saved a great deal of trouble and much loss of property had he been under the protection of the Lord Chancellor and the inspection of his Visitors. I submit that such control would have been better for the neighbourhood, better for his family, and better for the Hermit of Red-Coat's Green himself.

Some Observations on Different Forms of Stupor, and on its occurrence after Acute Mania in Females. By H. HAYES NEWINGTON, Senior-Assistant Physician to the Royal Edinburgh Asylum.

With the exception of the condition of a person labouring under acute mania, no phase of insanity so thoroughly arrests the attention of even an uneducated observer as that which has been styled stupor in late years. Painful as it is to see the vagaries and extravagances of the former, hardly less so is it to contemplate in the latter the great impairment of mental power, which may reach even to almost total obliteration. But while on the one hand acute mania has been elaborately described from every point of view—indeed, the very nature of its symptoms force a recognition, and demand prompt treatment—yet stupor has received but little attention, considering what an important element it may become in a case. In fact, it is only comparatively recently that it has been looked upon as anything more than mere "depression." For more than a casual mention of it, we must chiefly refer to French psychological literature, to the writings of such men as Baillarger, Esquirol, Brierre de Boismont, Dagonet, etc. But these authorities differ much in their opinions, even as to the fundamental nature or natures of the sets of mental phenomena which are included under this comprehensive term.

Not many years ago the condition in all its phases appears to have been regarded as possessing only one mode of origin, however much its manifestations may have varied in different cases. Our forefathers would seem to have looked upon it as a semi-physiological complication so to speak, which might naturally be expected to ensue after a morbid over-exercise of the functions of the sensorium commune. This view not being found satisfactory or exact enough as the study of morbid psychology became more scientific, much contention arose, firstly as to whether the condition had a single origin (that

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origin having in the meantime been traced farther than mere "depression"); and secondly, as to whether if duality of origin were admitted, stupor was to be regarded as a complication only of other forms of mental disease, or was to be classed as a separate and independent malady.

It is now recognised by most authors that stupor may result both from an inhibition of the functions of the higher nervous centres on the one hand, and also from the intervention of some fearful and terrifying delusion on the other—that is to say, a double origin is allowed. It cannot be denied, again, that it may occur both as an original disease and as a complication. When a delusion intervenes it is of course only a complication, but when it results from inhibition of action it may be both a primary alienation as well as a complication.

Esquirol seems to have been the first to have given a specific name—Acute Dementia*—to a malady of which it is the primary and paramount feature, but he also fully admits the occurrence of stupor in cases of extreme melancholia.

Baillarger, and after him Griesinger, on the other hand seem to claim nearly every case of the kind for his own well-known class of *Melancholia avec Stupeur*. These two writers especially consider that Esquirol and Etoc-Demazy have classed erroneously some of their cases. But both admit the occurrence, though very rare, of acute dementia. M. Dagonet in an exhaustive essay on stupeur† is broader in his views on this subject than Baillarger. He is prepared at once to recognise Baillarger's views in some cases, but he also considers that there are many cases in which delusions have nothing to do with determining the stupor. He also is of opinion that the difference between the authors he cites is "*au fond plus apparente que réelle; tous admettent en effet la suspension plus ou moins complète des actes intellectuelles chez un certain nombres de malades.*"

A great deal of this diversity of opinion and uncertainty

* This name has been objected to for various reasons, *e.g.*, that Dementia is essentially incurable, that the condition is not Dementia, etc. There seems to me to be a close analogy between Esquirol's work in this department and Bright's in Renal disease. In both organs experience shows that there may occur—1st, an acute form of disease with a favourable prognosis, and leaving no immediately apparent mischief behind; and 2nd, a chronic form leaving no hope for cure. And in Dementia, besides, as in kidney disease, there seems a probability that both the acute and chronic forms may have a similar mode of origin, but that the acute form, being a primary disease, and having generally a rapid invasion, lights on a comparatively healthy organ, which, with appropriate treatment, is able to throw it off again; while in the chronic form there is no power of recuperation, and matters can but go from bad to worse.

