PART III.—PSYCHOLOGICAL RETROSPECT.

Associated Delusions and Transformation of Delusions.

Dr. H. Dagonet ("Annales Médico-Psychologiques," No. 1, 1895) draws attention to those cases which exhibit simultaneously delusions of a contradictory nature and to the alternation of different kinds of delusions, *e.g.*, delusions of persecution with those of grandeur, etc.—cases which are usually classified as folie circulaire, melancholia with delusions of grandeur, megalomania with delusions of persecution, etc. A girl, for example, admitted under his care with "religious" melancholia of several months' duration, is seized with acute mania, with marked excitement lasting a year, and then recovers. Again: M. becomes affected with active melancholia, which lasts three years, and passes into a chronic condition, marked with delusions of self-importance and exuberant activity, etc. The explanation is generally obscure. Cases in which we find simultaneously delusions of well-being associated with ideas of depression, or hypochondriacal delusions with those of grandeur, etc., may belong to general paralysis, or alcoholism, or dementia. In the hypochondriacal form of general paralysis, for instance, one nearly always finds associated delusions of grandeur, of wealth, etc. (cases of D., G., J., G., etc.).

Megalomania may be associated with or alternate with stupor.

Interesting observations of certain cases of anxious melancholia with delusions of negation (patient thinks he is a great criminal, is the devil, has Satanic power, etc.) point to an intimate association between melancholia and ideas of grandeur. Delusions of grandeur are certainly not necessarily a stage in the evolution of chronic delusional insanity with ideas of persecution, as Magnan and others believe, although the association is frequent; they frequently appear in the *early* course of the disease.

Dr. Cramer, in "Allg. Zeitschrift für. Psychiatrie," contrasts the diametrically opposite views of Magnan and Krafft-Ebing concerning cases of delusional insanity of sudden onset, with epileptoid prodromata, hallucinations, etc. (Westphal's "Acute Verrücktheit"), and their relation to mental degeneration. Krafft-Ebing classifies them among the pure psychoneuroses, while Magnan looks on them as characteristic of degeneration.

Christian, as a result of careful observations on cases of delusional insanity, concludes that the ideas of grandeur met with in the "insane persecuted" arise as complications and not by transformation of delusions. Dr. Dagonet confirms also Christian's conclusion that "insanity of persecution," with or without ideas of grandeur, is of all forms of mental disease the one which most rarely ends in dementia.

In searching for the *modus operandi* in the transformation of

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

delusions or their association, we must not forget the alteration which occurs in the general sensation and feelings of the patient; that is the possibility of the new association of ideas being dependent on the affective state of the patient.

The *prognosis* in these cases (excluding more or less acute cases of alcoholism) is often very grave, but one must consider the underlying mental condition as of paramount importance.

The real pathological interest in these cases lies in *their course* and the general symptoms. To attach great importance to a certain group of delusions, *e.g.*, those of persecution, as is generally done, and very little to the accompanying delusions of grandeur, is unreasonable.

The Importance of Inquiring into the Mental Condition of Criminals.

In June, 1894, Dr. H. Monod ("Annales Médico-Psychologiques," No. 2, 1895) requested the superintendents of public asylums in France to forward him the notes of cases (among their patients) in which a verdict of guilty had been pronounced in the law courts for a crime *unmistakably caused by their mental disease*, and committed at some time preceding their admission to the lunatic asylum. A collection of 271 cases, extending over five years, was thus made—cases in which a medico-legal inquiry would have prevented undeserved punishment and disgrace. For obvious reasons (only asylum superintendents were consulted; several gave no replies; only those criminals subsequently declared *pauper lunatics* were scheduled, etc.) this only expresses a percentage of the "convict lunatics" condemned in the five years (1886, 1887, 1888, 1889, 1890), and 700 would be a fair estimate of these *preventable convictions*, *i e.*, 140 per annum.

This is a serious evil, and a remedy should be found. Dr. Monod suggests that magistrates should possess knowledge sufficient to decide in suitable cases upon calling in a medical expert, or there should be in some way a strengthening of the bonds which unite medicine with the law. The question requires study. We note that among the 271 cases, 223 were men; 96 were between 30 and 40 years of age; 94 were condemned for theft. In their order of frequency we find that 65 were cases of dementia or mental enfeeblement, 58 general paralytics, 21 either epileptic or hysterical patients, etc.

Notes of some of the most interesting cases are given at the end of Dr. Monod's article. We cannot but fervently pray for reform when we read of a general paralytic being condemned to six months' imprisonment for injuring a tree.

The Part Played by Fixed Ideas in the Pathology of Hysterical Polyuria.

A. Souques ("Archives de Neurologie," No. 94) relates at length the notes of a case of polyuria, and shows that in most cases of nervous polyuria, *sine materia*, hysteria plays an important part, the im-

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

mediate factor being a fixed idea. A man, A. D., æt. 37 years, was admitted in the Salpêtrière on May 12th, 1894, under M. Brissaud. On the mother's side, a neurotic history. Patient had infantile paralysis when three years old; later on he drank freely. At age of 28 he suffered from acute rheumatism. The illness began in November, 1893, after a blow on the head; at about the same time he had hysterical crises. On examination when admitted, he was suffering from left hemianæsthesia, bilateral narrowing of the visual field (70° left, 80° right), marked thirst, and polyuria. Observations carried over one month showed that he passed on an average 16-19 litres of urine per diem. Urine: Sp. gr. 1002-1003; no alb.; no sugar. Complains of dry mouth. Other secretions (but the urinary) almost suppressed. Sleeplessness frequent. Patient is depressed, irritable, and anxious. On June 13th treatment by hypnotism was begun, and gradually less and less urine was passed. On July 4th the amount is only four litres. On September 2nd he left the hospital practically well.

