have come from Private Asylums, and none of them have many imbecile boarders. Some physicians of Private Asylums have written that they habitually refuse such boarders.

In the Special Asylums and Training Schools for Idiots there are in:—

	Under 15.	Above 15.
Earlswood	114	459
Royal Albert, Lancaster	225	317
Midland Counties Asylum, Knowle ...	21	29
Western Counties Asylum, Exeter	56	53
Metropolitan Asylum for Idiots at Darenth ...	376	224

I learn from Mr. Millard that there are in the Eastern Counties Asylum, at Colchester, about 128 idiots and imbeciles, of whom perhaps one half are under fifteen, but no return has as yet been received from the present superintendent.

On the Appetite in Insanity. By J. A. CAMPBELL, M.D., F.R.S.Edin., Medical Superintendent, Counties Asylum, Carlisle.

(Read at the Carlisle meeting of the Medico-Psychological Association, April 8th, 1886.)

In submitting the following short paper, I do so clearly realizing that deductions from limited observations present many sources of fallacy; also that even extended observations made in a limited area are very liable to error, and need correction by extended observation; that peculiarities of race, and circumstances connected with locality may even in such a matter as this exercise a marked influence. I trust, however, to hear the experience of others on the subject.

In speaking of normal appetite I take what appears to me the common-sense view of the term, *i.e.*, a normal appetite is the appetite at varying ages of a healthy person located in health-retaining surroundings, and enjoying with regularity a sufficient and proper amount of outdoor exercise in a temperate climate.

Appetite in health is, as we all know, easily affected, even by slight causes. Previous excesses produce in many what is in common *parlance* called a bilious attack, and even stopping short of this, a want of appetite for a day or two. The effects of certain mental feelings and states in those who are sane also affect the appetite; excitement, joy, grief, expectation, even surprise, have been known by experience in many individuals to do away with appetite for a time.

Ordinary physical diseases exercise a great influence on the appetite, and during the initiatory stages of most diseases a marked want of appetite is present. Yet there are certain diseases in which an excess of waste takes place in which the contrary is observed, as in diabetes, and there are certain states recognised as natural in which perversities of appetite are common, as in pregnancy, while in the borderland cases of hysteria the vagaries of appetite have been much written about, and in very many physical diseases the appetite is uncertain, irregular, and capricious, as in phthisis. In certain persons a craving is at times felt for certain kinds of food or vegetables, and, even among the sane, dislike of what was at one time much relished is often observable.

The varying tastes of varying ages as to food-supply is well known. Even in children there is a vast difference in the appetite for different forms of diet, some having a keen desire and appetite for flesh food, while in others this is almost entirely wanting.

The extraordinary appetites of certain nations for what would be revolting to others is no doubt in many instances as much the result of climatic and natural calls from the system as anything else. The taste of the Esquimaux for half-putrid blubber, oil and fats generally, and no doubt the high seasonings which are so much in use in hot climates, from the curry of the Indies, to the assafœtida in use as a condiment in Persia, could be rationally accounted for not merely as an acquired taste, but a supplying of some required want, if the matter was closely investigated. Natural longings for articles of diet meet now with considerable attention. At one time in the history of medicine, when sickness occurred, the sufferer usually got none of the things he felt a desire for, hardly even cold water; nowadays the tendency seems to be that what you feel an appetite for is what will be good for you, a much more pleasant doctrine, and probably as safe as the other.

Seeing what variations take place in the appetite in the sane, even in health, and much more so in disease which does not to a great extent affect the mind, it is not extraordinary that very marked alterations in this function should be met with in insanity.

In glancing at the indices of six recognised text-books on insanity I find that appetite does not find a place in three; in three it does: in Griesinger it is shortly treated of, in Maudsley perverted appetites are dealt with, and in Buck-

nill and Tuke an analysis of the state of the appetite in 50 maniacal cases by Dr. Jacobi is quoted, showing that in 23 of the 50 only it was normal.

Of course, in dealing with the different varieties, the subject is dealt with. There are certain recognised and well-marked abnormalities of appetite recorded by all observers in given forms of insanity, viz.:—

1. The voracity of *General Paralysis*.
2. The same to a slighter extent in *Epilepsy*.
3. The same in certain cases of *Chronic Mania*.
4. Want of appetite in *Melancholia*.
5. Cases of *Mania* in which certain delusions are of such potency that they overcome the natural feelings of hunger.
6. Extraordinary voracity, with persistent thinness, in cases of *Masturbation*.
7. Certain cases of intense excitement, in which the patient talks so rapidly that he has not even time to swallow.
8. Certain cases in which the excitement is so intense that it seems to prevent the absorbents of the stomach and intestines from acting.
9. *Perverted Appetites* in several forms of insanity, when all sorts of things abominable and indigestible are swallowed.

