CLINICAL NOTES AND CASES.

The Insanity of the Climacteric Period. By Drs. E. Goodall and M. Craig, West Riding Asylum, Wakefield.

Although much of a speculative kind appears to have been written upon the subject of climacteric insanity, more especially as regards the pathology of the disorder, the accumulation of actual facts, bearing upon its genesis, symptomatology, and terminations is comparatively small. Exception must be made for the highly practical paper lately read by Dr. Savage at the Medical Society. A further contribution dealing as far as possible with matters of observation may be serviceable. For the purpose of this paper, in addition to the cases coming under the direct observation of the writers, the records of Bethlem (10 years, 102 cases) and the West Riding Asylum, Wakefield (10 years, 120 cases) have been drawn upon. We are indebted to Dr. Salter, Clinical Assistant, Bethlem Hospital, for much assistance in collecting the cases, and Dr. Percy Smith for permission to use the records of Bethlem.

Age.—In the first place insanity in women appears at a later period of life than men (excluding G.P.I). This period is fixed by Tilt at from 40-60. Clearly, therefore, a large proportion of the insanity of women occurs during the climacteric years. This statement is seen to be the more accurate when we extend our observations to other countries. The menopause in some countries may from climatic or racial conditions be deferred to so late a date that the climacteric years become almost co-extensive with the periods in which insanity preponderates in women. A review of the statistics shows that even in this country the climacteric years cannot be stated with precision; for this there are many reasons, the insidiousness of the onset, mode of life, the lack of observation (on the part of women) dependent on apathy and ignorance, etc. From 43-51 appears a fair computation. Average age of Bethlem cases is 46·77; West Riding Asylum 47·5.

Forms of Insanity.—The question of the prevalent form of disorder is soon dismissed, since all writers are agreed that *melancholia* is exhibited far more frequently than any other variety of insanity. Krafft-Ebing is a notable exception, since he gives amongst 60 cases 36 of paranoia (ideas of persecution) and only four of melancholia. *Mania*, in its sub-acute form, and *delusional insanity*, though less common

https://doi.org/10.1192/bjp.40.169.235 Published online by Cambridge University Press

than states of depression, are by no means rare. Whether a case shall be classed with delusional insanity or with the affective disorders depends much upon the observer's conception of the term "paranoia." If this is comprehensive the proportion of delusional cases will probably be large. Whatever its form, it may be stated that in degree the disorder is commonly sub-acute. *Primary dementia* is decidedly rare.

The percentage of *general paralysis of the insane* given below agrees very nearly with Matusch* (3·5 per cent). Krafft-Ebing, however, gives the proportion of 20 per cent.

Bethlem (102 Cases).				
Melancholic.	Mania.	Delusional.	Weak-mindedness.	G. P.
68·6 per cent.	15·6 per cent.	9·8 per cent.	2·9 per cent.	2·9 per cent.
70 cases.	16 cases.	10 cases.	3 cases.	3 cases.

W. R. A., Wakefield (120 Cases).				
Melancholic.	Mania.	Delusional.	Weak-mindedness.	G. P.
63·3 per cent.	18·3 per cent.	14·1 per cent.	1·7 per cent.	1·7 per cent.
76 cases.	22 cases.	17 cases.	2 cases.	2 cases.

Prodromata.—The mental alteration and the somatic disturbances frequently exhibited by the healthy woman at the menopause may be the prodromata of actual insanity. They are therefore of grave import in the presence of an insane heredity. In estimating their value the practitioner will do well to give due weight to this factor. The chief mental disturbances are:—Insomnia, alteration in temper, neuroses, noises in the ears and deafness; hallucinations of the various senses; suspicions, jealousies, false accusations; failure of attention, impairment of memory; sexual perversions (eroticism, frigidity, masturbation, etc). Amongst somatic disorders those referable to the vascular system are prominent, viz., general flushings, congestion of the head, and giddiness; in addition gastro-intestinal disturbances are

