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PART 1.—ORIGINAL ARTICLES.

The Morisonian Lectures on Insanity for 1873. By the late DAVID SKAE, M.D., F.R.C.S.E., Physician-Superintendent of the Royal Edinburgh Asylum, &c., &c. Edited by T. S. CLOUSTON, M.D., F.R.C.P.E.

(*Continued from page* 507, *Vol.* xix.)

LECTURE III.

The forms of insanity which we passed under review, with the exception of the epileptic insanity, were all more or less connected with the organs and function of generation, and the next five forms are also of the same class. The first three, as you will see by a reference to the table, are connected with child-bearing—the Insanity of Pregnancy, of Parturition (or puerperal insanity), and of Lactation.

These three forms of insanity, intimately connected as they are etiologically, present, as we might expect, a certain similarity within certain limits in their symptoms; yet each presents a group of symptoms so characteristic and peculiar that each might be described by its natural history as a distinct form, and at the same time be referred to its origin for a name.

A cursory review of the three forms of insanity named will, I think, justify this statement, and show how this method of classification is justified by its results.

My friend, Dr. John B. Tuke, took up this form of insanity with special reference to my classification, and his able papers on the subject, in the "Edinburgh Medical Journal" for 1865 and 1867, have fully established the positions I have claimed, and from them I shall quote freely in the remarks I am about to make.

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The *Insanity of Pregnancy* most frequently occurs in the case of women who have married late in life, and whose first confinement has taken place between the ages of 30 and 40. The symptoms are mostly those of melancholia, or of melancholia with dementia. "In no form of insanity," says Dr. Tuke, "is the suicidal tendency so well marked; 13 patients" —out of 28—"had either attempted or meditated suicide. In some the attempts were most determined, a loathing of life and an intense desire to get rid of it being the actuating motives. In the melancholic cases we can frequently trace back the delusions to the morbid fears, restlessness, capriciousness, and irritability of the pregnant woman, which becoming exacerbated, amount to actual insanity, and prompt the unhappy victim to self-destruction." "Moral insanity is by no means an unfrequent one of the varied symptoms this name implies or includes; dipsomania is the most common one in the cases under notice." This morbid and insane craving for stimulants, occurring generally in the earlier months of gestation, is probably, as Dr. Tuke observes, only an aggravated form of the well known craving or longing for particular articles of food, which characterises the earlier months of pregnancy. As it advances it increases in intensity, and gives rise to actual delusion and attempts at suicide. In two cases the moral perversion was evinced by a homicidal impulse.

This disease is not an incurable nor a fatal one. The recoveries are 70 per cent., and the remaining cases either pass into dementia, or have maniacal attacks after parturition, and then become demented, or die of phthisis or some other bodily disease.

Puerperal Insanity is a disease occurring within the month, or by a little latitude it may be extended to cases within six or eight weeks after confinement. The risk of puerperal insanity is greatest between the ages of 30 and 40, and in primipara, as in the last form. The danger of its recurrence diminishes with each successive pregnancy. It does, however, tend to recur, and it seems to predispose the woman to other forms of insanity. The hereditary predisposition is very constant, and is more easily ascertained than in most other insanities.

All cases of puerperal insanity, when melancholia is the prevailing symptom, are cases where the insanity developed itself 16 days or more after labour. All cases developed before the 16th day evinced maniacal symptoms. "Dementia

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and melancholia characterise the derangement appearing towards the end of the month after labour," and this is the most incurable form of the disease.* Of the 73 cases analysed by Dr. Tuke, from the Asylum records, he says, "Mania, which was the first symptom in 57 cases out of the total of 73, as a rule was violent, the patient being noisy, restless, sleepless, and occasionally afflicted with hallucinations of the various senses. The suicidal tendency was strongly marked, 25 patients having either attempted, or expressed a design to commit, self-destruction. As a rule, however, this propensity did not last long, but abated with the violence of the symptoms. The suicidal tendency of the puerperal differed also from that of the pregnant patient in assuming the character more of impulse than the result of a perverted train of thought.

"In three violent cases of puerperal mania, I have noticed an extraordinary amount of salacity, a very few days after labour; masturbation was excessive in all these patients, but whether this was the result of the irritation consequent on the labour causing perverted sensation or actual salacity, I cannot say." I look on this symptom as purely reflex in those cases.

