yet it may, by depriving the accused of intention, excuse him from punishment.

The judge, in summing up, said that if a man by reason of drunkenness did not know what he was doing, or was incapable of forming an intention, he would not be guilty, but he pointed out that the purchase of a revolver and cartridges and driving to the injured man's house and shooting at him the moment he appeared were distinct evidences of intention. He added that if prisoner had a delusion that Mr. Sargood had done him a wrong, and did the act to avenge that wrong, then, even if the delusion existed, that was not sufficient to justify a verdict of not guilty on the ground of insanity.

Jury acquitted prisoner on the ground that he was insane at the time the offence was committed.

Now no plea of insanity was raised in this case by the defence, and the judge was quite clear in his instructions to the jury that such a plea could not be raised. Yet popular sympathy with the prisoner was such that the jury were influenced by it, as it appeared he had a wife whose conduct was such that he was driven to drink.

It is therefore abundantly clear that no precise lines can be laid down in any case in which the plea of insanity may be raised. All we, who are called upon to give evidence, can do is to form the best judgment we can on the case, having ascertained the personal history and having made a careful examination of the prisoner. It is for us to say: "Is the prisoner in our opinion insane? and if so, how far such insanity can be pleaded as an excuse for, or in extenuation of, the offence," leaving to the judge and jury to accept or reject our conclusions.

(1) A paper read at the Irish Divisional Meeting held at The Stewart Institution, Chapelizod, Co. Dublin, on April 18th, 1912.

Observations on a Case of Dementia Præcox.(1) By JAMES PARKER, L.R.C.S. & P.I., Assistant Medical Officer, West Riding Asylum, Wakefield.

THE following case presents some important features from a diagnostic point of view, owing to its unusual onset and course, and the relative absence of initial symptoms indicative of the actual character of the psychosis.

The patient, H. S—, a Jew, æt. 36, was admitted to the West Riding Asylum, Wakefield, in June, 1911. He came of neurotic stock; two sisters had suffered from insanity; one is at present confined in an asylum, having had three or four attacks, and is obviously a manic-

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depressive; the other passed through a stuporose attack, apparently hysterical, eight years ago and has remained well since. The previous history of the patient was, that he was a quiet, socially disposed young man, who followed his employment as a tailor regularly, and who up to the time of his illness was not regarded as abnormal in any respect. Fifteen weeks prior to admission he was involved in a tram accident and sustained a fractured clavicle and dislocated shoulder, traces of which injury he still retained in a slight paresis of the right arm.

He received hospital treatment and on his recovery returned to his home. It was noticed at this period that he was inclined to worry owing to his inability to work, and he also suffered from occasional "attacks of shivering." Whilst convalescing at his home he frequently visited a neighbour, who was regarded as a "spiritualist"; she made some vague predictions concerning the patient, told him he would not live long, and suggested that he should change his religion. These assertions patient was convinced were undoubted assurances of impending disaster. He became terrified, solitary, and apprehensive, and from some stray and bantering jests he began to believe that there was a movement on foot to convert him to Christianity; as a consequence he became exceedingly suspicious and in course of time very depressed. He was admitted in this state of melancholia. He gave a clear and connected account of himself, spoke readily of his delusionary ideas, and inquiry into the latter disclosed a mild systematised delusionary formation which was strictly localised and showed no tendency to spread, the false ideas being founded on some actual basis of fact. He believed the "spiritualist" had cast a spell over him, that he would not live long, and that there was a conspiracy to undermine his faith. Auditory hallucinations were also admitted, but these were referred to vaguely as "voices," and their content was not ascertainable. He exhibited no mental confusion and apprehension was normal; there was distinct exaggeration of the emotional tone, and his conduct was in accord with a state of mild depression. Physical examination, in addition to the previously mentioned traumatic paresis, revealed stigmata—faulty head-formation and features.

Very quickly, within a few days, patient was cheerful, neat in his attire, and a smart and energetic ward worker. Repeated conversations with him disclosed an apparent subsidence of delusionary ideas, and he was now amused at his former credulity. His conduct called for no comment in any particular, and he conversed sensibly, exhibiting a fair order of intelligence. He suggested that he had got into a "low state," owing to his accident; he quite agreed that his stay in the asylum would benefit him, and though anxious to be at home, he was perfectly willing to be advised by us and did not question in any way his continued detention. In due course he was sent forward for discharge and left the asylum recovered after three months' stay.

He was readmitted four days later, the information accompanying him being that on his arrival home he was rather talkative, and on the following day he was distinctly excitable and peculiar in his behaviour; when returning from a walk he insisted on going a very round about way to his home, and on arrival there he became destructive, chattered to himself, and was quite uncontrollable. His certificate stated that

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"he is excitable and violent, that he tears and burns things, that he talks nonsense and carries on imaginary conversations." He had greatly altered since last being seen; he now adopts a rather grandiose and pompous style, is very garrulous, and careless and inattentive when spoken to. He was quite aware of his surroundings, and when asked for an explanation of his recent behaviour he replied, "You know all about it; you are a doctor, so you must know all about it"; further information he refused to give. When put to bed his garrulity subsided and he gradually lapsed into a cataleptoid state, being quite indifferent to his environment; he now kept his eyes firmly closed, and he would not reply or obey directions. His apprehension showed no impairment, and emotionally he was buoyant and hilarious, his facial expression being that of extreme self-satisfaction. Negativism became extreme, from slight resistance to ordinary movements, and refusal of food, he eventually required tube-feeding, and retained his urine and fæces. All attempts to induce him to void urine were without result until preparations to catheterise were proceeded with; he then voluntarily left his bed and passed close on 40 oz., smiling quietly to himself. This condition was reached within two days of admission, though there were brief periods, lasting five or ten minutes, during which he was clear mentally, conversed fairly sensibly, and showed a thorough awareness of his position and surroundings. Within the next few days he became deeply stuporose, required regular nasal feeding and catheterisation. This state gradually merged again into talkativeness, which led up to typical catatoniac excitement, in which condition he remains up to the present time.

