The minutes of the last quarterly meeting having been previously printed in the JOURNAL, were taken as read, agreed to, and signed.

The following new members were unanimously elected:

Harold Reginald Burpitt, M.D.Brux., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Metropolitan Asylum, Darenth, Dartford, Kent. Proposed by A. Rotherham, R. H. Steen, and H. Hallett.

John Stothart Farries, L.R.C.P., L.R.C.S.Edin., Assistant Medical Officer, Royal Albert Asylum, Lancaster. Proposed by Archibald R. Douglas, D. M. Cassidy, and H. Hayes Newington.

Mules, Bertha Mary, M.B., B.S.Durh., Court Hall, Kenton, South Devon. Proposed by P. Maury Deas, H. Hayes Newington, and C. Hubert Bond.

James Parker, L.R.C.S.&P. and L.M.Irel., Assistant Medical Officer, West Riding Asylum, Wakefield. Proposed by W. Bevan-Lewis, H. Hayes Newington, and C. Hubert Bond.

Helen C. Stewart, M.B., Ch.B.Birm., Edae, Chigwell, Essex. Proposed by Frederick W. Mott, A. I. de Steiger, and W. Stanley Hughes.

The PRESIDENT said that before he called on Dr. Albert Wilson, he wished to make one or two brief observations. He was sure it was the desire of the meeting, and of the whole Association, that there should be officially communicated to Mrs. Urmson an expression of their sincere sympathy in the loss of Mr. G. H. Urmson, who had been for many years a Commissioner in Lunacy. It would be agreed by every one who knew him that Mr. Urmson was one of the truest English gentlemen they could wish to meet. He also thought that reference should be made, at that the first meeting after the event, to the signal and great honour which had been conferred on an honorary member of the Association, Sir Thomas Clifford Allbutt, K.C.B., and to him they offered hearty congratulations. He next mentioned, with regret, the long and serious illness of a former President of the Association, Mr. G. W. Mould, late of the Cheadle Asylum, who was now lying seriously ill in Wales. He was sure it would be the wish of members to convey their sympathy to him in his illness.

Dr. G. H. SAVAGE said that it was perhaps scarcely necessary to put in the form of a vote the expression of the feeling of members concerning the death of the late Commissioner in Lunacy, Mr. Urmson. Some of them knew him not only officially, but personally, and in whatever capacity they knew him they always respected him, and looked upon him as being as fine a type of English gentleman, English lawyer, and Commissioner as could be found anywhere. Therefore he was sure all would agree that a message of condolence and sympathy should be sent to Mrs. Urmson and family.

The resolution was agreed to in silence.

The PRESIDENT called upon Dr. Albert Wilson to supplement his previous paper by a few short observations, and expressed the pleasure he felt at seeing so many visitors present.

Several visitors and members took part in the discussion which ensued and Dr. WILSON replied.

Dr. Robert Jones was to have communicated an account of the International Congress on School Hygiene (at which he was the Association's delegate) but was unavoidably prevented from being present at the meeting.

In view of the lateness of the hour the description of the Amsterdam International Congress on Psychiatry, etc. (held last September), which Dr. F. W. Mott, F.R.S., had similarly kindly promised to give, was taken as read.

The members afterwards dined together at the Café Monico.

SOUTH-EASTERN DIVISION.

The AUTUMN MEETING of the South-Eastern Division was held by the courtesy of Dr. R. J. Stilwell at Moorcroft, Hillingdon, on October 8th, 1907.

Among those present were Drs. David Bower, W. H. Bailey, H. Baird, A. Bowles, R. H. Cole, James Chambers, F. G. Crookshank, Augustus C. Dove, R. Langdon-Down, F. Edridge-Green, J. Francis Dixon, David Hunter, J. Higginson, H. E. Haynes, T. B. Hyslop, G. H. Johnston, P. G. Kennedy, J. Gordon Munn, E. D. Macnarmara, J. J. Murphy, H. J. Macevoy, Mary E. Martin, E. S.

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Pasmore, J. P. Race, W. Rawes, H. J. Stilwell, G. E. Shuttleworth, G. H. Savage, J. Stewart, A. H. B. Stoddart, E. F. Sall, G. N. O. Slater, T. Outterson Wood, F. Watson, and R. H. Steen (Hon. Sec.).

The visitors included Drs. Parry, C. R. Wood, R. Brown, and Mr. J. Stilwell.

Apologies were received from the President and Drs. J. Bayley, Fletcher Beach, Bond, Boycott, Edwards, Elkins, Haslett, R. Jones, A. S. Newington, H. H. Newington, P. C. Smith, Percy Smith, A. De Steiger, Seward, Taylor, and Thomson.

The house, adjoining villas, and Hayes Park were inspected, and subsequently Dr. R. J. Stilwell entertained the members to luncheon. At the termination of the lunch Dr. T. Outterson Wood proposed a vote of thanks to Dr. R. J. Stilwell for so hospitably receiving the Division.

A meeting of the Divisional Committee was held at 2.15, Drs. Crookshank, Dixon, Langdon-Down, Slater, Stoddart, and Steen being present.

The general meeting was held at 3 p.m., Dr. T. Outterson Wood in the chair. The minutes of the last meeting having appeared in the JOURNAL were taken as read and confirmed.

The invitation of Dr. Seward to hold the spring meeting of the Division at Colney Hatch Asylum on April 28th, 1908, was unanimously accepted, with much pleasure.