Hereditary tendency was ascertained in 22 of the cases. In 23 the labours were complicated, showing how much this cause—along with other causes, such as loss of blood—tends to the development of this disease.

The recoveries were 76.7 per cent., and the only two fatal cases of puerperal insanity in the Asylum Records were two, in which the symptoms were those of the puerperal paraphrenitis (*sic*) of W. Hunter. Recovery generally takes place within 3 to 6 months, and after nine months the prospect gets unfavourable. Dr. Tuke says (Op. Cit.), "Within my own experience the following is the most usual train in cases who recover their reason. Within three weeks, or more frequently earlier, the mania gradually subsides, and is replaced by a state of dementia, generally accompanied by delusions, which almost invariably assume the form of *mistaken identity*. These gradually disappear, leaving a haziness of apprehension, and a state suggesting the idea of waking from a dream." The patient can now be induced to work, and she progresses steadily in strength of body and of mind towards complete recovery.

* Dr. Tuke, Op. cit., 1865, p. 1021.

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This symptom of making mistakes as to the identity of individuals, although occasionally met with in other forms of insanity of a sexual type, is certainly nearly peculiar to puerperal cases, and very characteristic. The patient, the doctor, or any stranger who comes near her is addressed by a familiar name, *e.g.*, "Oh, John, is that you?" "Eh, Mr. Smith, I am so glad to see you, sit down," and so forth. Any such utterances from a young woman in bed, with perspiration on her skin and general restlessness, would be almost pathognomonic of the puerperal origin of her insanity.

On the subject of diagnosis Dr. Tuke makes this remark in his paper—"It has been said by no less an authority than Dr. Gooch that no physician could, by simply looking at and examining a patient, diagnose that hers was a case of puerperal insanity, unless her history was at the same time afforded to him. This I take the liberty of doubting, and will instance a case in point. A woman was brought some months ago to the Royal Edinburgh Asylum, by the police, under a certificate of emergency, in a highly maniacal condition. No information could be afforded, further than that she had been found in this state by the police, and had been at once removed to the Asylum. There was no other evidence whatever, but the physicians who saw her on admission, before she was taken to the ward, came to the conclusion that she was suffering from puerperal mania. Within a few days the Inspector of Poor of her parish informed them that she had been confined five days previous to her admission."

"The puerperal maniac has symptoms which, as a rule, cannot be mistaken for any other form of insanity, with perhaps one exception—*mania à potu;* but even here there are points of diagnosis which are very prominent. The bodily symptoms are in direct variance with the mental. She is pale, cold, often clammy, with a quick, small, irritable pulse, features pinched, generally weak in the extreme, at times almost collapsed-looking. But withal she is blatantly noisy, incoherent in word and gesture; she seems to have hallucinations of vision, staring wildly at imaginary objects, seizes on any word spoken by those near her, which suggests for a moment a new volume of words; catches at anything or anyone about her, picks at the bed-clothes, curses and swears; will not lie in bed, starts up constantly, as if vaguely anxious to wander away; and over all there is a characteristic obscenity and lasciviousness. Suicide is often attempted, but in a manner which shows that it is not the result of any

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direct intention. She may wildly throw herself on the floor, attempt to jump from the window, or draw her cap-strings round her throat; but there is no method about it—it is an impulse, the incentive of which is purely abstract."

The homicidal influence to destroy the newly-born infant is much more frequently carried into effect than the suicidal. In almost every case of puerperal insanity there is some morbid change in the maternal feeling towards the child. The mysterious sympathy between the mother and child, which is at its strongest at this very time, is lost; she looks on it with aversion, asks it to be removed—she is afraid, although she may not say so, that she may injure it. She feels some horrible impulses in her mind, and fears she may not be able to control them, and most probably if the child is not immediately removed, she will destroy it.

I may give two cases in illustration, in both of which the commission of the act seemed to exercise a peculiar power in modifying the symptoms.

Mrs. R., the wife of a spirit dealer, three days after her confinement, began to rave, calling out that there were people under the bed—that the bed was on fire. In the middle of this raving she caught hold of her child and deliberately cut its throat with a knife, the child dying immediately. She was sent out to the asylum without any delay, where we could not see any symptoms of insanity about her, except that she seemed unconscious of what she had done, and hoped nothing had happened to her bairn. She was quiet, industrious, and correct in her conversation and habits. It looked as if her homicidal act had shaken reason back to its place.

