PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

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Annales Médico-Psychologiques. November, 1877—September, 1878.

La Folie à Deux, ou Folie Communiquée. By Drs. Lasègue and Falret.

In this paper, after detailing several cases in which insanity was evidently the result of long and close association with the insane, the authors arrive at the following conclusions:—

1. Under ordinary circumstances insanity is not contagious, and it is rare, even among the insane, for a delusion to be communicated from one individual to another.

2. Insanity only becomes contagious under exceptional circumstances.

3. These special conditions are:—

(*a.*) In the "Folie à deux," one of the two individuals is the active, the other the passive element. The former is the more intelligent of the two, creates the delusions, and imparts them to the latter, who receives them but slowly, and, generally, after altering them to some extent. In time they agree on all points, and tell exactly the same story.

(*b.*) To arrive at this condition the individuals must have lived long together, must have led the same lives, shared the same hopes and fears, and have been free from all external influences.

4. All the cases observed have presented nearly identical symptoms, and have only become developed under circumstances such as those described.

5. This variety of insanity is more common among women than among men.

6. The patients may be related, but frequently are not.

7. The chief point in the treatment is the separation of the patients from each other.

8. The second individual recovers first.

9. Very rarely delusions have been communicated by one person to several in his neighbourhood.

Aphasia Occurring in a Patient with Exalted Delusions. By Dr. Marandon de Montyel.

Théophile B., forty-seven years of age, was transferred to the Asylum of Evreux, in 1870. His chief mental symptoms, as indicated by his correspondence, were slight enfeeblement of intellect, and delusions of an exalted character. Four years after admission he suffered

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an attack of apoplexy, which left him aphasic and paralysed on the right side. When partially recovered, he was able to understand everything said in his presence, and he began to renew his correspondence, attempting to write with his left hand. He was now found to suffer from agraphia, many words in his letters bearing but a faint resemblance to the words they were evidently intended to represent. The patient was conscious of these errors, and made repeated attempts to correct them, but generally failed to write the word correctly. This symptom gradually disappeared, and two years after the attack was not appreciable, though B. was much more demented. The patient died of chronic enteritis in March, 1877.

After death, over the upper part of the posterior parietal convolution, the membranes were adherent, brain substance being detached on their removal. The frontal and anterior parietal convolutions were free from adhesions. The grey matter generally was atrophied, and the smaller vessels atheromatous. There was no special lesion of the posterior part of the third left frontal convolution. The Island of Reil was normal on the right side, on the left atrophied. The right corpus striatum presented in the extraventricular nucleus, and the outer part of the ventricular nucleus, traces of an old hæmorrhage, a large fibrinous clot being found.

Catalepsy following Acute Mania. By Dr. Lagardelle.

G. A., nineteen years of age, suffered an attack of acute mania, and, during its course, leapt from his window on the third story, but escaped with trifling bruises. He was then removed to an asylum, where, after a week, during which he was restless and noisy, he suddenly became silent and motionless, allowing his head to hang forward, and the saliva to dribble from his mouth. Next morning the symptoms of catalepsy appeared. Pricking with pins was not followed by movement of any kind, and his limbs remained in any position in which they were placed. He was treated by shower baths, and each succeeding day was more easily roused. In the intervals between the cataleptic attacks he was free from mania, and able to describe his sensations during the attack, stating that while he saw that he was pricked, and that his limbs were extended, he suffered no pain, and was unable to move. As the attacks became less intense, the skin responded more readily to friction, and in about three weeks he completely recovered. This cataleptic state differed from that usually described, in that consciousness and memory were retained, while volition was lost.

On the Different Kinds of Remission in General Paralysis. By Dr. Doutrebente.

In the first part of this paper the author insists that mania, or melancholia, occurring in a general paralytic, is a complication, and not a part of the disease. He says: "General paralysis, or diffuse interstitial encephalitis, is a morbid entity, clearly characterised and localised. It matters little if it be accompanied by delusions, exalted

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or the reverse. The mania, if it exists, is only a complication, besides, in a large number of cases, the mania is replaced by a simple mental enfeeblement, the presence of which is not absolutely indispensable." General paralysis may descend directly from father to son, but its occurrence in the father does not render the son more liable to other forms of nervous disease.

