Amentia and Dementia: a Clinico-Pathological Study.

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CONTENTS.

HIGH-GRADE AMENTIA.

GROUP III.

RECURRENT CASES.

	Males.	Females.	Total.
(*a*) Relapsing . .	6	13	19
(*b*) Now chronic . .	11	17	28
Total . .	17	30	47

THIS group includes recurrent cases of insanity or cases subject to relapses from an apparently normal mental condition to one of mental alienation. The patients differ from those of the previous group in that during their lucid intervals they pass as normal sane individuals. They are, however, liable to become so far out of accord with an environment which would have little or no influence on normal individuals, that attacks of temporary mental alienation develop at regular or irregular intervals. In other words, the mental equilibrium of these patients is so unstable that it becomes upset by the various influences which constitute the normal "stress" to which the several members of a civilised community are necessarily subject. Though the cases in this group grade in-

sensibly into and, during their attacks, exhibit a mental symptomatology similar to that of those included in Group II, classes (*a*) and (*b*), the fact that they are sane during a greater or a lesser portion of their lives affords a sufficient reason for placing them in a separate group as one of the types of high-grade amentia.

As is the case generally in high-grade amentia, the ages of incidence of the several attacks are uncertain, and the symptomatology exhibited is various. An attack may be precipitated by the normal physiological changes occurring at any of the "critical" periods of life, or by any undue or unusual condition of "stress," whether toxic, physical, or mental, etc. A patient may, for example, suffer from one or more attacks of insanity during the period of adolescence, and may then develop another, some years later, after confinement, or may continue sane until the pre-senile or even the senile period of life. Other cases, again, may not suffer from any attack whatever until middle life or later, and in some instances no psychic phenomena of so abnormal a character as to necessitate an asylum *régime* may appear until even the senile period of life is reached. Whatever be the age of incidence, however, the result is recovery, after a varying period, without the development of an appreciable amount of dementia. The period elapsing between the recurring attacks of insanity varies in different cases, and is largely dependent on the inherent resistance of the individual to his environment. In cases of low resistance, the attacks may be almost or quite periodic, whereas if the resistance is greater many years may elapse before a recurrence of insanity. It is, in fact, probable that a large proportion of the cases of "recovery" from an attack of insanity relapse sooner or later, and that the remainder would also do so were it not that they die before the recurrence actually happens or that their environment has been made suitable to their capacity of resistance by their friends or relatives.

The symptomatology manifested during the attacks is as various as is the age-incidence of these. Whilst, however, in the case of the latter the important factors are the resistance of the individual and the external "stress" which is applied, in that of the former individual temperament and general psychic experience are probably the determining causes of the phenomena manifested. The symptoms may be those asso-

ciated with excitement or with depression, or a period of excitement may be followed by one of depression. The order of sanity, excitement, depression, and again sanity may always be the same, and each of these phases may even be of approximately the same respective duration in subsequent attacks, as in patients whose mental equilibrium is very unstable. The psychic disturbance may, however, be of an entirely different character in the several attacks, as in patients who are more stable mentally, and in whose cases environment is the most important factor in determining the incidence and even the course of a relapse. Almost any phase of psychic disturbance may exist during an attack, and if more than one phase occurs, each may vary in duration independently of the other. It is, nevertheless, common to find that the more regularly and the more frequently the attacks of insanity recur in a given individual, the more usually do they resemble one another both in symptomatology and in duration; and this statement applies both to still relapsing cases, a proportion of whom are usually described as "folie circulaire," and to cases permanently under asylum treatment.

The usual, if not the invariable, result in cases which live long enough is a gradual shortening of the lucid intervals, with, finally, permanent confinement in asylums; and in a large proportion of the cases little or no dementia supervenes even when the patient has become aged, unless normal senile involution of the cortical neurones ensues, or any of the causes of progressive and secondary dementia interfere with the course of the case.

Amongst the exciting causes of the onset of attacks, alcoholic excess is one of the most potent, but it does not, in the type of case under consideration, necessarily produce any cerebral dissolution. Cases, in fact, which readily lose their mental equilibrium under the influence of alcohol may be brought before a magistrate scores of times before or without going to asylums at all, and may continue up to old age without the development of dementia. On the other hand, however, cases, which exhibit greater resistance to breakdown, will, under the prolonged and excessive abuse of alcohol, with the other necessarily concurrent mental and physical forms of "stress," sooner or later develop some or even considerable dementia.