The other case was that of a young woman, of 21, the wife of a tradesman. Her sister and maternal aunt were insane, the latter having been three times in an asylum under treatment.

"During the fifth month of her first pregnancy she became very low spirited and depressed. She attempted suicide by drowning, but did not succeed in her intention, from the shallowness of the water, although she persevered for several hours. The attempt was made in the sea, when the sands were not deeply covered, and extended so far out as to make it difficult or impossible for her to reach deep water, so that as the tide receded she was always left high, if not dry, after each effort to effect her purpose. From this melancholy state she partially recovered, and her baby was born in due course. Eleven weeks after the birth she

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deliberately strangled it, and then attempted to poison herself with laudanum. At the instance of the Procurator Fiscal she was visited in prison on various occasions by Professor Maclagan and myself. We found her always happy and contented, exhibiting signs of a morbid exaltation, talking of the prison being a palace for her, and at times being mildly excitable. She was now removed to the asylum, where, on admission, she seemed perfectly happy, made herself quite at home, and settled at once to work. Her mind was evidently very weak, she was facile and reserved. A few weeks after admission I got her to converse about her child, and her motives for destroying it. She was not in the least confused, nor did she seem to appreciate her position. She said that her impression at the time was that it would be happier if it was dead, and that she attempted suicide so that her husband might not be tainted with having a murderess for his wife. She expressed no remorse nor regret. She continued in this state for nearly two months, when she again became depressed and melancholy, crying bitterly at times, as she said, about her child, but in no way alluding to her own guilt. She soon recovered her cheerfulness and enjoyed all the amusements, and worked industriously, steadily, and actively. Menstruation was re-established, and in six months she was discharged recovered. Two years afterwards she passed through her second confinement without a bad symptom, and made a good and perfect recovery."*

Insanity of Lactation.—So much for the insanity of pregnancy and of child bearing. The insanity of *Lactation* remains to be noticed, to complete this group. It is eminently a variety of asthenic insanity, and may be very shortly described.

It mostly occurs in females upwards of 30 years of age, and most frequently in those who have borne and nursed several children, or if a first confinement, have been debilitated by hæmorrhage. The insanity is ascribed to over nursing. No definite period can be fixed on to limit the term of nursing within safety to the mother. One woman

* It is important practically, and interesting physiologically, that perfect mental recovery almost never takes place until the menstrual function is restored and regular, and the sooner it takes place the better is the prognosis. If any further proof were needed than have been given of the soundness of the principle that the various forms of insanity are intimately connected with the state of other bodily functions, taking their origin and shape and departure in this way, this fact would confirm it strongly.—T. S. C.

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may nurse a boy till he is 12 or 15 months old and runs after her for a drink, before she succumbs to the debilitating influence of such a drain on her system. Another, already debilitated it may be by repeated child bearing and nursing at short intervals, or by hæmorrhage, or other causes, may suffer from this insanity within five or six months after her delivery.

The symptoms are either those of acute mania of an evanescent type, or more frequently of melancholia, and, in a very few cases, of dementia—in the proportion, in my experience, of nearly one-fifth of the former, nearly four-fifths of the second, and a tithe of the third. The premonitory symptoms are generally headache, tinnitus aurium, flashes of light before the eyes, sense of constriction round the head, præcordial anxiety, dragging pains in the pelvic region.* The maniacal symptoms are generally acute but evanescent; they rarely last more than ten or fourteen days, and are gradually attended with hallucinations of the different senses, and delusions (as in puerperal mania) of mistaken identity.

"The melancholia," says Dr. Tuke, "which characterises the insanity of lactation is of various degrees of intensity; but where a suicidal tendency is evinced, the attempts to carry out the purpose are most determined. Occasionally the duration of the attack is not greater than three weeks or a month, and in such cases a degree of hysteria is generally present."

"In almost all cases of insanity of lactation which have come under my notice during the last two years, exophthalmia and *bruit de diable* have been marked symptoms, increasing in intensity with the periods of nursing. As the bodily symptoms disappeared so did the mental, such cases almost always recovering."†

Of Dr. Tuke's 54 cases, 39 recovered, 12 became demented, one died, and two remained under treatment.