† "Annales Med. Psychol.," 1872.

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seems to me to be due firstly to confusion of terms applied, and secondly to the amount of chance or luck in obtaining the respective number of cases which furnished the means of description to the various writers.

Acute dementia and extreme melancholia afford us the two different types of stupor. In the first disease it is, as I have said, the paramount feature, but it must be recollected that it is not the disease itself. A perfectly identical condition, though not so prolonged, may constantly be seen after an epileptic attack of an insane person. We also may, I think, see it in a nascent stage in sane people after any occurrence that produces great exhaustion, such as hard mental work, prolonged or acute illness, dissipation, etc.

Acute dementia invariably presupposes one form of stupor, but this class of stupor, on the contrary, does not always presuppose acute dementia. The latter name, though its occasional use is necessary to mark the type, must be got rid of while discussing stupor. Instead, some name is wanting that will as clearly show the etiology of this form; the use of the term *delusional* before the word stupor will denote that of the other form. Each one of the authors I have quoted considers that the *non-delusional* class exhibits an "obliteration," or "abolition," or "suspension," or "veiling," etc., of the function. It is essentially not a question of over-work, or perverted work, on the part of the nervous centres; it is simply a case of no work at all. I therefore would suggest the use of the adjective "anergic," (ἀ without ἔργον, an action or duty), the title of course referring not to the patient *in toto*, but to his brain cells. We thus get two decided terms wherewith to grasp and separate the two forms, "anergic stupor" on the one hand, "delusional stupor" on the other. I shall make use of them in the remainder of this paper.

The following table shows, I think, most of the conditions in which stupor of either kind may be found:—

Anergic Stupor.	Delusional Stupor.
1. Primary— (Acute Dementia) generally caused by a sudden and intense shock. 2. Secondary— *a.* To convulsions of any kind. *b.* To mania in women (see second portion of this paper). *c.* To any other prolonged nervous exhaustion.	Result of intense (1) Melancholia, and may be intercurrent in (2) General Paralysis, and also supervenes on (3) an epileptic seizure.

I shall here cite typical cases of each kind. 1st, Anergic Stupor.

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Case I.—M. G., the wife of a shepherd, admitted July 22, 1873. First attack. It is stated that no other member of the family has been insane. Shortly before admission she was married, and her insanity seems to have arisen from the fact that coïtion was found to be impossible on account of some structural malformation on her part. Her husband, it is said, was unkind enough not only to inform his acquaintances of the fact, but also expressed his opinion that she was neither a man nor a woman. This preyed much on her mind, and she was brought to the Royal Infirmary, Edinburgh. It was then found that she had an imperforate hymen, which was successfully treated, and thereupon she was sent to Morningside. On admission she presented the appearances noted in the following table of symptoms. After some weeks she commenced to ameliorate rapidly on a treatment of tonics and ale. The course of her convalescence was in this wise. She became cleaner in her habits, and if work were put in her hands, she could manage to do a little when constantly looked after. She soon began to menstruate, and then became quite brisk, working hard and voluntarily. But as yet she did not speak, unless it were to say "yes" or "no." She eventually got back her speech, and recovered entirely, menstruating again before leaving. On her discharge, four months after admission, she informed me that she could remember nothing that had occurred during her illness, though her memory for facts happening before seemed to be good.

