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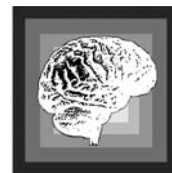
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Between Kraepelin and Freud: the integrative psychiatry of August Hoch

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Through examination of the career of the psychiatrist August Hoch (1868–1919), this essay challenges two assumptions implicit in histories of US progressive-era psychiatry: that the emergence of Freudian psychoanalysis signalled a devaluation of Kraepelin’s contributions and that theoretical and therapeutic eclecticism inhibited psychiatric research. Locating Hoch’s guiding principles within the context of Kraepelin’s clinical psychiatry, I analyse how Hoch mediated the demands of classification and the dynamic understanding of persons in prosecuting a new kind of clinical research that would not have been possible within either the Kraepelinian or Freudian perspective alone.

Keywords: *August Hoch; dynamic psychiatry; Emil Kraepelin; psychoanalysis; Sigmund Freud; USA*

Two new and seemingly disparate developments made their medical debut in the mid-1890s: Sigmund Freud’s nascent psychoanalytic theory and technique, brought together in Breuer and Freud’s ‘Studies on Hysteria’ (1893–95), and Emil Kraepelin’s new system for classifying mental disorders, introduced in the fifth edition of his *Psychiatrie* (1896). Both these developments slowly gained ground in US medicine, receiving professional recognition by the end of World War I.¹ Histories of US psychiatry, however, have focused almost exclusively on the reception of psychoanalysis by the so-called avant-garde, a group of physicians whose dynamic orientation to medicine and facility with the German language positioned them to follow this new development.² In this narrative, Kraepelin’s nosology, with its emphasis on the individual’s life history, paved the way for both the avant-garde’s reception of psychoanalysis and the development of dynamic psychiatry (Burnham, 1967: 66; Grob, 1983: 114;

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Leys, 1990a: 43–4). Largely overlooked in this narrative is the fate of Kraepelin's nosology among the avant-garde and its intellectual heirs.³ To be sure, it is well known that Kraepelin's two major categories of endogenous psychoses were codified in the dynamically-oriented first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (Blashfield, 1984: 271–2). Yet acceptance of certain diagnostic categories may not entail acceptance of a medicalized system of classification, with its attendant scientific canons, as the later struggle between dynamic psychiatrists and neo-Kraepelinians over the construction of *DSM-III* and *DSM-III-R* attests (Horwitz, 2002: ch. 3; Shorter, 1997: 300–5; Skodol, 2000: 441–4). As a counterpoint to the recent history of intellectual polarization within US psychiatry, I intend to show how the work of one avant-garde psychiatrist, August Hoch, effected an integration of Kraepelin's system with psychoanalysis.

Born in Basel, Switzerland, in 1868, Hoch came to the USA in 1887 to study medicine at the University of Pennsylvania, where he fell under the influence of William Osler. After receiving his medical degree from the University of Maryland in 1890, Hoch accepted a position as clinical assistant at Maryland's premier research university, Johns Hopkins (Kolb and Roizin, 1993: 39). In 1893 Hoch was hired as pathologist and first physician at the now-Harvard-affiliated McLean Hospital whose superintendent, Edward Cowles, had established laboratories for scientific research in emulation of the German clinics (Cowles, 1903: 212–13). Dispatched to Germany for further training, Hoch studied neuroanatomy with Gustav Schwalbe and pathological anatomy with Friedrich von Recklinghausen at Strassburg; experimental psychology with Wilhelm Wundt at Leipzig; and clinical psychiatry and experimental psychopathology with Kraepelin at Heidelberg (Kolb and Roizin, 1993: 39–40). After a second period of study with Kraepelin and the neuropathologist Franz Nissl in 1897, Hoch assumed greater responsibility for the clinical work at McLean (Sutton, 1986: 155–7).

Dynamic psychology gradually began to dominate Hoch's thinking about mental disorder, especially after 1905 when he became first assistant physician and special clinician at Bloomingdale Hospital in New York (Meyer, 1919: 519). While at Bloomingdale, Hoch developed a guide for the taking of anamneses in connection with his own clinical studies of pathological personality types (Hoch and Amsden, 1913).⁴ From 1910 until his retirement in 1917, Hoch advanced psychoanalytically-oriented teaching and research in his capacities as professor of psychiatry at Cornell and director of the Psychiatric Institute of the New York State Hospitals. Under Hoch's directorship, psychoanalysis became the subject of courses at the Psychiatric Institute as well as a valuable tool in psychiatric research and diagnosis.⁵ That Hoch drew inspiration from Freud in his teaching and research did not, however, signal his devaluation of Kraepelin's contributions. For throughout his career, Hoch drew on Kraepelin's clinical method in his efforts better to understand the two great groups of endogenous psychoses that Kraepelin had identified.

Insofar as psychoanalysis did not entirely displace Kraepelinian psychiatry in Hoch's clinical research, that research would seem to be of a piece with the 'eclecticism' of progressive-era psychiatry. According to John Burnham (1979: 129), eclectic psychiatrists used 'parts and pieces of psychoanalysis torn out of context'. Because this practice amalgamated psychoanalysis and somaticism, historians of progressive-era psychiatry have emphasized the inconsistency of outlook that resulted from eclecticism (Burnham, 1967: 42, 184–90; Grob, 1983: 110–12; Hale, 1971: 72–3, 222–3, 435–46). Possibly for this reason, they have paid scant attention to eclecticism's generative value.⁶ It is evident from examination of Hoch's career, however, that eclecticism enabled and even facilitated innovative psychiatric research. As I hope to show, Hoch's simultaneous utilization of Kraepelinian and Freudian perspectives gave rise to clinical researches that would not have been possible within either perspective alone. For Kraepelin's clinical method enabled Hoch to characterize types of pathological personality, just as, conversely, psychoanalysis was key to his refinement of Kraepelin's classification.

Hoch's research career may be divided into three phases. I first examine his appropriation and application of Kraepelin's precepts in the light of my discussion of Kraepelinian psychiatry. I then examine Hoch's reception of dynamic psychology and his use of Kraepelin's clinical method to challenge prevailing views about both the organic aetiology of dementia praecox and the irrelevance of delusional content to specification of clinical pictures. Finally, on the basis of my case study, I assess the ways in which Hoch's clinical research mediated Kraepelinian and Freudian perspectives, on one hand, and the challenge his legacy poses to histories of US psychiatry underpinned by the Kuhnian model of scientific revolutions, on the other.