I trust I have made out a case for these three forms of insanity,—all having an etiology to a certain extent common, all having a common type of symptoms, but each presenting such peculiarities as to distinguish it from the other, and each in the totality of the symptoms such as to indicate the probable cause, even were it not previously known.

* Those physical symptoms of an ill-nourished and exhausted brain are more constant in this form of insanity than in any other, and should certainly never be neglected in any case.—T. S. C.

† Op. cit.

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Climacteric Insanity.—The next form of insanity in my Table is *Climacteric Insanity.* I recognise it as existing both in the male and in the female. In the latter, as is well known to all of you, it occurs at the period of the cessation of the catamenia, between 40 and 50 years of age, the critical period of life—the grand climacteric.

But the man has, between 50 and 60 years of age, his critical period too—his grand climacteric as well as the female. I have had this assertion challenged by authorities for whom I have the highest respect, on the ground that I cannot point to any physiological change in the male corresponding to that which takes place in the female at her critical period. To this my answer has been—First, that such a climacteric period in the male has been recognised by such eminent authorities as Sir Henry Holland, Dr. Conolly, and many others whom I might cite; secondly, that it is a matter of common parlance and observation among non-medical men about this period of life to say that they have passed through their climacteric; that they have had a great trial; they have passed through severe mental trials, and such like phrases. Thirdly, that a form of insanity does certainly manifest itself at this time of life, in which the symptoms as a group and even individually are almost identical with those met with in the female at her critical period. Fourthly, I venture, with deference to the experience of others, on a question broached here probably for the first time—at least for the first time as far as I know—to assert that there is a great and fundamental change comes over the male at the period referred to in regard to his sexual organs and desires. While leading a chaste life he ceases to be liable, under the absence of any temptation, to lascivious dreams and seminal emissions during sleep. I do not for a moment assert that men are sexually impotent, or women either, at that age or for many years afterwards; but I believe that the sexual desires do not proceed primarily from the sexual organs—from the periphery of that chain of nerves—but that they proceed from the central organs of the nervous system to the periphery. If man is sensual in his sexual desires after that period of life, it is the result of *erotic* ideas in the higher sense of meaning of that much abused word. He loves the woman first—the Psyche;—the sexual desire is the ultimate, not the primary element of his passion. I believe it is the same with women too.

Be this as it may, and founding upon my first three reasons,

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I venture to describe this Climacteric Insanity very briefly as a disease affecting both sexes, the female between 40 and 50, and the male between 50 and 60 years of age, or nearly so, and producing in each similar symptoms, which may be briefly described as follows:—

"The first observable symptom of this disease are frequent fits of depression of spirits, gradually becoming more permanent. Alternating with those fits of depression, there are periods during which the patient is restless, morbidly sensitive, and extremely irritable. As the depression passes into confirmed melancholia, it is associated with suspicion of others, fear of impending but undefined evil—fear of the soul's loss, refusal of food, and not uncommonly persistent delusions, hallucinations of the senses, and determined suicidal tendency. In some cases there are transient paroxysms of excitement more or less maniacal, during which the patient is dangerous to others; but distinct homicidal impulse is rarely met with, while monomania of pride or delusions of exaltation are still more uncommonly seen. It is somewhat curious to remark that, in this form of insanity, the majority of the patients more or less readily admit that they are insane; they rarely if ever complain of being considered insane, and placed in an asylum; on the contrary, many of them express a sense of security at being placed in an asylum; and a fear of being left to themselves not unfrequently induces such patients to place themselves under treatment; and it is by no means rare to hear them remonstrate with the physician on being told that they are well enough to go home, and say that 'although they feel well enough in the asylum they are *afraid to trust themselves at home in case something should befall them.*'"*

One of the most strikingly characteristic and peculiar symptoms of climacteric insanity, both in the male and female, is the *fear of undefined evil.* "This symptom was present in one-third of the female cases, and in three-fourths of the male cases," in 45 out of 60 cases. This fear of some impending unknown evil gives rise to a very peculiar expression of terror in the patient's face, accompanied by a shrinking, startled manner, with great sleeplessness and restlessness. Although it would appear to be more common among men, the terror is not in them of such an intense kind as is seen in women. In men this fear seems to add very much to the

* "Ed. Med. Journal," 1865.