* Der Einfluss des climacterium auf Entstehung u. Form der Geistesstörungen: "Allgem. Zeitschr. f. Psych.," xlvi. B., 4 H.

common, also paræsthesiæ. The growth of hair on the face which has been remarked at this period is noteworthy in association with the disappearance of the reproductive function. The vagaries of the menstrual function at this epoch are well known, *e.g.*, gradual cessation, with irregularities in quantity and periodicity, sudden cessation. The proneness to alcoholism at the menopause deserves special notice. Drunkenness in women in England and Wales has been shown to be more common at this period than any other. Habits other than alcoholic are also easily acquired at this time, which is one of exaggerated "suggestibility" in regard to drugs generally (morphia, cocaine, and the like). These, therefore, should be recommended with the utmost caution. Medical men are often blamed, and not altogether with injustice, for habits so formed.

Symptoms.—These are mainly a continuation and elaboration of the prodromata, and are frequently remarkable for their diversity.

Hallucinations.—Most writers are agreed that those of hearing are the commonest. Krafft-Ebing, however, places those of smell first. Next in order come hallucinations of sight; less frequent are those of taste, smell, and common sensation. Various authors have affirmed an association between olfactory hallucinations (which, according to them, are relatively frequent in climacteric insanity) and ovarian disease. Matusch, though finding hallucinations of smell rare at this period, states that when present they were connected with uterine trouble and sexual craving. This writer, however, finds that such hallucinations are more common in young women. If the association between these hallucinations and ovarian disease really exist, the inference would be that olfactory hallucinations are mainly dependent on disorders of the active florid ovary, and in a minor degree upon mere atrophic changes in that organ. In view of the dangers of *à priori* assumption it is desirable that the evidence of ovarian disease should be as clear as possible.

Bethlem.

Of the 102 cases, 71 had hallucinations of one or more senses = 69·6 per cent.
No hallucinations in 30·4 per cent.
Of the 71 that had hallucinations—

49	had hallucinations	of hearing	= 69 per cent.
40	„	„	sight = 56·3 per cent.
25	„	„	common sensation = 35·2 per cent.
22	„	„	taste = 31·4 per cent.
19	„	„	smell = 26·7 per cent.

W. R. A., Wakefield.

Of the 120 cases, 81 had hallucinations of one or more senses = 67·5 per cent.
No hallucinations in 32·5 per cent.
Of the 81 that had hallucinations—

40	had	hallucinations of hearing	= 49·3 per cent.
19	„	„ sight	= 23·4 per cent.
22	„	„ common sensation	= 27·1 per cent.
16	„	„ taste	= 19·7 per cent.
9	„	„ smell	= 11·1 per cent.

Other symptoms are gastro-intestinal disturbances (indigestion, constipation), with delusions of poisoning based thereon; abdominal sensations leading to ideas of pregnancy; anomalous cutaneous sensations (burning, flushing, itching), forming the basis of delusions of electricity and the like. Head sensations, especially "pressure," are common. Ideas of filth (with consequent self-seclusion), of decay and bodily change; delusions of persecution; altered family feelings, with hostility; moral perversion leading to deceit and false accusations (especially of indecent character); eroticism, religious enthusiasm and religiosity; insomnia, and refusal of food.

Suicide.—Experience of observers in all countries goes to show that suicide in women is most common between the ages of 40-50. The tendency to self-injury is a prominent feature at this period.

Bethlem.

44 cases out of 102 were suicidal = 43·1 per cent.

W. R. A., Wakefield.

54 cases out of 120 were suicidal = 48·2 per cent.

Prognosis should be divided into (*a*) immediate, (*b*) ultimate, and depends upon various factors, of which the following are prominent: Heredity, previous attacks, exciting cause, early treatment, form of insanity, physical condition of the patient. When heredity is a marked feature remission and temporary recoveries are not uncommon, but the ultimate prognosis is unfavourable. The greater the number of previous attacks the more serious the prognosis, whether immediate or ultimate. With a definite and removable exciting cause the prognosis may be set down as better than in the reverse case.