Case II. Delusional Stupor.—A. M., æt. 25; admitted April 2nd, 1874. First attack. Very marked family history. Paternal grandmother was liable to occasional attacks of insanity. Her father was also a patient in Morningside for some months, about 1858. He laboured under melancholia, and had many gloomy delusions. He was discharged relieved. The present patient had been very industrious, but always of a reserved disposition. The exciting cause was supposed to be a love disappointment. She became at first wandering and restless, and suffered greatly from sleeplessness. Then she laboured under deep despondence, saying that her soul was lost. She talked casually of suicide. On the 14th day of actual insanity she was admitted, having refused all food for the preceding 48 hours. Her brother reported a fixed delusion that her soul was lost, and since admission she has expressed a strong wish that she were dead. The following is the state on admission:—Very great depression, as shown by her expression, moaning and crying. Apparently slight enfeeblement. Memory, coherence, and the existence of delusions could not be tested, as she would not answer questions. She was of cachectic appearance. Muscularity and fatness poor. No apparent abnormality in the motor or reflex system, or in the special senses. Pupils contracted and equal. Fluttering and harsh respiration at the apex of both lungs, especially the left. Heart very weak, no murmur. Tongue moist, slightly furred. Pulse 80. Temperature 97·6. As she continued to refuse food, the nose tube was had recourse to, but with little

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success, and eventually the stomach pump was used, and she was fed off and on some fifty times.*

After this had been going on for some weeks she got much worse, habits dirty, lying down for a short time, but often kneeling with the head on the floor as long as she was allowed to, and directly she was left alone she resumed this position. Her face was most woe-begone; in fact, at times she presented a most painful spectacle of mental distress. At the present time she is still here getting worse and worse. On one or two occasions she has started up suddenly, and broken a window, or used violence to her attendants. She takes her food well, often ravenously, and is reported by the night attendant to sleep well. She has not menstruated since admission.

This case presents to my mind nearly all the leading symptoms of delusional stupor, and the symptoms are here all that one has to go upon to make the diagnosis of that condition. At first she expressed delusions of a gloomy nature, after that she did not speak at all, but presented marked evidence of being possessed by such delusion. What is wanting is a declaration from the patient herself to the same effect; this she is not in a position to give. However, in the following case this desirable information has been obtained from the patient, and many such are on record, especially in the "Annales Medico-Psychologiques" (Baillarger, 1843, 1853—Dagonet, 1872).

Case III.—J. S., æt. 18, admitted May 12, 1874. First attack. Heredity well marked. Grandmother insane; uncle committed suicide; numerous other members of the family "nervous;" a sister epileptic. Exciting cause, over-work and religious anxiety. Symptoms

* It was a matter of great difficulty at first to open this patient's mouth with the usual steel expanding gag. In addition to violent resistance it was found that she could make her upper jaw so overhang the lower that nothing but the gum of the latter was visible; and again the left condyle of the lower jaw had a tendency to subluxation. (Sir A. Cooper describes a subluxation occurring in young and delicate women, in which the bone returns by itself, as it did on one occasion in this case.) Having noticed that when the nose tube was used, the patient used to collect some spoonfuls of nutriment in her mouth and then spit it out, I hit on the plan of first introducing it, and then lying in wait with the gag at the *ἕρκος ὀδόντων*. She was taken in the first time, but when she had to be fed again she recognised the trick. However, she was in the dilemma of either swallowing by the nose tube (which is the best thing when practicable) or of opening her mouth sufficiently wide to admit of the gag being introduced. Many drugs were introduced with the food, *e. g.*, quinine, opium, tincture of capsicum, and a combination of the last two. None of them seemed to have any effect.

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before admission: delusion that the Day of Judgment had come, refusal of food, attempt to throw himself out of the window. Medical certificates show that he was excited, incoherent, that he says that he takes port wine to be saved, that he is lost, that in his incoherence the word "sacrament" often occurs. On admission he was found to labour under great depression and some enfeeblement; memory impaired; incoherent; no delusions expressed; marked exhaustion; general bodily condition very weak; aortic murmur; pulse 120, very weak; temp. 97·8; tongue much furred; slept badly, and took but little food. Pneumonia of the left lung set in, but was not very severe, but was sufficiently so to account for a considerable amount of mental enfeeblement. He improved very slowly, and a few days ago the following is noted in the Case-book:—"Patient is up and able to be out in the garden. He answers questions slowly, and appears to have to think some time before being able to give an answer. States that during his illness he was conscious of what was going on around him; but that he fancied murderers were about him, that there were snakes in his bed, and that these ideas controlled his behaviour and actions. Says that he felt miserable during all this time." He is still under tonic treatment.