In cases of the type under consideration it is not uncommon

to find a premonition of the incidence of an attack, and patients after recovery may graphically describe their efforts at self-control and how these finally became ineffectual. In some instances there is complete recollection of the attack, and the patient is able to state exactly what occurred during it, and to describe his utter inability to control his thoughts and actions. In other cases, again, especially when the attack is of sudden onset and great severity, the patient has no recollection of what has occurred, and consequently on recovery shows complete loss of memory regarding the events during his illness. In such severe cases the patients, as regards their behaviour, their general appearance, and even their facial expression, may be quite unrecognisable. Modest and quiet girls, for example, become talkative, noisy, excited, and erotic, and pleasant and respectable women become foul-mouthed fiends.

In no type of high-grade amentia is the homologue in sane individuals more readily discoverable than in the group of cases under consideration ; and, though it be at the risk of a charge of exaggeration, the writer will now proceed to illustrate what appears to be the psychic relationship between recurrent insanity on the one hand and the lapses of control over the emotions, words, and actions which occur in the normal individual on the other. The ordinary sane person usually exercises relatively little voluntary control over his emotions or intellectual processes, but glides along according to accident of environment and pre-arranged duties ; and all individuals are subject to more or less severe lapses of voluntary control. Common examples of this are the excitement or depression which lasts for hours or days under unusual circumstances or after startling occurrences. In the presence of strangers one person may talk incessantly and volubly from sheer nervousness, whilst another can hardly be got to speak a word. Other individuals, again, whenever they converse, even with strangers, are quite unable to refrain from repeating all kinds of fact or gossip which ought to be kept secret, and afterwards are quite aware of their delinquency. A girl may be violently excited for hours before a ball or after the advent of a new gown ; and a man, after a game of golf or cricket, may be a perfect nuisance to uninterested listeners by persisting in recounting his exploits, and particularly in repeating what would have happened had so-and-so *not* occurred. More marked examples of loss of

voluntary control are the violent "passions" or "sulks" which in some individuals are precipitated by apparently inadequate causes, and these, again, pale before the extreme excitement and "delirium tremens" of acute alcoholism. To these examples may finally be added the tendency, as a natural reaction to prolonged application to work or to undue restraint, to break control for a few hours or more and to "go on the bust," which is so extremely common in nearly all individuals, and which, where resistance to environment is at all weak, may end in undesirable results. The last instance is especially instructive owing to the readiness with which it recalls the severe efforts to keep sane which are made by many cases of insanity, who suffer from frequent relapses, and who, during their lucid intervals, are most anxious to obtain their discharge and to return to their friends.

Group III.—Class (a).

Relapsing Cases.

This class contains 19 cases, of whom 6 are males and 13 are females.

Though, from what has already been stated, the number of cases in this class is no indication of the actual proportion of lunatics of the type under consideration, it serves a useful purpose in that it shows that patients suffering from relapses are not infrequently met with in an asylum population during any given period of time, in this instance a few months. As will be seen later, in Part III of the present paper, the total of 728 cases includes 48 examples of senile or "worn out" dementia, which were primarily cases of recurrent insanity, and 75 examples which had continued in asylums since primary certification. Both these numbers represent an accumulation of cases of varying duration, and their exact use would be beset with fallacies; but they at any rate indicate that the proportion of relapsing to primarily incurable cases is high, and they are therefore made use of in the absence of more trustworthy data. The writer does not, however, wish to attach any undue importance to these figures; for, though the average duration of life in relapsing cases is probably much higher than it is in the chronic insane, the proportion of the

former figure to the latter still perhaps remains higher than an average recovery rate of about 30 *per cent.* would allow of, even if the majority of these cases relapsed.

The symptomatology exhibited during recurrences of mental alienation is various and difficult to classify into types. In a large proportion of cases, however, certain emotional states, namely excitement, depression, and fear, predominate, and these may be associated with or may result in impulsive actions, *e.g.*, violence to others, destructiveness, and attempts at suicide, the last usually by such methods as can be carried out without premeditation.