Kraepelin's clinical psychiatry and its influence on Hoch

During the 1880s and early 1890s, US psychiatrists became aware of the increasing gap between their own specialty and general medicine. The stellar successes of bacteriology during the 1880s, which held out the promise of treatment for infectious disease, had greatly raised the scientific status of general medicine. At the same time, psychiatry remained at a standstill. Classifications were rife and lacking in empirical support; the relations between brain lesions and mental symptoms remained obscure; and therapeutics contracted to custodial care in overcrowded state asylums (Grob, 1983: ch. 3). But the advances of general medicine were turned to psychiatry's advantage in the revolutionary fifth edition of Kraepelin's *Psychiatrie* (1896), which, in exploiting a powerful analogy between physical and mental disease, held out the hope of a scientific advance in psychiatry comparable to the one that had occurred in general medicine (Burnham, 1967: 66; Grob, 1983: 112, 114).

The mental disorder that provided the template for Kraepelin's nosology was one with an infectious aetiology: paresis. By the mid-1890s, it was widely

believed that the necessary condition for the occurrence of paresis, which alarmingly seemed to be on the increase, was acquired or inherited syphilis (Meyer, 1897: 439–41). Kraepelin reasoned that, like paresis, other mental disorders were physical diseases, each having a specific cause and definite anatomical and symptomatological manifestations on the basis of which disease entities could be identified and a natural system of classification mounted (Hoff, 1994: 61–5; 1995: 269).⁷ In practice, however, little was known about essential causes and anatomical changes (Hoch, 1900: 285–6). Indeed, Hoch's (1898a) own experimental patho-anatomical research indicated that certain cortical changes frequently observed at post-mortem were artefacts.⁸ In educing nosological criteria, therefore, Kraepelin was led to eschew reliance on patho-anatomical evidence (Engstrom, 2003: 125–7) and instead to develop a clinical method that Adolf Meyer (1904a: 396–7; 1904b: 347) approvingly likened to experimentation.

Whereas previously a cross-sectional approach to symptomatology had prevailed in clinical psychiatry, Kraepelin, following Kahlbaum and Hecker, took a longitudinal approach (Berrios, 1996: 302; Engstrom, 2003: 128–9, 140–1; Jackson, 1986: 188; Lanczik, 1992). Observation of cases from intake to discharge (and even through post-discharge follow-up) enabled Kraepelin to track not only symptoms – which could manifest great variety – but also their recurrence or non-recurrence (the course) and their benign or destructive character (the outcome). Attention to course and outcome, in turn, enabled Kraepelin to identify which of the manifold symptoms in a given clinical picture were essential.⁹ For however heterogeneous the symptoms of cases within a clinical grouping, the essential symptoms could be precipitated from the accidental symptoms, as in an experiment, by application of Kraepelin's 'great principle' that the symptom-picture of a mental disorder is correlated with course and outcome (Hoch, 1913b: 323). Kraepelin's principle thus rendered traditional nosological criteria based on symptoms more accurate even as it recognized new criteria based on course and outcome. Central as Kraepelin's principle was to the clinical method, the clinical method in conjunction with other approaches potentially could pay even greater nosological dividends. For to the extent that essential symptoms, course and outcome in turn were correlated with aetiology and patho-anatomical changes, the clinical picture of a mental disorder circumscribed not only a certain combination of features but also a disease entity (Hoch, 1900). In the assessment of Meyer, Kraepelin's nosology, fully developed in the fifth edition of his *Psychiatrie* (1896), signalled that: 'The terms of a tradition of over 2000 years are overthrown. ... *Mental symptoms are dethroned unless they are characteristic of etiology, course and outcome*' (Meyer, 1904a: 393; original italics).

The advent of Kraepelin's nosology brought about a renaissance of diagnosis. Meyer (1902a: 93) recalls that as a young pathologist at Kankakee in the 1880s:

With regard to the examination of the mental condition, I found myself confronted with extreme indifference. The main trouble seemed to be the general idea that any agreement on this point could not be reached. ... Hence the unwillingness to collect the facts really needed for diagnostic decisions.

The classification that Kraepelin introduced in the fifth edition of his *Psychiatrie* was elegant in its simplicity, if not always easy to assimilate or employ in differential diagnosis (Meyer, 1904*b*: 350–1; Sutton, 1986: 150–2). Kraepelin (1896: 425–71, 595–653) had divided what we now call the endogenous psychoses into two major groups according to whether the disorder was characterized by degeneration or recurrence.¹⁰ Diagnosis thus was heavily weighted toward prognosis. As a result, the individual case assumed greater significance than hitherto, having both social consequences for the patient (Sutton, 1986: 152) and scientific salience for the physician (Meyer, 1902*b*: 89). Hoch, who had introduced Kraepelin's system at McLean, encouraged the emphasis on prognosis in both diagnosis of the individual case and efforts to improve diagnosis generally. He led the weekly staff clinical conferences, during which patients' diagnoses – largely in terms of prognosis – were intensely debated (Sutton, 1986: 150–1). He also instituted a new system of record-keeping similar to Kraepelin's. Kraepelin had made use of a method whereby, for each case, information was recorded on an index card concerning course of symptoms, outcome, correct diagnoses and diagnostic errors (Weber and Engstrom, 1997: 379) with the aim of identifying features prognostic of each disorder (Berrios and Hauser, 1995: 283–4).¹¹ Under Hoch's direction, McLean's case records were completed through post-discharge follow-up, abstracted and, based on a revised diagnosis, catalogued in accordance with Kraepelin's system (Cowles, 1902: 72; 1904: 206; 1905: 206). McLean's own patient cohort thus was to furnish the material for refinement of textbook clinical pictures that would enable more accurate diagnosis.