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general gloom and despondency; but it does not, as in women, take such complete possession of them as to make them shriek loudly for help, or crouch trembling in a corner, moaning and wringing their hands. One of the most common and characteristic evidences of this fear is the use of such expressions as 'When are you going to do it?' 'When will it be?' 'I wish it was over.' 'Isn't it awful?' I have frequently asked patients to describe this fear, or rather to say what they were afraid of, and they appeared quite unable to do so, further than to say that there was 'something awful hanging over them,' or 'they felt some terrible thing was going to come upon them.' Some, however, described this fear as the dread of some unknown but terrible death they sooner or later must die.

"The dread of this unknown form of death was so great, that it induced three patients, who were continually oppressed by it, to attempt suicide, yet none of them could describe the form or mode of death the fear of which was so terrible. Fear of undefined evil is often accompanied by, but is quite distinct from, the fear that the soul is lost. This is also a very common symptom of this form of insanity."

I shall not go into detail to describe more fully this or the other symptoms of climacteric insanity, the suicidal impulse, the occasional homicidal tendency, the refusal of food, suspicion of friends, and the hallucinations of the senses; but refer you to a full description of this disease, both in the female and in the male, to two papers published in the "Edinburgh Medical Journal" for 1865, by my son, Dr. Francis Skae, and from which I have freely quoted.

I conclude with another citation: "The foregoing mental symptoms, occurring as a *group*, are, I think, perfectly characteristic of climacteric insanity. They are identical in the male and in the female, and they are met with in a group only in that form of insanity which occurs at the climacteric period in both sexes."

Ovario-mania.—The next form of insanity on my Table is one also connected with the sexual organs; but it is the last of the series. I have called it *ovario-mania;* it has been denominated by other observers before me *utero-mania;* I prefer the former name.

There are a great number of female patients to be found in private, and especially in consulting practice, who have anomalous symptoms, more or less connected with the sexual

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passion. I do not include in this list cases of an hysterical type exactly, but cases where there are well marked and fixed delusions of a sexual type. Unmarried women, mostly—indeed, I often call it old maids' insanity—they imagine their clergyman has made love to them, has attempted to seduce them, or to poison them because they would not be seduced, that their medical attendant has played the same game. Under the excitement produced by such delusions, or from complaints lodged by them with the Presbytery or other public functionaries against these seducers, a number of such females land in our asylum. I had occasion to count them at one time. The doctor of a highly respectable hydropathic establishment in the south of England was charged with having had repeated connection with one of his boarders, whose husband brought an action of damages against him, and one of divorce against her. He denied the charge entirely, and wrote to me to ask if such a delusion was common, and how many patients I then had under my care who laboured under similar belief. On making inquiries I found that out of about 250 females, the majority of whom were dements, there were 23 who firmly believed that men had sexual intercourse with them every night. The doctor asked me to hold myself in readiness to appear as a witness if telegraphed for, but the charge against him was abandoned.

I have long believed that all such cases are connected with diseases of the ovaries or neighbouring parts acting on them by direct irritation, and by reflex action on the nervous centres. I have uniformly found such disease in every case where I have had an opportunity of making a post-mortem examination.

Dr. Stethill Wright has published a very good case in illustration of this form of insanity in the "Edinburgh Medical Journal" for 1871, where the disease was cancer of the ovaries, uterus and omentum. The symptoms were such as I have indicated, restlessness by day and night; she averred that spirits, whom she saw, were tearing her entrails, to which they gained admission by the vagina, and that persons unknown violated her person during the night. With various remissions this female died, but up to the last maintaining that spirits and other unknown agents regularly violated her person.

In connection with this case I may mention another which shows how the locality of a disease localises the delusion. It was that of a female who complained most piteously for

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many months that she was violated repeatedly every night through the rectum. On examination after death we found extensive cancer of the rectum.