In the progress of general paralysis there are two periods, that of congestion and that of disorganisation. The former varies much in duration, and, while it lasts, remissions are frequent, and treatment may be of value. The pathological condition, which immediately follows the congestive period, is that of sclerosis, which again is succeeded by disorganisation. The sclerosis is due to proliferation of the neuroglia, this gives rise to pressure on and destruction of the nervous elements.

Remissions may be complete or incomplete, temporary or lasting, a complete lasting remission being recovery. To prove that recovery is possible, Dr. Dontrebente refers to numerous instances in which it has been recorded, and describes twelve cases of the disease which have been under his own care. The longest complete remission noted in any of these latter cases lasted two years and two months.

Lypemania cured by the Voluntary Mutilation of the Genital Organs. By Dr. Solaville.

Joseph R., a labourer, thirty-four years of age, was admitted to the Asylum at Poitiers, in June, 1878, suffering from melancholia. He had hallucinations of sight and hearing, believed that he had killed his wife, and that he must mutilate himself. Six weeks after admission, while apparently much improved, he succeeded in mutilating himself, nearly severing his genitals with an axe. Three weeks later he was much improved, mentally, and in two months was discharged.

The Ecstatic of Fontet. By Dr. Bourdin.

In 1875 there appeared in the "Gazette Médicale de Bordeaux" an article entitled "Étude Médicale sur l'extatique de Fontet," by Drs. Mauriac and Verdalle. The opinions expressed in that article are not shared by Dr. Bourdin, and he criticises them at length, after detailing the phenomena on which they were founded.

Marie Bergadieu, at the age of fifteen, exhibited symptoms of hysteria, at thirty suffered from hallucinations, and at forty-four became ecstatic. The crises of ecstacy were numerous, thirty-seven occurring in less than a year, and were generally predicted by the patient, while great variations in pulse, respirations and temperature were noted during their occurrence. Drs. Mauriac and Verdalle concluded that the crises had long been entirely dependent on the will of the patient for their production, because —

1st. The attack often appeared at the exact time predicted by the patient.

2nd. In the midst of one the patient would arrange her dress according to the rules of decency.

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3rd. There was ground to suspect a secret understanding between the visionary and those about her.

4th. Because, as a rule, it is possible to aid or even to induce the phenomena of ecstasy by psychical means, and above all by mechanical procedure.

Dr. Bourdin believes, however, that the attacks were not under the control of the patient, and further that, in the present state of science, it is useless to attempt to demonstrate the nervous lesions on which the phenomena of ecstasy depend.

On the Use of Atropine in the Sialorrhœa of the Insane. By Dr. Dufour.

In this note the use of atropine is advocated in cases where the saliva is secreted in excess and dribbles from the patient's mouth. Three successful cases are recorded. From a-half to two milligrammes of the drug were given daily.

Encephaloid Cancer of the Brain in an Epileptic. Absence of the Right Inferior Parietal Lobule without Ocular Disturbance of the opposite side. By Dr. Clovis Gallopain.

The patient, a woman thirty-nine years of age, entered the asylum of Evreux in May, 1875. She was imbecile and helpless, and for two years suffered attacks of vertigo with twitchings of the facial muscles. She had slight difficulty of speech, and dragged the left leg a little. Sight was good, the pupils were equal, and the movements of the eye normal. In May, 1877, she had several severe attacks of convulsions, and from that time until her death, in October, suffered from cephalalgia, vomiting, drowsiness, and apoplectiform attacks. In August hemiplegia of the right side was noted.

Autopsy.—The right parietal bone presents on its outer surface a projection, corresponding to a depression in the middle of its inner surface. The pia mater at the level of the inferior parietal lobule is thickened and projects in the form of a fluctuating tumour, from which, on incision, a fluid resembling cerebro-spinal fluid escaped, leaving a deep excavation. This excavation occupying the site of the inferior parietal lobule, reaches from the Sylvian fissure back to the parieto-occipital fissure and upwards to within three cent. of the longitudinal fissure. Posteriorly the bottom of the excavation is separated from the lateral ventricle by a membrane 1 or 2 mills. in thickness; while anteriorly it corresponds with the external face of the corpus striatum. The first frontal convolution is very large, while the Island of Reil is smooth and not convoluted. The convolutions undeveloped are the ascending parietal in its lower two-thirds, the angular gyrus and its lobule, and the upper extremity of the first temporal.