Particularly where alcohol is the exciting and removable cause (care being taken to discriminate between cause and early symptoms) the outlook is favourable, provided there are no organized delusions. The importance of early treatment, using the term in a wide sense, is evident. The prognosis will be more favourable in the affective than the delusional

types of insanity. In estimating the influence of physical states it is necessary to determine whether a deterioration in health is functional or organic in origin. Mere functional derangements, when not excessive, allow a favourable prognosis, whereas when organic disease, such as cardio-vascular and renal, are present the forecast must of necessity be gloomy. It is obvious that a combination of the conditions specified may be present in any given case, under which circumstances the above prognosis would require modification.

Duration of the disorder in cases treated in asylums may be set down from 9 to 18 months, many getting well within the year. Of the cases collected in Wakefield Asylum the average duration of insanity in those discharged recovered was 10½ months.

Terminations.—Cases may be classed as recovered, relieved, uncured (including chronic insanity and premature senility), died. In addition there are exceptional cases which may be described as temporarily cured—we refer to instances of circular insanity. In estimating the statistics of the recovery rate the personal equation of the compiler must be taken into consideration. In most quarters there is a natural desire to swell the recovery rate, so that not infrequently cases are reckoned as recoveries which are merely relieved or in remission—a state not uncommon in climacteric insanity. Although the return of last-mentioned patients should take place within a few days of discharge, thus rendering it evident that the condition was one merely of remission, the recovery already claimed would not be cancelled. The variation in the statistics and the large recovery rate, quoted by some writers, seem to justify the preceding observations. The following were the terminations in the cases collected. With respect to the Bethlem cases it must be borne in mind that patients are discharged from that institution at the termination of a year. This in a measure accounts for the large proportion of uncured cases.

Bethlem (102 Cases).			
Recovered.	Uncured.	Relieved.	Deaths.
35·29 per cent.	50 per cent.	8·8 per cent.	3·9 per cent.
36 cases.	51 cases.	9 cases.	4 cases.

https://doi.org/10.1192/bjp.40.169.235 Published online by Cambridge University Press

W. R. A., Wakefield (120 Cases).			
Recovered.	Uncured.	Relieved.	Deaths.
40·8 per cent.	34·1 per cent.	11·6 per cent.	13·4 per cent.
49 cases.	41 cases.	14 cases.	16 cases.

Treatment.—When symptoms, which may be prodromata of insanity, appear at the climacteric period in patients with heredity, or a history of a previous attack, prophylaxis of a general kind may be adopted, such as rest, change of environment, Weir-Mitchell treatment (in neurasthenic cases), and ordinary hygienic measures. At this time women not infrequently consult medical men for obscure symptoms referred to the uterus and appendages, and receive local treatment for conditions more or less vague, and it would seem of a minor nature. Such measures are to be deprecated, as they tend to an undesirable self-concentration, and finally convert the patient into an hypochondriacal invalid. In view of the profound changes undergone by the organism at this stage of life, it appears highly unphilosophical to refer the associated mental disturbance to a mere flexion of the uterus or erosion of the os. Where actual insanity is present, in a large majority of cases it is highly desirable that the patient should be placed with as little delay as possible under asylum *régime*. Although home treatment, change, etc., have their value in the earlier stages of the disorder, an undue persistence in these measures involves a risk of chronicity. Obviously an individual, whose insanity is characterized (as is frequently the case in this disorder) by suspicions, jealousy, and the like, is best treated away from her ordinary environment. The treatment adopted must be on general lines. It may be noted that in climacteric psychoses (as also in puerperal) cases which, having improved to a certain point, appear to be stagnating, are stimulated to recovery by early removal home.