A consideration of these cases will, I think, show an additional, and perhaps the most important, cause of the confusion that I have before mentioned as existing in the differentiation of the forms of stupor. We can set aside Case I., as it seems to be a straightforward one. But in both of the other two, though delusions evidently governed the stupor, yet there can be no doubt that the intensity of the delusion produced a considerable amount of anergia, by acting on a congenitally weak mind, which was still further weakened by existing insanity, the original "delusional" form being, as it were, masked by the anergic form. This result was brought about at some interval in Case II., but was quick in its appearance in case III., where general cachexia, and after that pneumonia, were noticed. It is easy to conceive that anyone might be led into error who had not been able to follow the whole case, and who had instead to form his judgment on the "present" state of the patient. And it is not to be forgotten that, as in a case of any disease, symptoms may be wanting, or even entirely contradictory to what might have been expected. It is not always easy when a patient complains of having "raised blood" to detect its source, though the rules for its discovery are laid down hard and sharp enough. So in the instance of what I am endeavouring to describe—utter absence of response to external influences—symptoms may not always be found individually to coincide

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with the direction that the majority point out. Nevertheless, I have made the following table of differences, which on some points is great and constant enough to enable one almost to come to a certain opinion.

Anergic. (Acute Dementia type.)	Delusional. (Melancholic type.)
Hered. Predisposition.—Very marked; but beyond this there seems to be an individual liability, which will allow a more or less sudden and complete loss of *vis nervosa.*	Very marked.
Exciting Causes. — See preceding table.	
Invasion generally very rapid.	More deliberate, but may be almost instantaneous.
Symptoms.—Intellect evidently greatly impaired.	No oral evidence will be likely to be obtained on this point; but the conduct of the patient shows often considerable reasoning power, *e. g.*, the means of attempted suicide.
Memory.—Seems to be swept away as far as is possible.	Generally found after recovery to have been preserved to a great extent.
Emotional Capacity.—Nil, or almost so. Eyes are often suffused with tears, but this seems to be due to derangement of the lachrymal apparatus, and is, I think, additional evidence of anergia. Features relaxed, eye vacant, and is not constantly fixed.	There is evidence of grief, fear, etc., in the facile expression—wringing or clasping of the hands. It is very rare to find tears shed. Great contraction of the features. Eyes fixed on one point, usually upwards or downwards, or else obstinately closed.
Volition.—Almost absent.	Frequently great stubbornness, refusal to do what is wanted. And on the other intense determination in following out the patient's own plan.
Motor System.—Weak and uncertain. The patient has to be led about, and if placed on a seat or in a position does not move. (Cataleptoid condition of Dr. Monro.)	But little interfered with, independently of sheer asthenia, produced by the patient's conduct. A patient will for hours or days stand behind a door, or kneel in a constrained position on a bare floor.
Sensory System } *Reflex* „ } Both dull.	Do. There seems to be a much greater ability to bear very severe pain.
Pupils—dilated.	Generally tending to contraction.
Sleep—generally good.	Intense sleeplessness.
General Bodily Condition.—Emaciation sometimes extreme; when so it generally appears rapidly, and disappears equally so; but often times there is not very great loss of substance, though the whole tone is much lowered.	Is affected *pari passu* with mental state, and seems to be governed by it to a great extent.

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	Anergic.	Delusional.
Vascular System.	Pulse very slow, almost, sometimes quite, imperceptible. Cyanotic appearance, œdema and iciness of the extremities. Great decrease of vitality in peripheral structures, as shown by tendency to asthenic eruptions, and production of vermin.	Pulse very weak, and often quick and thready. Complexion anæmic and sallow. The other appearances may be present, but come on later, and are less marked.
Digestive System.	Tongue clean, or if furred it is moist. Appetite *apathetic*; bowels not very irregular, but habits very dirty.	Tongue very dry, small and furred, Refusal of food. Great constipation. Dirtiness of habits rare.