Unquestionably the patient was hysterical, and the rapid cure by hypnotism confirms the hysterical nature of his polyuria. Without denying the existence of traumatic polyuria, the author believes with Potain and others that hysteria is frequently the connecting link between traumatism and polyuria. So also as regards alcoholic polyuria, alcohol may be only a determining factor, hysteria being at the root of the trouble. Bearing in mind the importance of hysteria, 22 cases of hysterical polyuria have been found in the Paris hospitals during the last two years.

A careful consideration of the history of these cases shows the constant presence of nocturnal incontinence in childhood or of alcoholic excess later. This frequency of micturition, according to the author, no doubt becomes the origin of a fixed idea—increased micturition—*i.e.*, polyuria. It is psychologically that one must consider the genesis of hysterical polyuria, and the intermediary between the fixed idea and the urinary syndroma seems to be some functional disturbance of the vaso-motor system controlling the kidneys. In favour of this view is the fact that hypnotic suggestion may effect a cure. The pathology of true traumatic polyuria points to the existence of vaso-motor centres for the renal secretion in the bulb, so that we may suppose that in hysterical polyuria the fixed idea is the point of departure of a cortical reflex, which ends in the bulbar vaso-motor centres of the kidney and inhibits their action. In addition to traumatic polyuria, the author accepts the existence of hereditary polyuria observed in degenerate families as a distinct irreducible class.

Raynaud's Disease and Erythromelalgia of Hysterical Origin.

M. Leopold Lévi ("Archives de Neurologie," No. 95) relates the notes of cases which were under the care of Prof. Raymond, accompanied with hysterical manifestations (polyuria, *e.g.*) and readily hypnotisable. The author shows that these vaso-motor phenomena

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

(Raynaud's disease and erythromelalgia) have their origin in certain emotions which give rise to sub-conscious fixed ideas, and in the process of cure the latter are modified by hypnotic suggestion.

The first observation is that of a woman, aged 43, the disease affecting the hands, feet, forearms, etc., specially on the right side; it followed on a moral shock. The patient, who had also suffered from rheumatism, was undoubtedly hysterical (convulsions, polyuria, etc.). The author also analyses the observations of Burot, Armaingaud, etc., on this affection, especially as regards the *rôle* of hysteria and the influence of the emotions in its causation.

A second case is that of a woman, aged 37 years, hysterical, hypnotisable, in whom a painful emotion, arising in childhood, persists and gives rise gradually to a fixed idea. After the death of her mother she develops right hemiplegia, with hemianæsthesia, cured by hypnotism; then is attacked with rheumatic fever. After the death of her sister the phenomena of "erythromelalgia" appear, principally affecting the soles of the feet. The pains are so severe that for four months the patient scarcely slept. The disease is modified from day to day by hypnotism, and ultimately completely cured.

The general conclusions are:—

A. 1.—There is a form of Raynaud's disease which is purely hysterical. It may originate or reappear under the influence of a moral emotion or shock; may disappear or be improved by hypnotism, but there remains a vaso-motor system easily affected.

2.—Acute rheumatism is frequently found in the antecedents of patients, and may determine the localisation of hysterical manifestations.

3.—The onset is sudden, the origin emotional. The disease is psychical. There are present urinary symptoms (anuria, polyuria).

4.—Gangrene may possibly occur.

5.—Cases of Raynaud's disease in hysterical patients, or due to emotional troubles, are numerous. Occasionally the phenomena are present in other members of the family (case of two sisters, father, and daughter).

B. 6.—There is a form of erythromelalgia which is purely hysterical. It is related to a vivid emotion or a sub-conscious fixed idea.

We also find a history of acute rheumatism, urinary phenomena, the sudden onset, or the variation of phenomena related to the ideas or feelings of the patient.

It is cured by hypnotism, but leaves a vaso-motor system easily affected by various emotions.

C. 7.—The facts observed are important contributions to the study of diseases due to the emotions.

They are additions to the already long list of vaso-motor troubles in hysteria.

They do not constitute distinct diseases, but groups of symptoms, which may pass into one another, and in the present instance proceed from the same neurosis—hysteria.

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

D. 8.—To explain the syndroma of Raynaud and that of Weir Mitchell (erythromelalgia) related to hysteria, the central theory must be accepted (*i.e.*, a neurosis, with localization in cerebro-spinal centres).

Raynaud adduced in support of this view of the pathology of local asphyxia the phenomena observed in the optic papilla (constriction of the central artery). We would insist, in addition, on the urinary troubles and the concomitant cerebral troubles (deep sleep, congestion of the face, etc.) observed, and, on the other hand, draw attention to the existence of asphyxia of the extremities in melancholia, general paralysis, and especially in "la folie circulaire."

9.—It is necessary, in order to treat the patients and to appreciate the etiology of the syndroma, to investigate the psychological history of the subjects.

Hypnotism enables us to determine the immediate cause of the affection and to effect a cure.

Alcoholism in Children.

Dr. Paul Moreau [de Tours] ("Annales Médico-Psychologiques," No. 3, 1895) carefully discriminates between drunkenness, dipsomania, and alcoholism, and deals especially with the last. The causes are, above all, hereditary predisposition and the "observance of customs of country or family" (example it might be called), and such occasional or exciting causes as thirst, curiosity, etc., which act usually in predisposed subjects. Menstruation in young girls may excite dipsomania, the subjects being generally degenerates or predisposed. The common forms of alcoholism in children are the "massive" (coma), the furious, the lively; the sad or melancholic form seems very rare. Among the pathological manifestations are violence to property or person, not infrequently delirium tremens—and, of course, cirrhosis. Prognosis is usually bad. Treatment must be prophylactic. In the case of crimes committed under the influence of alcohol, it is important to be severe, and extenuating circumstances, so often considered in the case of adults, should not be admitted.

Hysterical Borborygmi.