On the left side the pia mater is adherent over the second and part of the first frontal convolutions. The first frontal convolution is atrophied, the second is of large size. The Island of Reil is large and presents five convolutions. The lateral ventricle is filled by a

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soft, fleshy mass which extends into the third ventricle. On section this growth presents numerous small clots, while its centre is occupied by a firm, yellowish nucleus studded with calcareous particles. The brain substance where the pia mater was found adherent is wasted and disorganised.

In his remarks, Dr. Gallopain calls attention to the fact that while the angular gyrus was congenitally absent on the one side and of only normal size on the other, sight and the movements of the eyes were unimpaired.

On Hæmatoma of the Ear. By Dr. Bouteille.

In this paper Dr. Bouteille expresses the opinion that hæmatoma of the ear is always the result of violence, and that too much importance has been attached to the influence of predisposing causes in its production. He believes that, in mental disorders, its occurrence does not contra-indicate the possibility of recovery.

General Paralysis and Aphasia. By Dr. Cullerre.

M. C., a demented general paralytic, was admitted to the asylum of Auxerre in May, 1877. Seven years previously he had contracted syphilis, and had been unable to submit himself to proper treatment. During his residence in the asylum he suffered several congestive attacks, which were invariably followed by aphasia of a few days duration. The patient was removed by his friends, and no post-mortem examination is recorded.

On Functional Localizations in the various forms of General Paralysis. By Dr. E. Dufour.

Dr. Dufour is of opinion that the varieties of general paralysis and the changes which occur in the course of the disease depend entirely upon the seat of the brain lesions, their subsequent extension and their intensity and importance. In support of his views he relates five cases, and furnishes drawings of the adhesions and atrophies discovered after death.

The first case is that of a man aged forty-two, who entered the asylum of Saint Robert in December, 1877. On admission he was quiet, and suffered from loss of memory. No hesitancy of speech existed, but his pupils were unequal. Six weeks later he gave expression to exalted delusions, and his speech at the same time became affected. Three months later he died of diarrhœa. On removal of the brain the right hemisphere presents numerous adhesions on the third frontal convolution, the angular gyrus and its lobule, also slight scattered points of adhesion on the upper part of the superior parietal lobule and the anterior four-fifths of the first frontal convolution. There are well-marked adhesions on the lower four-fifths of the ascending parietal and fourth frontal convolutions. On the median aspect there are numerous adhesions on the gyrus fornicatus, the anterior fourth of the first frontal convolution, the gyrus hippocampi, and the uncinate gyrus. The convolutions of the lower surface of the frontal lobe present similar adhesions. On the left side, adhesions

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very slight over the anterior half of the three frontal convolutions, but more numerous on the superior parietal lobule, the angular gyrus and its lobule, and the first and second temporo-sphenoidal convolutions. On the median aspect adhesions are seen on the anterior two-thirds of the first and second frontal convolutions, on the gyrus hippocampi and on the uncinate gyrus. They are also present on the orbital surface of the frontal lobe.

The second case is that of a man of forty years of age. When admitted he was noisy and restless, and had exalted delusions, his lips were tremulous, and his pupils unequal. He was agile and muscular, and four days after admission fatally injured himself by falling from a tree. On examination of the brain the membranes are thickened and opaque and adherent at many points. On the outer surface of the right hemisphere adhesions are found over the whole of the first frontal convolution, the upper middle part of the second, on the upper part of the second temporo-sphenoidal, and on the whole of the third. The lobule of the angular gyrus is much infected. On the median aspect adhesions are found on the front of the first frontal, on the gyrus hippocampi, and on the fourth and fifth temporal convolutions. On the left side they are seen on the anterior three-fourths of the first frontal, the greater part of the fourth frontal, the ascending parietal, and very slightly on the third and base of the second frontal convolutions, on the lobule of the angular gyrus, and on the second and third temporo-sphenoidal convolutions. The other convolutions are infected. On the median aspect there are adhesions on the gyrus hippocampi and the gyrus fornicatus.