Dr. Charles A. Mercier having, with regret, resigned his seat on the Council as Representative Member for the Division in that as President elect he is a member of the Council, Dr. H. Wolseley Lewis was unanimously elected Representative Member for the Division.

CONTRIBUTIONS.

"A Short Account of Moorcroft, Past and Present," by R. H. Cole, M.D.

In response to the invitation of our Divisional Secretary to contribute to the meeting to-day, it was thought possible that a few remarks dealing with the development of this institution, which for nearly a century has been an asylum for patients of the upper classes, might not be without interest. It would seem also to be an opportunity for reviewing our work, and for observing what advances have been made in the treatment of patients of this class.

The conditions of our practice here are somewhat different from those of most asylums, inasmuch as our patients are by no means under one roof. Indeed, our work resembles a system of colonies, the component units of which extend into our two neighbouring parishes; thus our male patients, with occasional exceptions, live here in Hillingdon, whilst our female patients, for the most part, reside in Hayes. It is hardly possible for one medical officer to make an efficient and complete round in the course of the morning, as this may entail a visit to nine or ten houses and villas, some of which are situated about a mile apart from one another.

Moorcroft, the parent institution, was officially opened as a house for the reception of the insane on July 1st, 1816. The great-grandfather of our colleague, Dr. Reginald Stilwell, lived here at that date. Tradition states that his family offered a homely shelter to occasional cases even earlier still. Most of these cases appear to have been derived from the immediately surrounding district, but its easy access from town soon commended it to some London physicians as a convenient home for treating their patients in these pre-asylum days, and no doubt stimulated the growth of the institution.

We have some early pictures of Moorcroft, which may be of interest to you in illustrating what the place was like in these olden times, and we will point out where the extensions were made. We are informed that the customary dress of the patients at this period consisted of nankeen breeches, a buff waistcoat, with a stock and a blue frock coat with brass buttons, and no one appeared in the garden without a silk hat.

On examining the files containing the old admission papers, which may interest you, we find the document for the reception of a patient was indeed simple in these days, and we hand round specimens for your inspection. You will observe that merely a written note from the medical attendant requesting the admission of a patient was all that was required. The earliest that we can find are dated 1816.

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During the ensuing four years the same procedure seems to have been followed. These letters were probably only looked upon as safeguards for those receiving the patients, and might be of use in the event of subsequent proceedings for supposed illegal detention, and were no doubt usual at this period.

In 1820 we notice the first printed form. This was called a medical certificate, but no facts indicating insanity were stated therein. It served the purpose, however, of showing that the patient had been personally examined by a medical man whose opinion was that suitable confinement in a licensed house was necessary and proper.

Nine years later, namely in 1829, new forms came into use, whereby two separate medical examinations were necessary, but even then the certificates were of a similar simple character. These were accompanied by an order of the patient's relative or guardian, together with a statement of particulars which was in duplicate, and involved the responsibility of the certifying medical men as well as that of the person who signed the order. Perhaps the object of this was to corroborate the identity of the patient.

This method continued for the next sixteen years, which brings us to the year 1845, when the basis of our present certificates was formulated. Facts indicating insanity were then for the first time insisted upon, and, indeed, the certificates were in substance much as they are now, but they appeared on the same sheet of paper. This, as you are aware, was altered in 1890, when the order of a magistrate, on the petition of a relative, was introduced.

The first report by officials that we can find here is dated in 1828, so that it is improbable that the house was ever visited before that time by the commissioners appointed by the College of Physicians. The house being embraced within the sphere of the Metropolitan Commissioners, who were appointed by the Home Secretary in that year, was subject to regular visitation by them four times annually until the present Board was constituted in 1845, since which time the visits have been increased to the present number.

The gradual development of Moorcroft and its annexes has been the natural outcome of the increasing number who have applied for treatment. It has been the ambition of the proprietors to make such improvements as are possible with old buildings to give adequate accommodation to the class of patients that is received, and to keep abreast of all modern tendencies in the care and treatment of the insane.

The oldest part of Moorcroft House dates back to Tudor times and forms the central part of the present structure. With greater foresight than was shown in many contemporary houses the original designers fortunately planned the building in such a manner that the principal living rooms face south. At this period it was a farmhouse and the front door was where the garden entrance to the smoking room now is. The age of this room is established by what remains of the original fireplace and its supporting oak beam. The characteristic bricks and their arrangement in herring-bone pattern deserve notice. There is also a portion of the old masonry to which additions have been made in recent times. The window frames in this room, the adjoining dining-room and in the bedrooms above on the first floor, indicate the extent of the first house. The electricians found considerable difficulty in wiring this portion of the building for lighting purposes owing to the thickness of the floors.

There are small cellars below this part, and it is recorded that ten priests were once concealed there for four days, having sought a hiding place in the days of their persecution; a priest-hole perhaps secure, if not comfortable, since it is mentioned at that time the floor was covered some inches in water. Reference is made to this in a book entitled *Secret Hiding Places in England*, by Mr. Fae.

The kitchen and offices for the steward, etc., are at the back of the central part of the house and they have been modernised from time to time.

Both sexes were at first tended in Moorcroft House itself, and the numbers increased year by year so that there were 18 in 1837, 25 in 1840, 30 in 1843. Extensions became necessary, another storey was superimposed, and the structure was augmented in both easterly and westerly directions. In 1848 Woodend House was acquired and the ladies were transferred to that establishment in order to give more accommodation to the gentlemen. The west wing which contains the large general sitting-room, attendant's quarters, and dispensary was built in 1876, and is

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that part of the present building which is used by our less tractable patients. The east wing was added in 1891 and has served largely as a family residence of our colleague's parents, Mr. and Mrs. John Stilwell, who undertake the lay management of the institution.

