally opposed). It constitutes a diminution of all capabilities of a personality, in part real and in part imaginary, leading to its compensatory aggrandisement, by virtue of various fictitious or real means, shaping a particular psychic physiognomy of the individual, reflecting on all his acts, as well as on his contribution to society.

Adler approached the concept of feeling of inferiority from two directions: one positive and one negative. On taking the first direction, he noted that all symptoms of a nervous temperament and of neurotic people, which had been described by various authors, had at their nucleus what Janet had described as a sentiment of incompleteness and concluded that the deeper aetiology of the neurosis was the assault against the individual's personality, mainly expressed through the creation of a feeling of insecurity and a feeling of masculine inadequacy; the ultimate purpose being to restore the personality. Taking the second –negative– direction, Adler considered erroneous Freud's concept on a sexual source and aetiology of all neuroses, arising specifically from libido in childhood. So Freud's conclusion: "All

neuroses stem from the Libido” was not consonant with Adler’s conclusion: “All neuroses arise from feelings of inferiority”.

From this point begins the description of the clinical picture of inferiority complex and the means used by it in order to achieve a rectification, i.e. to capture the missing feeling of security and masculine confidence, in order to acquire superiority, thus eliminating the feeling of inferiority and restoring the shaken personality.

Before we begin to dissect the opposing views held by Freud and Adler, before being swayed in favour of one or the other or a third view, we will focus on the description of the manifestations of an inferiority feeling, because we believe that this, regardless of disputes on aetiology, constitutes a clinical reality.

The person who feels inferior, according to Adler, “is dominated to such an extent by the awareness of his weaknesses that, frequently without even releasing it, he utilises all his strength in order to create an ideal and imaginary personality in which he seeks shelter and protection”.

“By striving this, his sensitivity becomes more acute to the point of being able to perceive details, correlations and causes of various events that escape the perception of normal individuals. Consequently, he becomes excessive in his measures of prudence and protection, increases his perspicacity, foresees every possible adverse consequence of a task he intends to undertake, becomes suspicious and querulous, loses his trust in his fellow men and his confidence in himself, becomes increasingly selfish, arrogant, unkind, envious, furtive, avaricious, stingy, misanthropic, aggressive and so forth; or becomes self-effacing,

servile, subservient, pedantic, hesitant, restless, touchy, peevish, reserved, hypocritical, righteous, law-abiding and so forth”.

“This dual set of manifestations, both active and passive, are simple ways to combat feelings of insecurity and masculine uncertainty, in other words to acquire self-confidence and to assert himself over his fellow men, either as a hero or as a martyr; as a conqueror or victim; in imaginary settings of his own creation, which characteristically lack any objectivity”.

“These manifestations of a neurotic nature are revealed to us, as serving an imaginary purpose. In other words, these are not the logical consequence of factors and dynamics related to biology or temperament. But rather they are the super-creations of compensatory tendencies. Individuals, who feel inferior, feeling the lash of insecurity, employ all means at their disposal in order to find security, sometimes defensively and sometimes aggressively. In this effort they seek the reinforcement of their masculinity, protesting their manliness over their masculine uncertainty”. Thus, holding insecurity as a shield and masculinity as a spear, they proceed to create a superior personality in order to eradicate their feeling of inferiority”.

[...]

Objections and additions

We would like here to summarise our objections to Adler's theory and our additions, as discussed exhaustively above.

I. Objections to Adler

1. The feeling of inferiority does not exclude sexual factors from its pathogenesis, but stems from the violation of two basic instincts, the instinct for self-preservation and the

sexual instinct, and does, indeed, more readily fall under the influence of the sexual aetiology.

2. Adler's feeling of insecurity corresponds to the assault of the instinct of self-preservation and the feeling of masculine uncertainty to the assault of the sexual instinct.
3. The feeling of reduced personality consists of the combined assault on the two basic instincts and consequently Adler's theory, more or less, corresponds to this sum total.
4. The principle male/female does not exist in the form of a struggle between these two elements in persons with a feeling of inferiority, but the feminine psychic structure of such an individual is caused by a childish fixation and not by a feminine proclivity, indeed all these defensive and aggressive manifestations have the childish psychic features as their point of departure.
5. Those who suffer feelings of inferiority do not follow a single line in their endeavour to compensate, but rather can be classified into two major opposite types (both pursuing the same purpose), namely the oppressive and the reactive type, in which the sexual factor plays the paramount role.

II. Additions and clarifications (ed: on Adler's views)

1. The inferiority feeling in women originates from a childish fixation, of predominantly sexual aetiology, by virtue of the castration complex, which shapes what is termed the female psyche. Accordingly, the inferiority complex in a woman is more or less a normal condition.
2. Freud's castration complex and Adler's masculine protest are identical for women.

3. Apart from a general feeling of inferiority in women, there are transcendental forms of inferiority feeling (being equal to men – in competition with men) and regressive forms (childish regression – psychoneurotic refuge), which comprise the main pathological forms of inferiority feelings in women.
4. The inferiority feeling is also manifested in a collective form in certain ethnic groups, creating a particular temperament in peoples, through which one can interpret their acts and actions. The aetiology of collective inferiority feeling is clear; the mechanism is similar to that of individual inferiority feelings.
5. Similarly, ethnic groups present group's idealisation and compensation, with a stable or a transitional character.
6. A clear example of compensatory idealisation of feelings of inferiority is that of Plato, the great philosopher, who presented the following noteworthy characteristic : he permits us to distinguish his idealising compensation, not on the resultant of the two basic instincts, that is to say the personality, but on the two isolated components of this resultant. Thus, the compensatory idealisation related to the violation of the instinct of self preservation gave rise to Plato's Republic and the compensatory idealisation of the sexual instinct gave rise to Platonic Eros.

[...]



Georgios Lyketsos (1916–)

**Application of electroshock treatment
on outpatients basis.**

**Observations concerning its effectiveness
on psychoneuroses**

*(Εφαρμογή τῆς δι' electroshock θεραπευτικῆς
μεθόδου ἐπὶ ἐξωτερικῶν ἀσθενῶν.*

*Παρατηρήσεις διὰ τὴν ἀποτελεσματικότητα
ταύτης ἐπὶ τῶν ψυχονευρώσεων)*

Cliniki (Clinical Practice), 14, 1947, pp. 2–7

Only 18 months since the first implementation of electroshock treatment in Greece and a strong trend in favour of this method is very prominent. Most of the major institutions and psychiatric departments in our capital have abandoned cardiazol treatment and are implementing the electroshock method, given the multiple difficulties associated with the implementation of insulin therapy. The following describe the advantages of the electroshock method [...]:

1. It does not cause any unpleasant feelings while during the long latent time involved in cardiazol treatment, feelings of impending death etc. have been reported.

2. It has less serious complications. For example, fractures due to electroshock occur in 5% of cases in foreign statistics, while those from cardiazol reach 22% (Smith et al). This is due to the fact that the convulsions caused by electroshock are milder and shorter in duration.
3. The implementation of electroshock treatment is simpler, swifter and more economical.
4. There are none of the unpleasant consequences of cardiazol injection (vein thrombosis, etc.).
5. As a rule, we do not observe the state of agitation, sometimes observed in the post-epileptic, twilight states of the cardiazol treatment.

To the aforementioned advantages we should add that in Greece the implementation of the electroshock method, to the extent that we know, has proved to be entirely harmless. In a previous treatise we mentioned four deaths reported in the foreign literature. To these we add two more deaths from Impastato and Almansi and four from Koll and Vogel out of 7,207 shocks [...].

The aforementioned advantages [...] constitute the basic reasons making possible the implementation of the method on an outpatients basis. In other countries and in the United States in particular, the implementation of electroshock treatments on outpatients already exists, since a long time [...]:

1. Because in certain cases it is preferable to collaborate with patients on their treatment, instead of impelling it through confinement in a psychiatric hospital.
2. Because for many patients, a confinement in a psychiatric hospital causes great difficulty in adaptation and often aggravates the disease.
3. Because certain patients, for various reasons, seek to leave the hospital before their treatment is completed.

4. Because experience shows that outpatient treatment is often preferable in patients who manifest an acute disorder in their behaviour and after spending some time in hospital, usually a few days, improve rapidly and can continue the rest of their treatment as outpatients.
 5. Because outpatient treatment is cheaper.
 6. Because we avoid overcrowding of psychiatric hospitals and it becomes easier to provide assistance to many neglected cases.
- [...]

The provision of electroshock treatment on outpatient basis will perhaps enable our psychiatric hospitals to serve the patients who have an absolute need of confinement, and will abolish the long waiting lists, which often prolong admission for months. This admission is often so problematic that patients' relatives, usually from the provinces, return home, often forced to leave the patients without care. It will also allow a more comfortable implementation of electroshock to hospital in-patients, in combination with psychotherapy, which cannot now take place in our psychiatric hospitals, despite the fact that this combination is well known to be most beneficial in most cases. [...]

Starting on April 30th, 1946, and up to December 31st 1946, we implemented electroshock treatment using a Greek machine (Lyketsos – Athanassoulas type) on 50 outpatients, 21 men and 29 women. These patients received a total of 511 electroshock sessions

[...]

We can distinguish three categories of therapeutic results, as with our previous studies:

1. Perfect remissions, where clinical examination does not detect any morbid mental symptom, where the patient has

insight in the recovered disease and his professional ability is unaffected.

2. Imperfect remissions, where professional ability has decreased, there are remnants of delusional ideas or hallucinations and, in general, the rehabilitation of the personality is not complete.
3. Unaltered cases, where the mental symptoms remain basically unaffected. In some of these patients, however, the psychotic symptoms receded temporarily and in most of them the general clinical picture improved.

Of the 44 patients who received treatment, 17 suffered from schizophrenia and 27 suffered from other mental illnesses.

A. Schizophrenic cases

Seven paranoid forms: two of them had complete remission, three incomplete remission and two remained unchanged.

Four catatonic forms: one of them had complete remission, two incomplete remission and one remained unchanged.

Two hebephrenic forms: both had incomplete remission.

Four simple forms: two of them had complete remission, 1 incomplete remission and one remained unchanged.

[...]

Of the seventeen aforementioned cases: seven were acute (onset within one year). Of these, three had complete remission, another three had incomplete remission and one remained unchanged. The remaining ten cases were chronic, with onset from one to three years. Of these, two had complete remission, five had incomplete remission and three remained unchanged.

The results of these findings are better than those we published concerning electroshock treatment of inpatients at the

Dromokaiteion Psychiatric Hospital. This should be attributed to the fact that during the implementation of the treatment on outpatients, it became possible to make a better selection. [...] We should mention that in one case we achieved complete remission with 30 sessions of shock. We decided to implement a great number of sessions in this case, because the improvement was taking place gradually and constantly, towards a perfect remission. [...]

B. Non schizophrenic cases

Three cases of melancholia (possibly a first melancholic attack): all had a stable complete remission.

Three hypo maniac cases: All had a stable complete remission.

Nine cases of manic-depressive psychosis: of which eight concerned melancholic phases and all had a complete stable remission, one case concerned the manic phase of a manic-depressive psychosis and had complete remission.

Three evolutionary psychoses, two of them having a melancholic form: of which two had full remission and one remained unchanged.

Nine psychoneuroses: of which three had full remission, three had incomplete remission and three remained unchanged.

[...]

A basic aim of this work was to study the application of electroshock treatment on patients with psychoneuroses, because out-patient treatment is recommended in such cases and also because the implementation of this treatment on this kind of disorders has not been reported before in Greece.

In the foreign literature we have noted great differences concerning the effect of this on patients with psychoneuroses mainly due, as we believe, to the varying definition and classification thereof.

[...]

In the Greek bibliography, G. Filippopoulos mentions a full remission of three reactive melancholic patients, one patient with hysteria and one patient with anxiety who only showed some improvement [*Helliniki Iatriki (Hellenic Medicine)*, issue 4th, 1946].

Of our own cases:

Four concerned obsessive psychoneuroses: of which two had incomplete remission and two remained unchanged.

Two concerned hypochondriacal psychoneuroses: one had full and the other had incomplete remission.

Two concerned mixed psychoneuroses: one had full and the other had incomplete remission. Finally, one case of reactive melancholia had complete remission.

With the exception of one case, where remission was achieved using few sessions of shock treatment, in each of the remaining cases we had to exceed ten sessions and in one case perfect remission was achieved with 20 sessions. In most cases the treatment was further assisted by psychotherapy.

The treatment implemented seems to act rapidly and safely on: melancholic symptoms and in general, affective states, anxiety, excitatory conditions or, on the contrary, cases where volition and initiative are missing.

Furthermore, electroshock facilitates contact with the patient and renders psychotherapy easier and more amenable.

[...]

**Fotis Skouras (1903–1953),
Athanasios Hatzidimos
(1902–1967),
Andreas Kaloutsis (1910–1986),
Georgios Papadimitriou
(1912–1985)**

**The psychopathology of hunger, fear and anxiety.
Neuroses and psychoneuroses**

*(Η ψυχοπαθολογία τῆς πείνας τοῦ φόβου καὶ τοῦ
ἄγχους. Νευρώσεις καὶ ψυχονευρώσεις)*

Karavias Publications, Athens, 1947

Preface

[...]

The period of the German Occupation (ed: of Greece) will long remain a topic suitable for multiple studies. Its impact on all sectors is still apparent and most of the problems it has caused remain unresolved. Thus, a study concerning some of these and, in particular, a scientific study on the mental conditions and the psychopathology that occurred during the

German Occupation of Greece is still appropriate. We grasp the opportunity to express, here, our regret that systematic research, particularly pertaining to psychological matters is lacking, in general. We are convinced of its usefulness by the valuable material that we managed to collect in our research, mentioned in the next chapter (sources). The aim of this study is to fill this vacuum in certain areas which are close to our field of endeavour.

The psychopathological phenomena of particular interest are numerous. We believe, however, that amongst these, two basic, fundamental series must be distinguished, stemming from the two major protagonists of the German Occupation: hunger and terror. Our work deals with the study of these. In order to proceed, it was necessary to study in greater detail certain concepts and conditions. Thus, we made a broad study of anxiety, fear, the psychopathology of hunger, etc.

[...]

The study is structured as follows:

- Sources: A chapter that lays out the foundations of our study. (ed: The summary of this chapter is as follows concerning the sources of this study):
 - The personal experiences of the authors
 - Various chronicles of the Occupation.
 - Official reports.
 - Historical and literary works.
 - Verbal witness reports and answers.
 - The elaboration of the collected answers to a questionnaire prepared and distributed by the authors.

They received 876 anonymous written responses. The questionnaire was also published in newspapers and from 3 to 6 August 1946 they attempted to collect answers throughout Greece. In this way, another 520 responses were gathered. Finally, teachers gave this as an essay topic to a school class, an excursions association and to youth clubs, gathering another 261 responses. In total 1,657 responses.

The questions were the following:

(1) Profession before and during the Occupation; (2) Gender and age; (3) Residence; (4) What were your major emotions during the Occupation? (5) What event made the greatest impression on you? (6) What happened to you personally? (7) Question (omitted for schools) concerning sexual mood during the Occupation and on falling in love.

The authors report that the responses ranged from laconic to carefully structured or even epic in scope.

- Part A of the book. Studied the psychopathological phenomena stemming from terror in particular.
- Part B of the book. Studied the psychopathological manifestations of hunger).

Part A is divided into three sections

1. Anxiety and fear

Chapter 1. The views of various authors concerning anxiety and fear are set out. From this review the need to distinguish between these concepts becomes clear, as various authors display considerable confusion of the two terms. That is why the next chapter was included, attempting to distinguish them. The chapter ends by criticising the methods of psychologi-

cal research and by attempting to analyse the anatomical and physiological bases of anxiety.

Chapter 2. Distinguishing anxiety from fear.

Chapter 3. Defining the terms “normal-pathological” fear and “normal-pathological” anxiety.

Chapter 4. This chapter uses arguments taken from comparative psychology (animals, humans), from the psychology of primitive people, from psychic ontogenesis (the psychic development of an infant) and from psychopathology, to develop personal theoretical views, concerning the links between anxiety and the unknown.

Chapter 5. We investigate conditions related to anxiety: fright, worry, agony, etc.

II. Here our theoretical views are validated by events of the Occupation, thus allowing us to have a better understanding of these events.

Chapter 6. General mechanisms of terror.

Chapter 7. Military camps, torture, prisons.

2. *Specific psychopathology*

Chapters 9, 10, 11. These are introductory chapters examining sequentially the psychoneuroses, traumatic psychoneurosis, war-time mental disorders and the clinical approach to such disorders. It was judged expedient to extend our study on these topics, in order to render the psychopathological syndromes of the Occupation more comprehensible, as they have not, so far, been studied in the Greek scientific literature.

Chapter 12. Describes the mental disorders of the Occupation. In particular, we examine the problem of the specificity of these mental disorders and include in the chapter the psy-

chological climate of the Occupation, which, in any case, is examined more extensively in other chapters of this treatise. Finally, we analyse our conclusions on psychopathological syndromes, manifested in this period and particularly in relation to terror, conclusions based on the cases contained within chapter 14, with 42 clinical observations.

Part B of the book

This deals with the study of hunger and particularly with its psychopathological manifestations.

Hunger was a tool of terror, which in the hands of the occupants had clear-cut and specific purposes. Many thousands fell victim to the toll of hunger, which affected everyone with tremendous impact on the morale of people, which was attacked from all sides.

We divided this study into four major chapters.

In the first chapter we have used objective criteria in an attempt to show how acute the food supply problem was during the Occupation and how hunger affected everybody, particularly in the winter of 1941–1942. The statistics of our daily ration, morbidity, mortality, clinical symptoms and direct public health consequences are irrefutable witnesses indicating the extent of the damage and devastation caused by hunger.

Studies by Greek physicians who selflessly fought to bring to the light of science the morbid consequences of hunger can be found here. Their contribution to such an important topic has, besides its scientific significance, a great historical and patriotic value.

In the second chapter we study hunger and appetite in their normal aspect, because we believe that the issue of the physiology of hunger has not been studied in detail, and because knowledge of the normal mechanisms of hunger is required when seeking to study its psychopathology. Illness does not create new mechanisms; it simply “releases” those already existing.

In the third chapter we describe the psychopathology of the disease of hunger, which is our main topic. Here we distinguish between the anxiety of hunger, which was a general psychological phenomenon and one of the main factors influencing the psychological climate of the Occupation period, from the psychopathology of the specific disease of hunger, which had all the characteristics of psychoses of an exogenous type. The mental manifestations of the disease of hunger are described both in their development over time and in their various phenomenological and psychogenetic forms, both in their medico-legal and their social consequences.

Finally, in the fourth chapter we study the physiological mechanism for the creation of the mental manifestations of hunger. The latest research on the diencephalon and its appendages has provided us with the occasion to attempt to offer a physio pathological and biological explanation of the major mental manifestations of the disease of hunger, and to classify them within the general framework of “retrogression”, which, in our opinion, was a particular feature of the psychology of Occupation.

We believe that such a synthetic study on the psychopathology of the disease of hunger, based on broad-ranging research and objective criteria, is being carried out for the first time, particularly with respect to the paucity of the relevant literature.

[...]

*Part I.**Chapter 12. The mental disorders of the occupation*

[...]

The aforementioned theoretical formulations interpret our observations and are confirmed by them. We believe that we can, in conclusion, summarise the psychopathological influence of the Occupation as follows:

1. The conditions of the Occupation created a constant anxious state, the anxiety of the Occupation.
2. The ceaseless influence of this environment resulted in a retrogression of the personality and the manifestation on a large scale of pathological states, which diminished and degraded the personality (depression, athymia, cataplexy) that often went hand in hand with physical exhaustion.
3. In the resisting population, where, to a certain extent, anxiety could be neutralised, personality attained higher levels of good sense and was less likely to “succumb”.
4. The ceaseless anxiety acted to protect, to a certain extent, from the traumatic influence of the stimuli in the environment, and for this reason psychotraumatic reactions were observed on a far smaller scale than one would expect, during that period. They were observed more often in individuals who did not succumb. In many cases they took the form of an intense and transient reaction to an emotional flood and constituted the first psychic trauma, on which real traumatic psychoneurosis would be constructed later.
5. After the liberation of our country there was a surfeit of psychoneuroses. Today we can see far more psychoneuroses than in the pre-war period. It is typical that the clientele in private hospitals is nowadays mostly composed of people with psychoneurotic reactions.