Cases of the excited type are boisterous, restless, violent, noisy, mischievous, and imitative. They possess only the slightest power of fixing the attention and are unable to settle to anything, but react to sensory stimuli so rapidly that their actions appear wild and their speech incoherent. Their attention flits to and fro; whatever they begin to do, or say, or sing they leave unfinished, and their mental functions at times appear to be in a state of confusion. With patience it may be possible to get them to write their names, but they either leave the name unfinished, or cover it with flourishes, or end by performing some violent or absurd antic. They can usually be got to answer occasional questions, at any rate if their attention can be attracted long enough to enable them to understand them; and therefore short questions are more frequently replied to than long ones. They often, however, give inconsequent or inapposite replies, and they may make voluntary remarks, usually about objects near them or sounds heard by them, which appear quite incoherent unless both the patient and his surroundings are most carefully and minutely studied. Such replies and remarks usually form sentences and phrases which in themselves are verbally correct, and in cases where the ideation is so rapid, and the attention is so flitting that no sequence of ideas can be traced, this characteristic of verbal correctness in the phrases and sentences spoken is still maintained. In the more marked cases of exaggerated reaction to external stimuli, where the capacity of attention is practically absent, only the shortest phrases, or single words even, may be repeated, and here especially association by similarity becomes evident, and whole strings of words which rhyme or sound alike may be repeated. Beyond this stage it is not usual for sensory and

ideational hyper-reaction to pass in cases of the type now under consideration, for on the one hand aberrant and grotesque ideational processes generally occur in cases belonging to Classes (*b*), (*c*), and (*d*) of the preceding group, who are never really sane, and on the other, still more abnormal ideation is, at any rate as a rule, inconsistent with recovery, and cases exhibiting it are in the preliminary stages to or have actually developed more or less dementia. Hallucinations are not common in cases of relapsing insanity, unless the attack is precipitated by alcoholic excess or some other cause of cerebral toxæmia; and many examples are credited with this symptom when the explanation of the phenomena exhibited is to be found in the hyper-æsthesia of the special senses, which occurs in association with an abnormally rapid reaction to the sensations experienced.

In certain cases, of the excited and apprehensive types especially, it is not uncommon to meet with a psychic state which, without analysis, might be mistaken for confusion, but which is really allied, on the one hand, to the inability to think which occurs in some persons owing to nervousness, *e.g.*, a student at a *viva-voce* examination, and, on the other, to the thoughtless remarks of children, or of persons who happen to be talking "through the backs of their heads." As an example of the former may be mentioned a patient who, on being asked her name, appeared quite uncertain as to her personal identity, asked the nurse who she was, and finally mentioned certain marks of identification which she possessed, and which would enable the question to be settled; and, of the latter, a patient who, when asked to open her mouth and show her teeth, said that she would like to have all her teeth removed and requested me to at once perform the operation.

Cases of the depressed type are more or less melancholic, and, if the depression is not so profound as to annul the capacity of attention, the patient is either unable to give a reason for his condition or he affords an intelligent explanation, which, in many cases at least, is in essentials true. At times a correct or possible cause may be grossly exaggerated, but the elaborate introspection seen in developing delusional cases does not occur. A certain patient gave, as the cause of his first relapse, his anxiety about his aged mother, who had recently become insane, and his mother gave as the cause of her attack

her anxiety about her son, who had just before developed his first attack of insanity. The son, again, as the cause of his first attack, which became obvious owing to a determined attempt to cut his throat, stated that he had begun to think that he could not help it, as it was born in him, for his grandmother was like his mother in the fact that she suffered from depression at times. The son, during the period he was under observation, recovered from his second attack, again relapsed, and once more recovered; and the mother remained an inmate of the asylum and suffered periodically from mild depression. As an example of a possible but exaggerated cause, which the patient, on recovery, ceased to accept, may be mentioned an individual who stated that his attack began owing to the worry from which he suffered owing to his having made a mistake in his accounts, which was the cause of great monetary loss to his employers.

Fear or apprehensiveness is the important symptom in many of the cases in the class under consideration. The patient is perfectly frantic owing to terror which he cannot explain or give a reason for. The emotion is in such a case not the apprehensiveness of a confused or lost patient, but is downright honest fear, and it may lead to violent behaviour or to sudden and unpremeditated attempts at suicide. One such patient could not be kept in bed a moment, and would not stay in a side-room unless the door was fastened. The opening of the door resulted in frantic attempts to escape, which, on one occasion, led to a struggle between the patient and a nurse, who, contrary to instructions, had entered the room alone. The contest lasted until they were both exhausted, and were found thus by another patrol nurse. This patient, in her frenzy, on more than one occasion mistook one of the medical officers for a relative, implored him to protect her, and clasped hold of him so tightly that he was with great difficulty removed from her clutches. Cases of this type do not form an especial variety but grade insensibly into those already described.