The license for Moorcroft is granted for 48 patients, including 8 ladies, who are accommodated at Laurel Lodge and the cottage.

The Lawn—the house in the front garden, formerly occupied by Dr. Henry Stilwell, who retired last year after forty-six years' service, is now used as a reception house for borderland cases or for a single certified patient. There is also a separate villa at the farm, which has been used as occasion arises, and we frequently have single cases in houses in the district further afield.

The extent of the gardens, orchard, and pasture lands comprises nearly sixty acres of ground surrounding Moorcroft. The cricket ground is largely patronised, and there are ample walks for those patients who are unable to take their exercise beyond the grounds. The flower garden is used for convalescent and quiet patients, and here the usual tennis courts, croquet lawns, golf and bowling greens are provided. The billiard room is built away from the house, which in our opinion has some advantages.

Church services are held morning and evening every Sunday in the large general sitting room in the west wing, where also our entertainments usually take place. The fire arrangements consists of hydrants and hose, both inside and outside the house, connected with a water supply of considerable pressure. We also have Minimax extinguishers to be used in case of need. Periodical fire-drills are practised by the attendants under the superintendence of one of the medical officers.

Woodend House and Hayes Park, where most of our ladies reside, are licensed for 19 each, and were opened in 1848 and 1849 respectively. The former is an old-fashioned building with a delightful old garden, and is very comfortable. It is said to be on the site of a former house which served as a hunting-box for Henry VIII. Hayes Park, which was annexed five years ago, is a more modern mansion standing in sixty acres of ground. It has some separate villas, in one of which our colleague, Dr. Higginson, the special medical officer resides.

Our registers show that over 1300 cases (700 males and 600 females) have been under treatment since the three licensed houses were opened. The average numbers in residence during the past five years are 39 gentlemen and 39 ladies, excluding a few single cases and voluntary boarders, whilst the admission rates on the licenses during this period consists of 11 gentlemen and 18 ladies, 29 in all per annum. These numbers vary considerably in individual years and depend to some extent on the vacancies which arise, and we usually have more changes on the female than on the male side. Our recovery rate, according to our books of the last quinquennium, excluding the transfers on admission, works out at 39·5 *per cent.* for our gentlemen, and 44·7 *per cent.* for our ladies. The death-rate in the same period has been 5·3 *per cent.*, or 8·7 *per cent.* for the gentlemen, and 2 *per cent.* for the ladies. These figures are of little value with our small numbers, but apparently we have progressed during the past half-century, for, on taking the five years, 1839 to 1843, the statistics of which are available, in the Commissioners' reports we notice that the recovery rate for both sexes in this asylum was 19 *per cent.* and the death-rate was 10·2 *per cent.*

With regard to our patients we regret that we are unable to give you any demonstration of them as can be done with pauper patients, especially as we have some of great interest. We do not appear to receive so many cases of acute mania as in former years. Delusional melancholiacs with refusal of food and suicidal tendencies, paranoiacs, and cases of dementia præcox are very prevalent amongst our recent admissions. General paralysis we receive practically on the male side only, and we have as many as five in the house at the present time, all of whom have a reliable history of specific infection. During the past five years they form 7 per cent. of the total admissions—in one of these years we received as many as seven, whilst in the previous year not one was admitted. During the past sixteen years we have had 30 cases, including one juvenile general paralytic. Their average age has been forty-four, the youngest being 27, the oldest 62. Two have lasted over six years, but their average duration has been two and a half years. Latterly we have found the operation of lumbar puncture to be helpful in establishing the diagnosis in doubtful cases.

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We endeavour to trace family histories with special regard to hereditary taint, but it is difficult to obtain accurate information inasmuch as the relatives of private patients wilfully mislead us in the matter. We do not propose to discuss etiological factors, but we would like to mention that alcohol, in our opinion, plays but a small part as a causative agent in our cases. This we believe to be in accord with the experience of most private asylum medical officers.

As to treatment our aim has been to guide our patients through their attacks with the feeling of as little restraint as possible. This has entailed no little anxiety at times, although our staff of nurses and attendants is adequate. The convalescing patients are encouraged to feel the freedom of an ordinary country house, and are duly classified and separated from those of a more disturbing nature. We try to individualise our treatment as much as possible, and we believe greatly in the beneficial effect of the sane on the insane mind. Besides the gentlemen companions that are engaged as occasion arises the medical officers devote a large proportion of their time to the patients, for it has not seemed right to leave sensitive and convalescing patients of the upper classes too much to the care of attendants. It has always been difficult to induce our patients to take up manual work; we endeavour, however, to promote this object by encouraging them to assist in some of the lighter occupations connected with the farm and garden. To amusements rather than work we are bound to have recourse to find employment for them. Bicycling, motoring, and horse exercise are encouraged, as well as the usual pastimes and recreations.