Concerning authentic endogenous psychoses, we cannot propose a decisive view. On the one hand the great degree of retrogression, touching the foundations of the personality, may be considered as a factor that could favour the manifestation of a psychotic break down, because of the (limited) resistance of an already “diminished” personality (After the liberation of the concentration camp of Belsen, 46 individuals with psychoses were found. However, this small number can be attributed to the systematic extermination of individuals of this category by the Nazis (M. Nibereski, J. Ment. Sc, 92, Jan. 1946, p. 60–74). On the other hand, however, the intensity of real conditions of life and the imperative need for the personality to respond daily to its vital problems, may probably be conceived as capable of reactivating the function of reality (la fonction du réel), which constitutes an unfavourable condition for a psychotic “agglomeration”.

[...]

Part Two

Chapter 4. Physiopathology of mechanisms producing the mental disorders of hunger

[...]

An attempt at synthesis: If we try to propose a synthesis of the aforementioned views, as provided by the interpretation of the mental disorders of hunger through the instincts and the diencephalon and we try to find a central defining idea, we will observe that all these mental disturbances have the characteristics of retrogression and regression, which we can only distinguish thanks to Jackson’s methodology.

As we have seen, hunger triggers a major retrogression of the mental functions to lower functions, in their simplest

forms, while higher forms of synthesis, which man strived so hard to gain, break down entirely. A starving individual disposes in our view of a form of decorticated psychic organism, acting under the impetus of lower affects and instincts and whose mental abnormalities express the dissolution of the conventional structure of higher reflexes that humans have acquired through education and culture.

Thus, we can consider the mental disorders of hunger as components of a broader psychopathological syndrome, similar to certain retrogressive psychoses, which are also exclusively characterised by manifestations of a sub-cortical nature. We could name these psychotic syndromes psychoses of the diencephalon. [...] We must seek the mechanisms of psychoses of the diencephalon, caused by hunger, in this very area of the brain. It is in this small region that the dissolutive process of regression most often stops, “decorticating” the nervous system and mutilating the mental organism. However, it isn’t rare for this level to be overcome in those psychoses of the diencephalon due to hunger, when the disease approaches the foundations of life.

Retrogression is the major law regulating psychopathology and its manifestations. It is encountered as a result of hunger, as well as of terror. Civilisation, the achievement of long-term efforts of mankind, breaks down liberating the primitive core of the ego that sleeps in the depths of each human soul with all the violence produced by its continuous repression. This primitive core, which re-lives amongst us, with its retrograde motion appears as maladjusted, incomprehensible and foreign, similar to the mental disease brought about by retrogression.



Panagiotis Kokkoris (1912–2006)

**On a primitive shock method applied
to this day in the Greek countryside
for the treatment of mental diseases**

(Περὶ μιᾶς πρωτογόνου μεθόδου *shock*
ἐφαρμοζομένης καὶ σήμερον εἰσέτι
εἰς τὴν ἐλληνικὴν ὑπαιθρον πρὸς θεραπείαν
ψυχικῶν νόσων)

*Minutes of the Athens Medical Society, 1948,
Meeting 17/4/1948, pp. 290–297*

Views on the nature and consequently on the treatment of mental disease in the Greek countryside do not seem to have changed much from the time of Hippocrates and the treatment in the Asclepieia.

[...]

As was the case in ancient times, it is the priests who undertake the role of the healer. Two examples in Northern Greece, the church of Agios Antonios (Saint Anthony) in Verria and the holy monastery of Agia Triada (The Holy Trinity) in Edessa, are known throughout Macedonia for their miraculous curative power over the mentally ill. In special solitary cells, the patients,

in addition to the miraculous curative powers of the Saint, are also subjected to treatment by the priests. The kind of treatment they receive is reminiscent of the treatments administered to the mentally ill in various Asclepieia (ed: Ancient Greek places of worship of the god Asclepios)...(tied with chains, fasting, cold baths, beatings, sleep deprivation, etc.).

[...]

The “treatment” of mental patients with a red-hot iron seems to be widely practiced throughout Greece. We had the opportunity to observe this method applied in two parts of Greece very distant from each other, in the mountain region of Arcadia and in Central Macedonia.

[...]

After a fasting of 2–3 days, receiving only water, the mental patient was considered fully prepared for “*kapsimo*” (burn), as this “method” is commonly known (the agitated patient is held by force and “branded” on the back of the neck with a red-hot iron).

The patients, in both cases which I have observed, immediately after the contact with the red-hot metal brand, let out a terrible cry and lost their senses. [...] The loss of consciousness in both cases lasted for approximately half an hour. Subsequently, the patients gained consciousness slowly, and appeared to be confused for a period of approximately 1–2 hours. During this period they complained bitterly of the pain of the burn, which the local “healer” had in the meantime bandaged with an ointment of his own, obviously based on some fatty substance.

Subsequently, in both cases the mental condition of the patients appeared to have improved. One of the men, with whom

I was acquainted and I had monitored for a long time, suffered from manic-depressive psychosis, with manic and depressive phases succeeding one another after the period of one month (“a moon”) without free intervals. He received the application of the red-hot iron brand at approximately the end of the manic phase, still manifesting a strong psychomotor excitation.

Immediately after the “treatment”, the patient looked quiet, was calm, requested food and in general his behaviour changed for the better. The depressive phase that should have followed did not take place and the subsequent manic phase was milder. Later, the course of the disease resumed its prior course and the patient died, during the German occupation in the public psychiatric hospital. Therefore, the improvement achieved was clear and lasted for approximately two months. We were not able to monitor the course of the second patient, who was suffering from schizophrenia.

We requested and received from the two respective healers information concerning their views on the action of this “method” on the mentally ill. We were astonished to hear both of them offering, more or less, the same explanation: The said that the “evil” –the cause of the disease– ascends and descends through the marrow of the spine (the spinal cord) to the brain. When it is situated low the patient is quiet, but when it rises to the brain the madness commences. When they produce a burn to the patient this communication is interrupted and if the “evil” is at a lower level, then the sick person recovers. If, however, recovery does not occur, this means that the “evil” is in the brain and must be repeated.

[...]

Both healers were of the opinion that the treatment should be repeated two, three times or maybe more. One of them assured me that he had cured a patient suffering for five years with four “burns”.

[...]

Is the term of shock we have used to characterise this method, appropriate in this case? [...] L. Boss (1936), studying various methods implemented in many countries and throughout the ages in order to cure mental disease, came to the conclusion that these methods should be classified into two contrasting categories:

- One group attempts to stimulate directly the remaining instincts of life in the mental patient, in order to reorganise his personality.
- The other group acts in a completely opposite way, threatening the instincts of life, shaking the organism of the patients and in fact, according to the opinion of most experienced healers, these methods are more effective the closer they bring the individual to death, in a way that the instincts of life become more stimulated, as the threat against the living organism is greater.

The method of treating mental disease with burning iron brands, without doubt belongs to this latter category.

[...]

The intense emotion produced, upon applying the burning iron brand, is finally, a powerful biological shock, whose links to the hypothalamus are well known. If we add, to this, the effect of burning, it is obvious that a serious upheaval is taking place in the body.

[...]

This primitive method, despite its overwhelming grisliness, constitutes a form of shock, which could be compared to modern treatment methods utilising insulin, cardiazol, acetylcholine shock, etc.

Discussion

I. Lameris: The Medicine of Hippocrates was not theological. It is known that Hippocrates, by gathering, completing and putting together medical knowledge into a system became the creator of the medical science, supported on the one hand by experience, clinical observation and logic; free on the other hand of all unscientific practices and all the empty, vague and superficial hypotheses. [...] God, said Hippocrates [...] would not harm the weakest, would not harm man, consequently disease is not of divine provenance, but the result of some human or secular cause. [...] According to Hippocrates, therefore, the true doctor is duty bound to undertake the treatment of the sick with the scientific means at his disposal and not by purifications and sorcery [...].

C.D. Konstantinides: This primitive method for treating mental diseases can be compared to convulsive therapy as practiced currently in psychiatry. In both cases, an intense shock of the nervous system takes place, influencing its overall way of functioning and, in general, the psychic functions of the body. The traumatic surface created has a long duration and can constitute a constant source of excitation by the absorption of alien albumin (protein therapy). We cannot rule out that a beneficial influence can exist in certain cases. [...] It is (also) worthy of note that this is an expression of the popular psyche. It is known that folk experience has created

empiric treatments, which exist in all nations, irrespective of intellectual level [...].

A. Mavros: The primitive treatment by causing burns to the back of the neck [...] was, in the past, implemented by professor Bier as a treatment for endocarditis lenta. [...] It is possible that transient results in mental patients [...] may be due to shock endured and to self-protein therapy.

K. Mitaftsis: [...] I am not able to consider a burn on the back of the neck, caused by a burning iron brand, as a therapeutic shock and to compare this to the therapeutic electroshock treatments we implement, because on the one hand the former causes a lesion, [...] while the latter is a modern medical method for certain mental diseases, although we don't know yet its mode of therapeutic action. [...] In Germany, Siegelberg and Leinkind [...] came to the conclusion that causing acute pain the so-called pain-therapy, would bring about the same therapeutic result (as Cardiazol shock), but luckily they were proven false. It would have been terrible to make mental patients suffer whippings and beatings in order to cure them.

G. Danilatos: [...] I would like to add that lay Medicine, and particularly that of pre-War of Independence years (ed: 1821), has a diversity of treatment methods. One can still observe it, to this day, and this is a remnant of medicine that in olden days was practiced by the clergy. [...]

K. Eliadis: [...] Concerning the mechanism of shock treatment, allow me to add that the most recent studies undertaken by Mr. Cerletti on the substances produced by the body during a shock, are particularly fascinating. These substances, named "acrogonins" (from the Greek *acros* ago, the ultimate

struggle) have, as he claims, a therapeutic effect not only upon mental diseases, but on infectious diseases as well. [...]

E. Danopoulos: [...] “Interpretive” or “descriptive” psychology, which is currently dominant, accepts that mental phenomena cannot be explained, as is the case with a natural phenomenon, but can only be “interpreted” or “described”, by projecting them through our own mental world. In fact, we cannot ascertain how is it possible for biochemical processes taking place in the cells of the brain to give rise to emotion, thought or volition. This is one of the seven major world riddles, to which, according to du Bois-Reymond, man will never be able to provide an answer. If, therefore, under normal conditions, it is not possible to provide an explanation for mental processes, you can imagine how unachievable this is under abnormal conditions [...].

P. Kokkoris: [...] We all agree that inhabitants of the countryside, before taking recourse to doctors, try out various folk remedies on themselves. [...] Usually, the one called upon to apply these remedies is the most experienced elder, who either runs this as a sideline, or has performed this professionally. [...] The practice of various lay “healers” is not constituted solely from the most uneducated section of the people. The so-called “higher classes” also accept it, to a considerable extent. We have in mind the treatise by J. Lhermitte entitled “Essai sur les phénomènes de possession démoniaques”, which was recently published in the journal “L’Encéphale” in which he states that many mentally ill individuals in Paris, before they ever reach a psychiatrist and the various asylums are previously subjected to exorcisms and “religious practices” for an extended period of time. [...] We agree entirely that the action of shock does not refer entirely to the psychic field, but also to the biological

substrate of it. [...] Naturally, nobody claimed that these folk “healers” apply their methods following preliminary theoretical reflection. In our opinion they act not by “intuition”, as certain colleagues have claimed, but simply on the basis of experience gained, which they have learned from their ancestors, the origin of the initial application being some random event, which did not pass unnoticed by men of acute perception. [...] We believe that attempting to cure the mentally ill by branding them with a burning iron, which brings about loss of consciousness and a strong upheaval in the body, has nothing in common with the small dotted burns produced in the past by the electric burners.

Dear colleagues,

[...] I did not discuss, nor did I attempt to provide an “explanation” or “interpretation” to the various mental phenomena which take place in the brain under normal or pathological conditions [...].

Over the past years, Psychiatry has finally stopped being considered as belonging to the sphere of metaphysics, and has received its fitting position among the other sciences, basing its conclusions on biochemical research. The laboratory has become a necessary accoutrement of every well-run psychiatric hospital, as in any other kind of hospital. And if we haven’t yet managed to cache and study the fine alterations of cells and humours implicated in mental functions or in their disorders, gentlemen, you will have to admit that this is not the fault of Psychiatry, but rather, that of the means at its disposal.



Georgios Lyketsos (1916–) & Nikolaos Rassidakis (1918–1982)

On occupational therapy at the Dromokaiteion Psychiatric Hospital

(Ἐπὶ τῆς διὰ ἀπασχολήσεως θεραπείας
ἐν τῷ Δρομοκαϊτείῳ Θεραπευτηρίῳ)

Nosokomeiaka Chronika (Hospital Annals)
Volume 9, Issue 3, September 1950, 1–17

Studies on occupational therapy (OT) of mental patients are rarely encountered in psychiatric journals. In many foreign countries, occupational therapists are individuals who specialise in this profession, and there are journals dealing exclusively with this topic, such as the American Journal of Occupational Therapy, The Journal of Occupational Therapy and Rehabilitation, The Canadian Journal of Occupational Therapy, Journal of Occupational Therapy Association, and others.

In Greece, the implementation of occupational therapy, so necessary in the big psychiatric institutions of our country, depends on the available resources, the interest of their

directors, suitable individuals to specialise in this profession and the contribution of psychiatrists of these institutions. [...]

OT in mental patients has recently evolved into one of the most significant forms of psychotherapy. It is well known, that this is not a method of full treatment, from the beginning to the end, leading to recovery, but acts as an adjuvant therapy. [...]

Any initiatives for re-establishing OT at the “Dromokait-ion” psychiatric hospital were only possible after the liberation of the country (ed: from German occupation). [...] Financial concerns and lack of space were the main difficulties. For a long time it was necessary to remind the nurses seconded to the task that the purpose of OT is not to perform work but to benefit the patients. Repeated conferences took place with the nurses in order to advance their work. All nurses, both male and female, attended a special course. A special women’s section was established in 1947 and still functions systematically and effectively, due, in particular, to the noteworthy efforts of the matron and her assistants. The compassion and assiduous follow up and monitoring individual data contribute greatly to this work. In this section, the usual work given to the majority of patients is spinning, as well as preparatory work for weaving (winding yarn into balls, and onto spools, etc.) and dyeing. Some patients –usually those who improve with treatment– are involved in weaving, embroidery and knitting. Since this section started functioning, many patients sought remuneration for their work and some of them, whose request was not satisfied, refused to work. In contrast, when a small wage was granted, as well as an additional, improved breakfast, patients readily

participated and worked with zeal and satisfaction. The benefit to the recovery of their illness was obvious. They consider themselves useful members of the society and they are satisfied because their work is recognised and rewarded.

Over the past year, 37 of the 103 women treated in the 3rd inpatients unit, worked in the OT department. Six of them, having improved with psychiatric treatment, were assisted by OT to such a degree that they recovered and were discharged; seven of them improved greatly, while eight others improved to a lesser degree. For the others, the work constituted a pleasant and beneficial occupation.

[...]

We met greater difficulties in OT for men. [...] It seems easier to propose to them an occupational task more or less similar to the profession they used to practice in the past, but some of them have found benefit, pleasure or relief when occupied with some other work. We provide an example of occupational therapy for men in the 3rd Unit, in a randomly selected day in February 1950. The men's OT department on that day involved 48 patients as follows: Of the 34 educated patients (who have received secondary education or higher) nine were involved in OT five of which did work in the office, pharmacy, typewriting, farming, stock-farming, and two in unskilled occupations. Of the 32 agricultural workers, 16 were occupied and of these: ten in farming, two in stock-farming and four in unskilled occupations and labour. Of the 20 skilled workmen, five were occupied: three in skilled work (two tailors in tailoring and one house painter in painting), one in stock-farming and 1 in unskilled labour. Of the three stock farmers, two were occupied with stock-farming. Of the 17 unemployed: seven were occupied with farming and unskilled occupations. At

the same time, approximately 20 other patients were occupied in the wards, the reading room, in painting or had a free pass to take a walk. Thus in a total of 129 patients, approximately 68 patients were available for various occupations. The work offered by patients varied, in different cases, from two to five hours per day and naturally we seek to motivate them and not to force them to work. In the afternoon of the same day, approximately 15 patients played volleyball or other games, on the play grounds.

[...]

Approximately 25% of patients of the 3rd Unit have had a secondary or higher education. It has been possible to provide occupational rehabilitation activity for a quarter of these patients. The others either refused, or could not work, due to their illnesses (chronic schizophrenia, dementia and other illnesses). It was noted that educated chronic patients were unable to be occupied in work consistent with their profession due to their illness, but were also more reticent to do simple work. We should note here that a large number of these patients had paranoid symptoms, while patients with schizophrenic personality disintegration and other chronic forms of schizophrenia were easier to occupy with simple work.

[...]

Amongst uneducated patients a larger proportion, which varied –usually up to 50%– was easier to occupy. Twenty five percent of the patients of the 3rd Unit were, agricultural workers. Half of them were occupied mainly with farming, as well as with other regular pursuits, according to their preference. Furthermore, half of the unskilled labourers could also be occupied with various tasks. [...] With rare exceptions, to this

date, we have not managed to specialise patients to undertake particular tasks, mainly, due to lack of special sub-divisions within the men's OT unit, as for example basket-makers, book-binders, etc. [...] Certainly the majority of patients in the psychiatric hospital have chronic psychoses, particularly schizophrenic and organic dementias, feeble-mindedness, etc. and thus farming, stock-farming and unskilled work is always the most suitable occupation for them.

Particular care is taken to monitor those who have been submitted to a lobotomy operation. [...] Ten days after the operation we seek to have all those operated upon working appropriately and this constitutes the first step towards adapting to the environment of the psychiatric hospital and sometimes to the social environment.

[...]

Within the framework of occupational therapy we also include activities of entertainment. Essentially, these activities are analogous to the entertainment of healthy people, certainly within the limitations of life of mental patients.

[...]



Georgios Anastasopoulos (1906–1977)

Disorders of the somatic ego

[Inaugural lecture at the University ceremonial hall
of the University of Thessalonica]

(Αἱ διαταραχαὶ τοῦ σωματικοῦ ἐγῶ)

Helliniki Iatriki (Hellenic Medicine) 1951, 12, 1107–1122

There are reports indicating that blind individuals, whose blindness was the consequence of a lesion in the occipital lobe, were unaware of their blindness and refuted its existence (reported for the first time by Anton). Later, Babinski observed the same phenomenon in persons suffering from left hemiplegia produced by a lesion in the right hemisphere. These patients are unaware of their hemiplegia and deny it when shown by others, i.e. these patients presented anosognosia, a phenomenon characterized by Babinski with that term, and since known as such. [...] However, the opposite phenomenon of psychic paralysis also exist, where patients consider themselves to be paralysed while, in fact, they are not. Other patients are completely unaware of the existence of the left hemiplegic half of their body, thus neglecting it and when urged to show the left, point to the healthy right limb. [...] In these cases we are talking about

hemiasomatognosia. This disappearance from the consciousness of parts of the body also occurs during the aura of epileptic fits, as well as in mental diseases without any co-existence of neurological disorders. Many of these patients claim that the disappearance of parts of their body does not only pertain to themselves, but also to others.

[...]

Conversely, in individuals who have undergone amputation of a limb, we frequently observe the so-called phantom limb, i.e. these individuals continue to feel their amputated part, continue to sense their missing digits and complain of feeling pain, as if they really existed.