Advancement of the practical aims of psychiatry, then, was dependent on clinical research aimed at sharpening clinical pictures. Kraepelin himself solicited suggestions for how to split the dementia praecox group into clinical subtypes (Berrios and Hauser, 1995: 285). Hoch's response was to recommend not specific groups but a refinement of Kraepelin's own strategy for grouping, namely, the observation of clinical pictures at a degree of magnification high enough to resolve their fundamental features.

Thus it would be found that it is not enough to say that a patient is depressed or exhilarated, shows motor excitement or motor retardation, that he has delusions or hears voices, or that he is incoherent in his talk, etc.; but that we can add finer traits and nicer discriminations which give a special cast to these symptoms. In doing this we have arrived at a more accurate description; our attention has been called to features which in succeeding cases we shall look for and which will become objects of our study. (Hoch, 1900: 292)

When cases provisionally grouped together were compared with respect to qualitative differences, first in their individual and co-occurring symptoms, and then in their course and outcome, clinical pictures superficially belonging together could be separated, enabling both more accurate classification and differential diagnosis (Hoch, 1900: 291–5). Hoch's emphasis on separating superficially uniform clinical pictures on the basis of qualitative differences in their essential features, together with his presentation of these features in individual cases, represented, in the view of Meyer (1904*b*: 352), 'Kraepelin at his best.'¹²

There is no question that, up to this point, Hoch had been a faithful follower of Kraepelin. Like Kraepelin, he had applied the method of clinical observation in psychiatry with the proximal aim of identifying fundamental features of clinical pictures and the more distal aim of identifying specific disease entities. But Hoch did not retain this bipartite goal for long. Already by 1902 he had begun to emphasize the heuristic value of the clinical criteria by which a disease entity was to be identified. Acknowledging manic-depressive insanity to be 'an excellent clinical group' on the basis of criteria related to course and episodic outcome, Hoch (1902*a*: 120–1) averred, 'Nevertheless we are not justified in speaking of even this as a disease entity, for obviously when we know so little about the etiology and the actual nature of a condition, it is well to be cautious.' The caution that prevented Hoch from accepting manic-depressive insanity as a disease entity, however, did not prevent his conceptualizing mental disorder in terms other than physical disease. As we shall see, Hoch did not abandon Kraepelin's project of identifying fundamental features of clinical pictures. Nor did he abandon Kraepelin's clinical principle of first correlating symptom-picture with course and outcome, and then correlating the essential features of these manifestations with whatever was known of aetiology. Indeed, application of Kraepelin's principle enabled Hoch to identify essential aetiological features – conceived not as physical but as psychogenic.¹³ For in Hoch's thinking, the paresis model of mental disorder had given way to a dynamic model largely indebted to Sigmund Freud's psychoanalysis.

Hoch's reception of dynamic psychology

Even before the Clark Conference in 1909, psychoanalysis had begun to turn heads in US medicine for reasons cultural and scientific. Looming over other developments and lending them its specific colouring was the pervasive optimism of progressive reformism (Burnham, 1960). By means of this movement, alternatives to moribund medical therapies and aetiologies could gain a hearing (Grob, 1983: 109–10, 121–2). Although historians have debated whether the somatic paradigm was in crisis,¹⁴ there is no doubt that the reception of Freud's work was abetted by alternatives to somaticism that created a ferment in psychiatric thinking. One such alternative was

the nosology of Kraepelin. A more radical alternative to somaticism was also germinating: an indigenous psychotherapy movement whose impact was marked even in the decade before the Clark Conference by the visits of Pierre Janet and by the translation of Paul Dubois' *Psychic Treatment of Mental Disorders* (Caplan, 1998: 114). Perceived as part of this new psychotherapy movement and yet as more scientific than its competitors, psychoanalysis initiated a shift in psychiatric practice, theory and research, as exemplified by Hoch's own reception of psychoanalysis.

Hoch was one of the first US physicians to report using psychoanalysis with psychotics, albeit in a watered-down form referred to in the literature as 'therapeutic talks'. Accepting Freud's (1905: 163) cautious invitation to submit psychotics to psychoanalysis, Hoch (1907*b*, 1908) reported on analyses of four cases of early-stage paranoia in 1907 and two cases of dementia praecox in 1908 at the annual meeting of the New York Psychiatric Society. The purpose of such therapeutic talks was twofold. First, the talks had didactic benefit in affording the patient both understanding of the psychogenesis of his symptoms and training in 'healthy mental habits' (Hoch, 1907*b*: 711). Second, because delusions – unlike dreams – were a direct pipeline to the unconscious, the study of psychotics confirmed psychoanalysis by circumventing the interpretative work that Freud had undertaken with normal persons and neurotics in making his discoveries (Hoch, cited in Burr, 1914: 323–4). Moreover, as the most incisive form of clinical observation, psychoanalysis promised to become co-extensive with diagnosis.

In each case ... a careful psycho-analysis is necessary, not only for the purpose of research, but for the diagnosis as well. By diagnosis we no longer mean merely that which can be expressed in a single word, but ... a thorough clearing up of the situation, that is, an understanding of the actual struggles and difficulties which the patient has, and which are hidden under the perplexing array of mental symptoms. (Hoch, quoted in Russell, 1945: 386)¹⁵

What enabled Hoch to seize on the potential value of psychoanalysis for therapy, research and diagnosis well ahead of his more conservative colleagues was his pragmatic view of science.

For Hoch, it was not the truth of psychoanalysis that was relevant but its utility – or, more precisely, its greater utility for therapeutic purposes than that of its competitor, the paresis model of mental disorder. By helping the physician to understand his patients as persons, the hypothesis of psychogenesis was 'bound to be fruitful, whether the ultimate formulations are quite correct, or not' (Hoch, 1915*c*: 295). Indeed, because the essential causes of mental disorder remained obscure, in Hoch's (1916: 383–4) estimation:

Much of the importance of any conception at this stage lies in the question of what we can *do* with it. Therefore, if some one comes and demonstrates

an organic basis which can be modified, this will be of the greatest value. In the meantime the emphasis which some of us lay on the mental side is not due to the fact that we exclude organic possibilities, but is because we know so little about these and because we feel that in the treatment this [mental side] is, for the present, the most important field. (original italics)

However, the limitations of the paresis model were apparent even before the patient was treated – in fact, from the moment he was admitted to the hospital or clinic.