As has already been stated, relapsing cases frequently suffer from impulses. Some cases snatch at everything within their reach, either from acquisitiveness or mischief; others destroy out of wantonness any article in their vicinity, and others, again, are violent and dangerous. The most serious impulse, however, is that prompted by fear or misery, namely, an unpremeditated

attempt at suicide by, *e.g.*, drowning, jumping out of windows, cutting the throat, or strangulation. In some instances the act appears to be carried out either without any motive at all, or from an entirely inadequate one, as in the case of a patient who awoke feeling that he could not go to his work and that everything had gone wrong, and who straightway ran downstairs and attempted to cut his throat. It is quite probable that in some cases the motive for a sudden attempt at suicide is elaborated after the act has been unsuccessfully accomplished; and that at least a number of successful suicides "during temporary insanity" are unrecognised examples of the type of case at present under description.

As the cases described in this section recover and are discharged, it is only to be expected that during their residence in asylums they are useful workers. Of the 6 males referred to as belonging to this class, 4 worked well; one, an educated and eccentric man, refused to work usefully; and one, who suffered from phthisis, was unable to work and eventually died. Of the 13 females, 12 were good workers, and one, who suffered from chorea, was therefore unable to work usefully, and, after discharge, soon relapsed and was readmitted. The following five cases are average examples of those referred to in the section:

Recurrent Melancholia, with Suicidal Impulses.

CASE 182.—D. D—, male, married, carpenter, æt. 41. Certified 1½ years, son of No. 211.

Patient is recovering from an attack of recurrent melancholia of one and a half years' duration. He is somewhat lively in manner, and is talkative and inquisitive. He tries to read what I am writing and readily tells me the date when asked, though he first looks at a newspaper to make certain. His memory for both recent and remote events is perfect, and he gives a clear account of his case with very little cross-examination.

His first attack began suddenly three and a half years ago. Without any warning he got up out of bed, ran into the scullery, cut his throat, and was taken to the hospital. He did this because he felt that everything was going wrong and that he could not do his work if he went to it. If he could not work his wife and family would "go to the dogs," so he suddenly felt that he must commit suicide, and he did so. He never meditated suicide till that very morning, and then it was a sudden impulse, and he has not had such an one since. He was in the asylum for eleven months as a result of this attempt. He was then sent out

on trial for a month, but at the end of this period he was taken to a workhouse for a time and was then sent to another asylum, where he remained for four months, and from which he was discharged recovered. He then went home and worked up a small lodging-house. He did well for two and a half months, and then received a severe shock owing to his mother becoming insane. He became very depressed and felt unable to work. He began to think that people looked down on him as a lunatic, and he worried a good deal about this. He has always been accustomed to dream frequently, and, as a rule, the dreams are of a pleasant nature. Just before his relapse, five months later, he, however, had a most unpleasant dream which he remembers vividly. He "dreamed that he was down in a cellar or cave, and that there was a window in it which opened on a balcony. He felt irresistibly that he must run out of the window and escape, and when he ran out someone was waiting to take him."

He gives a hereditary reason for his illness. He says that he has begun to think that he couldn't help it as it is born in him. His grandmother was like his mother in the fact that she suffered from depression at times, and he thinks that he is also like her. He is very sorry for what he has done, but thinks it is a misfortune rather than a fault. He, however, is anxious "to know if he has anything physically the matter with him."

For some months patient continued to be interfering, quarrelsome, and mischievous, and he was often in trouble with other patients. He then recovered and was discharged.

Some months later he was admitted in a condition of profound melancholia. He was a physical wreck and suffered from severe and recent gonorrhœa. He again improved and was again discharged recovered.

Marked Eccentricity, with Recurrent Attacks of Mania.

CASE 184.—G. S. T—, male, married, carver, æt. 56. During the past fifteen to twenty years patient has been erratic and peculiar and has suffered from attacks of mania. He was in an asylum some months ago and also four years ago.

He is at present in a condition of wild excitement. He is excited, restless, and violent and most destructive to everything near him. He tears his clothes, throws about and breaks the chairs, etc., and can only be managed when in a padded room in strong clothing. He is noisy and shouts loudly and unintelligibly and gesticulates wildly. He clasps his hands, jumps up and strikes out, etc.