It will be noticed that on nearly every point of the symptomatology of these two forms there is, as I have said before, more or less difference. If the observations of others convince them as strongly as my own have me—if, in a word, this difference is established—it follows that there must be a fundamental difference also between the two conditions themselves; and I think that this difference may be summed up thus: On the one hand there is to be found more or less complete *absence* of cerebration—the more complete the absence the more marked the symptoms; on the other the abnormal *presence* of intense but perverted cerebration is the agent—the more intense it is the more profound are its results.

A few of the symptoms themselves are worth a little discussion. The *invasion* of anergic stupor may be said to be rapid in almost every case. The history of these cases generally informs us that the patient has, as it were, been "struck" by the infirmity. In many observations on record a few seconds only have sufficed to have turned sanity into insanity. Its rapidity of seizure does not much influence the prognosis of the attack; while on the one hand it might be argued that but little good might be expected of a brain that is so easily and suddenly put off its balance, it may be advanced on the other, that as in the more purely physical maladies, the quicker that a disease seizes on what was previously healthy, the greater is the resistance to it, and the better the chance of recuperation. As a rule, the more sudden and active the exciting cause is, the quicker will the invasion be, but even when the exciting cause has been, so to speak, spread over a considerable period of time, the inhibition of function is soon established. In fact, this form does not grow, it does not feed on itself, the fall is abrupt. In delusional stupor, as a rule, some time elapses after seizure before a full height is reached, and its steps can be recognised with certainty, but in some cases the invasion is

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almost as rapid as in the preceding form. When such is the case, I think a modification of some of the symptoms may be found. The current of perversion of intellect, though marked, does not seem so strong. The features may betoken at times most intense mental suffering, but there are periods of relaxation. It seems as if the suddenness of the shock has deprived the intellect of the power of continuously fixing itself on the governing delusion. In these cases, too, the general bodily condition seems to suffer more.

The preservation or loss of *memory* is a most important point. It is a most wonderful fact that this faculty, which in itself is one of the first functions impaired in so many forms of insanity, should be preserved fairly even during a period when perhaps few other signs of psychical life can be discovered. Yet so it is, and in my opinion the fact of its existence, or the contrary, constitutes the first and sole legitimate reason for separating the two forms of disease, in place of their being considered as varieties of the one and the same; of course the best test of its not having been abolished is a conversation with a recovered patient. It needs but little skill to compare a patient's statements with actual occurrences, provided that he owns to remembering things that occurred during his illness, but no such positive proof can be obtained in cases where no recollection is manifested. It might be said that a patient's word was not to be trusted, that he was intentionally misleading his examiner. This would be at once disproved by the cases which are recorded in the second portion of the paper. These patients remembered and correctly described events occurring in the maniacal stage which preceded the anergic stupor, but had no recollection of anything that happened after it had set in. There would have been as much motive to deceive about the one stage as the other. Again, it might be said that it was possible that memory was alive during the stupor, that the mind had the power of connecting the present with the past, without the patient's being conscious when convalescent that that power had existed. However, it would be hard to conceive the possibility of the brain storing away facts while labouring under disease, and not being able to evolve them again when health had returned. Additional strength can be given to this idea by considering what occurs in the mind of a man who has been drinking up to a certain stage. We hear him, perhaps, originate the most brilliant remarks, or string together most ingenious argu-

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ments. Stop him, and ask him to retrace the steps of his argument, and he will find great difficulty in doing it, or even not be able to at all. He has then lost the power of recalling what has been said. To carry out the analogy, ask him next morning, when he has recovered his normal brain power, to recount what he said. His memory is completely gone touching that period, but he will most likely remember fairly what occurred before alcohol had produced its effects. I think, therefore, that if, setting aside intentional misrepresentation, a patient say that he cannot remember what occurred during his attack, we may take it for granted that no continuous delusion existed, for this latter could not exist without memory being called into action.