Kraepelin himself noted an increase in the number of unclassifiable cases notwithstanding the inclusiveness of his diagnostic categories (Hoche, 1912: 338). This phenomenon posed a challenge to Kraepelin's nosology, because if mental disorders were diseases identifiable through clinical observation of their symptom-picture, course and outcome, in principle there should be no overlap between the clinical pictures of distinct disease groups.¹⁶ More concretely, transitions should not be observed between hysteria and dementia praecox, and between dementia praecox and manic-depressive insanity, for example (Hoch, cited in Frost, 1910: 239; Hoch, 1912b: 277). It was only late in his career that Kraepelin, perhaps in response to criticism,¹⁷ recognized such transitions as problematic and introduced into his nosology another level of explanation that accounted for transitions in terms of individual variation without challenging the existence of natural disease entities (Kraepelin, 1920; see also Hoff, 1994: 65–8; 1995: 269–71). But on the hypothesis of psychogenesis, such transitions were not only explicable, but also expectable. Freud (1900: 550–72) had demonstrated that the same mental mechanisms were at work in the dreams of normal people and in the formation of neurotic symptoms, thereby placing normality and mild mental disorder on a continuum. After his espousal of psychogenesis, Hoch (1907a: 164–7) defended Freud's hypothesis of continuity between the mechanisms at work in normal mental life and in neurosis, and its extension by Jung and Bleuler to encompass the psychoses. Indeed, Hoch's own clinical case studies supported the hypothesis of continuity both between the neuroses and the psychoses and within the psychoses, as the Freudian mechanism of compensation was found to be operative in hysteria, on one hand, and dementia praecox and paranoia, on the other (Hoch, 1911a: 270–1). To the extent that the clinical pictures of mental disorders with no proven organic aetiology had any sharpness or central tendency, however, they could not be regarded as indicative of diseases or even merely as combinations of mental mechanisms, as the same mechanism subserved different ideas or behaviours in different clinical pictures (Hoch, 1911a: 270–1).

Rather, within the framework of his dynamic psychology, Hoch regarded the clinical pictures of mental disorders having no clear-cut organic aetiology as habitual, maladaptive *reactions* that grow out of normal reactions to life

difficulties in persons predisposed by defective traits of personality (Hoch, 1909a: 371–6; 1912b: 277; 1913a: 226). It was Meyer, however, whom Hoch (1907a: 167–8; 1909a: 374; 1910: 465) credited with formulating the principles underlying the progression from defective traits to maladaptive habits to mental pathology. According to Meyer, who himself was influenced by Freud,¹⁸ traits that are harbingers of later trouble either arise during infancy due to impairment or premature development of function or are precipitated in puberty by ‘precocious abnormal sexual practices’ (Meyer, 1903: 327). The ‘scars’ and ‘residuals’ of the difficulties thus incurred both stunt the individual’s development and predispose him to instinctual conflicts that lead not to temporary but to habitual ‘ suppressions’ or substitutive reactions (Meyer, 1903: 325; 1906: 433–6; 1908: 599). When pronounced, these habitual attempts at adjustment are recognizable as clinical pictures or transitional forms (Meyer, 1906: 434; 1912: 440).

Concurring with Meyer that functional mental disorders were largely faulty habits of adjustment, Hoch hoped that retrospective study of personality traits in psychotic individuals would enable both understanding and prevention of mental disorder.

The question which here presents itself is this: Do the different types of mental disorder develop in different types of personality? ... As a part of the general problem of the causation of insanity, it is, of course, very important to ascertain why the profound reactions of mental disorders can be produced in certain individuals by mental causes which in others do not produce such an effect; in other words, to ascertain where the weak spots in the personality are. ... If ever we are to develop a sound mental hygiene based upon a scientific foundation ... there would seem to be no better field upon which to gather data than this study of personality in individuals who have broken down. (Hoch, quoted in Russell, 1945: 387)¹⁹

Hoch’s programme of study was predicated on the assumption that the manifestations of personality and of psychosis were correlated, that is, that certain tendencies, habits or forms of reaction ‘even in the so-called normal period might be recognized as dangerous and indicate the direction along which the breakdown may occur’ (Hoch, 1909a: 359). This assumption, implicit in Hoch’s conception of mental reactions, was in some sense a Kraepelinian one. Kraepelin (1895: 28) had presumed that symptoms at psychotic onset differed from those at psychotic outbreak in degree rather than in kind.²⁰ Unlike Hoch, however, Kraepelin did not make the further assumption that in severe psychoses symptomatological manifestations were continuous with abnormal traits of personality, although such ‘personal peculiarities’ laid the genetic foundation for the development of manic-depressive insanity (Kraepelin, 1915: 1974).²¹ Only in neurosis and in mild, stable psychotic states, which lacked a circumscribed outbreak and a definite course and outcome, did psychosis grow out of personal peculiarities (Kraepelin, 1909: 207–8). Dynamic

psychology, in generalizing this development to severe psychoses and in specifying it in terms of conflict, suppression and attempts at adjustment, instead was indebted to – though it distorted – psychoanalytic theory.²² Nevertheless, Kraepelin's postulate of continuity of essential symptoms during disease incubation, together with his principle that symptom-picture is correlated with course and outcome, informed Hoch's clinical test of the hypothesis that types of pathological personality are at the root of severe psychoses.