With regard to medicinal treatment, on examining some of the old case books, one notices with surprise the large amount of opium that was administered in former years to allay excitement. Tartarated antimony seems to have been a favourite remedy for acute cases. The blue pill and black draught were freely given for the benefit supposed to be derived from a reducing effect. Our ideas have changed since then, for now we feed up our patients who are in a state of excitement, and our melancholics are washed out in accordance with modern toxæmic theories. We share the views held by the Association generally as regards the sparing use of hypnotics and sedatives. These, however, we have to give in obstinate cases of insomnia or where restlessness persists, and the new drugs are given a fair trial directly their virtues are extolled. It has been customary to rely a great deal on bromides judiciously administered sometimes in large doses, believing as we do that the bromides are less harmful than the more complex and modern drugs, especially to highly organised brains. Great things were hoped for when thyroid was first introduced as a therapeutic agent in mental diseases, and, although we have observed excitement supervene in cases of stupor from the administration of this drug, we cannot claim a recovery from its use.

Through the kindness of Dr. Ford Robertson and Dr. McRae, of Edinburgh, we have lately been enabled to treat two cases of general paralysis with their anti-diphtheroid serum. Both have shown marked improvement, whether *propter hoc* or *post hoc* we are not prepared to say. The one aged twenty-seven was first injected last Christmas after six months acute and violent excitement. To the other, aged forty-one, of a melancholic type, the serum was first administered in March shortly after admission. Twenty c.c. of the injections were given subcutaneously once a week, but latterly the serum has been poured through the nose or taken through the mouth. On every occasion there has been a slight feverish reaction, which we are informed does not take place in non-general paralytics. The first patient has so far recovered as to return to his wife, and continues to have the serum under our supervision in town. The other patient is still here, and shows certain improvement. Both still exhibit motor signs of the disease, but it is possible that a remission of mental symptoms at any rate may have been assisted by the use of this serum.

Treatment by baths plays a small part here, and, as in other institutions, we use the bath to subdue cases of excitement. The electric bath is also used from time to time for some of our neurasthenic cases. We do not treat our acute cases in bed so much as is customary in public asylums, but cases of acute delirious mania, cases of exhaustion, and melancholics with determined suicidal tendencies are kept in bed. We prefer still to let our acute manias expend their excitement as much as possible in the open air. We feel, in spite of what has been said against it, that it is better to have a healthy outlet for the morbid energising of the brain,

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rather than to subject a restless or violent patient to the restraining influence of enforced rest in bed during the daytime.

Open-air treatment for the insane is under discussion at the present time. Last year we treated a case of melancholic stupor in an open-air tent in the garden during the summer months with some improvement in the patient's general condition, although mentally there was practically no change.

Hanwell being in such close proximity to us, the dominant influence of Conolly made itself felt here from the commencement of his movement against the use of mechanical restraint. It appears from the past records that but little restraint was ever used at Moorcroft, and we have not been able to find any implements such as are exhibited in some of our old asylums. We still believe that a strait waistcoat has its proper place as a remedial agent to prevent injury to self or others in some cases where struggling with attendants would otherwise ensue. So also seclusion is, on rare occasions, practised here, and we find the benefit of a padded room. In cases of refusal of food our custom, as a rule, is to use the nasal tube with a funnel, our experience being that this is the best form of forcible feeding when this is impossible by means of a spoon. There are some antiquated stomach pumps here, but they are never used now, although sometimes the large œsophageal tube is passed in order to administer food of a thicker consistence or where the nasal tube is difficult to pass.

Suicidal attempts have occurred here as at most asylums. As each patient sleeps in a separate bedroom we have no system of partial supervision at night such as we can exercise in the day time. As a patient improves there comes a time when the presence of the attendant can be dispensed with to test the patient and to promote recovery, and we have to rely on our judgment in this matter. Casualties from actual violence affecting the medical officers and others have been rare, although not unknown, but we are glad to say nothing serious has ever happened. Occasional escapes have been made, but on the whole the system of parole given to patients has not been abused. Very rarely has any trouble arisen from patients when out for recreation, but we could mention instances of chronic patients, usually quiet and manageable, breaking out suddenly into excitement, so that one feels an insane person can never be implicitly trusted.

Our attendants' staff at Moorcroft consists of a head attendant and sixteen others, and a night attendant who makes hourly rounds. Extra attendants are engaged for suicidal cases. At our ladies' establishments we have twenty-one nurses who are supervised by six lady companions. The attendants for the most part live in cottages in the district, and are not prohibited from marrying. They therefore remain long in our service. A father and son in more than one instance have been employed at the same time. Our senior attendant, who can count upwards of forty-five years' service, and has been awarded the gold medal of the Asylum Workers' Association, has during the past year been placed on the pension list by reason of ill-health. We make it a rule now to insist on all new comers to our attendants' staff being total abstainers, and we have no difficulty in finding men willing to be teetotalers. A course of lectures is given each year for the instruction of nurses and attendants, many of whom possess the nursing certificate of the Medico-Psychological Association. They are encouraged to join the A.W.A., and to take a general interest in their calling. We prefer to engage as attendants for the most part men retired from the services, especially those who have been accustomed to valet and wait upon gentlemen.

Moorcroft being originally a family residence, its influence as such has been maintained to the present day. The two lady companions on the male side we find of the greatest assistance in promoting the patients welfare. No harm has ever come to them from their freely mixing with the quiet and orderly patients, and their presence has a distinctly humanising tendency. It must be remembered that more than half our patients are chronically insane, and therefore the general arrangements have to be adapted for their comfort and happiness, and it has been our object to make them feel their position as little as possible. Our dependencies being separate afford opportunities for frequent parties and entertainments, where those of both sexes who are well enough assemble together, and this association has a social and beneficial effect.