Hypochondriacal Insanity.—I have ventured to add at this point in my table a form of insanity which I omitted in my first table. It is one which I think has been recognised very generally in practice, although not appearing in our printed tables, or annual reports. The form I refer to is hypochondriacal insanity. Hypochondriasis, with its protean symptoms perpetually revolving round the centre ego, is familiar to us all, and so also must, those same symptoms be to most of us, when they so far master their unhappy subject as to leave him no longer master of himself, and he believes in such delusions, such bodily pains, ailments, changes destructive of his nerves, of his sleep, of his muscular power, or power to do anything, except to take medicine, as unfit him to manage his own affairs, to regulate his own conduct, almost to pass muster with even a passing spectator, as a rational being. I think this form of insanity needs no further illustration; it is a disease of advanced life and of idle men, whose earlier habits have been more or less sensuous, or at least luxurious. It is at best a tedious and not always a curable malady.

Senile Insanity.—This is a form of insanity doubtless connected with those changes in the vessels and the circulation of the blood within the cranium which take place after a certain period of life. This period varies in different individuals; in some indications of these changes may be observed in persons under the age of 60, in impaired memory and altered habits; in others not until an extreme old age. I have known a lady who, at the age of 105, was in the full possession of her memory and all her mental faculties; and I need not refer to our eminent judges—the Lords Lyndhurst and Brougham, and Dr. Lushington—and a host of others to prove that the circulation through the brain may preserve its integrity up to a great age, so far as the functions of that organ are concerned.

But in ordinary circumstances the memory, of recent events especially, begins generally to be impaired about the age of 70 or 75. Sometimes sooner, as I have said, and in such cases probably accelerated and precipitated by habits of free living, there being no doubt that habitual hard drinking produces serous effusion under the arachnoid, also one of the morbid

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effects of the atheromatous arteries of old age. It is to this atheromatous state of the arteries, causing serous effusion and absorption to a corresponding extent of brain substance, that we owe that series of symptoms comprehended under the name of *Senile Insanity*.

I need scarcely describe senile insanity to you; engraft a little excitement and extra-troublesomeness, a few more foolish fancies, and waywardness on the impaired memory gradually increasing, the garrulity passing into childishness, and this second childhood passing more or less rapidly into total fatuity "and mere oblivion—sans teeth, sans eyes, sans taste, sans everything,"—*("As You Like It")*—and you have the disease.

Phthisical Insanity.—The next form of insanity on my Table is that of *Phthisis*. The frequency of phthisis among the insane has been long remarked. Esquirol and Georget in France, Burrows and Ellis in this country, were the first to refer to the frequency of phthisis pulmonalis among the insane. My predecessor, Dr. McKinnon, in his last report for 1845, and myself in a succession of reports following, pointed out its great frequency. Dr. Clouston undertook to investigate the subject in 1863, and he did so in a most efficient manner, producing matter of much interest to the psychologist, and reflecting the highest credit upon his own industry and penetration.*

Dr. Clouston starts his inquiry by a careful investigation as to the relative frequency of tuberculosis among those dying insane, and those dying in general hospitals. He found an enormous difference, two-thirds of the cases who died in the Royal Edinburgh Asylum having had more or less tuberculosis—the cases in general hospitals not exceeding one-half.

He concludes this branch of the subject thus—"Whether, therefore, we take phthisis as the assigned cause of death, or tubercular deposition in the body, tuberculosis is much more common among the insane than among the sane."

That there is a special connection between insanity and tuberculosis is almost conclusively proved by these facts.

Van der Kolk thinks that a hereditary predisposition to phthisis may develop itself into outward insanity, and *vice versâ*. I have no doubt of it, and I have remarked, moreover, in well-marked cases of phthisical insanity, that an attack of

* "The connection between Tuberculosis and Insanity." By T. S. Clouston, M.D, "Journ. of Ment. Science," 1863.

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hectic fever, cough and hæmoptysis is often followed by a temporary remission of the insanity, while the passing off of the signs of tubercular deposit was followed by a recurrence of the symptoms of insanity, the two conditions in that active state being apparently vicarious.

The mental symptoms of phthisical insanity are mostly those of *suspicion.* Not unfrequently the attack begins with maniacal symptoms, which are, however, generally of short duration. These symptoms pass into melancholia, sometimes into insane suspicions, at other times into dementia, in which, indeed, most of them terminate before the fatal result.

Dr. Clouston made out the interesting fact that, although tuberculosis is not very common in general paralytic insanity, in all those cases where it did occur the patients had melancholia and general depression, instead of the happy and extravagant delusions of wealth, rank, and power, which generally characterise the general paralytic.