The subject of Hoch's investigation was the personality of dementia praecox, a putatively organic disorder, which, if caused by an endogenous toxin as Kraepelin (1896: 439–40; 1899: 204; 1913: 931–2) hypothesized, entailed that a 'healthy person can, out of the clear sky, suddenly develop dementia praecox' (Hoch, quoted in Sanford, 1913: 386). Two statistics led dynamic psychiatrists, notably Hoch and Meyer, to study the personality of individuals diagnosed with dementia praecox. First, Kraepelin predicted that 20% of cases would show prodromal signs, such as odd or labile behaviour, which he presumed were the consequence rather than the cause of the disorder. Second, at Heidelberg – where Kraepelin had introduced the concept of dementia praecox – the proportion of cases diagnosed with the disorder fluctuated between 8% and 52%, suggesting that the criterion of deterioration was still inexact (Meyer, 1910: 451–2). Although Meyer's (1903) study was the first to educe personality-based criteria predictive of deterioration, Hoch's more rigorous study provided, in the view of his contemporaries, compelling evidence of a dementia praecox personality.²³ Having obtained suggestive results from an exploratory study based on older material, Hoch developed the first guide specifically for the study of personality in collaboration with George S. Amsden (Hoch and Amsden, 1913) and used it in taking anamneses of newly-admitted patients. In order to demonstrate that particular defects of personality are predictive of the deterioration typical of dementia praecox in those who develop the disorder, Hoch (1910: 467–8, 473) divided his dementia praecox cases into two groups based on outcome and correlated outcome with differences in essential traits of personality that intensified between the onset and outbreak, and between the outbreak and outcome, of the disorder. The majority (66%) of deteriorating cases of dementia praecox manifested what Hoch called a 'shut-in' personality: social inhibition and withdrawal, and consistent inadaptability and retreat into fantasy.²⁴ As Hoch (1910: 473) expressed it, 'What is, after all, the deterioration in dementia praecox if not the expression of the constitutional tendencies in their extreme form, a shutting-out of the outside world, a deterioration of interests in the environment, a living in a world apart?' By contrast, the non-deteriorating cases of dementia praecox manifested either indications of shut-in personality or other defects, some of which formed a transition to traits found in paranoiac states (Hoch, 1910: 467); and none of the manic-depressive or melancholic controls evinced shut-in personality (Hoch, 1909b: 231). Together, these results indicated that specific traits of personality play

an important causal role in the prototypical clinical picture of dementia praecox, contra Kraepelin's view that in this disorder personal peculiarities are submerged in the disease process (Hoch, 1913a: 220).²⁵

What enabled Hoch to adduce evidence of the dementia praecox personality was his setting aside cases of atypical outcome after correlating outcome with traits of personality and symptom-picture at onset and outbreak. Hoch's purifying the clinical picture of dementia praecox by eliminating atypical cases raised new questions, however. For if the symptom-picture of dementia praecox was clouded by the inclusion of atypical cases, so might be the symptom-pictures of other mental disorders. In his studies of manic-depressive reactions, Hoch sought not merely to purify the clinical picture but to specify its characteristics more precisely through identification of qualitative differences in the fundamental symptoms of cases of typical and atypical outcome. Such intensive study of smaller, prognostically-based groups had implications not only for assessment of the individual case but also for classification (Hoch, 1911c: 486, 490). After the first decade of the twentieth century, dispute about the clinical position of certain forms of endogenous psychoses necessitated such studies, just as, coincidentally, Hoch's intensive reading of Freud placed in his hands a new tool for their prosecution.²⁶

Hoch's later clinical studies

Although Hoch stressed sizing up the features of the individual case (Hoch, 1913b: 322; State Hospital Commission, 1915: 150), he also recognized that physicians had a responsibility to provide statistics to the state based on 'accurately made and clearly conceived' diagnoses (quoted in State Hospital Commission, 1915: 149), which in turn were dependent on the uniformity of the clinical picture of each form of mental disorder. To be sure, clinical pictures could be made more uniform by setting aside cases that were atypical with respect to the quality or intensity of their presenting symptoms, as was accomplished by Meyer's (1905: 143–5) categories of 'allied to manic-depressive insanity' and 'allied to dementia praecox'. Nevertheless, diagnoses would not be clearly conceived as long as it remained doubtful whether certain forms of mental disorder should be classified within the manic-depressive or dementia praecox group because – as George H. Kirby (1908) and Karl Wilmanns (1907) had demonstrated – Kraepelin's classification of these forms had been based on cases from his Heidelberg clinic that collectively did not constitute uniform clinical pictures. During the post-war years, Hoch directed his research efforts towards clarification of the nosological position of such impure clinical forms through application of Kraepelin's own clinical method. By this means, Hoch provided evidence that cases of typical outcome differed from those of atypical outcome, on one hand, and that the cases of typical and atypical outcome were related to different groups of endogenous

psychoses, on the other. More specifically, Hoch clarified the nosological position of forms of mental disorder by specifying their clinical pictures more precisely, that is, by correlating outcome with qualitative differences in essential symptoms – which now, thanks to Freud, encompassed delusional content.

One target of Hoch's investigation was involuntional melancholia, which Kraepelin described as including 'all pathologically sad or anxious states in more advanced age, which are not episodes in the course of other forms of insanity' (Kraepelin, 1896: 561; my translation). From the fifth (1896) through the seventh (1904) editions of his *Psychiatrie*, Kraepelin had classified melancholia as a distinct involuntional disorder with variable prognosis. What led Kraepelin to change his mind was the contrary finding of follow-ups of cases that he himself had diagnosed as melancholia. The author of the study, Georges Louis Dreyfus (1907), purportedly demonstrated that, excepting cases of death due to advanced age, the prognosis of melancholia was as good as that of manic-depressive insanity. Citing Dreyfus's study, Kraepelin classified melancholia as a mixed form of manic-depressive insanity in the eighth edition of his *Psychiatrie* (Kraepelin, 1910: 534–5; see also Berrios, 1991; 1996: 311–13; Hoch and MacCurdy, 1922: 1–2; Jackson, 1986: 207–11, 271–2). The inclusion of deteriorating with benign cases in the manic-depressive group, however, undermined recovery as a cardinal feature of the group and opened the way to its further enlargement. Indeed, Kirby (1908: 504–5) concluded from a review of Dreyfus's case records that a significant number lacked the evidence to warrant the revised diagnosis of manic-depressive insanity. In 1919 Hoch initiated his own follow-up study of cases of melancholia (posthumously completed by John T. MacCurdy) in order to identify the essential symptoms in cases with different outcomes. Hoch and MacCurdy (1922) divided their patient cohort into groups of benign and deteriorating cases and compared the two groups in terms of qualitative differences in symptoms of irritability, adequacy of emotional reaction, and hypochondriasis. The similarity of the symptom-pictures of the benign cases to manic-depressive insanity and of the deteriorating cases to dementia praecox justified either classifying the former with the manic-depressive and the latter with the dementia praecox group or re-instantiating melancholia as a separate diagnostic category with variable prognosis (Hoch and MacCurdy, 1922: 16). Of particular interest were the delusions of violent death or immortality common to the two groups. Although uninterpreted, the content of these delusions being remarked as a typical feature of melancholia (Hoch and MacCurdy, 1922: 5) signalled Hoch's interest in death delusions as a differential feature of clinical pictures.