We may also find other signs of the presence of memory in the conduct of patients themselves. A. M., Case II., plainly recognized what was the meaning of the various preparations for feeding her by the stomach pump.

Cleanliness of habits is also a symptom worth looking after. It is rare for a purely melancholic person to be dirty, unless he be suffering under some great bodily weakness as well. It not only helps in forming a diagnosis between the two conditions, but uncleanliness occurring in a case of delusional stupor indicates pretty surely the supervention of more or less anergia.

It is my intention only to refer at the present time to one of the other conditions in which stupor is found to exist, viz., the form of the anergic type following acute mania (in females).

M. Dagonet (op. cit., p. 370) details three relations between stupor and mania. 1. Stupor succeeding mania. 2. Alternating with. 3. Preceding. It is with the first only that we have to do here. He recites five cases, all male. The first two were removed from his care before they were cured, and there is not evidence enough supplied in the account of their cases to enable one to form a judgment as to the existence or not of a terrifying delusion. About the other three there is no doubt. The patients' confessions show that they were weighed down by threatening voices, etc. It is my object to describe now the supervention of anergic stupor on acute mania. Observation and inquiries lead me to believe that sex plays a very important part in determining the nature of the stupor. I believe anergic stupor only follows acute mania in female cases, or that if it ever does occur in the male it is robbed of so many of its essential characteristics,

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that it should be regarded merely as the rest that is sent to remedy the effects of the preceding excitement.

The following cases have lately come under my observation:—

Case IV.—A. B., female, admitted Oct. 6, 1873, ætat 30. First attack; a lactation case. There is strong hereditary taint on the mother's side—an uncle and full cousin—the former dying insane, the latter recently discharged from this asylum after a short attack of sub-acute mania. A. B. certified to be maniacally excited, and came in so, and with great incoherence. Bodily condition good. After two months of excitement she quickly became anergic; habits very dirty, quite incapable of speaking, and with a very "daft" appearance. She remained like this for some time, and on the signs of slight improvement was placed in a gallery among convalescent patients, where she recovered quickly and completely. She menstruated shortly before leaving, and after convalescence had set in.

Case V.—A. M'C., female, admitted May 11th, 1873, ætat 16. First attack. No hereditary predisposition noted. She was stated to have had two fits of a doubtful nature a year before admission, and to have menstruated only twice at long intervals during that year. On admission was exceedingly noisy, violent, and impulsively destructive. She remained in this state for two months, when she rapidly sank into intense stupor, similar to, but more marked than in the preceding case. She came out of this in a few weeks, and had another turn of excitement, which was followed again by stupor. She improved, and was discharged, not completely recovered. During the nine months that she was in the asylum she had no more fits. She menstruated twice at proper intervals before departure.

Case VI.—M. E., female, admitted Oct. 22nd, 1873, æt. 23. First attack. Her mother is described as being very nervous and excitable, and her maternal great uncle was insane. She was apprehended by the police for making a disturbance, and was on admission very noisy and violent, declaiming that she was the Queen, etc. After a few days she also sank into deep stupor, becoming utterly silly, aphasic, and dirty. The circulation was very weak, and she showed a great tendency to be attacked by pediculi capitis. She made great improvement, but had a severe relapse into excitement, which was followed again by stupor. The recovery this time was very slow and gradual, but she has recently been discharged cured. For a long time the menses were absent, and she displayed considerable erotism.

Case VII.—A. R., female; admittted Oct. 20th, 1873, æt. 26. First attack. A lactation case. Hereditary predisposition is denied. She came in labouring under intense anergic stupor, but this had been preceded by ten days' great excitement, during which restraint had been necessary. The improvement was very slow in this case, but she was removed while convalescent, and has since entirely recovered.