"Dr. Skae," says my friend Dr. Clouston, "considers that every case of insanity comes much more under some natural group than under any of the divisions of Pinel, Esquirol, and Prichard. I have observed that there are certain cases of which, from their mental symptoms alone, I could predict they were likely to die of phthisis. They are not all cases of mania, nor of melancholia, nor of monomania, but some of them would come under one of these divisions, and some under another. There is no one symptom they have in common, and no well defined line of demarcation separating them from other cases. There is no diathetic mark, nor physical sign to distinguish them, yet they take their place in one's mind as a natural group notwithstanding. If they have been acute at first—either acutely maniacal, or acutely melancholic—the acute stage is of very short duration, and passes neither into a chronic stage, nor into deep dementia, but into an *irritable*, *excitable*, *sullen*, and *suspicious* state. There is a want of fixity in their mental condition. The intellect is not at first so much obscured, as there is a great disinclination to exert it, and there are occasional unaccountable little attacks of excitement, lasting only a very short time, unprovoked attacks of irritability and passion in a subdued form. There is a disinclination to enter into any kind of amusement, or continuous work, and if this is overcome there is no interest manifested in the employment. It might be called a mixture of sub-acute mania and dementia, being sometimes like the one and sometimes like the other.

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As the case advances the symptoms of dementia come to predominate; but it is seldom of that kind in which the mental faculties are entirely obscured, with no gleam of intelligence, or any tendency to excitement. If there is any tendency to periodicity in the symptoms at all, the remissions are not so regular, nor so complete nor so long, as in ordinary periodic insanity. If there is depression it is accompanied with an irritability, and the want of any fixed depressing idea or delusion. If there is any single tendency that characterises these cases, it is to be *suspicious*. I found that of the 136 men with tuberculosis, 56 manifested suspicions; and 64 of the 156 women did so. The state I have described may, I think, be called "phthisical insanity." The patients are not so apt to get stout, as in ordinary dementia, and frequently the appetite is capricious. The pulse is generally weak, and frequently more rapid than usual. There is a want of tone and energy about the system which is very noticeable. There is a want of interest in anything that goes on, and an absence of sympathy where there is not a positive suspicion of every one around. In many of the cases the suspicions are the chief symptoms. We have seen that nearly all the cases of pure monomania of suspicion are phthisical. In many of the cases the insanity commenced insidiously and showed itself by an alteration of conduct and affection, an increased irritability and waywardness, and a progressive weakening of the intellect, without any great excitement or depression. Some cases of the so-called moral insanity die of phthisis very soon. However demented these cases of phthisical mania may seem to be, there are fitful flashes of intelligence, and in them, perhaps, more frequently than in any other class of cases, there is increased intelligence, and, as it were, a slight unveiling of the mental faculties immediately before death."

Under the term "phthisical insanity," Dr. Clouston only "included those cases which died within five or six years after becoming insane, and in which the development of the two diseases was somewhat contemporaneous." Dr. Clouston excluded all the old chronic cases, and all cases where there was refusal of food, because in them we might have other causes for the development of tubercle.

I think that Dr. Clouston's description of phthisical insanity is most graphic and correct, and that no one accustomed to view insanity from this point of view would have any difficulty in diagnosing the true phthisical cases in

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the wards of an asylum. For details I must refer you to the admirable paper from which I have so largely quoted.

Dr. Clouston ascribes the insanity as the impaired nutrition of the brain in phthisis, and its special action on the brain as due in an unusually large number of cases to hereditary predisposition, determining the want of nutritive activity to that organ. The tuberculosis developes the hereditary predisposition into actual disease—a disease of an eminently anæmic type affecting the brain primarily by impaired and defective nutrition.*

Dr. Blandford appears to be of opinion that Dr. Clouston has failed to establish an etiological relation between phthisis and tuberculosis. He quotes the experience of Dr. Cotton and the Hospital for Consumption as being adverse to the theory.† He further cites Dr. Clouston, from his report for 1870, as if he resiled from his former position, by stating that the cases of phthisis and of phthisical insanity had diminished in the Carlisle from, he thinks, the introduction of a better dietary. "From this," says Dr. Blandford, "it would seem that Dr. Clouston himself suspects that the phthisis may be due to asylum influences, and not necessarily connected with the insanity." This is the most extraordinary *non sequitur* I ever read. Dr. Clouston nowhere ascribes the insanity to asylum influences, but to phthisis, and it follows that if the cases of phthisis in an asylum are fewer, the cases of insanity accompanying this disease must be fewer too, because *they are connected with it.*