The task of Hoch's last and possibly most important clinical investigation was to demonstrate that stupor as a clinical entity belonged to the

manic-depressive group.²⁷ From the sixth edition of his *Psychiatrie*, Kraepelin (1899: 163–8) had classified stupor as a catatonic form of dementia praecox. Questioning the inclusiveness of Kraepelin's dementia praecox group, Kirby (1913) demonstrated that the majority of stupor cases at the New York State Hospitals not only recovered, but also were either preceded by depression (in circular psychoses) or followed by manic excitement. In order to establish that stupor as a clinical entity belonged to the manic-depressive rather than the dementia praecox group, Hoch (1921) compared the symptom-picture – including the delusional content – of benign stupor with that of manic-depressive reactions. He found that, although quite different in some respects, these symptom-pictures share common features. In particular, benign stupor is characterized by the four cardinal symptoms of apathy, inactivity, thought disorder and negativism (Hoch, 1921: 30–2, chs 4–5, 7), one or more of which occur less markedly in manic-depressive reactions such as perplexity, retarded depression and absorbed mania (Hoch, 1921: 124–5, 149–64, 226–8). Also common to benign stupor and manic-depressive reactions are delusions of death, although differing qualitatively in affect and degree of elaboration. Consistent with the apathy of the clinical picture of stupor, the delusion of death, whether expressed cognitively or behaviourally, is 'an accepted fact, a Nirvana state', whereas in perplexity it is accompanied by anxiety, and in mania, by elation (Hoch, 1921: 166). Moreover, consistent with the extreme reduction in mental activity in stupor, the patient's delusions of death prior to the stupor rarely involve anyone but the patient and her father (Hoch, 1915*d*: 166; 1921: 109–10). That the idea of dying – interpreted as a wish to die – with the father has psychoanalytic meaning is evidenced by the kinship of the meaning of these ideas of death with those of perplexity and apathetic mania, wherein death 'is only part of a larger Oedipus drama the rest of which is usually lacking in stupors' (Hoch, 1921: 165).

Taking stock of the significance of this content, Hoch (1915*d*: 167) wrote:

We must have seen this content before, but it never impressed us as of any special significance. Now, however, with our knowledge of the infantile unconscious strivings which we had learned to regard as furnishing the most deep-seated motives in the interplay of adapted and non-adapted tendencies of the personality, we began to recognize in the appearance of these deep unconscious wishes important forces.

That a common meaning underlay qualitatively different delusions of death in stupor and manic-depressive reactions revealed the essential unity of these disorders (Hoch, 1921: 166–7).²⁸ This finding, together with the finding that common (though more or less marked) symptoms were correlated with good outcome in both stupor and manic-depressive reactions, justified the inclusion of stupor in the manic-depressive group (Hoch, 1921: 242).

Hoch's legacy

As his clinical studies attest, Hoch's psychiatry combined a dynamic psychology with a Kraepelinian orientation to research. More specifically, Hoch's understanding of functional mental disorders as growing out of traits of personality was conformable to the prosecution of Kraepelin's project (of identifying fundamental 'traits') by Kraepelin's principle (of correlating symptom-picture with course and outcome). But if Hoch's psychiatry was integrative, it was also selective. For Hoch tore Kraepelin's project and principle from their source in the paresis model of mental disorder in order to engraft them onto Freudian dynamics, which he in turn unmoored from the psychoanalytic technique in order to meet the demand of typologies, first of personality and then of mental disorder. To the extent that he ripped bits and pieces of Kraepelin and Freud out of context, Hoch was no different from other eclectic psychiatrists of the progressive era. But there were superadded consequences of Hoch's eclecticism that were missing from the usual case. For Hoch's eclectic borrowings did not come to an end with the combining of conflicting therapeutic and aetiological elements. Less to fill gaps in knowledge than to advance knowledge, Hoch took from disparate sources disparate elements that mutually constrained and facilitated his research.

In order to pursue on Freudian soil his programme of clinical research – aimed at understanding and classifying the forms of mental disorder – Hoch had to mediate two sets of constraints that his disparate borrowings imposed. On one hand, if psychoses were not discrete disease entities, as Kraepelin believed, but lay on a continuum with normality, as the US followers of Freud believed, then diagnosis and classification demanded more precise specification of the symptom-pictures of mental disorder. Indeed, studies had shown that fundamental symptoms – or what appeared to be fundamental symptoms at diagnosis – were not predictive of outcome. In his own clinical studies of types of pathological personality and manic-depressive reaction, Hoch identified qualitative differences in fundamental symptoms that were predictive of typical and atypical outcomes, enabling him at once to sharpen clinical pictures and to see as unproblematic their shading off and overlap. On the other hand, because Kraepelin analysed the form and US followers of Freud the ideational content of psychoses, classification in a Kraepelinian-dynamic vein demanded that ideational content correlate with essential features in a given clinical picture. By comparing the delusional content correlated with essential features in stupor and manic-depressive reactions, Hoch in effect translated content into form, and qualitative differences between content into formal differences. The hallmark of this research programme – the identification of qualitative differences in fundamental features of clinical pictures – thus enabled Hoch to mediate the theoretical demand of a gradient of mental illness and the practical demand of classification, on one hand, and the ideational content and the form of mental disorder, on the other – and, in so doing, to prosecute a new kind of clinical research.

After Hoch's untimely death in 1919, the tension inherent in this synthesis of Freudian and Kraepelinian perspectives became apparent. For studies that engaged the Hochian synthesis, like the clinical pictures of a reaction type, fell on a continuum: at one extreme, emphasis was placed on understanding the individual case for the purposes of accurate diagnosis and treatment and, at the other, on validating clinical entities.²⁹ During the interwar years, one or other perspective tended to predominate even in studies of ideational content or personality that drew on Hoch's work.