The third case is that of a man aged forty years. On admission he was found to answer with difficulty, his speech was hesitating, he mumbled, the muscles of his face quivered, and his pupils were contracted and unequal. On the day after admission there were involuntary movements of the arms. Four days later he died. The membranes are thick and opaque, and, on the right side, adhere to the base of the first and second frontal convolutions, to all the superior parietal lobule, and internally to the anterior part of the frontal convolutions. On the left side there are adhesions to various parts of the third frontal and to the gyrus hippocampi.

The fourth case occurred in a man of fifty-three. When admitted he was excited and incoherent, and, on becoming calm, was found to be partially demented, and to have hesitancy of speech. Before his death, which occurred eleven months after admission, he suffered several attacks of excitement, each attack being followed by increased dementia. His lips never became tremulous. The membranes are thickened and opaque, and blood is suffused on them anteriorily and at the sides. They are also, at numerous points, very œdematous, presenting a gelatinous appearance, and these points correspond to partial atrophies of the convolutions. There are adhesions over the anterior two-thirds of the first frontal convolution on the left side, and

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the convolution has a shrivelled appearance. The frontal convolutions and the angular gyrus have a rosy tint, and the ascending parietal convolution and the superior parietal lobule are wrinkled. There are very slight adhesions scattered over the anterior three-fourths of the first temporo-sphenoidal convolution. On the median aspect there are slight adhesions on and a rosy colouration of the first frontal convolution, and the anterior fourth of the gyrus fornicatus. On the right side there are adhesions on the anterior half of the first, and at the base of the third frontal, also on the third temporo-sphenoidal convolutions. The upper part of ascending parietal is wrinkled, the angular gyrus is injected. On the median aspect there are slight adhesions on the anterior part of the frontal convolutions.

The fifth case is that of a woman aged sixty-four, admitted in a condition of helpless dementia. Four months after admission she had an epileptiform attack, of short duration, the legs, arms, and face being convulsed. She died nine days later, having fractured her femur by falling. The membranes are thickened and easily removed, except over the upper two-thirds of the right ascending parietal convolution, where they are slightly adherent. The frontal sulci, the fissure of Rolando, and the interparietal fissure are enlarged, and the membranes at the corresponding parts are œdematous and gelatinous. This gelatinous condition exists on the median aspect in the neighbourhood of the paracentral lobule, of the quadrilateral lobule, and of the first frontal convolution. The convolutions are atrophied, particularly the first, second, and fourth frontal, the ascending parietal and part of the angula gyrus. All the lesions are more marked on the left side than on the right. There is no atheroma of the vessels.

Annales de la Société de Médicine de Gand, 1876, 1877, and 1878.

The only article specially interesting to English psychologists is that by Dr. Lentz.:—

History of the Progress of Mental Medicine, from the beginning of the 19th Century to the Present Time.

For this essay he was awarded the Guislain prize. Though, perhaps, not always correct, it is an excellent epitome of the subject. English superintendents will be puzzled to know the source of Dr Lentz's information, when he writes: "En Angleterre, cependant, quoique l'habitation en commun y soit devenue la règle pour le jour, l'isolement pour la nuit s'y est maintenu avec assez de ténacité pour résister à l'entraînement général, et les dortoirs communs ne s'y implantent que lentement et difficilement." It must not be inferred that he is unjust to us in any respect; on the contrary, he gives England full credit for all that it has done in psychology, in the practical treatment of lunatics, and the administration of Asylums.

The chapter on treatment appears to me specially good, and should be read by all those who vaunt the advantages of medical treatment. I willingly admit that in some asylums a large quantity of medicine is

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administered, but that is not medical treatment. When it is remembered that we do not know anything concerning the function of this or that convolution, need it excite surprise that a scientific treatment of mental diseases does not exist? It is quite true that patients recover; so they did a hundred years ago, when they were shamefully treated and drugged in a barbarous manner.