When I endeavour to attract his attention he shows that he possesses some power of attention. He becomes inquisitive and tries to seize my note-book and pencil. He makes a face at me, he points to his teeth and he tries to get me to shake hands. No satisfactory replies to questions can be obtained owing to his rapid reaction to sensory stimuli, but he says he represents the Queen and Crown, etc., and the more he is taken notice of the more grandiose he becomes. He is, however, quite rational and able to reply to questions if they are pre-

sented in a suitable manner, for he writes accurate replies when given a pencil and note-book.

Patient settled down gradually and at times was quite well behaved and apparently convalescent. He was, however, a good deal of trouble as he was constantly worrying some one or other, by correspondence or otherwise, about trifles, and he steadily refused to work. Eventually, some months later, he was removed from the asylum by his friends, and was then in all probability in what has been his normal mental condition during the past twenty years or so. He was an intelligent, well-educated, and clever man, and, in spite of the trouble he caused, was much liked and respected.

Recurrent Mania, with Apprehensiveness.

CASE 188.—E. S—, female, single, domestic servant, æt. 34. Previous attacks at the ages of 17, 21, and 33. No history of intemperance.

Patient on admission is a pale, restless woman, who is rather talkative and asks me to let her tell me what she has done. She only struggled with her brother in the house because she wanted to go for a walk. She has had no sleep for two or three nights. She thought she heard someone calling, "You ought to come up and see mother." Her brother said it was nothing. She asks me if her mother, Charlotte Clarke, later S—, is here.

She knows the day, month, and year, and approximately the date. She gives a fairly clear account of herself. She first went to an asylum when she was 17 or 18 years of age owing to brain fever, and she was there seven and a half months. She was in this asylum two or three times and was then in another asylum, whence she was discharged to the union. Then she went out to service. About a year ago she was again in an asylum for two months. She does not give this account very clearly and has difficulty in remembering details, and often returns to a question previously asked her, and adds the information.

About seven or eight years ago her baby Nellie was born, and she died when 7½ months old. Patient knows who was the father of the child.

She at times shows much confusion during her anxious efforts to remember and to give information. She would, *e.g.*, very much like to see her sister to find out whether she is married. Then she says that she has lived at home since she last left the asylum, and adds, apparently *apropos* of nothing, that she is certain that one of the doctors here was known to her at another asylum she names (untrue). She wants to know if the people here thinks she is someone else, because one day she thought that she was someone else. She used to think that she was her brother. She says she used to have some little marks on her finger-nails, and she might have been known by them to be herself. She often asks the nurse to confirm what she says, even if it is about a matter on which it is obviously impossible to do so. She does not seem to appreciate that we are all strangers to her. She seems to think that we must be friends, and she asks me if I am very much worried about her. Every now and then she clears of her confusion somewhat, *e.g.*, she

suddenly asks me whether she has told me she had a child seven or eight years ago, Nellie, who died, æt. 7½ months. She then adds that she thought she was going to have another two years ago, but nothing came of it. She fidgets with her hands and whispers to herself when left alone.

There is no history of alcoholic excess, and she does not resemble a case of alcoholic confusion. She is not improbably partially confused, owing to a draught which she says was administered last night (before admission).

On admission patient was extremely nervous and apprehensive, and she was readily frightened. She continued in this condition for several days, could not be kept in bed at night, and would not stay in a single room unless the door was fastened. She was almost frantic when the door was opened, and seized hold of anyone near and struggled like an eel to get away. On one occasion when a night-nurse, contrary to instructions, opened the door when alone, she and the patient struggled on the floor of the room for upwards of an hour till another nurse passed on her round.

This patient rapidly improved, and was discharged recovered after a residence of four months.

Extremely Acute Recurrent Mania.

CASE 192.—M. C. E—, female, married, housewife, æt. 39. Nervous attack seven years ago. Father and sister insane.

An excited, violent, impulsive, and mischievous woman whose attention it is almost impossible to fix even for a moment. She at once asks me why the b——y h——l I don't shave myself. Then she picks up the admission book, tries to get hold of my stethoscope, pulls my ear, rubs my hair, and then rapidly reads her admission paper aloud. She is as lively as a monkey and as mischievous, but is also dangerous. Whilst taking her case she twice slapped my face and once struck me on the jaw. She at times gesticulates in a vicious manner, and at others sings and talks continuously and inconsequently, but not incoherently. When asked to write her name she takes the pencil and complies with the request, ending with some violent and irregular strokes of the pencil, which she finally hurls in my face :

The patient rapidly recovered, became clean and tidy and well-behaved, and a good worker, and was discharged recovered after some months' residence.