Before entering into details, or treating of these special headings which I have given, I may roughly express the views which a long experience and a careful general observation have forced on my mind. The population from which the asylum inhabitants in Cumberland and Westmoreland are received live, as a rule, fairly well, and are fond, not only of good food, but of a sufficient supply of it. They are well-grown men and women, and have been accustomed to a nourishing and filling diet, yet my experience is that the recent insane take their food very badly, in many cases refuse it, and this, as far as I can learn, to a greater extent than in many other districts. A great number of the patients admitted here in the early part of their attack seem to want appetite, to loathe food, and in very many cases this is a source of very considerable trouble in their early treatment.

During early convalescence appetite returns with vigour, and frequently for a short time the patient eats voraciously. Ultimately the appetite decreases to its normal standard. I have exchanged opinions on this matter with numerous asylum physicians. Dr. Rorie, Dundee, some years ago told me that he had little or no trouble about making his patients take their food, and that up to that date he had not required

to use mechanical aid for forced alimentation. Several Irish superintendents have told me that their patients, who, as a rule, did not fare too sumptuously when at home, nearly always took food well in the asylum, and that complete refusal of food or necessity for forced alimentation was almost entirely unknown. I have, however, ceased to be surprised at incongruities in Irish affairs! The frequency of crimes and injuries in Ireland outside asylums, their paucity in asylums, must strike anyone who studies the subject. I know asylums in Great Britain in which more concatenations (this, I think, is the term used by the Scotch Commissioners for evils we care not to name) have frequently occurred in one year than in all the Irish asylums put together. In the Report for 1883 the Irish Inspectors are able to state that no death occurred from accident, violence, or suicide during the past year in the Irish asylums.

As I believe I shall show you, when I discuss the matter in detail, my experience is totally at variance with that of the Scotch Deputy-Commissioners. Their reports would lead one to think that the *summum bonum* of earthly bliss consists in being a boarded-out dement and being cheaply kept. Dr. Lawson gives a diet scale, in which the whole weekly expenditure of a patient amounted to 3s. 0¾d. a week for food, lodgings, &c., or rather total maintenance. My experience—and it now extends over 20 years—is that dements as a class have appetites greater than curable insane or than sane, and that in England the difference in diet scale is a principal cause of deterioration in mental state, physique, and habits when such cases are sent to workhouses. The food supply is under the demand.

This view is strongly expressed in the report for 1885 of Dr. Grierson, the sagacious and kindly superintendent of the Roxburgh Asylum, as regards the patients boarded out from his asylum.

I have gone over the patients in this asylum, which is worked greatly on the block system. I find in one portion containing 67 male dements, of whom only three have been less than eight years in the same building, that in all, the appetite is constantly good and regular, and, although the diet is ample, hardly anything is ever left from any meal.

The same occurs in another block with 82 patients, where the patients are of the best class of chronics, with a few convalescents; and in two similar blocks on the female side, containing 50 and 65 patients, the results are very similar.

I, however, find a very different state of matters to exist in the recent cases. I have examined into the last 50 admissions of public patients from these two counties, male and female, with the following results: Of the males 25 took food ill, and required pressure, five almost completely refused food at first, two had voracious appetites, one had perverted appetite, and in only 17 was the appetite normal.

Of the females 32 had bad appetites, and were got to take food with some trouble; 18 had normal appetite.

Of course it is only by exchanging opinions that we can arrive at general conclusions on such subjects. I think, however, that physical illness is very frequently concomitant with disordered mental action, in the public patients received into Carlisle Asylum more so, I think, than is the case in many asylums, and to this is partly perhaps due the high recovery rate which we have had for many years.

During the four years ending 1882, I admitted 495 patients; of these 38 per cent. required and received tonic treatment.

During 1885 sixty-two males were admitted from these two counties, 25 required immediate tonic treatment; fifty-one females, of whom 25 required tonic treatment—44 per cent. of the admissions.

I shall now conclude with some remarks on the special headings I have mentioned.

1. In *General Paralysis* the voracity is well known; patients bolt their food without regard to the size or heat of the viands, yet in my experience, as a rule, they confine themselves to articles of real food, and though they secrete and hide stones, &c., under the delusion that they are jewels and other valuables, this class of patient rarely eats clothing or dirt. In my experience I find it advisable at a very early stage to put these patients on special diet. We use here mince meat with potatoes two days in the week, broth and milk diet on the remainder, and restrict the food to a given allowance. I think it better that general paralytics should not be allowed to get very fat, as if they do they have a tendency to bedsores in the latter stages. The power of assimilating a vast quantity of food and of rapidly increasing in general bulk is most extraordinary in this disease.

2. In *Epilepsy*. In only one case of this disease have I seen persistent refusal of food; in nearly all the appetite tends to voracity. I hold the opinion that a reasonable restriction in diet is also necessary in this disease. A great

increase in fatness renders life more uncertain in epileptics, and I believe a surfeit may induce a succession of fits, and thus cause death. I recollect on two Christmas Days several years ago, a patient, after partaking too well of plum-pudding, succumbed to a succession of fits; post-mortem examination showed the stomach overloaded with plum-pudding; since then I have even put a restriction on the Christmas dinner of this class.