Moorcroft, like most other private asylums in the country, seems to have fulfilled its purpose to the satisfaction of the public and profession alike judging

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from its steady development in the past. As to the future we cannot increase our numbers as public asylums do, for, as you are aware, no extension of a license is permissible; we therefore try to improve our accommodation year by year for those included in the licenses, and take a few extra patients when their mental state permits in villas outside. We are in accord with the proposed clause in future lunacy legislation as to the notification of incipient cases of insanity. In the present state of public feeling this will be a great relief to those who have the horror of certification at the outset of an attack of insanity. Looking ahead at the probable future expansion of London it is not unlikely that the work here may some day have to be moved further afield. However, for the present we are in rural surroundings in a reposeful atmosphere, and our patients can still take their walks in country lanes.

Having made an inspection of our establishments this short account is merely meant to serve as a supplement, and may possibly provide material upon which some members of the division may feel inclined to raise a discussion as to the management of private patients. We shall therefore be glad of any criticisms and suggestions that may help us to further improve the condition which we have at present reached in our work at Moorcroft and its dependencies.

In the discussion which followed, the CHAIRMAN expressed the gratitude of the Division for the very interesting paper contributed by Dr. Cole, and in commenting upon the admirable nursing arrangements at Moorcroft he hoped that the word attendant would soon be banished, and that the word nurse would take its place for all those of both sexes who tend the insane.

Dr. BOWER stated that his own figures with regard to alcohol corresponded with those of Dr. Cole, and pointed out how they differed from those in the Blue Books. He believed that in many cases the alcoholic intemperance was more the result of the insanity than the cause of it. The supervision of the suicidal patients was an important question, and he often found difficulty in deciding as to when total supervision could best in the interest of a particular patient be withdrawn.

Dr. STEWART followed, and stated that in his opinion in 70 *per cent.* of the inebriates the inebriety was not the result of alcohol, but that the taking of alcohol to excess was the result of the inebriates being neurotics.

The Medico-Psychological Association should let the public know that it is not satisfied that alcohol is the cause of insanity to the extent it is supposed to be.

Dr. SAVAGE, in thanking Dr. Cole for his paper, pointed out the many advantages to be found in private as compared with public asylums. Among these he would specially mention the great individual care which was possible in a well-managed private institution.

Dr. COLE replied.

"Babinski's Conception of Hysteria." By W. H. B. Stoddart, M.D.

I am only too well aware that there may be several members of my audience to whom Babinski's views as to the nature of hysteria are familiar, and who may have come here under the misapprehension that I am about to offer a criticism of those views. To such I offer my apologies, for, at the outset, I wish to say that I am in entire agreement with Babinski in this matter, and I propose merely to give an exposition of his views, believing that they are not as well known in this country as they deserve to be.

The very name of the disease already predisposes to a misconception as to its nature, being derived from a Greek word ὕστερα, meaning the uterus; it being supposed in former times that hysteria was the result of some functional disturbance of the generative organs, perhaps sexual excess or sexual deprivation. With subsequent experience, however, we have come to learn that hysteria has nothing to do with the uterus, since it occurs almost as frequently in men as in women, and it occurs in children before the onset of puberty, and in old people after the sexual functions have become extinct.

Now Pye-Smith used to submit that the essential features of a good name for a disease were that it should be short, classical, meaningless, and capable of forming an adjective. The word hysteria possesses all these characteristics, if you will allow it to become meaningless. Just as you allow the word artery (a structure containing air) to be meaningless, so far as its derivation is concerned; there will

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then be no reason why we should not retain the name "hysteria" for the disorder we are about to discuss.

It is necessary, however, that the disorder known as hysteria should be defined. If you will take the trouble to look up the definition as given by various authors, you will find that there is no unanimity of opinion; and some authors, especially Laségue, go so far as to say that the definition of hysteria has never been given and never will be.

This is a deplorable state of affairs. To say that words, which we intend to retain, cannot be defined is as much as to suggest that words precede ideas. What would you think of a naturalist who said that it was impossible to define some zoological species, whose existence he admitted?

We must admit either that hysteria is a nosological entity with definite characteristics, and therefore capable of being defined, or that we are confusing it with other neuroses, to which the various cases, hitherto called hysterical, will have to be relegated. Such are the alternatives to which we are inevitably led, and I believe that no neurologist would hesitate to accept the former. The majority of medical men who have written on hysteria have not contested the possibility of a definition, but they have not felt equal to enunciating one, which even they themselves could regard as satisfactory.

Hysteria, according to the commonly accepted view, is characterised by a certain grouping of symptoms, and it is only possible to define it by describing these symptoms succinctly and showing how they are related to one another.

It is generally said that hysteria is manifested by two different kinds of disorder, the first being permanent—the stigmata of hysteria—and the second being transitory. The stigmata, to which great importance is attached, have the characteristic that, besides their fixity, they develop unknown to the patient. They are anæsthesia of the back of the throat, hemianæsthesia consisting, when well developed, of abolition of cutaneous sensation in its various forms, unilateral diminution of the acuity of the special senses, especially of vision, with concentric retraction of the visual fields, monocular diplopia or polypia, and a dyschromatopsia which, unlike that of tabes and alcoholism, affects blue and violet, while perception of red remains normal. The characteristic headache known as clavus hystericus, ovarian hyperæsthesia and submammary tenderness are also reckoned among the stigmata. Among the transitory phenomena are included such symptoms as hysterical convulsions, paralyses, contractures, aphonia and mutism. These usually appear quite suddenly, perhaps under the influence of some emotion, they last some time and then disappear just as suddenly, perhaps to give place to some other transitory phenomenon.