Prof. A. Pitres ("Le Progrès Médical," December 29th, 1894) draws attention to the presence of *rhythmical* borborygmi in hysteria synchronous with respiratory movements, and the rhythmical character of which has apparently escaped the observation of most authors who have referred to the presence of borborygmi in hysterical subjects. He describes two typical cases. The attacks or crises of borborygmi are regular, lasting two to four hours; the noises begin suddenly, are loud, synchronous with respiration; a rumbling is evident on palpating the epigastrium and left hypochondrium; they cease when the patient lies down; the patient usually feels some discomfort; the crises end also suddenly. Emotional disturbance often seems to determine the origin of the trouble, and the immediate cause is

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

frequently the taking of food. The duration of the disease is long—years often—and it is a source of much annoyance to the patients. Antidyspeptic and anstispasmodic remedies are without avail, and treatment altogether is almost futile. As to the explanation, it is uncertain whether they arise in the stomach or colon, but no doubt they depend on the *spasmodic* contraction of the respiratory muscles, so that Pitres looks on rhythmical borborygmi as one of the numerous varieties of the large nosological group of hysterical spasms.

Syphilis and General Paralysis.

Prof. Alf. Fournier ("Gazette des Hôpitaux," No. 128, 1894) lays great stress on the importance of collaboration from various special quarters in solving the problem of the relation of syphilis to general paralysis; we require a "syndicate of associated special observations." It is wrong to ask the general question: "Is general paralysis a symptom, a result, a complication of syphilis or not?" We must find a solution to the four following questions:—

1. Is there, or is there not, as a possible result of syphilis, a clinical syndroma which deserves the name of "syphilitic pseudo-general paralysis?"

2. May true general paralysis in any way be considered a complication of, or be derived from, syphilis? If so, with what degree of frequency?

3. Is true general paralysis, produced as a consequence of syphilis, of syphilitic nature or simply of syphilitic origin?

4. Is true general paralysis, produced as a consequence of syphilis, different clinically, anatomically, or otherwise, from general paralysis of different origin?

1. All observers must have met with syphilitic patients presenting such symptoms of general paralysis as: Muscular tremors (especially of hands and tongue), hesitation of speech, inequality of pupils, psychical troubles (enfeebled mind, impaired memory, alternating attacks of depression and exaltation, etc.), sensory disturbances, with partial paralysis or hemiplegia, etc., in whom the diagnosis between cerebral syphilis and general paralysis is, perhaps, impossible until the autopsy proves the presence of lesions of cerebral syphilis and not those of general paralysis. So that he concludes here that: α. There is unmistakably a clinical manifestation of cerebral syphilis which assumes the physiognomy of general paralysis, and β. To this Prof. Fournier proposes the name of pseudo-general paralysis, as it recalls more or less the pathological physiognomy of general paralysis.

2. In solving this question, we must remember the great frequency of syphilitic antecedents in general paralysis. Twenty-seven modern statistics from various quarters estimate this proportion at between 51 and 92 per cent., so that we are irresistibly led to the conclusion that syphilis constitutes a powerful factor in the etiology of general paralysis. And from his own experience, Fournier is led to consider as absolutely certain the proposition that a number of

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

syphilitics become general paralytics. And here we may add: that it is usually women of a certain class who become paralytics; that general paralysis is relatively rare in country districts, among ecclesiastics, quakers, etc.; that syphilitic antecedents are relatively much more frequent in general paralysis than in other forms of insanity (65 per cent. compared with 10 per cent., for example, in Régis's statistics); the common association of general paralysis with locomotor ataxy; and, finally, the powerful argument of youthful general paralysis—all considerations which are in favour of answering question two in the affirmative.

3. This offers many obscure points to unravel, and one cannot wonder at the various theories advanced to explain the relation; *e.g.*, that syphilis prepares the soil; that syphilis only produces general paralysis in a prepared soil; that general paralysis is a kind of residuum, a degeneration consecutive to former syphilitic lesions of the nervous system; that general paralysis is the result of an infectious cachexia; and, finally, the famous theory of syphilitic toxines, developed especially by Strümpell. Fournier's conclusion on this question is that his medical instinct rebels against the view that general paralysis is a *direct* consequence—a *direct* effect of syphilis; and in no way does he qualify it as syphilitic in the sense that a chancre or a gumma is syphilitic; for general paralysis, as an example (and there are other reasons, he adds), is in no way modified by antisyphilitic treatment. General paralysis he therefore classifies among the *parasyphilitic* affections, the characteristics of which are: α. That they do not exclusively and necessarily depend for their production on syphilis (tabes, rachitis, neurasthenia, hysteria, etc., are analogous in this respect), and β. They are not influenced by mercury and iodide of potassium as are true syphilitic affections.

4. Prof. Fournier disclaims any special ability or opportunity of giving a satisfactory answer to the 4th question, and it is in this connection especially that the assistance of workers in other fields is required. He has been struck, for instance, with the observation that general paralysis in his patients (syphilitic) often starts with phenomena of locomotor ataxy, or becomes associated with locomotor ataxy, forming a hybrid combination which he has called cerebro-spinal tabes. Frequently he has seen tabes end in general paralysis, and, again, tabes and general paralysis develop hand in hand, so to speak. Do cases of general paralysis of other origin present as often this combination of symptoms? Probably not. However, he does not insist on this point, which he considers outside his province. And so with regard to the evolution of the disease, the remissions, the apparent cures, the duration, etc. "Be sure," he says, in conclusion, "the question of the relations of general paralysis with syphilis will only be thoroughly studied, elucidated, and, finally, judged in all its multiple, complex, and difficult bearings by the union, the collaboration, the syndicate (to use such a word) of alienists, pathologists, and '*syphiliographers.*'"

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

A Case of Hysterical Anorexia.