Another phenomenon that we have described is related, in our opinion, to the above phenomenon and, in contrast to anosognosia, is observed in persons suffering from right-side hemiplegia, i.e. lesion of the left cerebral hemisphere. These individuals not only claim that their muscular strength has not diminished as a result of hemiplegia, but conversely that it has increased and the right half of their body has become stronger than it previously was, when in its normal condition. One of our patients in fact presented left hemiasomatognosia, as a consequence of left hemiplegia and on the right side presented the reported phenomenon in combination with hyperkinetic phenomena affecting the right half. This phenomenon of overestimating the right half reminds us of similar mental changes in frontal lobe lesions of the brain.

As this phenomenon of overestimating the right half is observed in lesions of the left cerebral hemisphere, we consider it expedient to mention two other phenomena of body schema disorders, which are also observed in lesions of the

left cerebral hemisphere. These phenomena are Pick's autotopagnosia and Gerstmann's digital agnosia.

[...]

These and other similar observations enabled us to admit the existence in the consciousness of a schema of the body, as determined by Head or an image of the body according to Shilder. Lhermitte discussed the existence of somatic ego awareness and expressed the conviction that all individuals retain in the margins of their consciousness the three-dimensional schema of their body, which can change from time to time in response to new impressions. According to these authors, this schema of the body should be constructed on the basis of impressions generated by the efferent tactile, muscular and joints' articulation motility senses.

[...]

We can observe that disorders of the schema of the body are noted in focal lesions of the brain in conjunction with neurological phenomena; as well as in mental disorders, even without the co-existence of neurological phenomena. Disorders of the schema of the body are observed in a host of mental diseases and constitute a significant part of the associated hallucinatory phenomena observed. This gives rise to the following question: do anosognosia and its related phenomena constitute a focal phenomenon, i.e. a disorder caused by a lesion in a specific cerebral centre, or must all these phenomena be considered as manifestations of a more general lesion of the cerebral cortex and in consequence be deprived of any value of localisation? The issue does not have only theoretical value, but also practical significance.

[At this point extensive reference was made to clinical data on phantom-limbs, autoscopia, anosognosia, aphasias, depersonalisation, which, according to the author, reinforce the opinion that the “consciousness of the somatic ego, cannot be localised in a specific centre”].

Jackson stated that if the lower vital centres were not adequately organised, life would not have been possible and, conversely, if the higher centres were not far less organised, and thus extremely accommodative, we would not be able to adapt to new situations and learn new things.

[...]

Zutt determined that during execution of an action, the part of the body and the objects implicated in this action constitute, for the duration of this act, a single entity, which can be differentiated and objectified to a certain degree. The effect of objects on us and their connection to various parts of the body result in a differentiation, permitting to parts of our body to predominate in our consciousness, as if they were in the spotlight- although the body holds a conventional position in its totality, within an objective world. Only in these cases we are able to talk about the schema of the body and this schema is not localised to a specific area of the brain, but instead various parts of the body's schema have a more prevalent localisation, mainly in certain areas of the left cerebral cortex. Indeed, this is not related to consciousness but it is rather a knowledge concerning various parts (of the body) and in particular their functional significance, with reference to the objective world, as well as the knowledge of using these organs.

Consciousness of the somatic ego, whose disorders give rise to anosognosia and its related phenomena, is not based, as it

was erroneously believed, upon a single schema of the body, which is corrected and completed by the changes occurring in the body, but it is something constantly renovated as based on the effort to preserve the volition to exist and to be in the surrounding world. There is a continuous affirmation of existing, continuously renewed with respect to a continuously changing existence. This continuous effort of affirmation of one's being, corresponds to the consciousness of being, manifested as an integrated totality, which only in theory can be distinguished into the consciousness of the existence of the world, the existence of the somatic ego and self-consciousness. Consciousness of the somatic ego as an isolated and independent function that can be localised in a specific cerebral centre does not exist. The fact that in some nosological conditions a distinct consciousness of the somatic ego seems to exist, must be attributed to the fact that in such conditions the person remains in the preliminary levels of full consciousness. Whether a person will manifest psychotic phenomena related to the allopsychic, somatopsychic or autopsychic sphere depends on the level of full consciousness of himself achieved by a person in his development or, on the contrary, the level of fixation of this development. The propensity to acquire consciousness of one's self does not come from the outer world, but rather from the internal world, from the depths of one's biological entity; from drives and tendencies; from instincts and biological needs and demands. Indeed, disorders of consciousness of the body's schema do not indicate the erroneous recognition of one's own body, but rather the defective consciousness of our drives and proclivities and of their correlation to our ego.

In conclusion, disorders of consciousness of the somatic ego are manifested in the effort to gain consciousness of one's self;

more specifically, in the effort to acquire consciousness of a personal tendency as such. Awareness of this tendency means localising it within ourselves. Essentially, in all morbid phenomena we have an erroneous localisation of this tendency, either in the outer world, or even within the body, such as in a disorder of the schema of the body, but not in the ego. It can be an erroneous spatial or temporal localisation. During the process of localising it (ed: a tendency) within the body, the individual comes closer to the consciousness of himself; however, in no way does the body, as a supposed vector of this tendency, depend on the ego and on the volition stemming from it. Consequently, the degree of correlation of this tendency to the ego determines, in morbid conditions, the way to experience the body.

[...]

If we were to make use of disorders of the somatic ego in order to draw conclusions concerning psychotic disorders, then we would say that in these disorders a simple and uniformly repeated function is disturbed, on which function depends the exact correlation and precise assessment of everything occurring within ourselves and arising from our ego. With respect to this function, we must seek an anatomical, a morphological substrate, which must be more or less uniform, since it is generally accepted that morphology and function are correlated. The entire cortex in both hemispheres and every part thereof may perform this function, in particular those areas of the cortex whose cell architecture proves to be relatively uniform. The common architectural aspect of the cortex is its configuration in six layers. This configuration cannot be devoid of importance for the function of the cortex and very probably it is related to its uniform and simple function of correlation with the ego.

Dimitrios Kouretas (1901–1984) & Georgios Tsoukantas (1904–?)

**At the frontiers of psychoanalysis.
Melampus' psychocathartic method for treating
the “childlessness” of Iphiclos**

(Εἰς τὰ μεθόρια τῆς ψυχαναλύσεως.

Ἡ ψυχοκαθαρκτικὴ μέθοδος θεραπείας

τῆς ἀτεκνίας τοῦ Ἰφίκλου ἀπὸ τὸν Μελάμποδα)

*Helliniki Iatriki (Hellenic Medicine) 1955,
second period b', issue 11, 1024–1029*

*To study the laws of the human psyche
on exceptional individuals*

is a particularly attractive work

S. Freud

Whether they actually took place or are products of imagination, certain incidents in ancient Greek Mythology contain psychological truths with a global, timeless value for all mankind.

The case of Iphiclos, a pre-Homeric king of the city of Phylace in Thessaly is a case of infertility, about which the relevant sources provide clear indications that it was due to Iphiclos, rather than his wife. To be more specific, this is a case of psychogenic impotence, for which the healer and seer Melampus applied appropriate treatment, after first having provided diagnosis, in other words, after discovering the psychological trauma in childhood, which caused a fear of castration and the accompanying inhibition of sexual function (Kastrationsangst).

A contemporary student of this case, as in all cases where the sufferer is not a current patient, is only entitled to express conjectures, according to the principle of “as if” (Als ob) [...] things took place in the way claimed and are interpreted, on the basis of contemporary scientific knowledge. The founder of Psychoanalysis, himself, who was known for his positive outlook, implemented this technique on people, such as Leonardo Da Vinci, and on works of literature, such as “Gradiva” by Jensen.

The ancient texts that refer to the treatment given by Melampus to Iphiclos belong to Hesiod, Pherecydes, Theocritos (comments), Apollonios of Rhodes (comments), Apollodoros and Eustathios (comments on Homer). They will be set out in detail in the extensive monograph on Melampus that will shortly be published by one of us (G. Tsoukantas).

On the basis of these sources, it is possible to present the events as in the following scenes:

Scene I: Melampus, carrying out the wishes of his brother Vias –who in order to wed Pyro was required by her father, Neleus, King of Pylos, to steal the cattle of Iphiclos– was captured attempting to realise this exploit (given that they were guarded by “invincible cattle-herders and wild dogs”) and was impris-

oned for approximately a year. Near the end of that year, he predicted that the roof of the building would collapse, after hearing the squeaking of the woodworms that had eaten through the central beam (“when there was only a short time left therein, he heard the woodworms in the rafters of the roof, one asking, what part of the rafter has been already eaten, and the other responding, that what is left is only a small amount” (Apollodoros).

Scene II: As soon as Phylacos, the father of Iphiclos, heard of the presence of this amazing healer-seer in his country, being in fact his prisoner, thought of making use of his skills and promised to let him go free and give him the cattle, if he would cure his son's sterility. Melampus accepted and during an impressive religious ritual, organised by him, with cattle sacrificed, invocations and other awe-inspiring ritual actions, he cut open the sacrificial bull and spread pieces of the carcass all around. The smell of this meat attracted vultures that were considered to be auspices.

From the harrier eagle, king of the auspices, whose voices, according to tradition he could understand, he learned of an old and long-forgotten event, which took place at the court of Phylacos, when Iphiclos was still a young child. At this point we would have to assume that Melampus had gathered this information from conversations he had had with guards and palace servants, and had retained it in order to use it at an appropriate moment.

According to the story, Phylacus was *castrating* rams in the fields, with his son Iphiclos, then a small child, close at hand. His father, according to a commentary found in Theocritos, “*sought to surprise*” him, in other words, sought to “startle him in jest”, and raised the knife to his son's genitals, pretending he was going to do the same to him, and while he intended to

drive the knife into a nearby tree (a sacred oak or a wild pear tree), the knife slipped through his fingers and fell near the child's private parts. Iphiclos fearful, imagined that he would be turned into a eunuch and ran away, whereupon his father was angered, picked up the knife (according to Apollodoros), rammed it into the tree and then ran after the child, in order, of course, to ease his fears. According to a different version (Pherecydes and comments by Eustathios to Homer's *Odyssey*, Book XI), nothing is said of castration, but rather that "the cause of the childlessness was that Iphiclus, when still a child, was once chased by his father, Phylacos, carrying a knife, who was enraged for having seen him do something inappropriate, and Phylacos being very angry (because he had not caught the child) did ram the knife into a wild pear tree and screwed it so far into the tree's bark that it was entirely covered and because of the fear Iphiclos was unable to have children. The vulture then showed Melampus the pear tree, where the knife was hidden, which he contrived to reveal by pulling off the bark and having scraped off the rust from the blade, he said that Iphiclos should be given this to drink in wine for ten days, and then he would be able to sire children".

Scene III: Melampus along with the father and son went apart from the others who were present at the ceremony in order to seek out the tree that was indicated by the vulture, which they did find. They then removed the bark from the tree and drew out the part of the blade that had been pounded in and which, with the passage of years, had been covered by the bark, and they scraped off the rust it had gathered.

Scene IV: For ten days Melampus administered the rust to Iphiclos in wine.

Scene V: After Iphiclos drank of this mixture, “this strengthened his loins”, and he sired two sons, Protesilaos and Podarces, in a second birth – following this event Melampus received the cattle as his reward.

The psychocathartic method of treatment, which was utilised by Freud in collaboration with Breuer, has no essential difference from the method applied by Melampus: a prerequisite is to seek out some form of (repressed) mental trauma in the patient’s past, which is overlooked by the conscious ego, in this case of a sexual nature. Becoming aware of the conditions under which this took place and reliving and discharging these emotions (Abreagierung – an abreaction) constitute, roughly speaking, components of the cure. The prescription of the drink, a suspension of rust within alcohol –in a minute quantity and without any special therapeutic value– must be considered as a way to reinforce the suggestion.

For the most well-grounded evaluation of this mythological treatment, expounded within the framework of current knowledge of science, we consider it more useful, instead of providing comments, to set out the following relevant excerpts from the bibliography of psychoanalysis.

A boy during the phallic phase of his sexual development, which coincides with the phase of the Oedipus complex, displays great curiosity and particular interest in his genitals, but swiftly comprehends that adults prohibit such autoerotic pursuits, and may even threaten to cut off his penis, if the boy continues to masturbate. According to Pherecydes, as we have already mentioned, Phylacos was enraged, because Iphiclos was discovered “*doing something inappropriate*”, possibly pleasuring himself.

According to the archaic idea that repercussions should match the affront (“an eye for an eye” – talion), the body part that sinned should also bear the punishment. The threat may have been less categorical, whether meant seriously or in jest (which is what Phylacos did, according to the commenter on Theocritus), but the child is subject to various impressions (such as the sight of a girl’s genitals that are without a penis and appear to be mutilated, or the castration of animals, as was the case with Iphiclos), which the child takes as exemplars of the image of this threatened castration, particularly when feeling guilty for fantasies or desires that are improper and unconfessed.

Psychoanalytical investigation led to the result –expressed here in a form that is purely schematic– that impotence of psychic origin is due to the persistence on the adult male of unconscious incestuous attachment (to his mother) and the subsequent fear of punishment and castration by his (rival) father, a fear that is even more effective, when the influence of psychic traumas experienced at a young age exist, such as those undergone by Iphiclos. The consequence of this on the unconscious psyche of the sufferer is that the sexual act is generally perceived as sinfull and worthy of punishment and, furthermore, as dangerous, as was during boyhood, in such a way that an inhibition thereof (impotence) allows the man to escape this unconsciously perceived danger and the childish fear of castration.



Panagis Lekatsas (1911–1970)

**The Soul (Psyche-Ψυχή).
The idea of the soul and its immortality
and the customs of death**

Ekdotiko Institutouto Athinon
(Athens Publishing Institute), Athens 1957
Reissued by: Kastaniotis Publications, Athens 2003

1. The Two Souls

The concept of the soul (psyche) is one of the most ecumenical: The fact that it can be traced in primitives was greeted with joy by religious people in the civilised world. It was taken as a most positive indicator of the existence of the soul and its immortality; the two most revered foundations of the salvation religions and of idealist philosophy. For them, it would be much more natural the concept of the soul in primitive people to be a revelation or an inherent concept for mankind, rather than the concept of the soul in civilised people to be an evolution of the concepts held by primitives.

One contributory factor to the topic –when the issue was dealt with scientifically– was *Animism*, the theory admitted by the first Anthropologists. According to this theory, man is inherently a dualist, distinguishing within himself a material

body and an incorporeal soul, which is the cause and carrier of life and its emotional and intellectual functions, and which, being immortal, is separated from the body, after death, in order to continue its life in a world of spirits. In other words, a primitive's idea concerning our composition and our fate after death, according to the theory of Animism, cannot be differentiated from the corresponding idea, made familiar to us by Greek philosophy and later on by Christian religion. However, it is not the primitives, but Animism itself that is philosophising and christianising: The projection of our images and ideas onto the world image of past times is one of the frequent stumbling points of this theory. The dualism that Animism detects in the primitives is the last step in the evolution of the concept of the soul. Despite the fact that it comes into a very advanced stage of civilisation, it remains simplistic in comparison to the complexity of initial beliefs concerning this issue.

The basic representations that interpret, to a great extent, the beliefs on the Soul and the Customs of Death are three: *The Vital Soul* (or the Soul of the Living), *The Living Corpse* (the Corpse that is considered to be Alive) and the *Dead Soul* (the Dead Man's Soul). The "Vital Soul" is life individualised, which sometimes is accounted for as a diffuse force and at other times is represented as an idol, and is the cause and carrier of life, the seat of emotional and intellectual functions and, after death, is reincarnated eternally in animals and humans. The "Living Corpse" is the Dead Man himself, who, although his body is eventually disintegrated, continues his life up to that time, in a sphere that is simultaneously real and at the same time "supernatural". Just like the living, the dead need food, retain their rights over their property and companions, like an unfortunate being who is outside social rules and all kinds of barriers, and must be destroyed or bound in order

not to harm others. The “Dead Soul”, finally, is the Soul of the Dead; it is the remembered image, the incorporeal idol representing the Living Corpse or its Ghost. This soul, which properly commences to exist from the moment when the Living Corpse is destroyed, either artificially or naturally, is imposed as an autonomous representation, and thus the Dead Soul is presented as co-existing with the Living Corpse, inhabiting the dead person’s grave or its environs, in order to find refuge finally in a world of shadows, once the remains are destroyed. The demonisation of the dead, which elevates their Soul to the level of a higher existence, is a latter-day branch of this tree of beliefs and customs.

Thus, according to initial beliefs, man did not have one but Two Souls, one, the Vital Soul, while he is alive, the other, the Dead Soul, once he dies. The only thing which is similar in these two souls is their representation as idols, because in all else they are fully differentiated. The Vital Soul is *Impersonal*, because it is only transiently associated with the personality of its carrier, it borrows only exceptionally few characteristics of that personality, and does not continue after death; it is *Conscious*, as the seat of emotional and intellectual functions; and finally it is *Immortal*, because it is continually reincarnated into its new carriers. In contrast, the soul of the Dead is *Unconscious*, reflecting the unconsciousness, lack of senses and lethargy of the corpse; it is *Personal*, as a faithful image of the dead; and finally, it is *Mortal*, because it does die, after a certain period of time, or else lives a life so ill-fated and unaware, that it cannot be counted in immortality. The later idea of a *Personal, Conscious and Immortal Soul*, is born (through complex routes, which we will try to date in the final stages of our study) through the identification of these Two Souls: the impersonal, conscious and immortal Vital Soul and

the personal, non conscious and mortal Dead Soul, into one, which gains the consciousness and immortality of one and the personality of the other.

2. The Two Souls: the soul of the living and the soul of the dead for primitive nations

People supplying information on the beliefs of primitive nations –travellers, clerks, missionaries and investigators– influenced by the later idea of a spiritual soul and by the mechanical theory of Animism, do not grasp the differences between various terms concerning the soul, or dealing as they are, from their perspective, with a gamut of conflicting beliefs, they muddle up their data desperately. But these mixed data are then forced through a second muddle by the disciples of Animism, who proceed to collect these data into more general works. Despite this, the distinction between the Two Souls is documented directly through the systematic distinction of conflicting beliefs and actions, which is the main issue of this book. On the other hand, examples bearing evidence of the distinction between the Two Souls, as an explicit and clear-cut belief in primitive nations, are not missing completely.

[...]

3. The Two Souls: the soul of the living and the soul of the dead for ancient nations

The distinction between the two souls, the Soul of the Living and the Soul of the Dead, is encountered sometimes clearly and at other times less clearly in ancient people who, having left behind them in immemorial time the stage of savagery and having finally overcome the stage of barbarity, pioneered the road

to Civilisation: the Semites, the Egyptians, the Greeks and the Romans; however the transfer of a name for the Vital Soul to the Soul of the Dead, between the Hebrews and the Greeks, and a peculiarity in the representation of the Vital Soul between the Egyptians and the Romans confuses this distinction to a certain extent, without, however, entirely eradicating it. The data are very familiar, but the honour of the first transfer in the distinction of the Two Souls goes to W.F. Otto (*Die Manen, oder von den Urformen des Totenglaubens*, Berlin, 1923). I take up this view here, with some freedom in documentation.