Such is the classical conception of hysteria. It follows that when one is confronted with a patient presenting any of the transitory hysterical manifestations, one proceeds to look for the stigmata; if they are present there is no longer any hesitation as to the diagnosis of hysteria. Many are not even as exacting as this; when any given symptom appears to them difficult of interpretation and cannot, in their opinion, be ascribed to any other neurosis, they feel justified in calling the symptom hysterical, provided they can discover any of the hysterical stigmata in the patient.

By such a method of procedure, the most varied symptoms are at times classed as hysterical. You will gain some idea of the extent to which this principle may be carried, if I enumerate some of the disorders which have been ascribed to hysteria.

Without referring to the convulsions and anæsthesias already referred to, we have paralyses of all kinds, hemiplegias, monoplegias, paraplegias, as well as paralyses limited to the distribution of one or more peripheral nerves, such as musculospiral paralysis, and paralyses of the third or sixth pair of cranial nerves. Hysterical neuralgias are also described, especially hysterical sciatica.

Divers forms of mental disorder are also at times attributed to hysteria.

The visual apparatus is held responsible for a wealthy array of hysterical manifestations; besides the diminution of visual acuity, retraction of the visual fields and ocular paralyses, already mentioned, hysteria is held responsible for pupillary immobility during the convulsions, and even between the convulsions, as well as for inequality of the pupils and abolition of the light reflex.

Cutaneous and vasomotor troubles are also from time to time ascribed to hys-

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teria:—Erythemata, hæmorrhages, petechiæ, bullæ, ulcers, and even gangrene. Numerous observations of hysterical œdema, especially œdema with cyanosis, have also been published.

Among hysterical disorders of the respiratory system, we hear of aphonia, mutism, spasm of the glottis, œdema of the glottis, pulmonary congestion and hæmoptysis.

Tachycardia, bradycardia, and angina pectoris are also sometimes described as hysterical. Gastralgia, vomiting, hæmatemesis, polyuria, anuria, hæmaturia, albuminuria, incontinence and retention of urine have all been described as manifestations of this neurosis.

Lastly, hysterical fever has frequently been described, and recently cases have been put on record, which have been considered indisputable. This is an incomplete list; but it will give you some idea of the various ways in which it is supposed that hysteria may manifest itself. Charcot used to say that hysteria was the great simulator; a more recent way of expressing the same opinion is, "Hysteria can do anything." There are plenty of medical men who are quite ready to accept such a view, since it conforms quite readily to their nebular conception of hysteria; but I think most of you will already have come to the conclusion that such a conception of hysteria is too wide.

I will now subject this conception to criticism, using, as far as possible, Babinski's own words, but, of course, substituting English for French.

First, let us consider the stigmata which, according to the classical doctrine, are of fundamental importance. Fixity or permanence is regarded as one of their essential features. We believe, however, that we are justified in contradicting this assertion, since for many years we have found that, whenever we are confronted with a patient presenting hemianæsthesia or contraction of the visual fields, we endeavour to cause these disorders to disappear, and, except in the case of those patients with whom hysteria is their profession and a source of income, we have succeeded in every case. When I have before me a patient presenting hysterical hemianæsthesia or general anæsthesia, however complete it may at first sight appear to be, transfixion of the integuments with a needle evoking no evidence of painful perception, I proceed as follows:—I apply to the pulp of the fingers two electrodes (one being a stiff wire brush) connected with a faradic battery giving a maximum current. Nineteen times out of twenty the patient withdraws his hand and makes a grimace denoting painful perception. Some of these patients will not allow the electrodes to be applied again, they prefer to go to some other doctor, whose electrical apparatus may be undergoing repair; others, who, I am glad to say, are in the majority, recognise that they have experienced the sensation, and wish to continue treatment. I then repeat the application with the assurance that it is an infallible cure for anæsthesia; and—as I have said—one meets invariably with success, the cure sometimes being effected at a single sitting. By analogous proceedings we can easily cure contraction of the visual fields, dyschromatopsia, and anæsthesia of the throat which, by the way, is *incorrectly* called "loss of the pharyngeal reflex," for reflex excitability is never abolished in these cases.

The second cardinal feature of the stigmata is that they develop unknown to the patient. Now, we are of the opinion that these phenomena are the result of autosuggestion, or rather of unconscious suggestion on the part of the medical man, a view which has previously been advanced by Bernheim, of Nancy. The usual mode of examination of a hysterical patient is of such a nature as to suggest to his mind the idea of hemianæsthesia or of some visual disorder; it is, therefore, of the utmost importance to take every precaution to avoid this fallacy.

It is inadvisable to examine these patients before others, or to talk to one's students before the patient about symptoms which may be observed in hysteria. The same circumspection should be observed when the patient is in a convulsion and apparently unconscious, seeing that we have to deal rather with a case of subconsciousness, in which every remark made in the patient's presence will be remembered. Before examining sensation it should be explained to the patient that he will feel light touches, pinpricks, pinches, sensations of warmth and cold, and that he will be required to say *what* he feels on each occasion. The various stimuli should then be applied, and interspersed with passive movements of the limbs. If there is no response, say "What do you feel, what did I do to you?"