Prof. Brissaud and A. Souques ("Nouvelle Iconographie de la Salpêtrière," No. 6, 1894), under the title of "Délire de Maigreur," relate the notes of an interesting case of hysterical anorexia in a girl aged 19 years, in order to illustrate its psychical origin, bearing out the more modern, and no doubt correct, view that hysteria is a mental disease.

A girl, aged nine, hereditarily predisposed, falls one day accidentally on her right hip; a painful swelling occurs, which soon disappears, but leaving a hyperalgesic spot (hysterical or of psychical nature), persisting for 10 years. By association of ideas other manifestations occur; tympanites, vomiting, fainting attacks. The patient being, in spite of this, somewhat stout, she was a good deal chaffed by schoolfellows; hence arises the fixed idea of wasting. She begins by abstaining from food, and vomiting soon occurs. At the age of 16, the hip becomes worse, and a diagnosis of peritonitis even was made; fortunately her general condition was so serious that an operation, which was suggested, was not performed. She suddenly improved after the application of the cautery to the iliac fossa, but relapsed a little later to be cured again apparently by drinking Lourdes water. A few months later vomiting recurs, and the hip becomes again painful, but a pilgrimage to Lourdes is of no avail. She thinks she is damned, has offended God, etc., and she now is sent to the Salpêtrière (17th April, 1894). On admission the wasting was extreme—weight 29 kilogrammes. No disease of the hip (or signs of former disease) present; she is sad, apathetic, and preoccupied by ideas of culpability, of being damned, etc. She was isolated and threatened with the stomach-pump and began to eat. Within three months her weight increased by 30 kilogrammes; mentally she improved *pari passu*. The authors show how it is possible behind each episode of the varied course of this case to trace the determining idea. The enormous increase of weight under treatment can only be compared with the wasting preceding her admission to the hospital; it is possible that under suitable circumstances in hysteria the trophic influence of the nervous system is stimulated by the idea of putting on weight. There are two accompanying plates of the patient on admission and after treatment.

---

2. *Asylum Reports.*

Some English County and Borough Asylums.

Birmingham. Winson Green.—Mr. Whitcombe makes mention of the increase in melancholiacs among the admissions, and found no less than 128 out of 396 cases admitted to be actively suicidal. He mentions among possible causes of this condition "cramming," which "by forcing brains irrespective of their capacity up to certain standards, gives rise not infrequently to mental distress

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

and disturbance, and this may act either immediately by causing a breakdown, or more remotely by originating ambitions which are found in a large number of instances to be unattainable." As to the present system of gathering all classes of patients into one institution he remarks :—

> The ages of those admitted varied from five to 84 years, 44 being over 60 years of age. The fact that it should have been found necessary to send a child of five years and a person of 84 into an asylum is not creditable, and shows a want, which I have before pointed out, of some proper accommodation for such cases.
>
> It cannot be just to idiot children, nor yet to those acute cases of insanity for whom the institution was provided, that they should be mixed together under the same roof, while for a poor old creature also, who has passed the average of life by so many years, to be placed in a similar position can hardly be looked upon as a humane treatment of senility.

The patients of both sexes dine together, males on one side of a table and females on the other, and no fixed respect is paid to the dietary, all favourable opportunities being taken to vary the dinner, *e.g.*, as the Commissioners found on their visit, by stewed rabbits and bacon, with potatoes and haricot beans. We believe that the breaking down of cast-iron customs by such means as the above can take almost equal rank with pathological research in forwarding the curative treatment of insanity.

At *Rubery Hill* there is but little for Dr. Suffern to make note of, since his patients are almost entirely chronic. He can report, however, two recoveries after seven and twelve years' illness.

Seeing that the nature and stage of the insanity of the residents in these sister asylums varies so much, we think it may be of interest to reproduce a few corresponding figures :—

	Winson Green.	Rubery Hill.
Total cases under treatment	1,020	710
Average number resident	626	651
Admissions in the year	396	68
Of these were transfers from other asylums ...	12	66
Average age on	40·83	39
Duration of insanity less than one year ...	271	6
Duration of insanity more than one year ...	80	62
Caused by alcohol	56	3
Discharges (recovered and not recovered)	296	5
Deaths	90	40
Average age on	49·36	48
From phthisis	7	7
General paralysis	20	1
Percentage on average numbers resident ...	14·3	6·14

The recovery rates can hardly be contrasted, and are not given here. The great divergence of the death-rate occurring in cases drawn presumably from the same sources, and residing under similar climatic and local conditions, affords convincing proof, if

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

any were wanted, of the enhanced mortality appertaining to acute mental disease.

Bristol.—Most Medical Superintendents have views similar to those so well put by Dr Benham on the subject of the extension of the 4s. grant.

> Some of the cases referred to above might, I think, be equally well treated in the imbecile wards of a workhouse, but the union authorities have at present no inducement to make provision for cases of this character, as, owing to their receiving a capitation grant of 4s. for every case under asylum treatment, they can keep any patient chargeable to them in an asylum at no additional cost to themselves.
>
> The proper remedy for this state of things has, in my opinion, already been suggested, viz., that the 4s. per week should be allowed to the union authorities not only for the patients in asylums as heretofore, but also be extended to any case at present under asylum treatment certified by the medical officer of that asylum as capable of being managed in a workhouse. This would encourage the workhouse authorities to supply suitable accommodation for cases of this kind, and benefit the asylums not only by relieving the congestion of their wards, but also improve the recovery rate by removing a portion of the dead weight of helpless and incurable patients, which experience has shown to be detrimental to the recovery of those amenable to treatment, whilst the asylum wards would be tenanted by the persons for whom they were originally built, viz., cases either capable of being benefited by treatment, or so violent or dangerous as to require special precautions for their safety.

