A Conceptual History in the Nineteenth Century

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The history of geriatric psychiatry can be written from two viewpoints. The ‘externalist’ approach focuses on the social and political variables that have controlled attitudes towards abnormal behaviour in old age, and on the professionalization of those charged with the care of the mentally infirm elderly. The ‘internalist’ approach – to be followed in this chapter – concentrates on the origin of the scientific language of psychogeriatrics. An adequate historical account should include information on theories of ageing, both physical and mental, brain sclerosis and the formation of a viable concept of mental illness. On the first rubric much research has been done\(^{1–9}\); far less work exists on the other two. On psychogeriatric care before the nineteenth century\(^{10,11}\) there is very little: this may simply reflect a historical reality.

VIEWS ON AGEING BEFORE THE NINETEENTH CENTURY

Like most other aspects of human life, ageing has also been portrayed in terms of metaphors. Classical views, following the nature–nurture controversy, conceived of ageing as resulting from either internal instructions or from the buffeting of foreign factors\(^{13}\).

The ‘wear and tear’ view happened to be popular during the early nineteenth century, the period on which this chapter will concentrate. It was based, as it had always been, on the ageless observation that all natural objects, whether animate or not, are subject to the ravages of time. Surprisingly enough, the ‘wear and tear’ view has not always generated an understanding attitude. In fact, across times and cultures great ambiguity has existed in regard to the treatment of old folk. Fortunately, a realistic acceptance seems to have predominated although there is plenty of evidence of hostility. The Hebrew tradition, and indeed its Christian offshoot, encouraged much reverence towards the wisdom and value of old age. But even in societies that have made great play of this view, veneration has been reserved for those in positions of power\(^1\). Historical evidence seems to show that these situations were neither more nor less perturbing than mental illness occurring at other periods of life. Indeed, fail-safe devices seem to have been available in these societies to cope with the upheavals created by such occurrences.

Men like Buffon, Darwin and Goethe reshaped ideas on ageing during the eighteenth century. Buffon\(^14\) wrote: ‘All changes and dies in Nature. As soon as it reaches its point of perfection it begins to decay. At first this is subtle and it takes years for one to realise that major changes have in fact taken place’ (p. 106). Buffon put this down to an ‘ossification’ process similar to that affecting trees: ‘this cause of death is common to animals and vegetables. Oaks die as their core becomes so hard that they can no longer feed. They trap humidity, and this eventually makes them rot away’ (p. 111).

Erasmus Darwin’s views resulted from the application of yet another metaphor, namely that ageing results from a breakdown of ‘communication’ between man and his environment\(^15\). Darwin suggested that such breakdown followed a loss of irritability (a property of nerve fibres) and a decreased response to sensation:

> It seems our bodies by long habit cease to obey the stimulus of the aliment, which support us ... three causes may conspire to render our nerves less excitable: 1. If a stimulus be greater than natural, it produces too great an exertion of the stimulated organ, and in consequence exhausts the spirit of animation; and the moving organ ceases to act, even though the stimulus is continued. 2. If excitations weaker than natural be applied, so as not to excite the organ into action, they may be gradually increased, without exciting the organ into action, which will thus acquire a habit of disobedience to the stimulus. 3. When irritative motions continue to be produced in consequence of stimulus, but are not succeeded by sensation. (p. 365)
VIEWS ON AGEING DURING THE NINETEENTH CENTURY

In 1807 Sir John Sinclair published a major compendium on ageing and longevity, which included references to most pre-nineteenth century sources. It was, in a way, the last grand glance to the past. Soon afterwards work started by those who, like Léon Rostan (1791–1866), based their claims on empirical findings. Rostan, one of the most original members of the Paris school, published in 1819 his *Recherches sur le Ramollissement du Cerveau*, where the view commenced that vascular disorders might be as important as parenchymal ones in brain ageing. Even more important was his uncompromising anti-vitalistic position enshrined in the claim that all diseases were related to pathological changes in specific organs.