Previous Attacks.—In only a small minority of cases is there a history of previous attacks, and the statement is borne out by the undermentioned figures. When there is a history of previous attacks not unfrequently the first attack

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occurred at puberty, a fact also brought out by Matusch's statistics :—

Bethlem (102 Cases).

79 cases were first attacks	... ...	77·4 per cent.
23 cases had had previous attacks	... ...	22·6 „

W. R. A., Wakefield (120 Cases).

100 cases were first attacks	... ...	83·4 per cent.
20 cases had had previous attacks	... ...	16·6 „

Heredity.—The figures quoted below, which sufficiently emphasize the importance of the hereditary factor, are derived from the cases observed at Bethlem, owing to the impossibility of obtaining reliable information from the relatives of patients in county asylums in the majority of instances. Out of the 102 cases under treatment during the last ten years heredity of insanity was present in 57, giving a percentage of 55·8. Matusch, in his monograph (probably the most complete of recent times), gives the proportion of 54·9 per cent. (heredity from father's side, 35 per cent.; heredity from mother's side, 54 per cent.). Apart from history of insanity, in reading over the cases at Wakefield one is struck by the frequency of alcoholic intemperance in the parents. In accordance with his theory of the pathology of the disorder, to be referred to presently, Matusch explains the influence of heredity on the supposition that there is transmitted an asthenia of the vaso-motor system, predisposing to chlorosis and cardio-vascular degeneration.

Civil State.—The proportion of married to single women was as follows :—

Bethlem (102 Cases).

59 Married (including a few Widows)	...	57·9 per cent.
43 Single	...	42·1 „

W. R. A., Wakefield (120 Cases).

94 Married	...	78·5 „
26 Single	...	21·5 „

Influence of the Climacterium on Existing Psychoses.—Experience does not justify the hope that improvement, much less cure, will occur in an existing psychosis at the climacteric. In the majority of cases the condition remains unaltered or undergoes positive deterioration. The figures given by Matusch would seem to be the best on this point, and are as follows: Out of 60 cases 13 showed improvement in the existing psychosis, 14 a deterioration, while 33 remained unaltered.

Pathology.—There is no record in the writers' experience

of a post-mortem examination of the brain in a case of climacteric insanity (uncomplicated by disease) dying from injury, self-inflicted or otherwise. Only in such a case would the pathological results be of value, since where there is intercurrent disorder (as phthisis) they must of necessity be vitiated. Thus in estimating the importance of any cerebral anæmia or hyperæmia due weight must be given to any existing pulmonary or cardiac disorder. As in most forms of insanity the pathology is altogether speculative. Theories on this subject, without basis, in which the vascular system especially plays a prominent part have been advanced from time to time. Thus Matusch states that the "vaso-motor system is at fault and gives out soonest." Such a statement appears altogether meaningless. The author himself evidently feels the want of a more tangible pathology, since he speaks of an early atheroma of the blood vessels as being present in this form of insanity. It may here be mentioned in passing that Schüle ascribes the aural hallucinations commonly present to local atheroma of the blood vessels, an explanation hypothetical and improbable, considering that not infrequently such disturbances are transitory. Krafft-Ebing and others are clearly of opinion that senile brain changes take place in climacteric insanity, since they regard the disorder as a premature senility. This view and the statement concerning the pathological importance of atheroma are incompatible with the recovery rate. Unfortunately it must be admitted that it is impossible with our present knowledge to trace a pathological connection between the known conditions, namely, the change in the reproductive organs and the mental disorder.

OCCASIONAL NOTES OF THE QUARTER.

Census of England and Wales, 1891.

The "General Report, with Summary Tables and Appendices," only came into our hands at the close of 1893. In the following very brief *résumé* of the section devoted to the insane we have omitted the reference to the alleged increase of insanity, as it has already been dealt with at p. 228. Sex, distribution, and age, however, remain.

As to *sex*, of the 97,388 lunatics 45,392 were males and 51,991 females, or 3,230 men per million living and 3,478 women to the same number of the population. But while it

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