We are not quite sure whether Dr. Benham looks for the extension in favour of future patients in the asylum who may become fit for transfer under section 25. We hope so, for the cardinal point in the proposed new departure is that only the Medical Superintendent shall have the power to say which cases are fit for residence in workhouses. If the Guardians receive the grant for patients retained by them and not forwarded to asylums for preliminary treatment and observation, the old mischief will assuredly follow. The criterion of removal to the asylum will be troublesomeness and not curability.

Carmarthen.—Our first duty in noting this report is to express our deep regret at missing in it the name of Dr. Hearder, who for 27 years ruled the destinies of this asylum. Though not known personally to the younger members of the Association, he was in former years an ardent and loyal supporter of it. Our next duty is to congratulate Dr. Goodall, his successor to the post of Medical Superintendent. He commences his work with a very full and elaborate report to his Committee, in which he gives evidence of extensive, sound and progressive knowledge of the matters placed under his charge. We have heard doubts expressed whether a Medical Superintendent's report should not be confined to a business-like statement of the transactions for the year made for the benefit of the County Council and other officials interested. But we hold very strongly the view that a Superintendent should never lose the opportunity annually given him of preaching—as he alone can preach in his district—the gospel of prevention and

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

the means to be taken to ensure prevention, as far as can be. The people have to be educated in these matters, as well as others. As we have stated before, the great object to attain is the awakening of all possible interest in the official mind, and this interest is sure to follow intelligent instruction in the elements of the question. Dr. Goodall has certainly spared no pains to arouse an interest in the minds of his readers.

Cheshire. Upton.—On December 31st, 1894, this asylum did not contain one case of general paralysis among its 617 inmates, notwithstanding it accommodates Birkenhead.

We extract from the report left by the Commissioners two statements:—

> We also hear of lunatics who should be here, but who are accumulating in workhouses and elsewhere, and so losing a chance of recovery by early treatment.
>
> We should be glad to see more extensive staining of floors to obviate too frequent scrubbing, which tends to introduce erysipelas.

Cumberland and Westmorland.—The Visiting Committee have definitely determined on the erection of the first house for private patients, and the plans have been prepared and approved by the Secretary of State. The buildings are in course of erection. Dr. Campbell shows a recovery rate of 51·8; two recoveries took place after five years, and one after ten years' residence. We think that in each case of prolonged and successful treatment a short *résumé* of the course would be of great service, especially if the Medical Superintendent would state whether it was, on the one hand, never regarded as hopeless, or, on the other, exhibited signs which pointed to permanent insanity.

A post-mortem examination was made in each of the 58 deaths.

Derby County.—Dr. Murray Lindsay's well-known energy in the matter of pensions has met with its reward in a "pension scheme as the scale for guidance of the Visiting Committee," which, he says, has given great satisfaction to the staff. In connection with this a valuable precedent has been established for granting a gratuity to the head attendant, Harry Bird, who died in office.

> A subscription among the staff for the widow and family was very quickly set in motion, speedily followed by a village subscription fund; in addition to which, by the kind advocacy of the Committee, a sum of £150 was granted by the County Council, subject to the sanction of the Local Government Board, which has since been obtained.

The post of chief female head attendant having become vacant, a new departure has been made in the appointment of a lady, with some years of previous training in a general hospital. Dr. Lindsay says that he has every reason to speak favourably of her appointment.

Derby Borough.—We are glad to see that Dr. Macphail has obtained from his Committee the generous grant of £4 extra

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

wages for holders of the Nursing Certificate after five years satisfactory service.

In relation to the physical condition of his admissions, we extract the following from Dr. Macphail's report:—

> Two-thirds of the admissions (64) suffered from recognisable physical disease. Each year we receive a larger proportion of patients exhausted from old age or advanced physical disease, and sent here merely to die. Over nine per cent. of the patients admitted died within the year, as compared with five per cent. among the admissions in 1893. One man was admitted in a dying condition, and only lived for four hours. He was suffering from advanced inflammation of both lungs, and in my opinion ought never to have been sent here. Another case in the last stage of paralysis died within a week, and a third patient, admitted from the infirmary after an operation for cancer, only lived a few weeks. From inquiries I find that these patients were sent to the asylum because there was no other course available, and in all of them the evidence of certifiable insanity was meagre in the extreme. These are not isolated instances in the history of this or any other public asylum, and it is perhaps desirable in the interests of humanity that our doors should be open to receive such cases, but facts of this kind should be borne in mind when we hear of the large increase of insanity that has taken place in recent years. The truth is that the limits of certifiable mental disease are yearly widening to include the most temporary mental aberration in the course of any physical disease, and the public have increasing confidence in the nursing resources of asylums, and are well satisfied to allow their aged relatives to be nursed by us in their "second childhood."

Devon.—A pension scheme for the officers has been established. Not more than 1-40th or less than 1-50th pay and emoluments is allowed for each year's service, the restrictions laid down by the Act being, of course, observed. The variation allowed for difference in value of service tends to obviate the one weak point in a fixed scheme—a dead level between the rewards of a good and mediocre officer.

Dorset.—Dr. Macdonald notes a large amount of acute mania among his admissions, larger than is usual in rural districts. He is not one of those who will accept the soothing plea that the increase in the number of lunatics is due to accumulation. He states that the incidence of the disease is increasing in Dorset. This he attributes to the stagnation of village life, leading to much intermarriage between families having hereditary predisposition. We trust that Dr. Macdonald will make further study of the statistics at his command, and that he will develop his argument in the pages of this Journal. He has induced his Committee to give medals for continuously good service—bronze for five years, silver for ten, and gold for twenty-one. Needless to say much satisfaction is produced. Any step like this, which tends to promote an honest pride in service, is to be heartily commended.