During the 1850s Reveillè-Parise saw his task as writing on ‘the history of ageing, that is, mapping the imprint of time on the human body, whether on its organs or on its spiritual essence’ (p. v). In regard to ageing itself he wrote: ‘the cause of ageing is a gradual increase in the work of decomposition … but how does it happen? What are the laws that control the degradation that affects the organization and mind of man?’ (p. 13). Reveillè-Parise dismissed the toxic view defended by the Italian writer Michel Lévy according to which there was a gradual accumulation of calcium phosphates that led to petrification, to an ‘anticipation of the grave’. This view, he stated, had no empirical foundation and was based on a generalization from localized findings. Reveillè-Parise supported the view that ageing results from a negative balance between composition and elimination, which equally affected the cardiovascular, respiratory and reproductive organs.

Finally, the views should be mentioned of J.M. Charcot, who in 1868 offered a series of 24 lectures on the diseases affecting the elderly. Charcot dedicated Lecture 1 to the ‘general characters of senile pathology’; he started by saying that all books on geriatrics up to his time had ‘a particularly literary or philosophical turn [and had been] more or less ingenious paraphrases of the famous treatise De Senectute’ (p. 25). He praised Rostan for his views on asthma and brain softening in the elderly, and predictably also mentioned Cruveilhier, Hourman and Dechambre, Durand-Fardel and Prus. He criticized Canstatt and other German physicians because in their work, ‘imagination holds an immense place at the expense of impartial and positive observation’ (p. 26). Charcot’s own contribution was based on the general principle that ‘changes of texture impressed on the organism by old age sometimes become so marked, that the physiological and pathological states seem to merge into one another by insensible transitions, and cannot be clearly distinguished’ (p. 27).

THE DEVELOPMENT OF THE NOTION OF BRAIN SCLEROSIS

When in 1833 Lobstein described the basic pathology of arteriosclerosis, he did not imagine that it would, during the second half of the century, become the mechanism of ‘senility’ par excellence. Motor and sensory deficits, vertigo, delusions, hallucinations and volitional, cognitive and affective disorder were all attributed to the effect of arteriosclerosis. They related to the brain via a two-stage speculative pathophysiology: parenchymal and/or vascular disorders could affect the brain, and the distribution of the lesions could be diffused or focal. Vascular changes included acute ischaemia (on which clinical observation was adequate) and chronic ischaemia, invented as a separate syndrome by extrapolating from the symptoms and signs observed during the acute states. The role of arteriosclerosis as a causal and prognostic factor in relation to the involutorial psychoses was challenged early in the twentieth century but this paper remained unnoticed. Hence, some of the old notions, such as that of ‘arteriosclerotic dementia’, remained active well into the 1960s.

Alienists during the same period, however, were already able to distinguish between states where a putative chronic and diffuse reduction in blood supply had taken place from focalized damage, i.e. what they called ‘multifocal arteriosclerotic dementia’ and was equivalent to what is currently called multi-infarct dementia.

NINETEENTH CENTURY VIEWS ON MENTAL DECAY IN THE ELDERLY

It is against this background that the history of the language and concepts dedicated to understanding mental disorders in the elderly must be understood. In addition to these neurobiological frameworks, a psychological theory that explained the manner of the decline was required. Such a psychopathology was provided by the heuristic combination of associationism, faculty psychology, and statistics that characterized the early and middle parts of the nineteenth century.

Yet another perspective, originating in clinical observation, was added during the 1830s. It led to the realization that, in addition to the well-known forms of mental disorder, the elderly might exhibit specific forms of deterioration, and that these could be related to recognizable brain changes. There is only space in this chapter to deal with two examples: one typifying a ‘specific’ disorder of old age, namely the history of chronic cognitive failure or dementia; the other illustrating the effect of a general mental disorder (melancholia) on the elderly.

THE FORMATION OF THE CONCEPT OF SENILE DEMENTIA

The history of the word and concept of dementia before the nineteenth century has been touched upon elsewhere. Suffice it to say here that, at the beginning of the nineteenth century, ‘dementia’ had a ‘legal’ and a ‘medical’ meaning and referred to most acquired states of intellectual dysfunction that resulted in serious psychosocial incompetence. Neither age of acquisition nor reversibility was part of its definition. These two dimensions were only incorporated during the nineteenth century and completely changed the semantic territory of the dementia concept.