He keeps the head bent forward, appears most unsteady on his feet, and though he dances about in a most agile and clownish fashion he never falls. He sings loudly to himself, breaks suddenly into loud wailing and moaning, his facial expression showing rapid play from grief to exaltation. He is slovenly and untidy, still very negativistic, and, though understanding, he takes no notice of what is said to him. He frequently indulges in stereotyped movements, rolling his head about for long periods; muscular rigidity is present, and he exhibits well-marked "snout-cramp." He is wet and dirty. His bodily health has deteriorated, he being now very emaciated, and in addition he has developed a "hæmatoma auris," possibly the result of injury during his senseless excitement.

From the preceding description it will be seen that the essential features of this case were the following: Subsequent to a somewhat severe physical upset, the patient developed a mild paranoic condition, which subsided a few days after admission to the asylum; a few months elapsed during which there was an apparent freedom from mental disturbance, but very shortly after his discharge from the asylum a typical condition of katatoniac excitement supervened, which condition exists at the present time. Whilst the latter phase of the psychosis presents the typical classical picture of katatonia,

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which is, of course, quite familiar, yet the earlier manifestations are not without interest, since they did not afford very clear indications of the actual mental disorder from which the patient suffered. The particular question, therefore, which would seem to merit some discussion is: What significance, especially in a prognostic sense, is to be attached to a mild delusional state, persecutory in character, such as the patient presented when first admitted?

Delusional states, of course, occur in a variety of conditions, most of which were clearly excluded in this case. Thus, in manic-depressive insanity, both in the depressed and excited phases, delusional formation is not infrequent, such being, however, accompanied by other symptoms characteristic of this psychosis. Thus in the depressed forms psycho-motor retardation, a mood of sadness, and "divergent" rather than "convergent" delusions are usual; in the excited phases, distractability, flight of ideas or some defect of thought, with pronounced emotional disturbance, are observed. The absence of these characteristics, therefore, excludes any association with manic-depressive insanity.

Acute alcoholic hallucinosis, a psychosis identified by auditory hallucinations, some degree of mental confusion, apprehensiveness and vague persecutory ideas, did not suggest itself, as patient's history was reliably non-alcoholic. There is, however, one group of psychoses which the paranoid phase in this case closely resembles, and from which it is necessary to distinguish it, since the prognosis is essentially different in the two conditions. I refer to what has been described by Gierlich and Friedmann respectively as "periodic" and "acute curable paranoia"; these cases were composed of certain types of individuals who were constitutionally prone to interpret worrying incidents into a localised system of persecution, and they were more prone to this interpretation when in a neurasthenic state consequent on lowered vitality or severe physical stress; when the exhausting influences were removed, there was a subsidence of delusions and recovery, though complete insight was not regained, and the condition recurred when the patients were again exposed to mental or physical trauma.

Friedmann, from his observations, deduces, "that if an otherwise healthy person, especially a female, begins to fret about a troublesome experience, and then develops delusions

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which do not spread, whilst the patient remains clear and *presents no hallucinations*, we have the prospect that the whole disorder will disappear in the course of two and a half or three years."

It is apparent from the preceding that the early paranoid symptoms in the case of H. S— bear a close resemblance to those of "acute curable paranoia," though the subsequent development is essentially different. There is, however, one important factor which serves to distinguish the two conditions, *viz.*, the existence of auditory hallucinations in the case under consideration. This would seem to indicate that the mental disturbance was of a graver nature than that occurring in the cases described by Friedmann and Gierlich, which is limited to delusions that may be regarded as exaggerated forms of similar reactions displayed by many so-called neurotic individuals in everyday life. Such persons, in difficult circumstances, tend to lose their sense of proportion, become morbidly suspicious and apprehensive, even to the extent of developing mild persecutory delusions. When, however, these symptoms are also associated with hallucinatory disorders, it would lead to the suspicion that the abnormal phenomena are the early expression of a definitely deteriorating process, rather than an episode in the mental life-history of a "neurasthenic."

Apart from the existence of hallucinations, there appears to have been no indications which would suggest the diagnosis of dementia præcox; thus the emotional indifference, senseless impulses, disorders of conduct, and fantastic delusions—features usually associated with the psychosis—were entirely absent. Remissions in dementia paranoides are also far from usual.

It is thus seen that dementia præcox may first manifest itself in an atypical form by a mild delusional state, only differing from other mental disorders with a much less serious prognosis by the presence of hallucinations. Since the recognition of this deteriorating psychosis in its earliest stages is of obvious importance, I have ventured to bring this somewhat unusual case to your notice.

(1) A paper read at the Northern and Midland Divisional Meeting, held at Garlands Asylum, Carlisle, on April 18th, 1912.

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