Essex.—Great pressure on space here has led the authorities to add another to the number of private houses taken over for the accommodation of patients. Such a course seems to be very commendable for various reasons. If, as in this case, there is a

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

certainty sooner or later of a large borough in the county removing its patients to accommodation of its own, the necessity for providing new permanent accommodation is tided over. Further, it helps to fill up the terribly wide gap between the asylum, with its necessarily restrictive discipline, and the workhouse with all its pauper associations. We have heard the argument used that these private houses drain off the patients who contribute so much to the routine labour of an asylum. But Essex seems to prove the hollowness of this view, for it now has three such houses, containing respectively 49 females, 53 females, and 75 males; 177 patients, out of a total number of 1,436 on the books on December 31st.

We note that local physicians carry out the daily visitation of these branch houses, though, of course, Dr. Amsden is primarily responsible for the efficient administration.

Glamorgan.—Dr. Pringle devotes a considerable part of his report to the subject of general paralysis, and seeing that he has year by year a far greater opportunity of studying its causation than most of his colleagues, his views command great respect.

Particularly is this the case in regard to that acute and rapidly fatal form of nervous disease, general paralysis. In the five years 1882-6, this variety constituted 7·1 per cent. of the admissions, but during the past five years the proportion has risen to 15·2, and this increase is half as great again in females as in males.

Of all forms of insanity heredity plays the smallest part in the causation of this particular variety; its origin lies mainly in causes which are to a very large extent within control, and is not to be found in altruistic strife and stress of life, the struggle for the good of others, or the awakened conscience of the present day, which will not tolerate unkindness or cruelty to man or beast, but in self-indulgent yielding to and perversion of natural instinct, and excesses of all kinds. An examination of the tables given in the reports of the Commissioners for England and Wales shows that excesses—alcoholic and sexual—form far and away the most prominent features in the immediate causation of insanity, and greatly more pronounced is this the case in general paralysis. Marked as this is as regards the whole country, it is, I regret to say, much more so for this county, as the following figures show:—The proportion of general paralytics per cent. of pauper admissions in England and Wales during the five years 1888-92, was for males 15, for females 3·7, total 9·1; but in Glamorgan the rate stands at 21·8 for males, 6·7 for females, total 15·2. Alcoholic excess is assigned as a cause of insanity in the pauper admissions during a like period as 21·1 for males, 8·3 for females, total 12·8; whereas for Glamorgan it is for males 36·0, for females 13·7, total 26·3; and as a cause of general paralysis in England and Wales it shows a percentage on admissions of males 26·1, females 20·1, total 24·9, as compared with Glamorgan, males 40·0, females 37·5, total 39·5. The foregoing afford sufficient evidence of the closeness of association of one form of excess with insanity in general, and its nearer relationship still to general paralysis in particular. A similar, but less pronounced, relationship exists as regards abnormal sexual excesses, though in practice it is found extremely difficult to obtain reliable information on this point in the history of the admissions.

As will be seen Dr. Pringle holds very much to the theory of vice-causation. Experience gained year by year leads, we think,

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

to increasing doubt whether the breach of moral laws in the coarser directions is quite so active in the production of the disease as has been maintained in earlier days. Scientifically the question is of course of great importance, but it also has most serious social bearings. If death from general paralysis is to be construed as presumptive death from vice, a very considerable number of those who have apparently walked in godliness will leave this world with damaged reputations.

We think that some of Dr. Pringle's figures weaken the contention. From 1882-6 7·1 per cent. of the admissions were paretics; during the past five years the average (15·2) has more than doubled. Can it be for a moment maintained that the people of Glamorganshire have become twice as wicked in such a short space of time? We are constrained to look for other contributing agencies, the more so since general paralysis being essentially a disease leading at its commencement to lost control of the passions, it is probable that in many cases vice is a symptom more than a cause.

We would also point out that the less frequent assignment of hereditary predisposition to general paralysis by no means goes to prove that the disease is therefore more personally acquired. The statistics relied on have regard to predisposition from insanity. Looking to the causation of other neuroses, epilepsy for example, it would be proper to assume parental failure in other neurotic directions.

In analysing Tables X. and XI. we find that sexual intemperance was assigned in two men and nine women, the percentage for women being 6·7, or nearly ten times the five-year average for paupers in all England and Wales. Three prostitutes and eight female general paralytics were admitted.

Gloucester.—Mr. Craddock continues to pay great attention to the statistics of his asylum. We notice that he does not adhere entirely to the tables of the Association. This, to our mind, is a pity, for instructive as his figures are they would be still more useful if they could be readily collated with those of the great majority of asylums. For instance we cannot find the tables dealing with the ages, or the duration of insanity on admission, nor indeed a concise statement of the form of insanity on admission, though the latter can be arrived at after considerable study of the highly detailed table of the physical condition of those admitted.

Mr. Craddock is very averse to withhold beer from his patients.

> I hold strongly that a man who has done an honest day's work on farm and garden, or a woman in kitchen or laundry are entitled, if they wish it, to a moderate allowance of beer, and that they are not only none the worse but decidedly the better for it.

The Visiting Committee remark in their report:—

> The Committee are pleased to be able to state that an increased number of

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

Boards of Guardians have this year visited the asylums, but they regret that 11 out of the 24 have not found it convenient to do so. Many of the patients who have been resident for some years receive no visits from their friends, and the only persons whom they can hope to interest in their welfare (apart from the Committee of Visitors) are the members of the Boards of Guardians of the different localities in which these poor patients have formerly resided.

And the Commissioners also state :—

One of the London patients seems, as far as we could ascertain, to have a valid grievance. He, H. L., was transferred from Cane Hill, where he says he was visited every fortnight. If this be the case he should be returned to Cane Hill, and some friendless patient sent in his place.

Some Registered Hospitals.

Barnwood House.—Dr. Soutar has had better fortune than most people in obtaining history as to hereditary predisposition, for he has ascertained hereditary predisposition in nearly three times the proportions of the Commissioners' five-year tables.

