We were interested to read Dr O'Connell's response to our paper. Unfortunately we did not have space to do justice to a discussion of reactive attachment disorder from an evolutionary point of view, although we agree that this is an important theoretical perspective. Dr Minnis first became interested in reactive attachment disorder when working as an orphanage doctor in Guatemala. Most of the children there displayed symptoms of the disinhibited form of the disorder and it seemed clear that these behaviours were adaptive in a setting where primary attachment figures were lacking. We have touched on the maintenance of these behaviours from an evolutionary perspective in a previous paper (Minnis *et al*, 2006).

Dr O'Connell also points out that we did not engage in a discussion of attachment theory, or the work of John Bowlby (Bowlby, 1973). We do not wish to underestimate the crucial role of Bowlby's work in advancing our understanding of childhood development, however, we were unable to do justice to the complex interplay between attachment patterns and reactive attachment disorder within the space allowed. This important topic is the focus of our prevous publication (Minnis *et al*, 2006). In short, children can be securely attached while suffering from reactive attachment disorder and children suffering from the disorder have difficulties in various domains of early development, not simply the domain of attachment (Richters & Volkmar, 1994; Green & Goldwyn, 2002). Research into reactive attachment disorder is in its infancy and is a field ripe for exploration on a number of fronts.

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One hundred years ago

Stereotypy in Dementia Praecox [Étude clinique sur la stéréotypie des démentia précoces]. (Arch. de Neurol., March, 1905.) Dromard, G.

Stereotyped movements are not limited to dementia præcox, but occur in secondary dementias, and also in some systematised delusional states. Many followers of Kraepelin, however, would bring these last largely under the head of dementia præcox.

1. *Classification:*

(A) *Akinetic stereotypy.* – Attitudes, either of the whole body or of an individual member. Refusal of food, and mutism – though usually referred to negativism – are sometimes examples of akinetic stereotypy – e.g., a patient who refuses to eat, but who offers no resistance when fed with the nasal tube.

(B) *Kinetic stereotypy.* – Movements, which may be further subdivided into stereotypies of (1) *speech – e.g.*, neologisms, constantly recurring words and phrases, modes of intonation; (2) *writing*; (3) *expression – e.g.*, grimaces; (4) *walking*; (5) *complex stereotypies – e.g.*, special modes of sitting, eating, or dressing. Masturbation is sometimes referred to in this group.

2. *Evolution.* – The stereotypies of the acute stages of the disease must be distinguished from those of the terminal period.

(A) *Primitive stereotypies.* – The prolonged attitudes and repeated movements of katatonia. The failure of physiological plasticity, the impeded psychical process of the katatonic, are probably of toxic origin. The movements are angular, jerky, awkward, like those of a mechanical toy. This type of movement tends to disappear in later stages.

(B) *Secondary stereotypies.* – Those of the terminal period. These are not to be correlated with a functional failure in the cells, but with an organic defect, the result of the previous toxin. These movements therefore arise from imperfect intercellular connections – that is to say, a state of disaggregation. Secondary stereotypies are the residue of acts which, though once adapted, conscious, and voluntary, are now purely automatic. The original idea is often to be found in the hallucinations and delusions, accompanied by profound emotional colouring, which occur in the early period of the disease. "Professional" acts also frequently form the basis of subsequent stereotypies, but some automatic movements must be regarded as of fortuitous origin.

Although the secondary forms imply a more advanced stage of disease than the primary, they nevertheless may occur comparatively early, often contemporaneously with the latter. This is analogous to the co-existence in a tissue of inflammation and sclerosis.

Secondary stereotypies tend to become reduced in number as time goes on, those remaining being usually those first formed.

3. *Clinical value.*

To preserve the value of stereotypy as a clinical sign, the meaning of the word must be strictly limited. A repeated action is not stereotypy if it is still joined to an idea. Acts committed under the influence of obsessions, the conjurations of paranoia, etc., must therefore be excluded.

Stereotypy is far commoner in dementia præcox than in other forms of mental disease. Primitive stereotypies are more frequent in katatonia, secondary in hebephrenia and dementia paranoides. Stereotypy serves to distinguish the excitement of dementia præcox from that of manic-depressive insanity and general paralysis. It occurs early in dementia præcox, late in systematised delusional insanity. It is also of service in distinguishing the terminal stages of dementia præcox from other terminal dementias.

As regards prognostic value, secondary stereotypies are of grave import; in primary stereotypy the outlook is less gloomy, especially if other signs of active katatonia are present. Nevertheless, in the so-called "cured" cases of dementia præcox a tendency to stereotypy persists. This tendency may be utilised in teaching the patients simple machine-like occupations.

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