3. In a limited number of cases of *Chronic Mania* the appetite is truly extraordinary. I have at present a private patient who eats two rations to each meal without either gain in bulk or making himself ill.

4. In the large number of *Melancholiacs* that come under care, want of appetitite is one of the most marked features in many cases; both it and the melancholia probably result from visceral causes. A good purge, a course of blue pill and saline treatment frequently proves efficacious. A pretty sensible melancholiac once told me if I just let him fast for a couple of days his tongue would become clean, and he would take his food; but though this in his case turned out quite true, the opposite is usually the rule.

5. *Cases of Mania* exist, and every now and then come under treatment, where certain delusions are so strongly held that they constrain the patient to overcome the feelings of natural hunger; such as when he thinks he is commanded by the Almighty not to eat for a given time—usually it is 40 days—or that he has no stomach, &c.

Recorded cases of sane sufferers from starvation state that the feeling of thirst is more severe than hunger, and that the pangs of hunger pass off after a limited time. I have in a former paper detailed the experience in this asylum as to forcible feeding, and the class I allude to here I always feed on the third day of abstention. I have had to feed less frequently during the past 18 months than ever previously in my asylum life, the "tube" only having been used in five cases. Of course feeding comes in runs, but I also think that, as one gains in experience, feeding is not so frequently required. Nurses press food better on patients; the obnoxious and deterrent effect of an enema of food is tried previous to feeding, and practically one does not feed so many cases; at least I, with a larger asylum, do not, and yet I do not let patients completely want for more than three days.

6. In *cases* of youths who *Masturbate* we often find

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voracity and extreme emaciation coexist. A satisfying, yet non-stimulating, diet is now quite recognised to be the correct thing for such cases—a farinaceous and milk diet, and little or no flesh food.

7. In my experience I have met with cases in which the excitement has been so intense, and the patient has been so restless, and talked so incessantly and rapidly that he seemed really not to have time to swallow. I have seen at least one case of this nature in which, owing to the patient being almost choked by the efforts made to spoon food into him, I have had to use the "tube." I should say that most probably the excitement entirely did away with the feelings of hunger in such a case.

8. I believe certain cases occur in which the absorbents fail to act, the nerve-supply which should reach them being misdirected, and acting to a fearful excess in other directions. I should think that this must really be the case in certain cases of acute and persistent excitement, as well as in certain cases of acute melancholia. Feed such cases how you will, little benefit seems to result. I believe this really is the explanation of the tolerance that certain cases exhibit to heavy doses of narcotics and to noxious substances picked up and eaten during attacks of excitement, such as the eating of laburnum and other injurious seeds without discomfort. I have had melancholiacs under my care who, though properly fed, have yet become weaker, and died without apparent lesion; and a marked case of the type I allude to occurred four years ago under my charge. A young lady, of a highly nervous organisation, became acutely excited. I fed her from an early period of her attack with most nourishing food and stimulants, and yet she died without apparent cause other than the excitement. In this case I rather regretted not having tried the effects of mechanical restraint. At the post-mortem I found undigested fluid food in her stomach, and in the course of the whole intestine. Both large and small intestines were uncommonly dilated. I believe the nerve-energy expended in her excitement had prevented the normal action of the intestines, and that her death really resulted from this.

I think it highly probable that want of action of the absorbents really accounts for the absence of ill effects in those patients that Dr. Clouston * describes as daily taking

* "Edinburgh Asylum Report for 1881."

16 eggs and eight pints of milk; few healthy people could do it.

9. I do not enter on this subject at any length; it is disagreeable and loathsome. That creatures originally made in God's image should so far descend in the scale, owing to disease, as to eat with relish the most filthy, disgusting, and unnatural things is a matter of deepest regret. I have patients under my charge at present who I have seen eat their own fæces, drink their urine from the pot, and, even more abominable still, I have one patient who has to be watched to prevent him from emptying the spittoons. Such cases are truly horrible, and fill one with intense sadness that human nature can descend to such an abyss. Though I have frequently read of masses of hair, cloth, &c., being found in the stomachs of patients dying in asylums, only one such case has come under my observation, though post-mortem examinations are the rule in the Carlisle Asylum. A report of this case will appear in the July number of the "Journal of Mental Science." In this case I considered death to have resulted from slow starvation, caused by the presence of an accumulation of hair, string, and portions of blankets in the stomach.

If my paper elicits from those I see here an expression of opinion on the points touched on, it will have done its work well, even if my views on many of the topics are not at all borne out by others.

St. John Ambulance Classes for Asylum Attendants. By G. E. Shuttleworth, B.A., M.D., Medical Superintendent, Royal Albert Asylum, Lancaster.

Much attention having recently been given (in the pages of this Journal and elsewhere) to the subject of the systematic training of asylum attendants, it occurred to me last autumn that some advantage might be gained in this direction by the instruction of the staff of this institution in "first aid to the injured," as prescribed in the scheme of the St. John Ambulance Association. I accordingly announced my willingness to give the necessary course of five lectures and demonstrations, and having obtained the moral and pecuniary support of my Committee, who granted £5 in