Presenile Mania, recurrent after an Interval of Twenty Years.

CASE 199.—M. J. F—, female, married, housewife, æt. 50. Previous attacks at the age of 30, and also three months before her present admission.

A restless, excited, violent woman who will not stay in bed. She laughs, springs about, and rapidly utters a conglomeration of incoherent

words and phrases. She picks up pencils or other articles that happen to be near her, imitates what is done or said in her presence, and at times gets quite violent. Age? "One pound twelve and sixpence I owe Dr. P—," then adds her name. Age? "Ten years older than you—44." "Dr. W— knows. Three months old I—." "Twelve and sixpence I owe you, sir." "So she seems to be, 3rd of May." "Look there" (pointing to a plant), "we've bought that for tenpence, sorry we had it." Throws a kiss at me. Then says, "13th June, wide, wide world. 23rd April, mind your business." "I beg your pardon, Dr. W—, you gave me a sovereign," etc.

Patient rapidly recovered except for a certain amount of dulness and slowness, probably associated with her fairly marked deafness. She relapsed several times for short periods during the next twelve months, and was eventually discharged recovered.

Group III.—Class (b).

Relapsing Cases who are under Permanent Treatment.

This class contains 28 cases, of whom 11 are males and 17 are females.

The chief constituents of the class are cases in whom the lucid intervals have become too short to make their discharge possible, or who rapidly relapse in consequence of the change of environment following discharge. The class also includes several examples of fairly-marked degeneracy who have succeeded in passing for normal individuals during a part of their lives, and who have, in consequence of prolonged confinement in asylums, become degraded to a much lower mental level. These cases, of which No. 205 is an example, have, in fact, lived in a refractory ward like beasts for so long a period that they have practically become lower animals without actual loss of intelligence. This condition of degradation finds its sane homologue in the case of well-bred "ne'er-do-weels" who, *e.g.*, join the army as privates and, after years of rough-and-tumble existence in this capacity, resemble, except for occasional glimpses of culture, the class with which they have mixed, in their actions and speech and in the general coarseness of their moral tone.

These degraded cases in many instances exactly resemble other types in symptomatology, and only differ in the fact that they have once been "sane" individuals and were originally of

the relapsing class. A difficulty thus arises, in the absence of a personal history, in distinguishing them from certain cases belonging to Classes (*a*), (*b*), and (*c*) of Group II ; and similarly cases belonging to Classes (*c*) and (*d*) of Group II are often with difficulty distinguishable from many of the systematised delusional cases described under Group VI. Far, however, from being a flaw in the general argument contained in the present paper, this gradual shading of type into type is important evidence of the relationship which exists between all the cases described under the term " high-grade amentia," for the separate groups into which the cases are divided are employed for convenience of exposition rather than with the object of suggesting that these several groups contain specific types of mental disease.

The recurrent cases of higher type than the preceding differ from these in possessing periodic intervals during which they are medically though not legally " sane." The prominent symptoms in these cases are maniacal excitement and melancholic depression, and the time relationship of these to one another and to the lucid interval varies in different cases, but is usually fairly periodic. Some cases may suffer from excitement only, and some from depression only, or the maniacal state may last a longer or a shorter period than the melancholic. It is even possible, as has already been remarked, to make the general statement, with reference to the cases contained in both the present and the preceding classes, that the shorter the duration of the lucid intervals is, the more the relapses resemble one another, in any individual case, in both symptomatology and duration ; and the longer the duration of the lucid intervals is, the less the relapses may be expected to resemble one another in either symptomatology or duration.

In their capacity for useful work, the cases in this class, during their lucid intervals, resemble those in the preceding. Of the 11 males, 9 were good workers, 1 refused to work, and 1 was permanently mentally incapable of work ; and of the 17 females, 5 were good, 3 were ordinary, and 2 were poor workers, 3 refused to work, and 4 were permanently mentally incapable of work.

The following six cases are inserted as illustrative examples :

Recurrent Mania, much Mental Degradation.

CASE 205.—H. W. A—, male, single, draper, æt. 46. Certified twelve years and previous attack at the age of 27.