The Babylonians knew one Soul of the Living, *kabittu*, which means “liver” or *libbu*, which means “heart” (the liver and the heart are familiar locations for the Living Soul: chapters 8 and 9), as do the Assyrians and all the Semites; and one living principle or soul, *napisthu* (derived from the verb *napashu* “to breathe”), which means “breath”, “life” and which is thus identified with the breath (chapter 14 and henceforward). On the other hand, they know a soul or ghost of the Dead, which is called *utukku* or *Ekimmu*, names that are both related to the demonic nature of the dead. Amongst Israelites there was a dominant double representation of a Soul of the Living and a Soul of the Dead. The Soul of the Living is called *nefesh* and *ruach*, referring to Breathing (chapter 14), and have the same meaning as the Greek words *psyche* and *pneuma*. They are, thus, synonyms, with the slight difference that *ruach* (=breath) means the impersonal and the general life-giving element and in the post-captivity texts the spiritual Soul that returns to God, while *nefesh* (“breath”, “life”, “soul”) means a more individualised and vegetal life and soul of the man. After death the *ruach* returns to its source, in other words to Wind and further on to God, while the *nefesh* inhabits the grave of the dead person (the gravestone

substantiating it is also known as *nefesh*) or dies. At these cross-roads, and in the double destiny of the Jewish soul, we find the familiar adventure of the Vital Soul, which, after death, loses its personal nature (thus dying as a personal soul) and returns to its beginnings or condition. On the other hand, we have an Israelite impersonal Hades, Sheol, and a soul or image of the dead, that descends there forever and which is also known as *nefesh*. Thus, the name *nefesh* of the vital soul is *transferred* to the soul or the ghost of the dead, which first inhabits the grave of the dead and then descends into the kingdom of shadows, just like the Greek name *psyche*, which, though initially meaning breath and by extension, life, also proceeds to mean the soul of the dead. This transfer does not arise from any relationship between the two souls, but, just as with the Greeks, it arises from a metaphorical use of the word, meaning the first soul. Due to the fact that it signifies an individualised life or soul, the *nefesh* is always that of a specific person, and thus is utilised as a synonym for the same word with a personal pronoun (my *nefesh*, your *nefesh*, his *nefesh*). Thus, by signifying the ego of the Living, and furthermore the Living self, it is extended to the dead self and furthermore to its image or ghost.

For Egyptians, the Vital Soul was the *Ka*, which is signified on monuments with the representation of both hands lifted, as if imploring. This appealing representation, is one of the emblems of the archaic totemic clans, seen in the earthenware idols and rock drawings of the Stone and Bronze Ages. This also explains why the *Ka* is considered a man's companion daemon, which guards and ensures his life, happiness, health and joy. It is the vital force that is considered diffused throughout a totemic clan, simultaneously part of the group and the individual, group-based within the entire clan and individual for each of its members. Security

and protection within the unity and solidarity of the ancient clan is transfused to the capacity of each member to have an individualised part of the integral Vital Soul, which thus becomes the guardian daemon. The same occurs with the Roman *Genius*, which is also a kind of Vital Soul of group origins and a guardian daemon; and just as that also appears as a demonised birth force, so is the *Ka* the one that procreates. When, finally the *Ka* abandons a man, that man dies. However, the *Ka* remains stranded in the generality and vagueness of vital force, but by preserving the capacity, on the other hand, of guardian daemon, distances itself from the very nature of the Vital Soul. Vital Soul has a multifaceted representation (chapter 22), and certain of its features, its duration here on earth, and its ability to reincarnate within all sorts of other creatures, are passed onto the soul *Ba*, written as a bird and also represented as a bird with a human head. The bird is a familiar representation and reincarnation of the Vital Soul (chapter 31). The nature of the vital souls is also evidenced by the ability of the *Ba* soul to be reincarnated in animals and plants (chapters 29, 123), and the prayer to the *Ba* to re-enter the mummy of a dead person, in order for that to come to life for an instant and thus consume the offerings that are provided for that mummy. On the other hand, the preservation of the dead through embalmment was a major obstacle to Egyptians to follow other peoples in the representation of the other soul, the Soul of the Dead, which is organically born from the destruction of the Corpse (chapter 72). Finally, they didn't escape from this representation and an underworld here was filled up by the spectral images of their dead. The same function makes the dead's mummy, *sahu*, appear with two aspects. On the one hand, as something fearful and awesome, inhabiting the person's grave, in magnificent isolation and silence, gifted with magical powers, the power to call out the ori-

gins of life and of intellect that have escaped to him, as well as his name, his heart and his shadow, the familiar elements of his vital soul (chapters 9, 18, 20), as a Living Dead, with its demonic force. Just as in the Living Dead of other civilizations, the image (soul or ghost) of the dead is cut out, here too, in a more advanced era, an incorporeal other *sahu*, from the mummy *sahu*, which is, in this case, a spiritual body is cut off. Thus, with the Egyptians we also see evidence of a Vital Soul, here also having a double representation, as *Ka* and as *Ba*, and the dead with their own double representation: that of the Living Dead, on the one hand, and of their spectral image on the other hand.

The Greeks of the Pre-Orphic period distinguish two souls, a Soul of the Living, which had the name *thymos*, and a Soul of the Dead, known as *nekys*, (*nekros*=*dead*) or *psyche* (a meaning of the word) and *eidolon*, “image”. The soul of the Living, in Homer and later poetry was truly the *thymos*, which in one interpretation can be identified as the Breath and according to another as vapour or the boiling of the blood. The Soul-Breath (chapter 14 and forward) and the Blood-Soul (chapter 13) were both types of Vital Soul. But there is a host of qualities and functions attributed to “*thymos*” that are evidence of its nature as a Vital Soul. When a person faints, when his “*thymos*” leaves him, his “*thymos*” returns only when he comes to. When somebody dies and leaves life, it is because his “*thymos*” was taken or somehow lost. This vital soul imbues the entire body, because we hear that with death it leaves the bones or parts. As a Vital Soul, the “*thymos*” is also the locus of emotional functioning. Here exist rage, anger and aggressiveness, love, hate, joy and elation, pain and mourning, perplexity and admiration, shame and respect, fear, hope, sympathy and mercy, willpower and liking, urges, regrets and doubts. Further more “*thymos*” is the locus of intel-

lectual function. Finally, as the locus of emotional and intellectual functions, “thymos” records and signifies character. Where does “thymos” go after death, and what becomes of it, are not mentioned; we can’t however speculate that they are re-incarnated in another person or creature or that the “thymos”, too, comes to an end. The evidence points that in Greece there were these two fates for the Vital Soul and we must speculate that the former belonged to the Pre-Hellenic strata and the latter to the Proto-Hellenic strata. There is in fact a multitude of facts –that we shall look into later on, and that we can speculate– deriving from the indigenous Pre-Hellenic peoples, providing evidence that, in Greece, the idea of a Vital Soul, which we know with the name “thymos”, is re-incarnated in endless cycles. The idea, on the other hand, that this vital/animating soul is destroyed by death was normal for nomadic peoples, such as the Achaeans, and is documented in their epic poetry with the use of specific adjectives, such as *thymophthora pharmaca*, *thymoraistes thanatos* and *thymoraistes deioei* (*soul-wrecking poisons, soul-destroying death and soul-destroying enemies*). Two fragments of the epics state that “thymos” descends to Hades and they cannot deceive us. The first from the *Odyssey* XI.39, where amongst the other souls in Hades, there appear before Odysseus *παρθενικαί τ’ αταλαί νεοπενθέα θυμόν έχουσαι* (*parthenikai t’ atalai neopentheia thymon echousai: virginal tender girls, their souls fresh burdened with mourning*). Here, however, the word thymos may now be corrected with the word aoton, because a fragment of “Kestoi” by Julius Africanus, which repeats unaltered verses 34–43 of the *Nekya* (Book XI of the *Odyssey*), includes the aforementioned verse as follows: *παρθενικαί τα’ αταλαί νεοπενθέ’ άωτον έχουσαι*, (*parthenikai ta’ atalai neopenthe’ aoton echousai: girls once vibrant and still new to grief*), which is far more

internally consistent and thus can be better supported. Thus, there only remains the second reference from Iliad Book VII, 131, where it is stated *θυμόν από μελέων δύναι δόμον Αιδός είσω* (*thymon apo meleon dynai domon Aidos eiso: and I may enter the house of Hades from the darkness in my soul*). The very uniqueness of the passage indicates that the expression is metaphorical and means that only “thymos dies” or “is lost”, because according to the Greeks, what descended to Hades was not the impersonal and amorphous *thymos*, but the far more personal *psyche* which is the image of the dead person, his ghost (chapter 72). The word *psyche* in fact first meant Breath (chapter 14) and, after that, life itself; and with this meaning, that of life, it is also encountered in far later years. However, it does not suffice to mean the vital soul and thus does not become the locus of emotional functioning. In contrast, it reverts to signify, just like the Jewish *nefesh*, the Soul of the Dead, the image that descends to Hades. Often, the names of this dead-soul are, as we have seen, far more fitting: *nekys*, which means “dead”, and *eidolon*, which means the “image” (here as elsewhere, incorporeal). This name transfer from Vital Soul, *psyche*, to the Soul of the Dead, is further due here to the individualising function of the term. Individualising the general concept of life to a specific person, a “soul”, which as an individual life, is always “somebody’s soul”, in other words some person’s soul. Thus, it comes to mean the “living self”, i.e. the individual himself; and the expression “my soul”, which means “my life” or “my living self” comes to mean “I”; the expression “your soul”, which means “your life” or “your living self” comes to mean “you” and the expression “his soul”, which means “his life” or “his living self” comes to mean “he” or “that individual”. Due to the individualising function and its equivalence with the personal pronoun, the term soul is trans-

ferred from the person of the living to the lost identity of the dead (“his living self”) and further to his spectral image. Therefore, the Greeks during the Pre-Orphic period also considered they had two souls, one for the Living, called *thymos* and one for the Dead, which is called *nekys*, *eidolon* and finally *psyche*, with an extreme underworld meaning.

For the Romans, the words *anima* and *animus* meant Breath (chapter 14) and, furthermore, the first means “life” while the second means “consciousness”, thus naming two types of Vital Soul, one more vegetal, the other more intellectual, in essence the Vital Soul in its two aspects, as the vital principle on the one hand and as the locus or organ of consciousness on the other. The *anima* is the soul (because the *animus* is presented more as a dependent action), which is absorbed by the dead person’s closest relative through their final embrace (chapter 15). However, this soul was insufficient to be autonomous as the Soul of the Living, nor, as with the Greek *psyche*, to mean the Soul of the Dead. For the Romans, the vital soul had a representation similar to the Egyptians’ *Ka*. From birth till death, man is followed by a spirit, bound tightly to his life itself, which acts as his guardian daemon. In men, this spirit is called the *Genius*; while for women, this is the *Juno*, which means that they distinguished between male and female, in accordance with a person’s gender. It is said that the word is derived from *gignere*, which means the reproductive function, to *give birth*, and this spirit is thus the demonised procreative force, which is inherited from father to son and exists in the sperm. Its seat, thus, is the forehead (through the brain, the head is associated with the sperm: chapter 7) and when a Roman wished to honour his *Genius* he would touch his forehead. However, nobody could trust this general interpretation, knowing that a man’s role in reproduction is unknown or undefined in the

lower stages, and that for the Romans themselves, who developed the strictest patriarchal regime, the relationship between mother and child was a “natural event” (*natura verum*), while paternity falls solely under the sphere of political law. On the other hand, what is hard to comprehend in this interpretation is the distinction of this genetic force into male for men and female for women. Thus, we can see that *Genius* is far closer to the concept of *genus*, rather than to the concept of *gignere* as refers to reproductive function, hence having a similar root and development with its homologue *Ka*, of the Egyptians. It is the vital force or life, in group and as an individual simultaneously, that is diffused within the genus (initially the totemic one), whose initial reversion to group status narrows down its inheritance from father to son, which, as the clan represents continuity, is related to reproduction, and where from the one-time unity and solidarity of the clan, it reverts to a guardian daemon of the clan member. From this perspective, it is worth noting a recent view, according to which the *Genius* was one for each family, and perhaps initially, *one for each clan*. On the other hand, for the Romans, the Soul of the Dead, also known poetically as the *umbra* (shadow-which corresponds to the Greek *skie*), belongs to the group entity of all the dead souls, defined using plural terms as *mortui* and *manes*. The first word corresponds to the Greek *nekyes*, and indicates that the Roman Dead Soul was spectral and here means the image of the dead, while the word *manes* means more or less the same as the Greek *chthonioi* (χθόνιοι) concerning the dead, the dead souls elevated to the class of daemons (chapter 101).

However, these few examples of the distinction between the two souls in primitive and ancient peoples are complemented, in more ecumenical circles by the simultaneous, parallel and entirely distinct fates of the two souls: the everlasting reincar-

nation of the Vital Soul and the refuge taken by the Dead Soul to a remote kingdom of shadows; with customs that struggle to save, win over, or free the Vital Soul, and to kill, send off or bind the Soul of the Dead; and finally, the demonisation or deification of the Soul of the Dead, carrying the bearer's personality to a higher plain. Finally, self-localised and self-interpreted, within this distinction between the Two Souls, lies the immense, incoherent, contradictory and arbitrary host of beliefs about the soul and customs surrounding Death.

Therefore, the First stage of our study will observe the beliefs regarding nature, facets, functions, adventures in life and reincarnations after death of the Vital Soul, as well as the means to ensure its rebirth. In the Second part we will go through the risks and the ways to safeguard the living from the Living Corpse and the Soul of the Dead, its rights over movable property and its companions and the meaning and customs of Mourning. In the Third part we will follow the Soul of the Dead on its journey and see the worlds of the souls which await it and certain stable features they share. In the Fourth part we will study the deification of the Soul of the Dead with the ceremonies of the Royal Coronation, which are transferred to the Burial and certain elements of the worship of the dead.

In the Fifth part of the study we will see how through the ideology of thiasus (ed: thiasus is an organisation of men having a divinity as their patron that honour this divinity with festal and pompous observances), the faceless, aware and unseen Vital Soul is identified with the personal, not conscious and mortal Soul of the Dead, in order to provide a new idea of the personal, conscious, immortal Spiritual Soul, shaped by the Orphics and imposed by Greek philosophy.

[...]

120. The new idea of a Spiritual Soul

We saw that primitive, as well as folk beliefs, are familiar with the existence of two different souls for man. The first one is the Vital Soul or the Soul of the Living, which is nothing more or less than Life itself, conceived sometimes as a force that flows through the body and at other times as an eidolon, that leaves the body at the time of death and, after death, is eternally incarnated in all kinds of living beings and people. The main characteristics of this Soul are that it is represented as *Impersonal* (it does not hold on to the carriers' personality after death), *Conscious* (as the seat of emotions and of intellectual functions), and *Immortal* (as it perpetuates its existence through its ceaseless series of re-incarnations). The second soul is the Dead Soul, or the Soul of the Dead, which is no less than the imaginary effigy of the Corpse which, at advanced stages (of civilisation) retires to a remote kingdom of shadows. Its main characteristics are that, in contrast to the Vital Soul, it is represented as *Personal* (in fact absolutely personal, like the dead person's image), *Unconscious* (especially in the advanced stages of the Mediterranean world, which are relevant here), and, finally, *Mortal* (a feature that, in advanced stages, retreats before its demonisation). These two souls are a persistent representation of primitive beliefs that, even more do not acknowledge any divinity, in either one or the other. Thus, even the latest elevation of the Dead Soul to the order of Demon depends, not on its nature but rather on the initiation ceremonies that will achieve it. This representation of the two Souls does not give rise to any form of Dualism: there exists no contrast between the soul and the body, no separation of life into two lives of differing values and the world into

worlds with two different natures. These beliefs correspond to the representation of a unified Cosmos, a consciousness of the central value of Life and a longing to Enjoy this life, both on the path of the senses on one hand, and on the measure of the ideal on the other hand.

The reader, however, now familiar with the representation of the Two Souls also knows a third representation of the soul, which we shall call the *Spiritual Soul*, in order to differentiate it from the other two. This Soul is *Single, Personal, Conscious, Immortal* and, finally, *Divine* in its origins and essence, and was introduced to the world through Greek philosophy. This representation automatically separates Man from the Cosmos and life, into two existences, two worlds and two lives, antithetical in nature and of different value. This contrast of the divine, spiritual, immortal soul with the earthly, material and mortal body to which it corresponds, is the contrast of the spiritual, true and pure life of the soul with the sensual, deceptive and impure life of the body; the contrast, when it comes down to it, of the spiritual world, to which the soul belongs, with the material world, where it descends when incarnated. This idea of a spiritual soul, which has had a glorious life through Greek philosophy, the mystery religions and Christianity, first appeared in Greece during the sixth century BC, at a time of major social, political and ideological upheaval. Amongst the ideological movements of the age were also some very serious mystical movements, which set their own ineradicable seal on the world of the rational spirit of the Greeks. Some of these were purely religious, including the revival of the Dionysian Religion –which was imposed by popular demand– while others contained a religious morality, such as Orphism and Pythagoreanism, with

salvation teachings and action included in both. The former offered a mythical interpretation of the world, while the latter a philosophical one. Which of these movements formulated this new idea of a Spiritual Soul? Because the assertion that we are indebted to one of these movements for this new concept of a Soul, is irrefutable. In his old, but still excellent work on the concept of the Soul among the Greeks, Rohde attempted to support the theory that we are indebted to the Dionysian Religion for the idea of a Spiritual Soul. The pages he dedicates to this religious movement remain incomparable in their charm, but today, more substantial knowledge of the Dionysian Religion does not justify his beliefs. However, this renowned scholar didn't throw his spear too far from the invisible target. We are not indebted to the Dionysian Religion for this new idea of a Spiritual Soul, but the elements that comprise this concept are, in fact, derived from the Dionysian Religion, as we shall see.

In fact, the formulation of the concept of the Spiritual Soul can be traced back to the Orphics or to the Pythagoreans. The particularity of the problem resides in the fact that the amazing similarity of their dogmas cannot justify any deep differentiation between them. The divine nature of the Soul, its Reincarnation the Promise of Salvation, and the final re-deification of the Soul are accepted dogmas for both of them. The similarity in dogma and the commonalities in other elements of these movements –the organisation in *thiasus*, rules for living, abstaining from murder and the consumption of creatures with a soul, implementing cleansing rites– makes them replicas of one another. Other scholars ascribe the formulation of this new concept to the Pythagoreans. And in fact, the Orphics are at a disadvantage because their figurehead, Orpheus, is a

mythical person, whilst the Pythagoreans are at an advantage because their leader was one of the greatest intellectuals of antiquity, and the mythical fictionalisation of his biography by no means undermines his historical presence. There are two strong arguments in favour of the view that the formulation of the new concept of the Spiritual Soul belongs to the Orphics rather than the Pythagoreans. One of these arguments is that the mythical type of the cosmic interpretation in Orphism represents, necessarily, a stage preceding the rational (and in fact Mathematical) type of Pythagorean interpretation of the cosmos. Thus, as we are faced with two contemporaneous ideological movements which provide the same solution to the problem, it is natural to accept that the Pythagoreans transfigure in a rational way the solution put forward by the Orphics, rather than to side with the idea that the Orphics transfigured the solution provided by the Pythagoreans into mythical form (Guthrie WKC, *Orpheus and Greek Religion*, London, 1952). The other argument is based on the Dionysian derivation of elements that bring together the concept of a Spiritual Soul. [...]

The problem is which elements and through which pathways of elaboration did the new concept of a Spiritual Soul develop. Only the resolution of this problem can determine to whom we owe the formulation of this concept of the Soul, a problem not yet studied adequately, as far as I know, despite its importance. We will therefore limit ourselves to this, leaving for a later day the analysis of the elements of the Dionysian Religion the respective issues of Initiation and the Sacred Drama we will not discuss here an issue risking to alter the overall development of our thesis.

[...]

BIOGRAPHIES

Biographical notes of ancient authors

Information concerning the ancient Greek biographies is derived from Wikipedia's relevant items and some other biographical sources of encyclopedic nature, mainly Encyclopedia Americana and Encyclopedia Britannica.

A

Areteus of Cappadocia (1st–2nd century AD)

Areteus (Ἀρεταῖος), is one of the most celebrated of the ancient Greek physicians, of whose life, however, few particulars are known. It seems probable that he practiced in Rome in the 1st century, during the reign of Nero or Vespasian or in the later half of the 2nd century. He is generally styled “the Cappadocian”.

Areteus wrote in Ionic Greek a general treatise on diseases, which is still extant, and is certainly one of the most valuable relics of antiquity. The book displays great accuracy in the detail of symptoms, and in seizing the diagnostic character of diseases. In his practice he followed for the most part the method of Hippocrates... One disease he described was later known as *Celiac Disease* and is common in the world today.