Dynamic psychiatrists were mainly sceptical of Hoch's claim that manifest Oedipal content differs among clinical pictures. Because expressions of the unconscious Oedipus complex in ideas of death and rebirth are frequent in dementia praecox as well as in benign stupor, some investigators concluded that delusional content is not a differential feature or prognostic indicator (Rachlin, 1935: 557; Strecker and Willey, 1924: 675; 1928: 425; Wolff, 1932: 511; but see MacCurdy, 1925: chs 13–15). Similar conclusions were based on findings seemingly contrary to Hoch's claim that the Oedipal content of manic states is expressed differently in manic depression and dementia praecox (Hoch, 1915*d*: 168) – namely, findings of similar expressions of the Oedipus complex in the clinical pictures of *each* of the two major endogenous psychoses (Levin, 1922; Wright, 1921).³⁰ It is important to underscore, however, that these comparisons of ideational content were not circumscribed to groups of *homogeneous* cases personally studied by the investigator, contra Hoch's clinical method.

More revealing of the inherent tension in the Hochian synthesis is personality research, which, along with psychological research more generally, was in the ascendant by the late 1920s (Whitehorn & Zilboorg, 1933: 303–4). There is evidence that the Hoch-Amsden guide for the study of the personality, and revisions thereof, were widely circulated if not widely used. The guide was included in modified form in the Psychiatric Institute's own *Guides for History Taking* (Kirby, 1921) and *Outlines for Psychiatric Examinations* (Cheney, 1934, 1938; Lewis, 1943).³¹ Concomitantly, the topics covered in the Hoch-Amsden guide became both more expressive of a unitary framework (Amsden, 1923, 1924) and amenable to quantitative treatment (Wells, 1914). Although the guides were similar, use of one or other variant exposed – and reproduced – the tension within dynamic psychiatry between diagnostic accuracy and classificatory validity. With an eye towards the patient's analysis and treatment as well as diagnosis, one group of studies described pre-psychotic personalities associated with forms of dementia praecox (Amsden, 1928) or manic-depressive insanity (Bond and Partridge, 1925; Smalldon, 1934). With an eye towards nosology, another group of studies sought to predict the occurrence of mental disorder from quantitative measurements of traits either associated with a particular disorder (Kasanin & Rosen, 1933) or differing between cases of a particular mental disorder and control groups of cases (Bowman, 1934; Titley, 1936). Both types of investigation, however,

took for granted existing diagnostic categories, seeking either to transcend them through study of individual cases or to underpin them with objective criteria. A third group of studies, the most representative of the Hochian synthesis, sought to parse diagnostic categories by correlating personality traits and other features of the clinical picture in cases with a common diagnosis (Bowman and Kasanin, 1933; Davidoff and Whitaker, 1940; P. H. Hoch, 1940; Partridge, 1931; Strecker *et al.*, 1931). All three types of investigation, however, were overshadowed in the 1930s by experimental tests of personality whose accuracy as diagnostic aids was predicated on the relation of personality types to established categories of mental disorder (cf. Beck, 1938; Diethelm, 1934; Wertham, 1930).

Although ultimately of limited impact, Hoch's integrative psychiatry is instructive from a historiographical standpoint. The dominant model in recent histories describing change in US psychiatry is indebted to Thomas Kuhn's (1970) theory of scientific revolutions. Several histories have used all or part of the Kuhnian framework of paradigmatic crisis, conversion and revolution to describe US medicine's assimilation of Freudian psychoanalysis.³² These histories, as do histories of the reception of scientific ideas generally, tend a priori to assume adherents' unitary theoretical or methodological commitment, at the risk of considerable distortion of actors' positions.³³ Moreover, in casting their narratives as paradigmatic clashes, historians run the risk of selectively seeking in the past the hardened positions met with in the present.³⁴ Although it is probably impossible to avoid entirely the twin pitfalls of ahistoricism and anachronism, case studies can provide a corrective. For if the history of twentieth-century US psychiatry is marked by dominance of and rivalry between schools, it also contains echoes of individuals' efforts to effect a dialogue between, and productive integration of, differing points of view.

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Notes

1. The professional recognition of psychoanalysis in the USA was marked by the founding of the New York Psychoanalytic Society and the American Psychoanalytic Association in 1911 and the *Psychoanalytic Review* in 1916 (Hale, 1971: ch. 12). Kraepelin's dementia praecox and manic-depressive groups received official recognition in the American Medico-Psychological Association and National Committee for Mental Hygiene's (1918) *Statistical Manual*, although they were referred to as 'reactions'.
2. On the avant-garde in US medicine of the progressive era, see, for example: Burnham, 1967, 1979; Caplan, 1998: ch. 5; Hale, 1971: chs 4, 8, 12–13, 16; 1995: Introduction.