A dull-looking man. Eyes rather close together. Forehead low and narrow. Ears large and without lobules. He gives his name as Alec A—. Age? "That I couldn't tell you, sir." He was born on May 13th, 1857, but cannot reckon his age from this. When I press him he stamps on the floor and then asks if the wood is "wood, wheat, hops, or Puck and the fairy?" He says he doesn't know where he is, and has come from "mother's womb." He at times eyes me curiously. He writes his name correctly, though he gave it as "Alec A—." When I say "Alec," he says "Ain't Harry Alec?" When asked if he has ever heard of the asylum from which he has come, he says, "Yes, Hop-garden, ain't it?" Asked if he has been there, he says, "Yes, was at St. John's Wood, making bricks." He then begins voluntarily to make such remarks as "There are 52 weeks in a year and 1760 days in a year," and asks me to suppose that "there isn't fifty-two weeks in a year." I then ask the number of days in a week, and he says, "Seven, and 12.30 is the smallest hour of the morning and nearly one o'clock."

He is untidy and filthy and degraded in his habits. He eats filth and fæces—and on one occasion ate a dressing which had been applied to a cut on his head—and he drinks urine and the contents of spittoons. He is disgusting in his behaviour and very destructive to clothing, etc. He never works, and is at times very troublesome.

Recurrent Melancholia of long Duration.

CASE 208.—H. W—, male, single, farmer, æt. 59. Certified 22¼ years and had several previous attacks.

A dull, depressed-looking man, with bright eyes and a respectful manner. Palate V-shaped and very narrow in front, and not high. No lobules to ears.

He gives his name correctly. Was born on March 6th, 1844, and the present year is 1903, and therefore he is 59 years of age. He knows quite correctly the present day, date, month and year, and also the date of his admission here. He knows from what asylum he has come. He went there on August 3rd, 1881, and therefore was there 23 years. He did various kinds of work in that institution. He worked in the dining-hall and the stores chiefly. He does not smoke.

He is very ill, and he went to that asylum owing to being very ill. Now and then he suffers from dreams, but never from hallucinations. He complains a good deal of dyspepsia. "No doubt there is an enemy, but where it is I couldn't tell." He has "not been before the County Bench. I was summoned once before the County Bench for trespass and carrying and using a gun." He does not know who sent him here. They had orders at the other asylum to release him, but they didn't do so and sent him here. He supposed that this was ordered by "the onlookers." He is very dull and slow and hypochondriacal and is much worried about his different ailments, real or fancied, but especially about

a rupture from which he suffers. In spite of this, however, he is quiet and well-behaved and works willingly and industriously.

Recurrent Melancholia of long Duration without Dementia in a Patient æt. 76.

CASE 211.—E. D—, female, widow, no occupation, æt. 76. Certified since the age of 74, and has suffered from attacks of melancholia since the age of 37. Son insane (No. 182), and also a relapsing case.

A healthy and well-nourished old woman who is somewhat apathetic, as a rule, but is nervous and fidgety. Her memory is good, her intelligence is normal, and she can give a clear and quite satisfactory account of herself. Her present attack was precipitated by worry over her son, who had recently recovered from an attack of melancholia and was causing a good deal of anxiety. He relapsed shortly after she was sent to the asylum. She is more concerned about her son than about her own condition, and frequently asks to see him or sends him small presents. At uncertain intervals she suffers from mild depression, when she becomes tearful and miserable for a few days at a time. She is somewhat hypochondriacal, petted, and irritable, but is in relatively good health for her advanced age. She constantly asks for her discharge, and regularly corresponds with her family and friends. She attends to herself, makes her bed, etc., and behaves exactly like an ordinary decent old woman. She also does a little dusting in the ward, and she sews well as regards quality of work, though she does not do very much.

Recurrent Mania of long Duration, with still frequent Relapses.

CASE 215.—E. S—, female, single, servant, æt. 67. Certified since the age of 43. A previous attack at the age of 41. Son in the asylum (No. 24), an imbecile of moderate intelligence.

An intelligent-looking old woman who smiles in a pleasant manner, and readily gives a fairly clear account of herself. At present, during a lucid interval, her memory, apart from lapses during her attacks, and intelligence are good. She talks sensibly and rationally and asks many questions about what has happened during her last attack.

The lucid intervals are short, lasting a few days to a few weeks at most, and are followed by a much more lengthy attack of maniacal excitement, during which she is a totally different woman. She looks during these attacks a veritable fiend, and is excited, noisy, violent, spiteful, and dangerous, also destructive and of filthy habits. She is abusive and most foul-mouthed, and is possessed of remarkable activity and endurance considering her age and apparently delicate health.