The account which he gives of his treatment of various diseases indicates a simple and sagacious system... Thus he freely administered active purgatives; he did not object to narcotics; he was much less averse to bleeding; and upon the whole his *Materia Medica* was both ample and efficient.

It may be asserted generally that there are few of the ancient physicians, since the time of Hippocrates, who appear to have been less biased by attachment to any peculiar set of opinions, and whose account of the phenomena and treatment of disease has better stood the test of subsequent experience. Areteus is placed by some writers among the *Pneumatici* because he maintained the doctrines which are peculiar to this sect; other systematic writers, however, think that he is better entitled to be placed with the *Eclectics*.

Works: Aretaeus' work consists of eight books, two *De causis et signis acutorum morborum*, two *De causis et signis diuturnorum morborum*, two *De curatione acutorum morborum*, and two *De curatione diuturnorum morborum*. They are in a tolerably complete state of preservation, though a few chapters are lost.

Aristotle (Greek: Αριστοτέλης, Aristotélēs) (384 BC–322 BC)

Greek philosopher, one of the greatest thinkers and scientific investigators and organizers the world has ever seen (James Creighton, *Encyclopedia Americana*, 1829–1957, Americana Corporation, New York)

Aristotle was born in Stageira, Chalcidice, in 384 BC, about 55 km (34 mi) east of modern-day Thessaloniki. He died in Euboea, Greece of natural causes in 322 BC...

He was a student of Plato and teacher of Alexander the Great. His writings cover an incredible number of subjects, including physics, metaphysics, poetry, theater, music, logic, rhetoric, politics, government, ethics, biology, and zoology and he was referred to by his contemporaries as the philosopher. Together with Plato and Socrates (Plato's teacher), Aristotle is one of the most important founding figures in Western philosophy. Aristotle's writings constitute a first at creating a comprehensive system of Western philosophy, encompassing morality and aesthetics, logic and science, politics and metaphysics.

Aristotle's views on the physical sciences profoundly shaped medieval scholarship, and their influence extended well into the Renaissance. They were ultimately replaced by Newtonian

physics. In the biological sciences, some of his observations were confirmed to be accurate only in the nineteenth century. His works contain the earliest known formal study of logic, which was incorporated in the late nineteenth century into modern formal logic. In metaphysics, Aristotelianism had a profound influence on philosophical and theological thinking in the Islamic and Jewish traditions in the Middle Ages, and it continues to influence Christian theology, especially Eastern Orthodox theology, and the scholastic tradition of the Catholic Church. His ethics, though always influential, gained renewed interest with the modern advent of virtue ethics. All aspects of Aristotle's philosophy continue to be the object of active academic study today. Though Aristotle wrote many elegant treatises and dialogues (Cicero described his literary style as "a river of gold"), it is thought that the majority of his writings are now lost and only about one-third of the original works have survived.

Despite the far-reaching appeal that Aristotle's works have traditionally enjoyed, today modern scholarship questions a substantial portion of the Aristotelian corpus as authentically Aristotle's own.

He has written on:

Logic, History, Analytics (on: Categories, Interpretation, Prior Analytics, Posterior Analytics, Topics, Sophistical Refutations)

On scientific method: Like his teacher Plato, Aristotle's philosophy aims at the universal. Aristotle, however, found the universal in particular things, which he called the essence of things, while Plato finds that the universal exists apart from particular things, and is related to them as their

prototype or exemplar... Aristotle's method is both inductive and deductive, while Plato's is essentially deductive from a priori principles. In Aristotle's terminology, "natural philosophy" is a branch of philosophy examining the phenomena of the natural world, and includes fields that would be regarded today as physics, biology and other natural sciences. In modern times, the scope of philosophy has become limited to more generic or abstract inquiries, such as ethics and metaphysics, in which logic plays a major role. Today's philosophy tends to exclude empirical study of the natural world by means of the scientific method. In contrast, Aristotle's philosophical endeavors encompassed virtually all facets of intellectual inquiry.

In the larger sense of the word, Aristotle makes philosophy coextensive with reasoning, which he also would describe as "science". Note, however, that his use of the term science carries a different meaning than that covered by the term "scientific method". For Aristotle, "all science (*dianoia*) is either practical, poetical or theoretical" (*Metaphysics* 1025b25). By practical science, he means ethics and politics; by poetical science, he means the study of poetry and the other fine arts; by theoretical science, he means physics, mathematics and metaphysics.

If logic (or "analytics") is regarded as a study preliminary to philosophy, the divisions of Aristotelian philosophy would consist of: (1) Logic; (2) Theoretical Philosophy, including *Metaphysics*, *Physics*, *Mathematics*, (3) Practical Philosophy and (4) Poetical Philosophy...

Aristotle also had some scientific blind spots. He posited a geocentric cosmology that we may discern in selections of the *Metaphysics*, which was widely accepted up until the 1500s...

Physics: The five elements: Fire, which is hot and dry. Earth, which is cold and dry. Air, which is hot and wet. Water, which is cold and wet. Aether, which is the divine substance that makes up the heavenly spheres and heavenly bodies (stars and planets).

Each of the four earthly elements has its natural place; the earth at the centre of the universe, then water, then air, then fire. When they are out of their natural place they have natural motion, requiring no external cause, which is towards that place; so bodies sink in water, air bubbles rise up, rain falls, flame rises in air. The heavenly element has perpetual circular motion.

Causality: he describes Four Causes: Material cause, formal cause, efficient cause, final cause...

...All further investigations of causality will consist of imposing the favorite hierarchies on the order causes, such as final > efficient > material > formal (Thomas Aquinas), or of restricting all causality to the material and efficient causes or to the efficient causality (deterministic or chance) or just to regular sequences and correlations of natural phenomena (the natural sciences describing how things happen instead of explaining the whys and wherefores).

He has also written on: Optics, Chance and spontaneity, Universals and particulars

Metaphysics: Aristotle defines metaphysics as “the knowledge of *immaterial* being,” or of “being in the highest degree of abstraction.” He refers to metaphysics as “first philosophy”, as well as “the theologic science”...

Aristotle examines the concept of substance and essence (*ousia*) in his *Metaphysics*, Book VII and he concludes that a

particular substance is a combination of both matter and form. As he proceeds to the book VIII, he concludes that the matter of the substance is the substratum or the stuff of which it is composed, e.g. the matter of the house are the bricks, stones, timbers, etc., or whatever constitutes the *potential* house. While the form of the substance, is the *actual* house, namely 'covering for bodies and chattels' or any other differentia (see also predicables). The formula that gives the components is the account of the matter, and the formula that gives the differentia is the account of the form.

With regard to the change (*kinesis*) and its causes now, as he defines in his *Physics* and *On Generation and Corruption* 319b–320a, he distinguishes the coming to be from: (1) growth and diminution, which is change in quantity; (2) locomotion, which is change in space; and (3) alteration, which is change in quality.

The coming to be is a change where nothing persists of which the resultant is a property. In that particular change he introduces the concept of potentiality (*dynamis*) and actuality (*entelecheia*) in association with the matter and the form...

Biology and medicine: In Aristotelian science, most especially in biology, things he saw himself have stood the test of time better than his retelling of the reports of others, which contain error and superstition. He dissected animals, but not humans and his ideas on how the human body works have been almost entirely superseded...

Aristotle is the earliest natural historian whose work has survived in some detail. Aristotle certainly did research on the natural history of Lesbos, and the surrounding seas and neighbouring areas. The works that reflect this research, such

as *History of Animals*, *Generation of Animals*, and *Parts of Animals*, contain some observations and interpretations, along with sundry myths and mistakes. The most striking passages are about the sea-life visible from observation on Lesbos and available from the catches of fishermen...

Another good example of his methods comes from the *Generation of Animals* in which Aristotle describes breaking open fertilized chicken eggs at intervals to observe when visible organs were generated.

He gave accurate descriptions of ruminants' four-chambered fore-stomachs, and of the ovoviviparous embryological development of the hound shark *Mustelus mustelus*...

With reference to Psychology, Aristotle postulated that the soul is the "complete realization of a body endowed with the capacity of life". As a consequence every body that has life has soul and in that sense psychology would be a branch of biology.

G

Aelius Galenus or Claudius Galenus
(129 AD–201 AD) Greek: Γαληνός, Galēnos,
better known as **Galen of Pergamum**

He was a prominent Greek physician and philosopher, and probably the most accomplished medical researcher of the Roman period. He began the study of Medicine at Pergamum and later studied at Smyrna, Corinth and Alexandria. His theories dominated and influenced Western medical science for well over a millennium. His account of medical anatomy was based on monkeys as human dissection was not permitted in

his time, but it was unsurpassed until the printed description and illustrations of human dissections by Andreas Vesalius in 1543. Galen's account of the activities of the heart, arteries and veins endured until William Harvey established that the blood circulates with the heart acting as a pump in 1628. In the 19th century, student physicians would still read Galen to learn some concepts. Galen developed many nerve ligation experiments that supported the theory, which is still believed today, that the brain controls all the motions of the muscles by means of the cranial and peripheral nervous systems. Galen wrote a small work called "That the Best Physician is also a Philosopher", and he saw himself as being both, which meant grounding medical practice in theoretically sound knowledge or "philosophy" as it was called in his time. Galen was very interested in the dispute between Rationalist and Empiricist medical sects, and his use of direct observation, dissection and vivisection in medical training and as a way to ground medical practice can be understood as considering both of those perspectives and constructing a more complex and nuanced middle ground that avoided problems with each position. ...

He describes his early life in "*On the affections of the mind*"... In 148, when he was 19, his father died, leaving him independently wealthy. He then followed the advice he found in Hippocrates' teaching and travelled and studied widely including Smyrna (now Izmir), Corinth, Crete, Cilicia (now Çukurova), Cyprus and finally the great medical school of Alexandria, exposing himself to the various schools of thought in medicine. In 157, aged 28, he returned to Pergamon as physician to the gladiators of the High Priest of Asia, one of the most influential and wealthiest men in Asia. Over the four years there he learnt the importance of diet, fitness, hygiene and preventive mea-

tures, as well as living anatomy, and the treatment of fractures and severe trauma, referring to their wounds as “windows into the body”. Only five deaths occurred while he held the post, compared to sixty in his predecessor’s time, generally ascribed to his attention to their wounds. At the same time he pursued studies in theoretical medicine and philosophy... Galen provides accounts of his later life in Rome, in *On Prognosis*, and *On his own Books*. Στάσις (stasis, or political unrest) in Pergamon was probably the reason for Galen to leave Pergamon in 161, travelling in the Eastern Mediterranean studying the properties of minerals. His travels took him to Lemnos, Cyprus, and Palestinian Syria, before reaching Rome in August 162, aged 37, in the second year of the reign of the joint Emperors Marcus Aurelius and Lucius Verus. As a Greek in Rome, he faced cultural challenges, stiff competition and professional jealousy... One of his more famous patients was the peripatetic philosopher Eudemus, a friend of his father, and his former tutor. He recounts curing Eudemus of Quartan Fever in 162 (*Praen* 2:5)...

Work: Galen’s works covered a wide range of topics, from anatomy, physiology, and medicine to logic and philosophy, both summarising what was known and adding his own observations. His writings pay homage to, amongst others, Plato, Aristotle and the Stoics, but above all to Hippocrates, whom he refers to as “divine” (θείοτατος Ἱπποκράτης *Nat Fac* III: 13). Thus much of his explanation of pathology relies on Hippocrates’ humoral theories...

He assembled all the medical knowledge of his time and this assembly of knowledge for centuries continued to be the authoritative account of science.

He proceeded by observation, deductive reasoning, and experimentation, such as his demonstration of the effect of

ligating the ureters (*Nat Fac* I: 13), and the functions of the spinal cord. His medical practice drew on the biological theory and anatomical observations from Aristotle to the Alexandrians in addition to his own research. His therapeutics led him to travel widely gathering elements and plants. However his reasoning led him astray as much as it did to truth, such as his rejection of the role of the stomach wall in digestion (*Nat Fac* III: 4) and his concepts of specific attraction...

Galen developed an interest in anatomy from his studies of Herophilus and Erasistratus, who had dissected the human body and even living bodies (vivisection). Although Galen studied the human body, dissection of human corpses was against Roman law, so instead he performed vivisections on pigs, apes, and other animals (e.g. *Nat Fac* III: 8), to study the function of the kidneys and the spinal cord. In this study of comparative anatomy, he frequently dissected the Barbary Macaque and other primates, assuming their anatomy was basically the same as that of humans. The legal limitations forced on him led to quite a number of mistaken ideas about the body. For instance, he thought a group of blood vessels near the back of the brain, the rete mirabile, was common in humans, although it actually is absent in humans...

Galen identified venous (dark red) and arterial (brighter and thinner) blood, each with distinct and separate functions. Venous blood was thought to originate in the liver and arterial blood in the heart; the blood flowed from those organs to all parts of the body where it was consumed.

Galen's practice was based on two basic principles, namely that disease is contrary to nature and that nature should be preserved (an obvious influence of the teachings of Hippocrates).

H

Hippocrates of Cos or Hippokrates of Kos (c 460 BC–c 370 BC)

Greek: **Ἱπποκράτης; Hippokratēs.**

Ancient Greek physician referred to as the father of Western medicine. In recognition of his lasting contributions to the field as the founder of the Hippocratic School of medicine. This school revolutionized medicine in ancient Greece, establishing it as a discipline distinct from other fields that it had traditionally been associated with (notably theurgy and philosophy), thus making medicine a profession.

Hippocrates is credited with greatly advancing the systematic study of clinical medicine, summing up the medical knowledge of previous schools, and prescribing practices for physicians through the Hippocratic Oath or Corpus.

Hippocrates was born in the island of Cos, c. 460 B.C. and died in Larissa, Thessaly c. 377 B.C. Little is known about his life. He lived in the Golden Age of Pericles during which science and art flourished in Greece. He was the contemporary of Socrates, Herodotus, Democritus and Sophocles.

As exemplified in the Oath, Hippocrates (or his school for that matter) combined religious faith with scientific thinking but at the same time when it came to Medicine, he professed rational medicine as opposed to religious medicine. He was the first who had the courage to state that epilepsy was as “sacred” as any other illness, attributing its aetiology to organic causes. Hippocrates expressed in Medicine the enlightenment that occurred during the Golden Age in Greece. He placed special emphasis on diet, medicinal waters, climate, fresh air and gymnastics. He believed in the healing power of nature and

advocated that the physician should reinforce this power and at least not prevent it (“do no harm”). This decidedly modern and rationalistic spirit prevailed in his writings. The number of his (or his school’s) texts range from 60 to 100.

The careful clinical descriptions of Hippocrates are notorious. Among them, the description of the facial expression during approaching death is best known.

Hippocratic theory: Hippocrates is credited with being the first physician to reject superstitions, legends and beliefs that credited supernatural or divine forces with causing illness. Hippocrates was credited by the disciples of Pythagoras of allying philosophy and medicine. He separated the discipline of medicine from religion, believing and arguing that disease was not a punishment inflicted by the gods but rather the product of environmental factors, diet, and living habits. Indeed there is not a single mention of a mystical illness in the entirety of the Hippocratic Corpus...

Humorism and crisis: The Hippocratic school held that all illness was the result of an imbalance in the body of the four humours - fluids which in health were naturally equal in proportion. When the four humours, blood, black bile, yellow bile and phlegm, were not in balance (*dyscrasia*, meaning “bad mixture”), a person would become sick and remain that way until the balance was somehow restored. Hippocratic therapy was directed towards restoring this balance...

Another important concept in Hippocratic medicine was that of a *crisis*, a point in the progression of disease at which either the illness would begin to triumph and the patient would succumb to death, or the opposite would occur and natural processes would make the patient recover... The therapeutic approach was based on “the healing power of nature”...

Hippocratic medicine was notable for its strict professionalism, discipline and rigorous practice. The Hippocratic work *On the Physician* recommends that physicians always be well-kempt, honest, calm, understanding, and serious. ...

The Hippocratic School gave importance to the clinical doctrines of observation and documentation. These doctrines dictate that physicians record their findings and their medicinal methods in a very clear and objective manner, so that these records may be passed down and employed by other physicians...

Hippocrates began to categorize illnesses as acute, chronic, endemic and epidemic, and use terms such as, “exacerbation, relapse, resolution, crisis, paroxysm, peak, and convalescence. Another of Hippocrates’ major contributions may be found in his descriptions of the symptomatology, physical findings, surgical treatment and prognosis of thoracic empyema, i.e. suppuration of the lining of the chest cavity...

The Hippocratic school of medicine described well the ailments of the human rectum and the treatment thereof, despite the school’s poor theory of medicine. Hemorrhoids, for instance, though believed to be caused by an excess of bile and phlegm, were treated by Hippocratic physicians in relatively advanced ways. Cautery and excision are described in the Hippocratic Corpus, in addition to the preferred methods: ligating the hemorrhoids and drying them with a hot iron. Other treatments such as applying various salves are suggested as well...

The Hippocratic Corpus (Latin: Corpus Hippocraticum) is a collection of around seventy early medical works from ancient Greece, written in Ionic Greek. The question of whether Hippocrates himself was the author of the corpus has not been conclusively answered, but the volumes were probably produced by his students and followers. Because of the variety of subjects,

writing styles and apparent date of construction, scholars believe Hippocratic Corpus could not have been written by one person...

The Hippocratic Corpus contains textbooks, lectures, research, notes and philosophical essays on various subjects in medicine, in no particular order. These works were written for different audiences, both specialists and laymen

The *Hippocratic Oath*, a seminal document on the ethics of medical practice, was attributed to Hippocrates in antiquity although it may have been written after his death. This is probably the most famous document of the Hippocratic Corpus...

The influence of the Hippocratic thinking and the importance of the Hippocratic Oath in modern medical practice are still very strong and relevant.

N

Nemesius (c 390 AD)

He was a Christian philosopher and the author of a treatise *De Natura Hominis* ("On Human Nature"). He was the Bishop of Emesa (in Syria). Very little about his life is known. His book is an attempt to compile a system of anthropology from the standpoint of Christian philosophy.

Nemesius was also a physiological theorist. He based much of his writing on previous work of Aristotle and Galen, and it has been speculated that he anticipated William Harvey's discovery of the circulation of blood. Other views included a five-theory hierarchy of Divine Providence. These theories are developed from an earlier Platonic theory. His *Doctrine of Ventricle localization of Mental Functioning* is a reconciliation of Platonic doctrines on the soul with Christian philosophy and also emphasized Greek scientific interpretation and knowledge of the human body. This

doctrine was attributed to Gregory of Nyssa, and was not recognized as the work of Nemesius until the 7th century...

Nemesius is best known for his book "De Natura Hominis" ("On Human Nature"). Large sections of this book were incorporated in Saint John Damascene's *Defide Orthodoxia*.

In this book, Nemesius deals with the soul's immortality, free will, opposes fatalism and defends Divine Providence.

Nemesius' theory of *Devine Providence* is one that has been debated over the years. It was inspired by Plato. Nemesius considers providence as somewhat of a concern with particulars and those of universals. He states that it is the work of Divine Providence as the reason why everyone looks different from one another. He states that without divine providence nobody would be recognizable from the other...

Nemesius also contributed a Doctrine of Ventricle Localisation of Mental Functions. This doctrine, as a following of earlier platonic theory, identifies that all sensory perception were received in the anterior area of the brain (now known as the Lateral Ventricles). This area was later termed the *sensus communis* and is the region where all sensory perceptions were held in common. These were held by a force identified as the faculty of imagination. The middle or also known as the *Third Ventricle* was termed the region of the faculty of intellect. This is the area that was responsible for controlling the judging, approving, refuting, and assaying of the sensory perceptions which are gathered in the lateral ventricles. The third faculty was identified as memory, and the storehouse of all sensory perceptions after they had been judged by the faculty of intellect. Nemesius believed that the faculties operated through the agent of an animal spirit produced after it had been carried through a network of arteries. This network was referred as the *Rete Mirabile* and is located at the base of the brain.