An hereditary tendency to mental disorder has been ascertained in 63·6 per cent. of the cases admitted during the year. Many causes, more or less speculative, have been alleged as exciting the attacks of insanity, but as usual we have found that in a large proportion of the cases the development of mental manifestations has but marked a stage more or less advanced of a progressive deterioration of the general health.

We think that a great service might be rendered by any one who has the opportunity and zest for so doing, if he would work out a considerable number of cases in relation to hereditary predisposition. The optional table of the Association, which is given by few, is of little use except for recording the number of cases in which hereditary predisposition has been assigned. What is really wanted is a record of the *volume* of hereditary predisposition in a particular case, and a closer connection between volume and particular forms of the insanity and other material points.

Bethlem Hospital.—Remarks made by Dr. Percy Smith and the Commissioners as to the large proportion of melancholic cases admitted into this institution, together with Dr. Smith's observations in the subjoined paragraph, have tempted us to collate certain statistics contained in this report with those of St. Anne's Heath and the five-year tables of the Commissioners.

Next to the two great heads of hereditary influence and previous attacks, "domestic trouble," "adverse circumstances," and "mental anxiety and worry" were the most important factors in causing insanity in those patients admitted during the year: these groups together accounting for 79 cases, or 32·8 per cent. In the forty-eighth Annual Report of the Commissioners in Lunacy, these three groups together account for only 18·7 of all the cases admitted into asylums and hospitals for the insane for the five years—1888 to 1892. In the case of private patients as distinguished from paupers the percentage, however, is given as 24·5. The larger figure shown in the cases admitted here is probably accounted for by the fact that our patients belong principally to those classes in which the struggle for existence is most keenly felt, namely, the various groups of educated people of very limited means, clerks and governesses usually forming a large proportion of our admissions.

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

	Bethlem.		St. Anne's.		Commissioners' 5-year average Private Cases.	
	M.	F.	M.	F.	M.	F.
Admissions 1894	94	147	82	94	1129	1040
Proportion of admissions to average residence ...	100%		50%		—	
Percentage of recoveries ...	54·2	53·7	42·6	63·8	—	
Percentage of admissions in which there was found causation by domestic trouble, adverse circumstances, and mental anxiety, worry, and overwork	41·5	27 02	39·0	25·5	26·8	23·8
Hereditary predisposition ...	49·0	45·4	11·0	18·0	21·5	28·1
Mania (all forms)	31·9	30·6	53·6	62·6	42·0	46·9
Melancholia (all forms) ...	39·3	60·5	13·3	24·4	25·7	34·0
General paralysis	17·0	1·36	12·5	3·19	12·9	1·1

The disproportion in the cases of mania and melancholia as between the two institutions is very striking, and equally remarkable is the inverse departure from the mean averages in the Commissioners' tables. Looking at the occupations of the admitted patients (Table XII.), the struggle for existence with limited means is evidently more keen in the Bethlem patients than in those of St. Anne's. The disproportion in the assignment of hereditary predisposition, though remarkable, is not of the slightest value for founding any conclusion. Probably if mendacity could be tabulated the proportion would be the other way. It is curious that the statement as to hereditary predisposition which has to be made (theoretically under penalty for inaccuracy) is still so widely evaded.

The following note is worthy of preservation :—

One man who had previously been in an asylum abroad, hailed a cab in the street and said to the driver, "Drive me to an asylum," his sense of impending mental disease impelling him to take refuge in some such institution. Shortly after his admission dangerous homicidal tendency developed, and it became necessary to detain him under certificates, though he seemed so typically a voluntary patient that it was delayed as long as possible.

The Coppice, Nottingham.—There is much solid comfort in the domestic arrangements of this hospital, and were its management better known, there should never be a vacant bed. The payments are moderate; what is regrettable here is the difficulty found in enlargement of the grounds attached to the hospital, which do not exceed 17½ acres; the liberality of the Corporation, which owns the adjacent land, should be equal to an extension of the grounds of this truly charitable institution.

We cull the above from the report of the Commissioners on one of their visits, and remark with surprise, that though this is a truly charitable institution, in which the balance of receipts over expenditure is slender, in which every penny received from

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

patients, together with a considerable portion of the limited receipts from investments, etc., is spent on the patients, in which the year's ratio of recoveries is above and the ratio of deaths is below the average for hospitals, and in which are to be found just those patients for whom charitable institutions were founded, there is yet no detailed statement of or even a hint at the amount of charitable work done. Indeed, only by collating with the Commissioners' report can we find that nearly 50 per cent. of the patients cost more than they pay, and that the profit on each of those who pay more than their cost is limited to the magnificent amount of 3s. 4¼d. per week.

Some Scottish Royal Asylums.

Aberdeen.—The principal feature in this report is the description of the new hospital, which was nearly completed at the end of the year, and should now be quite finished. A satisfactory knowledge of its general arrangements can be obtained from a scale plan, amplified by a carefully prepared description. It is proposed to combine therein various views of what an asylum hospital should be; that is to say, part of it is for mental observation of recent hopeful cases, part for infirmary cases, and yet another small part for infectious disease. The whole building seems to have been designed so as to procure the greatest possible amount of light, ventilation, and space for the inmates. There are covered conservatories and areas, long and broad corridors, duplicated in the centre, and we calculate that the cubic capacity of the day accommodation is 500 feet per patient and in the dormitories upwards of 700. Electric lighting is to be used throughout. The total accommodation is for 150 patients, being about 23 per cent. of the *present* average in residence. The food will be supplied from the central asylum, from which the hospital is about 130 feet distant. An associated dining-hall is provided. The only point in the general arrangement on which we have doubts is the propinquity of the infectious blocks. These are at each end of the building, separated by about 25 feet of passage; but the connecting doors can be shut and cross access doors in the passage can be opened. But bacteria are wonderfully locomotive beings, and some communication must be kept up by the bringing backwards and forwards of sheets, cooking utensils, and food. We should have thought that it would have been wiser to have built a separate independent house, with its own kitchens and necessary disinfecting conveniences at a considerable distance.