3. Adolf Meyer's repudiation of Kraepelin's nosology is well documented; Leys, 1990a: 43–4; Lidz, 1966: 326–7; but see Shorter, 1997: 111.
4. Constructed while Hoch was at Bloomingdale, the guide, when published, included questions from a psychoanalytic standpoint that were added subsequent to Hoch's appointment as director of the Psychiatric Institute; Hoch and Amsden, 1913: 578–9.
5. See Hoch, 1911b, 1912a, 1913b, 1914b, 1915b.
6. For a notable exception, see Kolb and Roizin, 1993.
7. Kraepelin (1896: 88, 702, 757, 793–4, 798, 801, 805–6) tacitly acknowledged that persistent pathological states (neuroses, psychopathic states, and inhibitions of mental development) were poorly described by the paresis model of mental disorder because each such state, insofar as it could be distinguished, lacked a definite symptom-picture, course and outcome. That paresis itself had a definite clinical picture was questioned as early as 1904 by Meyer (1904b: 353–4).
8. Although Hoch (1907c) did not abandon attempts to correlate psychomotor symptoms and anatomical changes, he was chary of accepting the hypothesis that the latter, when known to be non-specific, were part of or induced by the disease process; Hoch, 1898b: 599, 604–5.
9. In this essay, I will follow Hoch in distinguishing between a mental disorder's 'symptom-picture' (essential symptoms) and 'clinical picture' (essential symptoms, course and outcome collectively).
10. Although Kraepelin identified manic-depressive insanity as an endogenous disorder in the sixth edition of his *Psychiatrie* (1899), he did not so identify dementia praecox until the eighth edition (1913); Beer, 1996: 15–16.
11. Based on an analysis of a sample of Kraepelin's *Zählkarten*, Weber and Engstrom (1997) conclude that the cards were not the basis of Kraepelin's nosological concepts but rather reinforced his preconceived ideas.
12. Hoch's (1902a, 1902b) monographs on melancholia and manic-depressive insanity, based on material from McLean Hospital (Cowles, 1902: 76–7), illustrate his use of qualitative differences to distinguish clinical pictures and his presentation of these features in individual cases.
13. Hoch (1915a: 14) did not deny that mental disorder had a physical basis and, indeed, held that traits of personality were hereditary tendencies whose manifestations were shaped by experience.
14. Nathan Hale (1971: chs 3 and 4) argues that the somatic style, which comprised a model of mental disease and a treatment modality, came under attack in the late 1880s for its overextended hereditarian explanations concomitant with reports of falling rates of recovery. Contra Hale, Caplan (1998: 5, 95–116) has argued that the somatic style perdured despite criticism, and Grob (1983: 107, ch. 7) has shown that falling recovery rates can be accounted for by the increased number of hospitalized chronic patients after 1900 due to the admission of indigent and senile persons.
15. Copyright ©1945 by Columbia University Press; reprinted with permission of the publisher.
16. As Berrios (1987: 490) notes, nineteenth-century alienists were unwilling to consider the possibility that an individual could be afflicted with two independent psychoses simultaneously.
17. There is some difference of opinion among scholars as to whether Kraepelin was influenced by Alfred Hoche's (1912) critique of disease entities.
18. Although Meyer was influenced by Freudian theory, he rejected parts of it and modified others; Leys, 1990b: 97–8; Lidz, 1966: 328–9.

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20. The assumption of continuity between symptoms at psychotic onset and outbreak enabled Kraepelin to transfer understanding of mild psychoses induced in the laboratory to psychoses developed in the course of life (Kraepelin, 1895: 35). That Hoch was aware of Kraepelin's reasoning is indirectly evidenced by his review of Kraepelin's 'Der psychologische Versuch in der Psychiatrie' (Hoch, 1896).
21. Although Kraepelin believed that a predisposition to manic-depressive insanity was hereditary, 'the outbreak of the disease not infrequently appears as a simple intensification of peculiarities that were already indicated long before, and which continued throughout life in a weaker form as chronic, mild bad temper or excitement ... but we must not forget that the peculiarity of manic-depressive insanity consists not in a certain colouring of mood, but rather in the ease with which mood disorders of different coloration come into being' (Kraepelin, 1909: 207; my translation).
22. On the US interpretation of psychoanalysis, see, for example: Burnham, 1967: ch. 5; Hale, 1971: ch. 13; Leys, 1990b: 97–9.
23. A number of clinical studies of the dementia praecox personality corroborated Hoch's findings, although not all investigators strictly adhered to his method or agreed with his conclusions; cf. Bond, 1913; Hinsie, 1932; Pollock, Malzberg and Fuller, 1939: 363–4; Rowe, 1921.
24. Given that other factors supervene on personality in the course of development, Hoch (1910: 467) regarded the figure of 66% as compelling evidence of a dementia praecox personality.
25. Hoch may have overstated Kraepelin's position somewhat. In the eighth edition of his *Psychiatrie*, Kraepelin writes: 'It remains entirely unclear at this time whether the manifestations of dementia praecox are determined by personal peculiarity. The great diversity of the observed clinical pictures suggests the possibility that pre-existing factors are at work; on the other hand, we recurrently meet so many similar forms that the personality appears to be entirely submerged in the expression of the disease process' (Kraepelin, 1909: 206–7; my translation).
26. MacCurdy (1922: xi) reports that in 1913 and 1914, he and Hoch spent 'some hundreds of hours together in reading critically what Freud had written'.
27. On Hoch's place in the history of the description of stupor, see Berrios, 1981; 1996: 385–92.
28. Hoch (1914a) recognized that failure completely to resolve the Oedipus complex was also a predisposing factor in dementia praecox.
29. It should be noted that in privileging either diagnosis or classification, dynamic psychiatrists revealed both their divergence from Hoch's viewpoint and their misunderstanding of Kraepelin, who had an early and abiding interest in diagnosis; Engstrom and Weber, 2005.
30. Levin (1922: 584) erroneously imputed to Hoch the idea that the Oedipus complex is expressed in 'adult' terms in manic depression and 'infantile' terms in dementia praecox, although Hoch circumscribed his remarks to the *manic states* of manic depression and dementia praecox and noted, furthermore, that cases of manic-depression may express infantile ideas during the depressive phase (Hoch, 1915d: 168).
31. Cheney's (1934, 1938) and later Lewis's (1943) revisions of Kirby's (1921) *Guides*, although including a separate, modified Hoch-Amsden guide, attempted at once to expand the topical coverage of personality study and to integrate it with the personal history, which had the effect of rendering less static the individual's environment and his adjustment to it, consistent with Hoch's own thinking. This change was necessitated by

- the fact that, despite Hoch and Amsden's (1913: 581) insistence that reactions be studied in the context of events, users of the guide failed (or failed adequately) to take into account the circumstances surrounding and the apparent causes of the reaction, with the result that the purpose for which the guide was designed – namely, to illuminate through more precise clinical description the relation between personality abnormalities and mental disorder – was vitiated (Cheney, 1934: 6).
32. See, for example: Castel, Castel and Lovell, 1982: 1–2, ch. 2; Hale, 1971: 17, 177–8, 275, ch. 4; 1995: Introduction, chs 17, 20; Horwitz, 2002: 2, ch. 3. An exception is Eric Caplan (1998: 5, 95–116), who has challenged the existence of a crisis in the somatic paradigm.
 33. Romano (2002: 168) observes of histories of medicine, 'the contributions of men like Burdon Sanderson, Chauveau, and Panum are frequently truncated; parts of their research lives appear in general histories of physiology, others in histories of cardiology, bacteriology, or veterinary science.'
 34. A recent example is Horwitz, 2002. For a notable exception, see Sadowsky, 2006.

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