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Case VIII.—A. H., female; admitted Oct. 1st, 1873, ætat 19. First attack. Her paternal uncle died insane. She had been wrong in her mind for ten months before admission. The exciting cause is said to have been a love disappointment. The first thing noticed was great depression. She then became restless and erotic at the monthly periods, suffering from dysmenorrhœa. She became so excited that she was brought to Morningside, where shortly after admission she completely wrecked the strong room in which she was placed for the night. After some days of violence she also rapidly sank into stupor, with all the symptoms detailed in the preceding cases. She very slowly improved, but never could be got to work very much. She was sent home on trial, and when I saw her a short time back seemed to be getting on very well, and has since been discharged. In this case there was complete amenorrhœa from admission till shortly before her removal.

Case IX.—M. D., female; admitted March 10th, 1874, ætat 18. She has had two previous attacks before of slight degree. They are described as melancholic, and the present is at an interval of one year from the last. She was treated at home on both occasions. There is a very bad family history on the father's side. Her grandfather is stated to have laboured under many delusions, *e. g.*, that he was failing in business; but he never required confinement in an asylum. The father had many epileptiform seizures, after which he was often very irritable and excited. The elder sister became utterly "dazed" by the shock caused by her mother's death, and died herself insane four months after from phthisis; and her brother was very dissolute, ending up by enlisting, though his family had considerable means.

She was certified to be violent and threatening, and was so for a few days after admission. She then also sank into the most intense stupor. The feeble circulation was a very marked symptom. Her pulse at times was inappreciable, and she was very liable to sores on her extremities, similar to those that attend varicose veins.

She has considerably improved, and is now under treatment.*

Case X.—C. J., female; admitted November 10th, 1873, ætat 26. She had a similar attack two and a half years ago. The stupor, however, was not so intense. No hereditary predisposition noted. She had, on the former attack, a delusion that she had had a baby, and was married.

Before the present admission she had been maniacal for ten days. She came in with stupor on her. The bodily symptoms were not so well marked as the mental. She became slightly excited during the first catamenial period, but has been regular since. She has much

* Since this was written, three months ago, this patient has not improved. A few days ago she menstruated for the first time. This was preceded by a slight improvement, accompanied by considerable irritation, and followed by a relapse. It seems now to be a hopeless case.

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improved, so much so that she does housemaid's work excellently, but is still resident in the asylum.*

In all these cases, with the exception of A. R., who was removed suddenly, and that of M. D., who is still labouring under stupor, I have been at great pains to test their memory, and all made the same statement, viz., that they could remember what happened before and during the maniacal attack, but nothing during the stupor.

The female sex alone seems to be liable to this sequence to mania. Besides comparing a similar run of male cases, without lighting on one at all corresponding with those cited, I have extended my search further into our Case Books, and neither this, nor my own observation, nor that of others has supplied me with a solitary example.

I have classified (somewhat arbitrarily, I confess) the last 100 cases of mania in females that have come under my charge from admission onwards. This gives the following results:—Acute mania, 36 cases; sub-acute mania, 42 cases; senile mania, 10 cases; mania occurring in drunkards and prostitutes, 12 cases.

Anergic stupor has occurred in six out of the 36 acute cases, and it must be borne in mind that this may not be the maximum number, as some are quite recent, and others have been removed before any sort of termination had been observed. No case has occurred in any other of the three divisions. This, of course, leads to a conclusion that stupor is only to be looked for after a sharp outburst.

The *prognosis*, on the whole, must be considered favourable, if not quite so much so as in those cases where a steady improvement towards a cure takes place, yet it must be better than when symptoms, though less pronounced, show no signs of abating, and far more favourable than when mania and melancholia alternate. Absolute recovery has taken place in five of the cases. The sixth, I am afraid, is in a hopeless condition.

Of the 36 acute cases, putting aside two that are very recent, in which there has been no termination of the mania, complete recovery or convalescence has occurred in 17 cases. In five of these anergic stupor has followed the mania.