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But never say "Did you feel that?" or "Do you feel as well on one side as on the other?" because such a way of putting the question suggests anæsthesia to the patient. By adopting this method for many years Babinski has not found a single case of hemianæsthesia among patients, who had not *previously* been submitted to a neurological examination. Babinski's experience extends to more than one hundred such patients who were undoubtedly hysterical.

Similarly, contraction of the visual fields does not develop spontaneously without the influence of suggestion. You are all well aware of the usual method of investigating this symptom. The patient is placed in position before a perimeter, and he is asked to say, as the carrier is moved forward, when he sees the piece of paper which is placed in it; or, as the carrier is moved backward, when the paper disappears. This mode of procedure is insufficient and fallacious. Vision is normally indistinct at the periphery of the field, and a hysterical patient is liable to wait until his perception of the paper is perfectly clear, thus leading the observer into error, and serving as a point *d'appui* for subsequent suggestion and autosuggestion. It ought first to be explained to the patient that he is to make some sign as soon as he is able to say that there is anything there, and that he is not to wait until he has a clear perception of the paper. The carrier should occasionally be advanced without any paper in it, so as to ascertain that the patient is not making random shots, and it should be alternately advanced and retired so as to get the maximum visual field. Examined in this way none of Babinski's patients exhibited contraction of the visual field, provided they had not previously been subjected to similar ophthalmic examinations. Similarly, Babinski has never met with monocular diplopia or polyopia or so-called dyschromatopsia, *i. e.* among new patients. And similarly with the other stigmata, such as ovarian hyperæsthesia, they are all the result of suggestion.

Thus, gentlemen, you see that the symptoms called stigmata are not permanent phenomena, and that they do not develop unknown to the patient; they are found to be wanting, at least in the majority of cases, when the examination is carried out in the manner which I have indicated. They are not of that fundamental importance which the classical conception of hysteria attributes to them; and definitions of hysteria founded on their existence must find themselves shaken to their foundation.

Passing to the transitory manifestations of hysteria I will endeavour to show that, of all the characteristics above enumerated as contributing towards a definition of hysteria, there is not one which ought to be retained. That emotion plays an important *rôle* in the genesis of hysterical troubles is incontestable; but it may also be responsible for attacks of asthma, gout, circulatory troubles in patients suffering from certain vascular lesions, and even for the onset of diabetes; this feature is therefore not characteristic of hysteria, and can take no place in the definition. Nor can rapidity of disappearance be regarded as a special feature of hysterical phenomena; the pain of a renal colic or of a tabetic gastric crisis may disappear quite as suddenly. And as regards one manifestation clearing up and giving place to another, the same thing occurs in gout. Finally, hysteria is not the only malady which, as a rule, causes no disturbance of the general health; psychasthenics (patients who suffer from obsessions, morbid impulses, and morbid fears) enjoy good general health.

You see therefore, gentlemen, that the classical definition of hysteria cannot stand the test of criticism, either when examined as a whole or in respect of any of its details.

In order to frame a definition of hysteria it is necessary to determine and to enunciate the features which are peculiar to it. To do this we must analyse such nervous manifestations as hysterical fits, certain contractures, hemianæsthesia, monoplegia, and other paralyses and manifestations, all of which medical men are unanimous in regarding as hysterical; and we must compare them with those nervous troubles which, in the opinion of everybody, are certainly not hysterical. We shall then be able to judge of the distinctive characters of hysteria.

Having cleared the ground in this way Babinski is led to the conclusion that hysterical manifestations possess two attributes, viz.:

(1) The possibility of being reproduced by suggestion, with rigorous exactitude, in certain subjects, and

(2) The capability of disappearing under the *exclusive* influence of persuasion.

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Babinski draws an important distinction between suggestion and persuasion. Suggestion signifies the action by which we endeavour to make someone accept or realise an idea which is manifestly illogical. To tell someone whose muscles are functioning normally that he is hemiplegic or paraplegic is to *suggest*, but to declare to a patient with functional paralysis that he will get well, either by a simple effort of will, or by the aid of electrotherapy or other treatment, is to persuade, for the idea is reasonable or at least it is not an offence against reason.

To continue our argument. The symptoms undoubtedly hysterical, which I have already mentioned—fits, hemianæsthesia, and so on, can in certain subjects be reproduced by suggestion so faithfully that it is impossible to distinguish the copy from the model; I need not insist on this point, for I would certainly find no one to contradict it. On the other hand, any of the classical affections now regarded as non-hysterical can *not* be exactly reproduced by suggestion. One may, perhaps, obtain a very imperfect imitation, which it would be quite easy to distinguish from the original; but I defy anybody to reproduce by suggestion to any individual, however suggestible or hypnotisable he may be, the characters of a peripheral facial palsy, musculo-spiral palsy, paralysis of the oculo-motor nerves, organic hemiplegia or organic paraplegia. It would even be impossible to obtain a faithful reproduction of other neuroses. Assuredly, one might produce by suggestion a morbid fear, an obsession or a pain in the head, and one might thus create states of mind which might be mistaken for psychasthenia or neurasthenia by a superficial observer, but a medical man, familiar with these affections, would not allow himself to be so easily deceived, he would interrogate such subjects attentively and, if necessary, would *follow* the case for some time to avoid confusion.