Nemesius' doctrine of Ventricle Localisation of mental functions was greatly acknowledged but was later attacked by Brengarioda Carpi, and then by Vesalius and Varolio in 1543 and 1573.

P

Plato, Greek: Πλάτων, Plátōn, "broad" (427 BC–347 BC)

A classical Greek philosopher, mathematician, writer of philosophical dialogues, and founder of the Academy in Athens, the first institution of higher learning in the Western world. Along with his mentor, Socrates, and his student, Aristotle, Plato helped to lay the foundations of natural philosophy, science, and Western philosophy.

His name was given by Ariston, his athletics teacher, owing probably to his broad shoulders. He was born in Athens of aristocratic parents. His original name was Aristocles, the name of his grand father. His father came from the line of Codrus, last of the kings of Athens and his mother came from the line of Solon, famous Athenian archon. Plato originally distinguished himself as an athlete and allegedly was a victor in the Olympic Games. At a very young age, before the age of 20 he started writing dramatic and lyric verse. A critical point in his life was his meeting with Socrates in 407 B.C., whose interpreter and chief disciple he became. He traveled extensively to various places of the ancient world.

Plato's sophistication as a writer is evident in his Socratic dialogues; thirty-five dialogues and thirteen letters have been ascribed to him. Plato's writings have been published in several fashions; this has led to several conventions regarding the naming and referencing of Plato's texts...

Plato often discusses the father-son relationship and the “question” of whether a father’s interest in his sons has much to do with how well his sons turn out...

In several dialogues, Socrates floats the idea that Knowledge is a matter of recollection, and not of learning, observation, or study... In many middle period dialogues, such as the *Phaedo*, *Republic* and *Phaedrus* Plato advocates a belief in the immortality of the soul, and several dialogues end with long speeches imagining the afterlife. More than one dialogue contrasts knowledge and opinion, perception and reality, nature and custom, and body and soul...

...Socrates’ idea that reality is unavailable to those who use their senses is what puts him at odds with the common man, and with common sense. Socrates says that he who sees with his eyes is blind, and this idea is most famously captured in his allegory of the cave, and more explicitly in his description of the divided line. The allegory of the cave (begins *Republic* 7.514a) is a paradoxical analogy wherein Socrates argues that the invisible world is the most intelligible (“noeton”) and that the visible world (“(h)oraton”) is the least knowable, and the most obscure....

The allegory of the cave (often said by scholars to represent Plato’s own epistemology and metaphysics) is intimately connected to his political ideology (often said to also be Plato’s own), that only people who have climbed out of the cave and cast their eyes on a vision of goodness are fit to rule....

The word metaphysics derives from the fact that Aristotle’s musings about divine reality came after (“meta”) his lecture notes on his treatise on nature (“physics”). The term is in fact applied to Aristotle’s own teacher, and Plato’s “metaphysics” is understood as Socrates’ division of reality into the warring and irreconcilable domains of the material and the spiritual.

The theory has been of incalculable influence in the history of Western philosophy and religion...

The Theory of Forms typically refers to Plato's belief that the material world as it seems to us is not the real world, but only a shadow of the real world. Plato spoke of forms in formulating his solution to the problem of universals. The forms, according to Plato, are roughly speaking archetypes or abstract representations of the many types and properties (that is, of universals) of things we see all around us...

Many have interpreted Plato as stating that knowledge is justified true belief, an influential view which informed future developments in modern analytic epistemology. This interpretation is based on a reading of the *Theaetetus* wherein Plato argues that belief is to be distinguished from knowledge on account of justification...

Plato's philosophical views had many societal implications, especially on the idea of an ideal state or government. There is some discrepancy between his early and later views. Some of the most famous doctrines are contained in the *Republic* during his middle period, as well as in the *Laws* and the *Statesman*. However, because Plato wrote dialogues, it is assumed that Socrates is often speaking for Plato. This assumption may not be true in all cases...

According to Plato, a state which is made up of different kinds of souls, will overall decline from an aristocracy (rule by the best) to a timocracy (rule by the honorable), then to an oligarchy (rule by the few), then to a democracy (rule by the people), and finally to tyranny (rule by one person, rule by a tyrant)...

Works: No work of Plato known to antiquity has been lost. Most of his works are written in dialogue form, a form which grew out of the Socratic conversations.

Plato's Dialogues: The exact order in which Plato's dialogues were written is not known, nor is the extent to which some might have been later revised and rewritten.

Early dialogues: Apology, Charmides, Crito, Euthyphro, Ion, Laches, Lesser Hippias, Lysis, Menexenus, Protagoras (often considered as one of the last of these "earlier" dialogue).

The following are often considered "transitional" or "pre-middle" dialogues: Euthydemus, Gorgias, Meno

Middle dialogues: Cratylus, Parmenides, Phaedo, Phaedrus, Republic, Symposium, Theaetetus.

...The Symposium and the Republic are considered the centerpieces of Plato's middle period. The Parmenides and Theaetetus are often considered to come late in this period and transitional to the next, as they seem to treat the Theory of Forms critically (Parmenides) or not at all (Theaetetus).

Late dialogues: Critias, Laws, Philebus, Sophist, Statesman, Timaeus

...The late dialogues are also an important place to look for Plato's mature thought on most of the issues dealt with in the earlier dialogues. There is much work still to be done by scholars on the working out of what these views are...

S

Soranus, Greek: Σωρανός (98–138 AD)

A Greek physician from Ephesus, Asia Minor. He lived in the reign of emperors Trajan and Hadrien. He practiced in Alexandria and subsequently in Rome, and was one of the chief representatives of the Methodic school of medicine. Several of his writings still survive, most notably his four-vol-

ume treatise on gynaecology, and a Latin translation of his *On Acute and Chronic diseases*.

Little else is known about his life, except that he passed some time in Aquitania for the purpose of treating some skin diseases which were very prevalent there at the time.

Works: His treatise *Gynaecology* is extant (first printed in 1838, later by V. Rose, in 1882, with a 6th-century Latin translation by Muscio). Also extant are parts of treatises *On Signs of Fractures* and *On Bandages*. Of his most important work (*On Acute and Chronic Diseases*) only a few fragments in Greek remain, but there is a complete Latin translation by Caelius Aurelianus (5th century). The *Life of Hippocrates* probably formed one of the collection of medical biographies by Soranus and is valuable as practically the only source of information for the life of the great physician; The *Introduction to the Science of Medicine* is considered spurious.

Besides these works, Soranus was the author of several others, of which only the titles and some fragments have been preserved. Galen mentions two works on *Pharmacy*, from which he quotes some passages. Caelius Aurelianus quotes from several other works, and Soranus himself refers to many additional works which have not survived. Tertullian quotes a work *De Anima*, in four books, in which Soranus divided the soul into seven parts, and denied its immortality. He is quoted by Paulus Aegineta, as being one of the earliest Greek medical writers who had described the Guinea Worm; and he appears to have enjoyed a great reputation among the ancients, as Augustine calls him "Medicinae auctor nobilissimus," and Tertullian, "Methodicae Medicinae instructissimus auctor."

Biographical notes of contemporary authors

A

Anastasopoulos, Georgios (1906–1977)

Born in Kiato (ancient Sikyon) in the Peloponnese (southern Greece). He studied Neurology and Psychiatry at Berlin and in Paris. In Greece, he worked in the Psychiatric Department of Athens University (“Eginiteion” Hospital) during 1935–1939 and the renowned Department of Neurology of “Evangelismos” Hospital (1939–1945), serving as its Director from 1942 to 1945. He became Reader of the University of Athens in 1941 and returned to the “Eginition” hospital as a Reader of Psychiatry/Neurology (1946–1949). He was a member of the editorial board of the *Archeia Neurologias kai Psychiatrikis* (*Archives of Neurology and Psychiatry*), journal of the Hellenic Neurological and Psychiatric Association, since 1947. In 1950 he was elected Professor of Neurology and Psychiatry in “Aristotle University” of Thessaloniki and contributed greatly to the organisation of academic and clinical studies in Neurology and Psychiatry in Macedonia (northern Greece). He retired in 1971.

Anastasopoulos has published topics mainly on Neurology and presented numerous neurologic vignettes in sessions of the Hellenic Neurological and Psychiatric Association. His disciple Prof. G. Zervopoulos (see G. Zervopoulos) in his paper on “*Somatic hallucinations of self-scoping in individuals suffering from general paralysis of the insane, GPI*” (*Elliniki Iatriki* 1950, period B, year 19th, 10:923–929) mentions that “atypical” mental syndromes of individuals suffering from GPI were first studied by Professor G. Anastasopoulos, in his Reader’s dissertation. These atypical forms of GPI were

observed more frequently after fever treatment was introduced in the treatment of this disease. These psychotic manifestations of patients suffering from GPI are related to changes in the paralytic process, fever treatment acting as a releasing and aggravating factor. Nevertheless, exogenous factors can cause confusion and hallucinations without affecting the paralytic process, in its overall course.

He has also published: “The problem of changed body conditions as a result of pathological experience”. *Nervenarzt* 1954, 25:492–500 (in German).

“Participation of the exogenous factor in detection of pre-formed psychotic syndromes”. *Zh Nevropatol Psikhiatr Im S S Korsakova* 1960, 60:1634–1643 (in Russian)

“On the pathogenesis of exogenous psychoses”. *Arch Psychiatr Nervenkr Z Gesamte Neurol Psychiatr* 1961, 202:527–539

Apostolides, Petros [Pavlos Nirvanas] (1866–1937)

Born in Mariupol in Russia, he studied medicine at the Medical School of Athens University. Graduated in 1890, he enlisted as a Second Lieutenant (Medical) in the Navy, from which he retired as chief medical officer in 1922. He has been a well known Greek literary man, under the pseudonym of Pavlos Nirvanas. He was elected member of the Academy of Athens in 1928. Along with A. Tanagras (see A. Tanagras) they established, in 1923, the “*Etaireia Psychikon Erevnon*” (*Society for Psychic Research*) focusing on parapsychology. He has written an extensive essay on *Art and Psychopathology*, first published in *Nevrologiki kai Psychiatriki Epiteorisis* (Neurological and Psychiatric Review) in 1902 (see S.Vlavianos) and reprinted in the journal *Σύναψις* (Synopsis) in No 1: 2005, 80–85, No 2:

2005, 88–101 and No 3: 2006, 102–113 (in Greek). He also published an introduction to Nietzsche's philosophy in 1898.

Apostolides, Simon (1853–1919)

Born in Varna, Bulgaria, he graduated from the School of Medicine of Athens University, and specialised in Neurology and Psychiatry in Paris and Vienna. In 1883 he moved to Constantinople, where he became Director of the Mental Asylum, which was (and still is) a section of the Greek Hospital of Baloukli. Following a disagreement with the Board of Directors of this hospital, he moved in Athens, in 1885. He returned to his previous position in Constantinople in 1894, where he remained for the rest of his life. He contributed greatly to the renovation of the psychiatric section of this traditional hospital, founded in the 18th century. His book was the first extensive book on the central nervous system and mental diseases published in Greece, *Ai Psychoseis. Meletai Iatrikai, koinonikai kai philosophikai peri frenopatheion* (*Psychoses. Medical, Social and Philosophical Studies on Mental Diseases*) (1889) and it raised great interest but also controversial opinions.

Arkalides, Nikolaos M (1901–1972)

Born on the island of Tinos, he graduated from the Medical School of Athens University. His career as a psychiatrist commenced at the “Dromokaiteion” Psychiatric Hospital, in 1926, where he served as an assistant. At the end of the 1920s he was trained in Vienna, and Budapest, where he was a disciple of L. von Meduna. On his return to Greece he performed con-

vulsive treatments using cardiazol (Metrazol), as well as coma and sub-coma insulin therapy and later electroconvulsive therapy. He continued as Deputy Director of the Second Psychiatric Department of “Dromokaiteion”, from 1927 to 1947 and then he became its Director. He retired in 1951.

Besides numerous papers on convulsive therapies, he has also written on the admission of drug abusers in Greek psychiatric hospitals “*Oi toxikomaneis en Elladi*”, in the volume in honour of Prof. M. Katsaras, (ed: P.D. Sakellarios, Athens 1928) and published numerous clinical neurological and psychiatric vignettes.

Archigenis, Sarantis (1809–1874)

Born in Epivates (a Greek city in Eastern Thrace), he studied medicine in Paris and received postgraduate training at various Universities and Hospitals in European cities. He was Professor of Internal Medicine and Surgery at the Imperial Medical School of Constantinople. In 1841 he wrote in Greek and French the works *Hygeionomia* (*Public Health*) and *Stoicheia Iatrikis Pathologias* (*Elements of Medical Pathology*), which were published in Paris.

C

Constantinides, Constantinos D (1902–1981)

Born in Polydrosso of Parnassus (central Greece) he studied medicine in Berlin, where he obtained a specialisation in Neurology and Psychiatry, under the supervision of Prof. K.

Boenhoffer. In 1929 he was appointed at the Public Psychiatric Hospital of Athens, of which he became director in 1946. He became a Reader at the University of Athens Medical School in 1938 and was elected Professor Extraordinarius of Psychiatry and Neurology in 1948. He produced extensive published work, covering a broad range of topics, from the elaborations of C. Jung to psychosurgery. His works include: *Ai Psychoseis kai I Exelixis tis Psychis* (*Psychoses and the Development of the Psyche*), Athens 1935; *I psychologia tou Polemou* (*The Psychology of War*), Athens, 1946).

D

Diakoyiannis, Agapitos (1915–1999)

Born on the island of Symi in the Dodecanese, he received a degree in Medicine from the University of Athens in 1938. In 1941 he qualified as a neurologist – psychiatrist and in 1942 defended his M.D. thesis on “Hyperkinetic psychoses”. He worked as a resident at the “Eginiteion” Hospital up to 1945, and then served as Scientific Director of the Psychiatric Hospital of Thessaloniki from 1946 to 1951. In 1949 he became Director of the Neurology Department of the 403 Army Hospital. From 1951 to 1953 he attended postgraduate courses in Paris, London and Varese. From 1953 to 1957 he worked as Chief Assistant of the Neurological and Psychiatric Department of the Aristotle University of Thessaloniki, where he became a Reader in 1955. He became Director of the Neurological Department of the Municipal Hospital of Thessaloniki (1957–1966). He was elected full Professor in 1971 and held

the chair of Neurology and Psychiatry in the Aristotle University of Thessaloniki, until his retirement in 1983.

He has produced a textbook of Psychiatry and many publications, with the following two mentioned in this book:

Anastasopoulos G, Diakoyiannis A, Routsonis K. "Three cases of temporal lobe epilepsy with endocrinopathy". *J Neuropsychiatr* 1959, 1:65–76

Kaprinis G, Diakoyiannis A. "Factors influencing mental health in Greece". *Ann Med Psychol* (Paris) 1976, 2:81–84 (In French).

Drakoulidis, Nikolaos (1900–1988)

Born in Constantinople, he studied medicine in Athens, Paris and Vienna, as well as Aesthetics at the *École Supérieure des Beaux Arts in Paris*. He was Director of the Centre for venereal diseases at the "Andreas Syngros" Hospital of Athens and was a leader in the campaign to combat venereal disease. He was recognised as a physician with psychoanalytical inclinations, but was also a writer, better known under the pseudonym Angelos Doxas. He was a member of the *Société Française de Dermatologie et de Syphiligraphie*. In 1935 he took over the chairmanship of the Hellenic Society against Venereal Diseases. In 1950 he founded the *Hellenic Society of Psychobiology*.

His participation in the first psychoanalytic group in Greece, under the leadership of princess Marie Bonaparte was rather stormy. He had a particular interest for the psychoanalytical approach of A. Adler.

A prolific writer and columnist, he wrote poetry, short stories, novels and plays, but also medical essays and psychoanalytical contributions, including: *Inferiority Complex* (Athens, 1948), *Psychoanalytical interpretation of Art* (Athens 1948) and *Costis Palamas; A Psychological analysis of his work and life* (1959), in Greek language (ed: C. Palamas is a famous Greek poet). He also published in French: *Psychanalyse de l'artiste et de son oeuvre*; (ed: du Montblanc, Geneva, 1945, *Psychanalyse d'Aristophane*; ed: Universitaire, Paris; 1967).

E

Economakis, Miltiades (?–1922)

Neurologist and Psychiatrist (phrenologist) with extensive studies in Germany (1900–1903) with Erb, Leyden, Oppenheim (neurology) and Jolly, Mendel, Kraepelin (psychiatry). He was a Senior Registrar at the “Eginiteion” hospital (Psychiatric Department of Athens University) from the time it was founded in 1904 up to 1907, when he departed after a disagreement with Professor Katsaras. In 1906 he was elected Reader in Neurology and Psychiatry at the University of Athens. In 1907 he established the private clinic “Galenos” (Galen) along with Docent C. Tsiminakis (against whom he wrote a series of articles in 1915 for the importance the latter placed on the “pressure of the carotids” as a diagnostic criterion for epilepsy). Economakis is also considered to be the first to introduce in Greece E. Kraepelin’s views, with his monograph *Protogonos anoia, Ivi-phrenia, Katatonia, Paranoia (Dementia praecox, Hebephrenia, Catatonia, Paranoia)* (Athens 1907), which had previously been

published in 1906, in several fascicules of the journal *Archeia Iatrikis* (*Annals of Medicine*) (in Greek).

Economo, Constantin von (1877–1931)

His family originated from Macedonia (northern Greece). Born in Vraila (Romania), he studied, first, engineering at the Vienna Polytechnic School and he was involved in aeronautics. In 1895 he enrolled in the Medical School of the University of Vienna. He obtained his doctor's degree in 1901 and worked as an assistant physiologist up to 1903. In 1906 he started working as an assistant at the Neurological and Psychiatric Department of the University of Vienna and was elected Professor in 1920. He declined the offer of the chair of Neurology and Mental diseases of the University of Athens in 1910. He founded the *Institute of Brain Research*. He gained distinction in 1917 for his study on lethargic encephalitis as an independent disease. Along with George Koskinas, he wrote the monumental work *Die Cytoarchitektonik der Hirnrinde des erwachsenen Menschen* (*The cytoarchitectonics of the human cerebral cortex*). Atlas of cytoarchitectonics of the adult human cerebral cortex. 2nd edition; (ed: Karger, Basel, Vienna, 2008).

F

Filippopoulos, Georgios (1911–1984)

Born in Argos (Peloponnese), he was a military physician who served in the Middle East during the German Occupation. In 1946 he studied psychometric tests in Great Britain. In 1947 he joined the editorial board of the *Archeia Neurologias kai Psychiatrikis* (*Archives of Neurology and Psychiatry*).

He obtained his Doctor's degree from the University of Athens Medical School in 1948 (his dissertation was a study of the Sturge-Weber-Krabbe syndrome). In 1950 he went to the USA for postgraduate training in psychoanalysis and psychosomatics. He was Reader-Director of the Psychiatric Department of the University of Athens from 1969 to 1970.

He published first, with M. Papageorgiou, the first study on the use of psychometric tests in the selection of officers in the Greek army:

G. Filippopoulos, M. Papageorgiou. "Psychological tests in diagnosing mental disorders". [Presented to the Athens Neuropsychiatry Society – Meeting of the 28-2-50]. published in: *Archeia Nevrologias & Psychiatrikis (Neurology & Psychiatry Archives)*, 1950, 2:292–299.

Foustanos, Ioannis (1856–1933)

Born in Sparta (Peloponnese), he obtained his Doctor's degree from the University of Athens in 1881 and carried out postgraduate studies in Paris (1881–1883) with Landouzy and Charcot. Returning to Greece, he settled on the island of Syros, where he practiced internal medicine. From 1890–1906 he was Director of the Internal Medicine Clinic of the Municipal Hospital of Syros. In 1885, he published a book on *Hypnotismos and Zoikos Magnitismos (Hypnotism and vital magnetism)*, ed: Freri brothers, Syros 1895) where he mainly refers to Charcot's views. In 1896 on Syros, he founded the prestigious journal *Iatriki Proodos (Medical Progress, 1896–1948)*, which he later transferred to Athens, in collaboration with P. Rondopoulos. *Iatriki Proodos* has always included numerous papers on psychiatry and mental diseases. He also published the international Greek medical journal *La Grèce Médicale* (1899–1933).