We shall be much interested to hear later on how the warming arrangements succeed. These are to be on the Sturtevant principle. Air is admitted through regulating louvres, screened from soot and impurities by wire canvas, heated by steam coils and finally *propelled* by a fan along a huge trunk of 36 inches

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

square, from which branches radiate to the blocks. From these branches the air is taken by fire clay pipes to the various apartments and delivered in to them with carefully regulated velocity at a height of eight feet from the floor. A corresponding amount of ventilation by air outlets and fireplaces is provided. In summer the air comes in in the same way (subvented by the opening of the window sashes when necessary), but the steam is turned off from the heater. No doubt provision is made, though not detailed in the account, for insuring that the distribution of heat between all rooms far and near is fairly equable. We should have liked to have heard how much heating space is provided on the steam-coils, for this we take to be an essential to success. A small superheated space must assuredly lead to "cooking" of the air, the impression of which cannot be easily got rid of by dilution.

The other parts of the report betoken much energy and progress. Dr. Reid has strong views as to the all-powerfulness of heredity, and attempted to make minute inquiry on this point in each new case, but was defeated by *suppressio veri* on the part of relatives.

Edinburgh Royal Asylum. — As usual, this report contains interesting matter and plenty of it. The great event of the year was the opening of the new Craig House by the Duke of Buccleuch. Some of the outlying villas were occupied, but the removal of the patients to the main building had to be postponed till this spring on account of the severity of the winter. The *finis* of the work has brought the usual *corona* of exceeded estimates, but what is that to Morningside? The Visiting Commissioners speak very warmly of the comfort and efficiency of the accommodation taken up at the time of the report, and when the whole is in working order we are convinced that the North of England will be tempted to send its contribution of affluent inmates, and thus help to give financial stability to this great venture.

Dr. Clouston coincides with the Scottish Commissioners in their views of the absence of proof that insanity, as an occurring disease, is on the increase. While giving due allowance in causation to physical ailments and badly managed normal *crises*—such as puberty, adolescence, the climacteric—he strongly insists on the pernicious effects of bad brain hygiene.

> Little may make the difference whether an originally sensitive and highly imaginative brain becomes, under bad conditions, insanely delusional, or under good ones, brilliantly imaginative. Many such brains well worth taking care of are now lost to the world through bad conditions.

General paralysis continues to contribute in increasing quantity its formidable quota of incurable fatal admissions, the males being close on 20 per cent. and the females nearly three per cent. Dr. Clouston gives several probable causes—high pressure, debauchery *sometimes*, overwork, etc. We would suggest a geographical predisponent in the shape of Edinburgh's seaport Leith. In

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press

looking over asylum statistics from year to year, we have been much struck with the high percentages of this disease in districts consisting of or comprising busy seafaring communities. As instances, we can give Hull, Newcastle, Bristol, Portsmouth, Glamorgan.

Dr. Bruce's successful introduction of thyroid treatment in cases other than those of myxœdema is referred to with warm approbation, and his subsequent receipt of the University gold medal for his thesis on this subject is recorded.

PART IV.—NOTES AND NEWS.

MEDICO-PSYCHOLOGICAL ASSOCIATION.

GENERAL MEETING.

A General Meeting of the Association was held at 11, Chandos Street, London, on Thursday, November 21st, 1895, David Nicolson, M.D., President, in the chair.

This was the first statutory meeting since the incorporation of the Association, and according to the Companies Acts, 1862 to 1890, the first meeting must be held within four months of the granting of the Certificate.

The minutes of the last General Meeting (held on May 16th) having been read and approved,

The PRESIDENT said that, before beginning the ordinary business, he might be allowed to say a few words about one of the oldest members of the Association, who was that day laid in the grave. Dr. Jamieson, of Aberdeen, lately the oldest Asylum Superintendent in Scotland, was a man of singular capacity, who, though but little known to the junior members of their specialty, in his day did a great work in bringing his asylum up to the standard, while his writings and lectures were well worth perusal, even in the light of the best work of recent years.

ELECTION OF MEMBERS.

The following were declared to have been duly elected:—William Bubb, M.R.C.S., L.R.C.P.Lond., Second Assistant Medical Officer, Worcester County Asylum; Arthur George Ewbank, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Middlesex County Asylum, Tooting, S.W.; George Baths Griffiths, M.R.C.S., L.R.C.P.Lond., Assistant Surgeon, H.M. Convict Prison, Portland; Frederick Walter Mott, M.D., B.S.Lond., F.R.C.P., Pathologist, London County Asylums, Assistant Physician, Charing Cross Hospital; Gilbert Edward Mould, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Peckham House, S.E.; Margaret Cochran Dewar, M.B., C.M. Univ., Glasg., Assistant Medical Officer, Crichton Royal Institution, Dumfries.

LATAH.

Dr. W. GILMORE ELLIS read a paper on "Latah," which will be published in a future number of the Journal.*

Dr. COOKE referred to Mr. H. A. Forbes' book, "A Naturalist's Wanderings in the Eastern Archipelago," in which almost all the symptoms alluded to by Dr. Ellis were clearly described, and instances of several cases were given. Mr. Forbes regarded it as being of a hysterical nature, and mentioned that it was chiefly found among women, although occasionally men were affected by it. He also pointed out, as Dr. Ellis had done, that the onset of the attack was due to the person being startled by some object of terror, or by being suddenly excited. The marked tendency to imitate other people on the part of the subjects of *latah* was also well illustrated by Mr. Forbes. According to him the condition varied in degree, so that whilst some were utterly incapacitated by it others were only

* But see "Journal of Mental Science," Vol. xli., pp. 537 and 728.

https://doi.org/10.1192/bjp.42.176.191 Published online by Cambridge University Press