But, stopping short of actual recovery, great improvement may be looked for; this, of course, being much influenced by

* She was discharged cured, and and after being two and a half months out has lately come back in a state of acute mania.

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the time that has elapsed since the excitement passed off. The two following cases are good instances:—

CASE XI.—M. M., female, admitted Feb. 2nd, 1871, ætat 22. Brother insane. She was apprehended by the police for violent conduct. On admission was very noisy, stripping herself, and destructive. This lasted some months; she then sank into stupor, and remained in it for nearly a year. She began slowly to improve, and has had almost to be educated again. Is now going on very well; is very useful in all kinds of household work, and is shortly to be sent out. [Has been discharged.]

CASE XII.—M. A. W., female, admitted (first time) Nov. 7th, 1866, æt. 17. No history. Was very excited on admission, and is described as having been a particularly troublesome patient for some months. She sank into stupor, but became excited again, stupor once more coming on. About two years after admission she was removed to the Poor-house. After an interval of three years, she was re-admitted, and was again a very bad patient. Stupor followed also in this instance. She improved very much; from being just a heap of flesh and bones, she became fat and a very useful person, sewing, scribbling, &c., and very clean and tidy. She was discharged a little time back.

Such instances show that no effort should be spared in these cases, however hopeless they may seem, if they have the advantage of youth.

With regard to making a forecast, while the patient is still labouring under mania, that she will pass into stupor, no certainty can be attained. In all my cases uterine disturbance, in some shape or another, has occurred, and in all but one strong hereditary predisposition has been discovered, and the stronger it has been the deeper has been the depression. The ages have all been below 30—some very young. In some of the cases, too, during the maniacal stage there may be considerable enfeeblement for a little time previous to the stupor. The incoherence became babbling and utterly unintelligible, without any of the fire and vigour that generally mark acute mania. The most vicious and destructive acts were done with a smiling face, giving no impression of some delusion or hallucination originating the misconduct shown.

It is worthy of remark that in two cases there occurred a distinct relapse into excitement, stupor again succeeding, and in three there have been previous attacks of a similar character.

This form of disease seems to be extremely amenable to treatment. Tonics are of especial service, and should be

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given directly the excitement has passed off; indeed before it has done so, in lactation and other anæmic cases. Pil. Aloes et. Fer. should be given for a long time together in cases where the cessation of the catamenia has not followed on child-birth, and in these too if the normal period has been passed without their appearance. Stimulants are called for in the same way—ale or porter. Where the stupor is very intense, and the circulation proportionately feeble, more direct alcoholic stimulation is necessary. A marked change for the better took place in Case VI. on the administration of 4 oz. of brandy per diem in a very small quantity of water. The reverse happened when it was discontinued.

A blister over the lower half of the occiput has been followed by improvement in some cases. In a parallel case mentioned by Esquirol, the actual cautery was employed, producing a brief attack of excitement, followed by a speedy and complete recovery.

But no medical treatment is of use unless it is well backed up by moral pressure. Special attention must be paid to the surroundings of the patients. Nothing but harm can arise from their being left to vegetate in galleries or wards, where noisy and dirty patients are situated, and to which their own unruliness may have consigned them. It must be remembered that the mind is for the time a blank—a *tabula rasa*—ready to be impressed again by what is seen around, and without the power to recognise and avoid what is harmful. In common with even the most confirmed dements, they are influenced readily by the wish to imitate others. Let them have good to imitate, and not bad. Therefore, as soon as they are sufficiently improved as not to cause annoyance to others by their bad habits, they should be placed among convalescent patients of the best type, under the care of a kind but firm attendant, who will take any amount of trouble with them. These fellow patients will not only stimulate them by displaying industry and correct habits, but are often of the greatest service in giving help and assistance, which will come more acceptably from one who has perhaps laboured under similar affliction, than from any official, however well suited to the task.

The value of this, so to speak, hygienic treatment has been seen in all the above cases; in some, such as Case I., a change of scene has been followed by marked amelioration in a few hours.

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