H

Hatzidimos, Athanassios (1910–1967)

Born in Aidin (Asia Minor). After the war of 1922 and the ousting of Greek population from Asia Minor in Turkey, his family went to the Greek island of Lesbos. He studied medicine in Paris and specialised there in neurology and psychiatry. In 1940, he defended his Doctoral thesis on “Etudes cliniques de deux qualités du tonus musculaire, de l’expansibilité à la passivité” (Clinical studies on the two qualities of muscle tone, expansibility and passivity), under the supervision of G. Guislain. During World War II, he participated actively in the resistance against German occupation of Greece. He was one of the authors of the collective volume *Psychopathologia tis peinas tou fovou kai tou aghous* (Psychopathology of hunger, fear and anxiety) (1947). He published on neurology and electroconvulsive therapy. From 1950 to 1953 he was co-editor of the journal *Encephalos* (Brain), along with F. Skouras and M. Striggaris.

I

Imvriotis Yiannis (1898–1979)

Born in Kydonies (Aivali) in Asia Minor, he studied literature and philosophy at the University of Athens. He carried out postgraduate studies in France and Germany, where he also specialised in psychology. In 1937 he was elected professor of Systematic Philosophy at the University of Thessaloniki but was dismissed during the turbulent period of the Greek Civil War (1946–1949). He was particularly interested in Psychoanalysis and Memory (he wrote the book *Pathologic Memory*, in 1931)

and later in Pavlov's theory. In 1975 he was honoured as Professor Emeritus of Philosophy of the University of Thessaloniki.

K

Kallivoursis, Petros

He practiced internal medicine in Constantinople, later in Athens and again in Constantinople. In 1852, while still studying medicine, he translated from French a small booklet entitled *The magnetist methodologies of Mesmer and d' Eslon*. He prepared his doctoral thesis in France and defended it in 1859 at the *Institute Impérial de France, Académie des Sciences*, where he was nominated by Claude Bernard. His dissertation was published in 1861 in Greek with the title *Peiramatikai ereunai peri tis epirois tou thermogonou epi tas ekdioloseis tis ton organon systaltikotitos* (*Experimental research on the influence of heat on manifestations of the contractibility of organs*), Athens, 1861. In 1871 he became a member of the *Greek Literary Society of Constantinople*, which issued a journal with the same name, where he published (volume VI, 1871–1872, pp. 322–344) an expansive essay entitled *On the Brain, considered from a psychological point of view*. He then moved to Athens, where he published a short-lived journal entitled *Hippocrates* (in 1862 and from 1864 to 1865. He stated that it was not issued in 1863 due to Kallivoursis' participation in the events of the dethronement of King Otto). Beyond providing interesting medical material, the aim of the journal (which was never accomplished) was to publish Ancient Greek authors and to provide a French translation of

the work of contemporary Greek doctors. He is also referred to as Kallivoursos, Kallivourtsis, and Kallivourtsios.

Kaloutsis, Andreas (1910–1986)

Born in Athens, he graduated from the Military Medical School in 1932. During the German Occupation of Greece he worked at the NIMTS Military Hospital. He was an intern at the “Eginiteion” Hospital (Athens University Department of Neurology and Psychiatry) from 1940 to 1941 and became a Neurologist-Psychiatrist in 1945. The title of his Doctoral thesis (1947) was *Neurological and Psychiatric Disturbances of Pellagra*. He was demobilised in 1947. He was one of the authors of the collective volume *Psychopathologia tis peinas tou fovou kai tou aghous* (*Psychopathology of hunger, fear and anxiety*) (1947). That same year he commenced his studies at the hospital St. Anne in Paris, with P. Garcin and P. Guiraud. He continued his postgraduate studies in 1951–1952 at the University of Texas, Galveston. In 1953 he established the first medical-pedagogical facility in Greece, within the framework of the Athenaion educational association. Over the period 1954–1958 and under his direction, the sanatorium at “Daou Pendelis” was converted into a Psychiatric Hospital for Children. From 1958 to 1962 he directed the medico-pedagogical facility of the “Centre for Mental Health”, a non-profit organisation (now called: *Hellenic Centre for Mental Health and Research*). He also organised and directed the Child Psychiatry Clinic of the Public Psychiatric Hospital of Athens (1954–1972). Considered to be a major figure in the establishment of Child Psychiatry in Greece, he was the first to be certified in that field in October 1967. In

1975 he became director of the private hospital “Markomihelakeio Treatment Centre”.

He published: A. Kaloutsis. “The phenomenon of regression” *Iatriki Proodos* (Medical progress), year 51st, March 1950, 1–8 (in Greek). In this paper, he examined the views of H. Jackson on regression, warning the readers that “*in the past we had the opportunity to underscore that this Jacksonian line of thinking, risks not to be differentiated enough from a crude ‘mechanismus’, with a narrow-minded hierarchical conception of the construction of the nervous system, particularly of the sector of psychic functions*”. He presented, for the first time in Greece, the views of I. Pavlov on this issue, considering regression also as a de-conditioning. He concluded: “*Returning to regression, we will conclude by stating that this is not purely retrogression, this is not simply the reverse of evolution, but rather one of its main mechanisms*”.

Karambateas, Panagiotis (1904–?)

He was born in Messinia (Peloponnesus). A graduate of the Medical School of the University of Athens in 1929, he served at the Public Psychiatric Hospital of Athens from 1932 to 1945. He was certified as a neurologist and psychiatrist receiving his license in 1948. He ran a private practice and a private hospital in Kalamata. Later in his life, he moved to Athens.

Katsaras, Michael (1860–1939)

Born on the island of Symi in the Dodecanese. After graduating from the Medical School of Athens University, he received his doctorate degree in 1880 (his dissertation was on

echinococcus cysts in the liver). He studied the diseases of the nervous system in Paris, as a resident in “Salpêtrière” Hospital, under the supervision of J.M. Charcot. In 1896 he was elected member of the “Société Médico-Psychologique” in Paris. In 1893 he began teaching at the Medical School of the University of Athens, lecturing in Neurology and Psychiatry as a reader in Internal Medicine. In parallel he worked as deputy director of the “Dromokaiteion” psychiatric hospital. In 1897 he was the first Professor elected to the chair of Neurology and Mental Disorders. He was the first Director of the Psychiatric Department of Athens University. In 1904, he contributed decisively towards the founding of “Eginitaion” hospital, built and equipped in order to house the psychiatric department of Athens University. He was the author of a three-volume textbook entitled: *Pathologia ton Nevron kai Psychiatriki* (*Pathology of the Nerves and Psychiatry*, published in 1898 and 1900. This book had a considerable impact and for many years dominated the relevant field of academic knowledge in Greece. In the preface of the second edition of his textbook (ed: A. Vitsikounakis, Athens 1923) he wrote: “*Over the past six decades, no other field of Medicine has seen the plough of progress bring to light as many unexplored areas, cultivate as much fallow land and dig such hidden treasures of knowledge as in the field of Nerve Pathology and Psychiatry...*”

The requisite anatomical, histological and histopathological knowledge of the cerebral cortex precedes Psychiatry and it is impossible to understand mental diseases, without this knowledge. The anatomical clinical basis, which is the cornerstone of our teaching of Psychiatry, provides a real originality and a broader scientific understanding, supporting the idea that Psychiatry is a part of Brain Medicine and of Internal Medi-

cine... The new neuron theory offers a fresh understanding of physiology and pathology, the neuron representing the nervous system in miniature, Consequently anatomy, physiology and morbidity of the neuron represents the texture, physiology and pathology of the nervous system in miniature... We note that all neurons have a similar texture. Differences in size, shape, length of axons do not change their fundamental composition, which is similar in all neurons, whether motor, sensory, connective, psychic, etc.

The synapses of a neuron to its neighbouring neurons form a chain of neurons, which make up physiological systems, thus creating the motor system composed of two neurons superimposed, the peripheral motor and the distal motor neuron; the sensory system, which comprises the peripheral sensory and one or more central sensory neurons; the connective system, which comprises neurons that connect two major physiological lines, i.e. sensory and motor in various parts of the spinal cord and the brain; and the psychic system or the chains of neurons in the cerebral cortex related to psychic (ed: mental) life..."

He published extensively on the paralysis of sea divers. The most important of these papers is the "Clinical and experimental research on conditions arising from eliminating air pressure", published in Archives de Neurologie, in French.

He retired in 1930.

Kokkoris, Panayiotis (1912–2006)

Born in Valtetsi of Arkadia (Peloponnese), he graduated from the Military Medical School of Athens in 1934. From 1938 to 1940 he carried out postgraduate studies at the hos-

pitals of Salpêtrière and Ste Anne, in Paris. Since 1942 he worked at the Psychiatric Department of Athens University ("Eginitieion" Hospital), then directed by Professor Pamboukis, in parallel with his military duties. He left the Army in 1950. He was a member of the Directing Board of the *Hellenic Neurological and Psychiatric Association* (1947–1951). He received his Doctor's degree from the University of Athens in 1950 (his dissertation was on Wallenberg's Syndrome). From 1951 to 1957 he was Director of the Second department of "Dromokaiteion" Hospital. From 1954 to 1956 he worked at the University of Madison, Wisconsin. He was one of the first to publish articles on chlorpromazine. He was elected Reader at the University of Athens in 1957 (his dissertation was on Prefrontal Lobotomy). From 1956 to 1975 he was Director of Clinic IV of the Public Psychiatric Hospital of Athens.

Kopanaris, Phocion (1883–1975)

Born in Constantinople (Istanbul), chemist and medical doctor, he carried out post graduate studies in Germany (in pharmacology and hygiene). He made major contributions to the organisation of Public Health in Greece as an officer of the Ministry of Health and Social Welfare, which was established in 1923. Initially he had the rank of Director of Public Hygiene (1924–1932) and later of Director General (1939–1949). He played a decisive role in the organisation of the Public Psychiatric Hospitals in Greece, especially of the Public Psychiatric Hospital of Athens, as well as in the organisation of other hospitals in Athens (especially the paediatric hospital "Aglaia Kyriakou") and in other Greek cities.

Koskinas, George (1876–1975)

Born in Geraki, in Laconia (Southern Greece), he completed his internship in Neurology and Psychiatry at the “Eginition” hospital. He received his doctor’s degree from the Medical School of the University of Athens, in 1911. From 1916 to 1927 he collaborated with Constantin von Economo at the Medical School of the University of Vienna, and contributed to the preparation of the monumental work *Die Cytoarchitektonik der Hirnrinde des erwachsenen Menschen* (*The cytoarchitectonics of the human cerebral cortex*, 1925). Atlas of cytoarchitectonics of the adult human cerebral cortex. 2nd edition: Ed. Karger, Basel, Vienna, 2008.

He also collaborated with the Austrian professor of neuropathology Ernst Straussler (1872–1959) in the histopathology of dementia paralytica (general paralysis of the insane). He returned to Greece in 1927. In 1934 he was a candidate Professor of Neurology and Psychiatry at the University of Athens, but was not elected, against the opinion of the nominating committee. Koskinas henceforward limited himself to private practice of neuropsychiatry in Athens and established a private psychiatric hospital in Kifissia, near Athens).

Kouretas, Dimitrios (1901–1984)

Born in Tripoli (Arcadia, in southern Greece), he commenced his studies in Athens and continued at the Military Medical School of Lyon, where he received his doctorate (his dissertation was in the sphere of cardiology). During his training time in Paris (military hospital of Val de Grace and Salpêtrière) he familiarized himself with the ideas of eminent

French professors of that time. In 1935 he became Director of the Psychiatric Department of the 401 Military Hospital. In 1937 he was elected Reader at the University of Athens Medical School (the topic of his dissertation: Emotions: Psychophysiology-Pathology). In 1942 he left the Army and was elected Professor of Neurology and Psychiatry at the newly-established chair of Psychiatry of the Medical School at the University of Thessaloniki. He was re-elected in 1945, after the war, but resigned in 1947. From 1946 he participated in the first psychoanalytical group in Greece, alongside G. Zavitsianos and Andreas Embeirikos, led by princess M. Bonaparte. He was a member of the French Psychoanalytic Society. He was elected Professor of Psychiatry at the University of Athens and served there from 1964 to 1968. He was the first to introduce psychoanalytic theory and praxis in Athens University. He published extensively on neurology, psychiatry and psychoanalysis:

- “Psychoanalysis, the psychology of the unconscious”. *Helliniki Iatriki* (Hellenic Medicine), March 1928 (in Greek)
- “Psychological and neurovegetative complications of dengue fever”. *Ελληνική Ιατρική* (Hellenic Medicine), 1, 1929 (in Greek)
- *Psychoses in literature (Ancient Hellenic Drama)*. Athens 1930 (in Greek)
- “Neurasthenia in the light of Adler’s theory”. *Ατομική Ψυχολογία* (Individual Psychology Journal), 1 and 4, 1933 (in Greek)
- “Foundations and prospects of contemporary psychiatry”. *Ιατρική Πρόοδος* (Medical Progress), Dec. 1934 (in Greek)
- “Emotions as a starting point of the ancient Hellenic concept for the site of psyche in viscera”. *Ελληνική Ιατρική* (Hellenic Medicine), 1, 1935 (in Greek)

- (with Ph. Skouras) “Le syndrome de l’ automatisme mental schizophrénique”. *Encéphale*, Juillet-Aout 1936 (in French)
- “Simulating nervous and mental illness at war times”. *Ιατρική Πρόοδος* (Medical Progress), January, 1941 (in Greek)
- “Le complexe d’ Io dans les "Suppliantes" et le "Prométhée Enchaîné" d’ Eschyle”. *Revue Française de Psychanalyse*, 3, 1949 (in French)
- “Le complexe de Candaule”. In *Dictionnaire de Psychanalyse et Psychotechnique*, ed: Psyché, Paris, 1949
- “Sur un cas de névrose à base d’ envie de pénis”. *Revue Française de Psychanalyse*, 4, 1950 (in French)
- “Le cas mythologique de l’ impuissance psychogène d’ Iphiclos et le traitement cathartique appliqué par Melampus”. *Bulletin de l’ Association Psychanalytique de Belgique*, Mars, 1956 (in French)
- “Psychoanalytical aspects of criminality in Greece”. *Ποινικά Χρονικά* (Penal Annals), June, July, 1956 (in Greek)
- “La névrose sexuelle des Danaïdes”. *Revue Française de Psychanalyse*, pp. 597–602, Juillet - Août 1957 (in French)
- “Some remarks on psychogenic impotence”. *Ελληνική Ιατρική* (Hellenic Medicine), June, 1959 (in Greek)
- “Nietzscheism and Freudism (Along with Freud to Nietzsche)”. *Ελληνική Ιατρική* (Hellenic Medicine), March, 1961 (in Greek)
- “Aspects modernes des cures psychothérapiques pratiquées dans les Sanctuaires de la Grèce antique”. *Revue Française de Psychanalyse*, Tome XXVI, pp.299–309, Mars–Juin 1962 (in French).

L

Lekatsas, Panayis (1911–1970)

Born on the island of Ithaca, he studied law at the University of Athens. An anthropologist and classical philologist, he wrote on the institutions and society of Ancient Greece, the history of religions, while providing commentaries and translations for works of Ancient Greek literature. In 1933 he published a book on the history of philosophy. His strong political views were an obstacle to an academic carrier and for the same reason a large proportion of his works was published after his death. He has contributed extensively with articles on ancient Greek philosophy and medicine in all major Greek encyclopedias. He has published only in Greek.

A fragment of his important work on the Psyche is presented in this volume: *I idea tis psychis kai tis athanassias tis kai ta ethima tou thanatou* (Soul/Psyche: The idea of the soul and its immortality and the customs of death) (1957).

He has also produced the following books, among others:

- *Η πολιτεία του Ηλίου* (The City of the Sun). *The communitarian revolution of slaves and proletarians in Asia Major, 133–128 B.C.* ed: Nea Vivlia, Athens, 1946
- *Η καταγωγή των θεσμών, των εθίμων και των δοξασιών. Κεφάλαια της κοινωνικής ιστορίας των Ελλήνων και άλλων λαών* (The origin of institutions, of habits and beliefs. Chapters of Social History of the Greeks and other people). Athens, 1951 (in Greek)
- *Πόλεμοι των δούλων στην ελληνική και ρωμαϊκή αρχαιότητα* (Wars of slaves in Greek and Roman Antiquity). ed: Ekdotiko Institutouto Athinon, Athens, 1957

- *Έρως* (Eros). First edition, Difros, Athens, 1963. 2nd edition. ed: Kastanioti, Athens, 2003
- *Διόνυσος, καταγωγή και εξέλιξη της θρησκείας* (Dionysus, origins and evolution of religion). 1st edition. 1971. 2nd edition. ed: Kastanioti, Athens, 1999

Lyketsos, Georgios (1916–)

Born in Egypt, he received a degree from the University of Athens Medical School in 1939 and obtained his doctorate from the same University in 1947. He was one of the first to introduce electro-convulsive therapy to Greece, building the relevant device (Lyketsos-Athanassoulas). He also promoted psychosurgery in selected psychotic patients. From 1947 to 1985 he was director of the third department of “Dromokaiteion” psychiatric hospital. From 1950 to 1952 he carried out postgraduate studies at the Universities of London and Illinois. In 1957 he was elected Reader at the University of Athens. In 1947 he became a member of the editorial board of the *Archeia Neurologias kai Psychiatrikis* (*Archives of Neurology and Psychiatry*). In the early 1950s he was one of the first to introduce occupational therapy and socialising activities in “Dromokaiteion” mental hospital, where he implemented open-door policy for the majority of his patients. He has written extensively on electro-convulsive therapy, occupational therapy and reform of traditional psychiatric hospitals, towards a more humanistic function. He is still actively involved in Psychiatry, being an active member of the Hellenic Psychiatric Association and he is chair of the Panhellenic Society of Mental Hygiene, affiliated with the WPA.

M

Makris, Elias

Not much is known about him. He signed his publications as “a physician from Paris” (1901) and “doctor – neuroalienist” (1915).

Manthos, Constantinos T

He obtained his doctor’s degree from the University of Athens Medical School (1907) and served as Senior Lecturer at the Psychiatric Department of Athens University (“Eginiteion” hospital) from 1914 to 1918. He was a member of the *Société de Psychothérapie in Paris*. From 1920 to 1923, as an army reserve doctor, he was director of the Psychiatric Department of the First Military Hospital of Thessaloniki. In 1935 he published an extended scientific article, presented in this volume, in the review *Helliniki Iatriki (Hellenic Medicine)* on “epidemic (lethargic) encephalitis”.

Mavrogenis, Spyridon (1816–1902)

Descended from a renowned Greek family from Constantinople (Istanbul). He was Director of the Top Hané Hospital, head doctor to Sultan Abdulhamid II and a professor at the Ottoman Imperial Medical School. In 1861 he was one of the founders of the renowned *Greek Literary Society of Constantinople* and editor of the journal of the same name, in which numerous, pioneering, medical treatises were also published.

Mavroukakis, Antonios

He signed his publications as Neurologist-Psychiatrist and described himself as an internationally renowned hypnotist. For three years he served as “Maitre Assistant” at Berillon’s private clinic for “nervous and mental disorders”. A member of the Athens *Iatriki Etaireia* (*Medical Society*) and the Paris *Société d’Hypnologie et Psychologie*. He took part in the *Hypnology and Psychology Conference* of 1894, in Milan.