The period of excitement is followed sooner or later by a shorter period of depression, during which she is silent and moody and feeble, and from which she gradually awakens to lucidity. For several days before finally becoming cheerful she talks readily and rationally and asks questions about her attack. She is pleased to see her son during her lucid intervals, and often asks after him.

Recurrent Mania of Forty-four Years' Duration, with still frequent Relapses.

CASE 216.—M. A. M—, female, married, no occupation, æt. 64. Certified since the age of 49, and has suffered from recurrent attacks of insanity since the age of 20.

A lively old maniac, who is devouring bread as if she had not had anything to eat for a week. She at once asks me if I am doing a bit of shorthand work, and wants badly to know what I am writing. Her memory is perfect, and her intelligence is normal. She rapidly gives me full details of her past life, and when I turn over a leaf remarks that "I have soon filled a page with her logic." She was married, during a lucid interval, at the age of 42, and has no family. She was kept, she says, in the last asylum, "because Dr. — is an old fool," and then she shakes with laughter. During physical examination she squirms and rolls about, laughs almost without intermission, and wants to know "what the devil are you doing?" She places her hands on her groins and is very anxious to be covered whilst I am examining her abdomen, and when her nightdress is taken off she covers up her breasts and laughs in an erotic manner.

The patient for several weeks at a time was a useful worker, but was jovial, excitable, garrulous, and erotic. She then relapsed, and for a varying period was excited, noisy, violent, and foul-mouthed. This attack was then followed by a shorter, but also variable, period of depression, during which she was reserved, silent and lachrymose, and after which the lucid interval developed gradually. She was at times difficult to get on with, but was a favourite.

Recurrent Mania of Periodic Type since the Climacteric Period.

CASE 220.—M. W—, female, married, housewife, æt. 57. Previous attacks at the ages of 49 and 53.

An excited, restless, noisy and violent woman, who shouts, sings, laughs, and throws her limbs about. She at times plays with her fingers, tries to tear the sheet with her few remaining teeth, pats her limbs, and at the same time utters rapidly, with occasional pauses, such phrases etc., as the following: "What can I do? my boys are all girls. I can get nowhere. I'm a beggar outside Calvey. I say, my boys, I'm proud of you, George IV. and Henry VIII. You've got to meet the one you hate. Salome, I hate you." She covers her head with the sheet and then speaks of "dark things and light things." "Covered again in No. 2 and revealed in No. 3, and bless and kiss in No. 3 the Royal." Then she lies quietly for a few moments. "Cover A B C, Cover. Cover what you never did, though. Incline my daughter unto me, incline, decline, recline, my fair lady. I'll fair lady you." She takes practically no notice of her surroundings, and her attention is very difficult to retain even for a moment. She does not always react to external stimuli, but at times she responds with extreme rapidity. Once she suddenly snatched my handkerchief from me, but otherwise took little or no notice of my presence.

The patient recovered steadily, and was a good and willing worker for several weeks. She was then discharged, but she relapsed at once. She rapidly recovered and some months later she was again discharged.

(To be continued.)

Some Points in the Early Treatment of Mental and Nervous Cases (with Special Reference to the Poor).

By A. HELEN BOYLE, M.D., Medical Officer, Lewes Road Dispensary for Women and Children, Brighton.

THE object of the paper is to urge the establishment throughout the country of institutions for the treatment of nervous cases and of early uncertifiable insanity. The fact of certification leads to an erroneous view of insanity, for it does not make a person insane, nor does the absence of it prove sanity. The boundary line of certification is a purely arbitrary one, and, from the nature of the illness and our present ignorance of it, this is bound to be so. Certification does not necessarily mean that at such a moment a person became mentally upset, but rather that at such a time, after observation showing them not to be responsible for their actions, it became advisable, in the interests of themselves or others, to control them, if required, by force.

Treatment, therefore, should begin irrespective of certification. The law, a very valuable one, surely has importance purely in that connection; it merely sees that physical control, when given, is not abused. Certification is only an incident in the course of the insane illness, and not necessarily, nor even often, at the beginning of it.

To use a paradox as a short cut to what I mean, insanity begins before a person is insane, and it is then that recognition and skilled treatment are most valuable.

It is this truth which terribly needs to be driven and hammered into the understanding of the lay public, and even more into that of the general practitioner, who is too apt to associate mental trouble with the striking picture of an acute maniac and to think that psychic disturbance short of delusions,