"In order to establish a correct system of mental therapeutics, we must first know all the general or special causes of insanity; distinguish precisely their source of origin; determine whether it is the physical which acts on the mental or the mental which acts upon the physical: recognise the curable varieties, those which require moral remedies, those which need medicines; lastly, determine which require a mixed treatment. 'To treat insanity systematically, it is necessary, first of all to know its seat and its nature; to consider the nature and mode of action of its causes; to allow for individual tendencies connected with sex, age, temperament.' Such were the difficulties foreseen by Esquirol and Georget, and which science has attempted to resolve by the aid of the principles of ordinary therapeutics. And when Georget wrote, there is one general principle of therapeutics which must never be forgot, viz., that a function should be in repose and exercised as little as possible when the organ is in a state of irritation; that we must not attempt to divert and fatigue a lunatic by arguments when his brain is irritated, as we thereby irritate it still further, he enunciated one of the soundest maxims on mental therapeutics, and which Guislain afterwards so successfully applied in the treatment of melancholia.

"Such being at present our limited knowledge of the subject, this rational tendency must necessarily end in an expectant form of treatment:—'It is better to state what must not be done, than to describe the course to be pursued,' has become one of the great precepts in mental treatment.

"The still too psychological tendency of science, the predominating importance which is still attached to psychical symptoms, as well as the obscurity of the physical lesions, were not long in forcing treatment into a method too exclusively based on mental agencies; and that, not so much by conviction as by necessity. It is easily understood that, in sympathetic or symptomatic insanity, the cause is the principal, the essential indication; but that being too often quite unknown, drove treatment into the sterile and dangerous path of chance and groping in the dark, and they gladly turned to the mental form of treatment, a form always successful, whatever our theory may be about it.

"The asylum at once becomes the real mental medicine, it is an instrument of cure. All efforts are directed to this end; everything is done to develop the organisation and management, and the various forms of mental treatment, or rather of mental hygiene to which the lunatics are subjected, become perfected in proportion to the success of

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the administration. This, however, is almost the same as treatment, which is, so to speak, negative, though active. It is not at all that exclusive moral treatment, as understood by Leuret and Reil; that is to say, that influence exercised directly upon the diseased understanding, that influence which the first sought in punishment or reward, whilst he employed the douche; and which the second had chiefly in view, when he employed argument to cure the insane, and desired that in every asylum the physician should have as his assistants a moralist and an idealogist.

"It is to this latter direct, personal influence, that we should reserve the name of moral treatment, all the inconveniences of which have now been sufficiently recognised for it to be employed except in rare cases, and in certain circumstances, such as convalescence.

"The influence of the asylum, on the contrary, is quite otherwise, and, indeed, quite opposed; in place of being occupied with the morbid aspect, it has but one end, that of throwing the diseased into the shade, and of profiting by what remains normal in the lunatic to cure him of his disease. The good effect of the asylum is not limited to merely avoiding injury, by placing the lunatic where his disease may run its natural course towards recovery, free from any obstacle or unfavourable influence; it has besides a much more direct influence; the order, discipline, life in common, classification, work, amusements, and moral influences, which include the various agencies which the asylum brings to bear upon the lunatic, act powerfully against the tendencies which impel him towards solitariness and self-concentration, force him to self-command, and by the contrasts provoked, lead to the most beneficial mental operations.

"Such is the general treatment of the asylum; a treatment which acts only slowly and imperceptibly, and whose continuity of action is the more salutory as it is produced almost unconsciously as far as the patient is concerned.

"In these circumstances, individual treatment is lost, so to say, in the administration of the asylum.

"Thus it results that aggregation is generally a necessity which admits of but few exceptions. It is possible to exaggerate its importance at the expense of individual treatment, which, however, is still little advanced, and rather theoretical than practical.

"It is the same with the administration of drugs, the indications for which still continue very vague, and depend upon the general state of the patient rather than on other circumstances: thus the state of plethora or anæmia, of nervous irritability, feebleness, depression, or of stupor, are chiefly taken into account in deciding on the employment of physical treatment. We are still experimenting, working in the dark; and chance, perhaps as much as known facts, guides the physician in the administration of medicines which he thinks it his duty to give, and which the wise and prudent physician abstains from as much as possible.

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"In proportion as asylum organisation is perfected, and the pathological and pathogenic conditions of insanity are better known; in proportion as exclusive theories lose their importance and give place to eclectic doctrines, therapeutics will tend to become more individualised and rational. The progress made in the clinical study of mental disease rests upon the treatment; and at the same time that that morbid entity insanity is replaced by well defined distinct groups, therapeutics receives more precise indications, and draws them, no longer from the predominance of one symptom but from conditions more closely connected with the true nature of the disease.