Mitaftsis, Constantinos A (1893–1965)

Neurologist-Psychiatrist, the young brother of T. Mitaftsis. In 1932 he became a member of the *German Neurological and Psychiatric Society*. In 1940 he was appointed Director of the “Psychiatric Annex [of Prisons] and the Judicial Psychiatric Hospital”, which initially operated in a room of the “A. Syngros” prison and later in the “Averoff” prison of Athens. Later, this unit was transferred to the Psychiatric Hospital of Athens. He wrote a textbook entitled *Psychiatriki* (*Psychiatry*), published in Athens in 1932. We mention his paper: Konstantin Achill Mitaftsis. “Über die luciden Intervalle in psychiatrischer und justischer Hinsicht” (1937). Reprinted in *Intern. Journal of Legal Medicine* 2005, 27(Suppl 2):125–131

Mitaftsis, Telemachos A

He was one of the first physicians at the “Dromokaiteion” Psychiatric Hospital. A Reader in Nervous and Mental diseases at the University of Athens, he was a member of the *Société Médico-Psychologique* of Paris, where he was nominated by Legras, Magnan and Ritti, in 1889. He translated into Greek

(from the French edition) the book by German Psychiatrist H. Schule: *Kliniki pragmateia peri ton Frenikon noson*. (*Handbook of mental disorders*) (“Third German edition. Translated from the French with many extensive additions from up-to-date French journals”), Athens 1894. It is noteworthy that the French Edition was translated by Dagonet and Duhamel from the original edition (1888) and the supplements were from the *Manuel pratique de médecine mentale* (1892) by Regis and the *Leçons sur les maladies mentales* (1890) by Ball. We incorporate in the present volume a significant fragment of his book on the “Degenerates” (1899).

Michael, Constantinos (1751–1826)

Born in Castoria (northern Greece), he was a medical doctor and intellectual distinguished in the era of “Greek enlightenment”. His *Diaetitiki* (*Dietetics*) (1794) refers to the works of the most renowned doctors of his time, including Sanctorius, Zimmermann, Haller, Tissot, Boerhaave, Hoffman. He translated and published the: *Manual of the wisest of Doctors, M. Tissot. A treatise in French, translated into the most common of current Greek dialects, with some notes by C. Michael...*, Vienna, 1775.

N

Nikolaidis, Rigas (1856–1928)

Born in the village Portaria on Mount Pelion (central Greece), he commenced his medical studies in 1872 at the University of Athens, where he obtained his doctorate in 1876. He studied for 5 years in Berlin and Leipzig, with E. Du Bois

Reymond and K.F. Ludwig, before being elected Reader in Physiology at Athens University, in 1883. He was appointed Professor Extraordinarius of Anatomy in 1892 and full Professor the next year. He returned to Physiology in 1899, as a full Professor. Following his retirement in 1926, he became one of the founding members of the Academy of Athens.

P

Pamboukis, Georgios (1885–1959)

Born in Kiato, Peloponnese, he studied Medicine at Athens University and obtained his doctorate at the end of 1904. His studies in neurology and psychiatry with professor M. Katsaras, carried out in parallel with a long military service (1906–1908) were frequently interrupted, as were the courses he took in internal medicine at the “Evangelismos” hospital, in Athens. In 1911, he travelled to Europe for postgraduate studies interrupted by the Balkan Wars (1912–1913) and interrupted again, in 1915 by World War I. He was, at times, a student of Ziehen, E. Bleuler, von Monakov, Bohhoeffler and Minkowski. He became Director of the Neurology Department of the “Astikliniki” (City Hospital) of the University of Athens and Professor of Neurology and Psychiatry at the University of Athens, from 1934 to 1955. After World War II he participated actively in the activities of the *Hellenic Neurologic and Psychiatric Association*. He was the chair of the editorial board of the journal of the above mentioned Association, *Archeia Neurologias kai Psychiatrikis* (*Archives of Neurology and Psychiatry*). He published particularly on insulin and cardiazol coma treatment and various neurological topics.

Papageorgiou, Michael (1909–1988)

Born in Evia (Greece), he graduated from the Military Medical School of Athens, in 1932. From the beginning he was interested in Neurology and Psychiatry, but was licensed in his specialty after World War II. His doctoral thesis (defended in 1947) was on: “A contribution to the study of delusions in amputees, the so-called *phantom limb*”. That same year he became member of the editorial board of the journal *Archeia Neurologias kai Psychiatrikis* (*Archives of Neurology and Psychiatry*). From 1949 to 1951 he carried out postgraduate studies at the Letterman Army Hospital in San Francisco, where he specialised in electroencephalography. From 1951 to 1956 he was director of the Neuro-Psychiatric department of the 401 General Military Hospital. He carried out also postgraduate studies in Neurology in 1958 and 1960–1961 at the National Hospital, Queen Square, in the U.K. Upon leaving the military service and up to 1974 he was director of the VII Psychiatric Clinical Unit of the State Psychiatric Hospital of Athens. From 1975–1982 he was director of the private psychiatric hospital *Markomichelakeio Therapeutirio*.

He published first, with G. Filippopoulos, a study on the use of psychometric tests in the selection of officers in the Greek army:

G. Filippopoulos-M. Papageorgiou. “Psychological tests in diagnosing mental disorders”. [Presented to the Athens Neuropsychiatry Society – Meeting dated 28-2-50]. Published in: *Archeia Nevrologias & Psychiatrikis* (*Neurology & Psychiatry Archives* 1950, 2:292–299)

Papadimitriou, Georgios (1912–1985)

Born in Skoura of Laconia (Peloponnese), he initially studied medicine at the Military Medical School of Athens, received his degree in Medicine in 1939 and was certified in psychiatry in 1943. He worked at the “Dromokaiteion” Psychiatric Hospital starting in 1943 as Senior Registrar; becoming Deputy Director from 1950 to 1953 and from 1954 to 1958 Director of one of the departments of this hospital. He studied geriatrics under A. Aslan, a famous geriatrician of that time, in Romania. He obtained his Doctorate from the University of Paris (Prof. H. Baruk) in 1955. He was one of the co-authors of the collective volume *Psychopathologia tis peinas, tou fovou kai tou aghous* (*Psychopathology of hunger, fear and anxiety*) (1947).

He also authored *Talento kai Techni* (*Talent and Art*) (1961) and the textbook in 3 volumes, *Synchroni Psychiatriki* (*Modern Psychiatry*) (1975).

Papastratigakis, Constantinos (1891–1929)

He studied medicine at Athens University and at the Military Medical School of Lyon, where he also defended his doctoral thesis in 1916, shortly before returning to Greece. In 1929 he was elected Reader at the University of Athens. That same year he was killed in Athens in a traffic accident. He served for many years as a director of military Neurological Clinics in Athens and Thessaloniki. He published on Neurology, on hysteria and on mental illnesses occurring in the army.

Patrikios, Ioannis (1895–1977)

Born in Assos on the island of Kephallonia, he studied Medicine in Paris. He was internationally renowned for his work in Neurology. He had a close collaboration with P. Marie which commenced in 1918. He carried out his doctoral dissertation on *Sclérose latérale amyotrophique* (Amyotrophic Lateral Sclerosis) in 1917 in Paris, and his work became the reference work on this subject. He served as director of the Neurology Department at “Evangelismos” Hospital from 1929 to 1942 and from 1945 to 1957 until his election to the chair of Neurology and Psychiatry at the University of Athens, where he served from 1957 to 1962.

Patrikios produced a significant body of clinical and written work, mainly in the field of Neurology. His doctorate - *Contribution à l'étude des formes cliniques et de l'anatomie pathologique de la sclérose latérale amyotrophique*, Imprimerie de la faculté de Médecine, Paris, 1918- has been a book of reference on this issue.

He also published: J.S. Patrikios. *L'évolution de la syphilis du système nerveux et de ses enveloppes*. Editions Médicales, Paris, 1930.

His views on the function of the nervous system are stated concisely in his inaugural professorial speech in April 1957, on *I nevríki leitourgia dia mesou tis exelixeos* (*Nerve function through evolution*). He stated, that the stereotypical, automatic, instinctive operation of the CNS evolutionarily precedes the more flexible and differentiated activity expressed at the higher “psychic” level of man, where the intellect is expressed basically using as an organ the neocortex, due to inherited directions, but also due to each individual's experiences. The elevation of the individual intellect in humans has led to what

we now call personality, due to the extensive growth of memory. It is on this that representations and speech are based, speech functioning as a tool for the intellect. The “struggle” between instinctive traits –that surface from the dark past and are located in the subconscious– and rational thought is the “struggle” that psychopathology deals with and constitutes the squalor but also the grandeur of the human being. *Nosokomei-aka Chronica* (*Hospital Chronicle* 1957, 4:1–14).

Pezopoulos, Nikolaos (1859–1911)

Born in Athens, he studied Medicine at Athens University. According to an entry he made in the newspaper *Chronos* (1885), he studied the “disorders of nerves and mental disorders” in Paris for four years, with V. Magnan. In 1891 he was appointed Senior Lecturer of Internal Medicine at the University of Athens and in 1895 he was elected Professor of Pathological Anatomy.

Polyzoides, Anastasios (1802–1873)

Born in Meleniko in Macedonia (Greece), he was a politician and a high-ranking member of the judiciary. From 1818 to 1821 he studied at the universities of Vienna, Goettingen and Berlin, combining studies in medicine and theoretical disciplines. In 1818 he published his translations on animal magnetism (mesmerism) in the periodical edition of the Modern Greek Enlightenment *Ermis o Logios* (*the Scholar Hermes*). He abandoned medicine and returned to Greece as secretary to the high ranking political leader A. Mavrocordatos. He had a long and eminent career in the judicial body.

R

Rassidakis, Nikolaos (1918–1982)

Born in Herakleion, Crete, he graduated from the University of Athens Medical School in 1942. He worked as a resident at the Neurology Department of “Evangelismos” hospital (1947–1948) and subsequently at the Psychiatry Department of the “Dromokaiteion” Psychiatric Hospital, initially as a Registrar and later on as Senior Registrar. He received postgraduate training in Neurology and Psychiatry in London on a British Council fellowship between 1950 and 1951. He attended the First International Congress of Psychiatry that took place in Paris in 1950, where he presented his paper on “sub-coma insulin therapy”, which also became his doctoral thesis (1952). In 1953 he became Director of the Fourth Psychiatry Clinic of the Public Mental Hospital of Athens, where he organised the occupational therapy department and promoted the concept of the “therapeutic community”. He retired in 1980. His book *Stoicheia Psychiatrikis* (*Elements of Psychiatry*) was re-edited four times from 1967 to 1976.

S

Serouios, Georgios (1783–1849)

Born on the island of Kea in the Cyclades, he studied at the Patriarchal Academy in Constantinople. In 1812 he was hired as a tutor by the noble family of Alexandros Soutsos (with whom he travelled from Constantinople to Bucharest and Stephanopol

in Transylvania). He returned to Greece in 1827 and from 1833 he entered the educational system of the newly established Greek State. From 1836 up to his death he was head of the Gymnasium (Grammar School) in Ermoupolis of Syros, where he taught Psychology on his own initiative, having also published a *Psychologia Stoiheiodis (Elementary Psychology)* in 1841.

Skouras, Fotis (1903–1953)

Born in Tripoli (Peloponnese), he began his medical studies at Athens university and continued, since 1925 at the Military Medical School of Lyon. In 1929 he defended his doctoral thesis entitled: “*Essai médico-psychologique sur Ch. Baudelaire*” (Medico-psychological essay on Ch. Baudelaire). He was Director of neuro-psychiatric units of various Military Hospitals. He played a significant role in organising the Hellenic Neurological and Psychiatric Association in 1936. He was elected Reader at the University of Athens in 1942, where he defended his thesis on “Anxiety and war psychoses”. He was one of the authors of the collective volume *Psychopathologia tis peinas tou fovou kai tou aghous (Psychopathology of hunger, fear and anxiety)* (1947). From 1950 to 1953 he was co-editor of the journal *Encephalos (Brain)*, along with M. Striggaris and A. Hatzidimos. He wrote extensively on clinical psychiatry and psychosomatics.

Striggaris, Michael (1903–1996)

Born in Athens, he studied medicine at the Universities of Jena, Basle and Munich, where he obtained his Doctor's degree in 1928. From 1929 to 1933 he remained in Germany, receiving training in psychiatry and neurology. His work on “Hash-

ish" (1937) had a great impact and his observation on hashish use producing psychotic states, received particular attention. In 1942 he was elected Reader at the University of Athens. He was actively involved in issues of Forensic Psychiatry and was active in the establishment and development of the *Hellenic Neurological and Psychiatric Association*. From 1950 to 1953 he was co-editor of the journal *Encephalos (Brain)*, along with F. Skouras and A. Hatzidimos. He was Director of the Neurology Department of the "Aglaia Kyriakou" Children's Hospital (1955–1961) and later on he collaborated with the Psychiatry Department of Athens University in educational activities.

T

Tanagras (Evangelides) Angelos (1887–1964)

Born in Athens, he was both neurologist - psychiatrist and novelist, as was the case with Petros Apostolides (Pavlos Nirvanas) and additionally both men served in the Royal Navy. He retired as a vice admiral of the medical services. In 1923, along with P. Nirvanas he established the *Etaireia Psychikon Ereunon (Society for Psychic Research)*, which represented Greece in the Third International Conference on Psychophysiology (Paris, 1927) and he organised in Athens the next conference, in 1930. He directed the journal *Psychikai Ereunai (Psychic Investigations)*, investigating the so-called psychic phenomena (parapsychology). Initially the readership of the *Society for Psychic Research* in the Athenian scientific and academic community was very large.

In his paper on hypnotism "What is hypnotism?" *Psychikai Ereunai (Mental Research)* 2, 1, 13–15, 1926, he wrote:

“Hypnotism seems to be the result of the temporary paralysis of certain parts of the brain, perhaps those parts that develop earlier (Schidler) and is characterised by a lethargic state, between awareness and sleep, by anaesthesia, lack of will and a particular propensity to suggestion... Everyone can not be hypnotised. It has been calculated that only 20% can be hypnotised and these to a different extent. Those who are hypnotisable cannot be hypnotised against their will, at least the first time, except under special circumstances, mainly through suggestion. Moreover, susceptibility bears no relation whatsoever to character, as it is a known fact that idiots cannot be hypnotised, whilst persons with a very strong character are sometimes the most susceptible. However, in contrast to the prevailing opinion, hypnotism bears, mostly, no relationship to the hypnotist, but only to the susceptibility of the person. Therefore, anybody can hypnotise a susceptible individual... Professor Sir Oliver Lodge, the eminent English physicist, correctly refers to hypnotism as a “window” through which man can observe the mystery of the unknown.

Tastsoglou, Isaac (1880–1959)

Founder and director of a Private Psychiatric Hospital in Smyrna (Asia Minor), he settled in Greece after the Asia Minor disaster. He served as Director of the Public Psychiatric Hospital of Agia Eleousa (1924), which was a forerunner of the Public Psychiatric Hospital of Athens. He remained at the Public Psychiatric Hospital of Athens until his retirement in 1947.

Tsirigotis, Christos (1841–1919)

Born in Corfu, he studied Medicine in Pisa, in Italy. He was Director of the Psychiatric Hospital of Corfu (1884–1887)

and published four medical statistical reports concerning the hospital under his direction. He went on to become the first director of the “Dromokaiteion” Psychiatric Hospital (1887–1902) in Athens.

Triantafyllides, Manolis (1883–1959)

Born in Athens, he became known as one of the leading advocates for the use of the demotic form of the Greek language in education. He was a Professor of Linguistics at the newly formed (in 1926) University of Thessaloniki. He had an active interest in the Freudian theory and was the first in Greece to publish a paper on psychoanalysis, included in this volume, entitled *I arhi tis glossas kai I froydiani psychologia* (*The principle of language and Freudian psychology*) (1915).

Triantafyllos, Dionyssios (1872–1945)

Born in Amaliada (Peloponnese), he studied medicine at the University of Athens, where he obtained his Doctorate in 1897. He received postgraduate training in Paris, with professors Raymond, Dejerine, Pierre Marie, Babinski, and Garnier. He was elected Reader in “Neurology and Mental Disorders” in 1905 and worked as a doctor at the Athens City Hospital (1907–1912) and as Chief Assistant at the University Department of “Eginiteion” Hospital (1918–1925) under Professor M. Katsaras. He was once more elected Reader in Neurology and Psychiatry in 1927, served as Director of the Public Psychiatric Hospital of Athens-Agia Eleousa (1925–1927). He was one of the physicians who introduced the ideas of H. Jackson to Greece.

Tsiminakis, Constantinos (1875–1942)

Born in Kozani (Macedonia, Greece), he obtained his Doctor's degree from the Medical School of Athens University in 1897. He served as a reserve officer in the war of 1897. From 1898 to 1903 he studied in Vienna with Nothnagel, Krafft-Ebing and Wagner von Jauregg and was elected Reader in Neurology and Psychiatry at the University of Athens in 1905. For many years he served as Senior Lecturer at the "Eginition" Hospital.

Tsoukantas, Georgios (1904–?)

Born in Athens, he was a medical doctor and an intellectual. He settled in Argolis for health reasons, suffering from tuberculosis (1927 to 1943), and practiced medicine there. He published a medical review (*Ηραία*) *Heraea* (1937-1941) in Argos, where he wrote extensively on the issue of psychoanalysis and its Ancient Greek roots.

V**Vardakoulas, Euthymios (1848–1923)**

Born in Nafpaktos (central Greece), he graduated from the University of Athens Medical School and continued his studies in Vienna and Paris. He settled in Nafpaktos, where he offered his services and even medication free of charge to indigent patients. He became well known in the Nafpaktos region, as the "poor-man's doctor". He wrote two scientific works, *Phobopatheia* (*Phobiopathy*) and *Paidiatriki* (*Paediatrics*).

Vlavianos, Simonides (1873–1946)

Born on the Greek island Amorgos, he studied Medicine at the University of Athens and received his medical degree in 1894. He carried out postgraduate studies in Neurology and Psychiatry in Paris from 1898 to 1900 and worked with professors Dejerine and Raymond (at Salpêtrière hospital) and Jauffroy (at St. Anne hospital). He became a Reader at the University of Athens in 1909 and founded the *Neurologiki kai Psychiatriki Epitheorisi* (*Neurological and Psychiatric Review*) (1902–1911) and the first Neurological/Psychiatric private hospital (in 1904). He was elected member of the Société Médico-Psychologique of Paris in 1912 and was the Director, in Greece of the *Iatriki Ephimerida* (*Medical Journal*) (1928–1940).

Y

Yianniris, Michael (1865–1956)

Born at Pyrgi on the island of Chios, he studied medicine at the Medical School of Athens University and received postgraduate training in France. He was Deputy Director of the Dromokaiteion Psychiatric Hospital from its beginning (1887) and then from 1903 to 1942 he served as its Director. He was elected member of the Société Médico-Psychologique of Paris, nominated by Magnan, Meuriot and Ritti, in 1900. He was a founding member of the *Hellenic Neurological and Psychiatric Association*, established in 1936. His main contribution concerned the organisation of services for mental patients in Greece.

Z

Zervopoulos, Georgios (1910–1992)

Born in Corfu, he graduated in 1934 from the Medical Military School. From 1941 to 1944 he worked with D. Kouretas, G. Pamboukis and F. Skouras. He became a member of the *Hellenic Neurological and Psychiatric Association* in 1943. In 1945 he became director of the Neuropsychiatric Department of the 424 Military Hospital in Thessaloniki. He received his Doctorate from the University of Thessaloniki in 1946 with a dissertation on Steinert's Disease – myotonic dystrophy. In 1952 he left the Army. Since 1945, he held the post of Chief Assistant at the Neurological and Psychiatric Department of the Aristotle University of Thessaloniki. He was elected Reader at the same University in 1956 (his dissertation was on the Weil-Reys-Adie syndrome, 1955). In 1957 he became director of the First Neuropsychiatric Clinic of the Thessaloniki Psychiatric Hospital, and retired in 1972. His publications concerned mainly neurological topics.