Just as all the major hysterical manifestations may be reproduced by suggestion, they are susceptible of being dispelled under the exclusive influence of persuasion, and there is not one of these manifestations, which one has not at some time or other seen dispelled a few moments after adopting the proper means of inspiring the patient's confidence in a successful termination. This occurs in no other affection, and, if one has had no experience in this method of treatment, one is surprised at the setbacks one receives when one attempts to cure by persuasion certain patients, with whom one would, *à priori*, expect this method of cure to be efficacious. Take the case of a patient suffering from obsessions, probably an intelligent man, having no delusion and fully realising the absurdity of his thoughts, knowing that there is no ground for his fears, and animated with an ardent desire to get rid of a trouble which renders his life intolerable; let us suppose, further, that this patient is readily hypnotisable. Such a case appears to offer the most favourable conditions for cure by persuasion. But experience gives the lie direct to such preconceived notions; persuasion may procure for the patient a certain degree of calm which is *useful* to him; but it is incapable of *curing* him. Again, let us suppose that we have to deal with a neurasthenic who is in constant fear of mental enfeeblement, and is tormented by hypochondriacal ideas that he cannot chase away; he beholds himself threatened with insanity, and this obsession, which is a real mental process, aggravates his neurasthenic symptoms. If one can manage to persuade the patient that his fears are ill-founded, and that therefore he ought to get well, one procures that mental rest which is indispensable for him, and which accelerates his return to normal health. The psychotherapy has done good, it has accelerated the amelioration of the patient's disorder, but it has not been the *sole* means of cure; in such cases, we have recourse to other means, especially mental and physical rest more or less prolonged.

I have so far referred only to the primary manifestations of hysteria, such as anæsthesiæ, paralyses, contractures, crises, mutism, etc., which may appear without having been *preceded* by *other* hysterical manifestations. I take it, however, that it is legitimate also to call those symptoms hysterical which, without presenting the characters of primary symptoms, arise as a direct result of these, and are dependent upon them. To such symptoms, Babinski applies the epithet secondary. Muscular atrophy in hysteria is of this kind; it never appears primarily; it cannot be induced by suggestion; it is entirely dependent on and subordinate to some hysterical paralysis or contracture. It is an atrophy from disuse—a *secondary* manifestation.

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You will say that I have only defined hysterical symptoms, and you would ask me to define hysteria.

I might reply that hysteria is a psychical condition rendering an individual, suffering from it, susceptible of suggestion and liable to autosuggestion; we have seen, in fact, that certain symptoms, such as hemianæsthesia and contraction of the visual fields are the result of medical suggestion and, in the cases in which the suggestion is not apparent, it is justifiable to conclude that we have been unable to trace it or that autosuggestion has been at play. But you may object that certain disorders, absolutely foreign to hysteria, are also the result of autosuggestion; is it not by some sort of autosuggestion that the hypochondriac comes to the conclusion that he is suffering from an incurable disease, or the paranoiac imagines that a conspiracy is at work against him? As a matter of fact, the mental process is quite different, for this reason:—The autosuggestions of the hysterical patient are susceptible, as I have just shown of being reproduced by suggestion and dispelled by persuasion; this is not the case with the delusions of the hypochondriac or the paranoiac.

It is, of course, impossible to separate hysteria from its manifestations; to do so would be to materialise an abstraction; and if we wish to remain within the realm of fact, on clinical terra firma, so to speak, it is the hysterical *manifestations* which we should seek to define. From such consderations, I now make a slight modification in the text of the definition which I have already given and, by way of *résumé*, I submit to you the following definition (Babinski's):

Hysteria is a peculiar psychical state which is capable of giving rise to certain conditions which have features of their own.

It manifests itself in primary and in secondary symptoms.

The former can be exactly reproduced by suggestion in certain subjects, and can be made to disappear under the *sole* influence of persuasion.

The secondary symptoms are in direct relationship and subordination to the primary ones.

In the discussion which followed the Chairman, Drs. Savage, McNamara, Dixon, and Crookshank took part.

Dr. STODDART having replied the meeting then terminated.

The members to the number of fourteen dined together afterwards at the Café Monico.

SOUTH-WESTERN DIVISION.

THE AUTUMN MEETING of this Division was held on October 25th, 1907, at Fisherton House, Salisbury, by invitation of Dr. Baskin, who kindly entertained the members to luncheon.

The following members were present: The President, Drs. Baskin, Ireland Bowes, Glendinning, Mackeown, Morton, Nelis, Eden Paul, Pope, Prentice, (the Hon. Div. Secretary), and one visitor.

The Chair was taken by the President.

William Edward Ruttledge, L.R.C.P.Lond., M.R.C.S.Eng., Assistant Medical Officer, Somerset and Bath Asylum, Wells, was, on the recommendation of Drs. Pope, Shera and Aveline, elected a member of the Association.

Dr. Pope showed plans and gave a short description of the York City Asylum, and Dr. Baskin read a paper on "Insane Movements," illustrated by a case.

The proceedings terminated in a vote of thanks to Dr. P. W. Macdonald for presiding, and to Dr. Baskin for his hospitality.

NORTHERN AND MIDLAND DIVISION.

The AUTUMN MEETING of the Northern and Midland Division was held, by the invitation of Dr. Middlemass, at the Sunderland Borough Asylum, Ryhope, on Thursday, October 17th, 1907, at 2.30 p.m. Dr. Middlemass presided.

The following members were present:—Drs. Archdale, Eades, Fraser, Geddes, Harris-Liston, Hopkins, Kershaw, C. MacDowall, T. W. MacDowall, Mackenzie, Merson, Miller, B. Pierce and Dr. Middlemass.

The following visitors were also present:—Dr. C. A. Drew, of the Massachusetts

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