Anecdotal observation of cases of senile dementia abound both in the fictional literature and in historical documents, but the concept of ‘senile dementia’, as it is currently understood, only took shape during the latter part of the nineteenth century. Indeed, it could not have been otherwise, as the neurobiological and clinical language that made it possible only became available during this period. But even after the nosological status of senile dementia had become clearer, there were many who, like Rauzier, felt able to state: ‘it may appear either as a primary state or follow most of the mental disorders affecting the elderly’ (p. 615). Following Rogues de Fursac, Adrien Pic – the author of one of the most influential geriatric manuals during this period – defined senile dementia as: ‘a state of intellectual decline, whether or not accompanied by delusions, that results from brain lesions associated with ageing’ (pp. 364–365). It was against this background that the concept of Alzheimer’s disease,
which became the prototype for all senile dementias, was created during the first decade of the twentieth century\(^3^7\). Recent work has shown that its ‘discovery’ was controlled by ideological forces well beyond what could be described as ‘scientific’\(^3^7,4^2\). These forces also introduced unwarranted clinical strictures, such as the exclusion of non-cognitive symptoms\(^3^3,4^4\) and false age boundaries, which took many years to disappear.

THE FORMATION OF THE CONCEPT OF INVOLUTATIONAL MELANCHOLIA

The concept of ‘senile or involutational psychoses’, which featured so prominently in Kraepelin’s early classification, included presenile delusional insanity, senile dementia, late catatonia and involutational melancholia\(^4^5,4^6\). The reasons that led Kraepelin to separate this group were mostly theoretical, to wit, that they appeared during a period of life when ‘sclerotic’ changes were beginning to occur; the same factor accounted for their bad prognosis\(^4^6\).

The general history of melancholia and depression has been analysed elsewhere\(^4^7–4^9\). Suffice it to say here that by the 1860s depression was considered to be an independent syndrome resulting from a primary disorder of affect. This meant that hallucinations, delusions and cognitive impairment were secondary to the pathological feelings. This conviction was particularly strong towards the end of the century, when emotional mechanisms became popular in the explanation of most forms of mental disorder\(^5^0\). By the end of the century the metaphor of depression as a form of ‘reduction’ or ‘loss’ had become firmly established. No better example can be found than the fact that up to 1893 (fourth edition) Kraepelin felt obliged to classify all forms of agitated depression as manic!\(^5^1\)

KRAEPELIN AND INVOLUTATIONAL MELANCHOLIA

Much of the current confusion on the meaning of involutational melancholia can be explained if attention is given to the circumstances of its historical development (for a full analysis of this process and list of references, see Berrios\(^5^2\)). The conventional story\(^5^3–5^6\) is that up to the seventh edition of his textbook Kraepelin considered involutational melancholia as a separate disease, and that when confronted by the evidence collected by Dreyfus\(^5^7\), he decided to include it, in the eighth edition, under the general heading of manic depressive insanity. Indeed, this account was first offered by Kraepelin himself (see Dreyfus, p. 169).

The story is, however, more complex and it is unlikely that the findings of Dreyfus alone caused Kraepelin’s change of heart. For example, Thalbitzer\(^5^8\) claimed that his own work had also been influential (p. 41). In the eighth edition Kraepelin abandoned not only involutational melancholia but the entire group of ‘senile psychoses’. A recent statistical analysis of Dreyfus’s old series has also shown that his conclusion that the natural history of involutational melancholia was no different from that of depression affecting younger subjects was wrong\(^5^1\).

CONCLUSIONS

This short chapter, providing a historical vignette on the origin of the language of old age psychiatry, suggests that it was born during the nineteenth century from three conceptual sources: theories of ageing, neurobiological hypotheses concerning brain sclerosis, and the realization that specific forms of mental disorder might affect the elderly. Two clinical illustrations were provided, one pertaining to the origins of the concept of senile dementia, and the other to the notion of involutational melancholia.

REFERENCES