"The progress of pathological anatomy exercises a very beneficial influence upon scientific mental treatment, and seems full of promise. Not indeed that these researches have as yet furnished many new indications, but they have cleared the ground, and furnished a thread through that labyrinth of unconnected varieties of disease.

"When pathological anatomy has succeeded in dividing the great class of psycho-cerebral disorders into insanity proper, organic insanity and insanity connected with convulsive diseases, the science of treatment has achieved a great step; negative, if you like, in this sense that it has furnished no new fact, but considerable, if one takes into account all the mischief it prevents.

"When pathogeny, aided by the discoveries of pathological anatomy, succeeds in raising a corner of the veil which covers the morbid processes of insanity, and permits us to differentiate the initial phenomena of the disease from those which are only secondary; when, finally, in later times, they have attempted to examine more closely the relations which exist between organic lesions and physical disorders and psycho-cerebral symptoms, and to penetrate into the nature of these latter, therapeutics received at least a more scientific basis if nothing further.

"Treatment is becoming more than ever etiological and individual. 'We ought to be thoroughly convinced,' says Griesinger, 'that what we have to treat is not a disease, but a diseased person; it is not mania, but a person who has become maniacal.' 'We ought always to seek carefully for the sometimes obscure connection between the circumstances which have caused the disease. The first indication to be fulfilled is to avoid as far as possible the circumstances which, by their simultaneous action, have led to the development of the disease.'"

We need not reproduce further Dr. Lintz's remarks on treatment, for they may be shortly summarised: The scientific medical treatment of mental diseases is unknown; all that is done at present by the best and most careful physicians is to place their patients in conditions of body and surroundings least likely to interfere with the curative powers of Nature. We do not cure our patients, they recover.

These views are so contrary to those now firmly held by many

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physicians in this country, that I have reproduced them at some length, being convinced of their truth. Unless care be taken, the prevailing system of giving tonics will retard and not hasten the genuine medical treatment of lunatics. All the benefits to be derived from tonics can be obtained from careful dieting, perhaps more slowly, but quite as surely. It is customary to consider this tonic and physicking form of treatment as something quite new, a step in advance achieved during the last few years. Nothing could be a greater mistake. At the beginning of this century tonics, barks, &c., were administered with no sparing hand, and our grandfathers abandoned the whole affair as vanity and vexation of spirit. But some modern physicians seem to be either more sanguine or more credulous, else we could never find a man placing medical treatment, as at present conducted, in the first and hygiene in the second rank of remedial agents.

T. W. McD.

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2. *German Retrospect.*

By W. W. Ireland, M.D.

The German Retrospect has been made from the following periodicals:—

"Archiv. für Psychiatrie und Nervenkrankheiten." viii. Band, Heft 1, 2, and 3, and ix. Band, 1 Heft. Berlin, 1877 and 1878.

"Allgemeine Zeitschrift für Psychiatrie," xxxv. Band, 1, 2, 3 and 4 Heft. Berlin, 1878.

"Verhandlungen der Berliner Medicinischen Gesellschaft," Band viii. Berlin, 1877.

"Medizinische Jährbucher" herausgegeben von der K. K. Gesellschaft der Arzte, Jahrgang, 1877. iv. Heft, and Jahrgang, 1878. i., ii., and iii. Heft. Vienna.

"Psychiatrisches Centralblatt," from Number 6, 1877, to Nr. 3, 1878. Vienna.

"Correspondenz Blatt der Deutschen Gesellschaft für Psychiatrie und Gerichtliche Psychologie," Numbers from 8 to 12, 1877. Neuwied.

"Centralblatt für Nervenheilkunde Psychiatrie und Gerichtliche Medicin," first ten numbers. Coblenz, 1878.

The "Correspondenz Blatt" has been given up, on the death of its distinguished editor, Dr. Adolph Albrecht Erlenmeyer, after having lasted 23 years. The reader, in seeking out references, ought to distinguish between the "Psychiatrisches Centralblatt," edited by Drs. Gauster and Meynert, and the new "Centralblatt für Nervenheilkunde," edited by Dr. A. Erlenmeyer. I have availed myself of the excellent *résumés* in the new periodical, where they reproduce matter taken from German journals or books, not in my hands.

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