"Whatever the disease in the lungs, the circulation in the brain appears to be vigorous, as we should expect from the high rate of the pulse. And we know that phthisical, beyond any others, retain their mental faculties unimpaired to the last."‡

Dr. Clouston had anticipated this statement as likely to be made in objection to his paper, and has admirably anticipated his defence in the following reply to it:—

* In 1854 I pointed out that the specific gravity of the gray matter of the brain was below the average in all patients who died of *phthisis.*—An. Rep. for 1854.

† When we consider that it was not so much insanity occurring in the course of consumption as the two diseases appearing simultaneously, and that very few indeed of my cases had well developed insanity on admission, we see that the cases would not be so apt to go to the Hospital for Consumption as be sent to the lunatic asylum. Even if all the cases of phthisical insanity had first been in the hospital, and supposing that it is twice as common among the phthisical as ordinary insanity among the general population, then Dr. Cotton would only have met with one insane person in 170 patients.—T. S. C.

‡ Dr. Blandford, Op. cit., p. 86.

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"The greater frequency of hereditary predisposition to insanity among the tubercular than among the non-tubercular shows that tuberculosis, more than any other cause, develops such a predisposition into an actual disease. And in how many ordinary phthisical patients do we find an irritability, lassitude, fancifulness, and fickleness of purpose, that borders on an unhealthy state of mind? It has been my experience that phthisical patients can seldom apply themselves to any continuous mental exertion, but on this point I speak with diffidence. Their intellects may be clear and unclouded to a preternatural degree, but their efforts resemble more the brilliant flashings of an ill-supplied lamp, than the continuous steady light of a healthy mind. Ask anyone who has watched two or three phthisical relatives during their illness, and they will tell you of the absurd fancies, amounting almost to delusions, and of the sudden causeless changes from hope to despondency, from cheerfulness to irritability, of the whims and wanderings of mind, and transitory moments of delirium, that accompanied the disease. All these symptoms have a cause in an ill-nourished brain, and when they are more developed they become insanity.*†

The general results to which Dr. Clouston's investigations led him are summed up in the following abstract, with which I shall conclude this subject:—

1.—Phthisis pulmonalis is much more frequent as an

* Op. cit.

† My experience since the foregoing was written, ten years ago, has led me to believe that there is a phthisical insanity that occurs in persons of this diathesis with no local symptoms of tuberculisation at all, and that under proper treatment and hygienic conditions it is by no means an incurable disease. I have also observed that the coming on of phthisis in a patient, who has been for many years insane, will often affect the character of the insanity, and affect them in the direction of the special symptoms of true phthisical insanity. I also believe now that this form of insanity is not so incurable as I stated in 1863, even if there are local deposits of tubercule in the lungs.

It has also been urged that phthisis is really no more prevalent in lunatic asylums than among the population, if as much so. This is a fallacy resulting from the mode of calculating the comparative prevalence of the disease, as was well shown in the last report of the Scotch Commissioners in Lunacy. Counting the proportion of deaths from phthisis to the average population of an asylum, and comparing it with the same proportion in the case of the general population, we find it to be quite three times as much. During the last ten years ten patients to the thousand of the average population have died of consumption in the Carlisle Asylum (and in it the disease had been rare compared with many similar institutions), while in the general population above three years of age the proportion is not more than three, or at *most* four, to the thousand, as shown by the registrar's returns.

The proportion of cases of phthisical insanity to the whole number of insane has been 5 per cent. in the Carlisle Asylum for the last ten years.—T. S. C.

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assigned cause of death among the insane, than among the general population.

2.—Tubercular deposition is about twice as frequent in the bodies of those dying insane as in the sane.

3.—Phthisis pulmonalis is the "assigned cause of death" in only about one half of those in whom tubercular deposition is found after death.

4.—The brain in the cases of tuberculosis is not so frequently diseased in a marked manner as it is in those dying of other diseases among the insane. In the majority of the cases the brain is pale, anæmic, irregularly vascular, with a tendency to softening of the white substance of the fornix and its neighbourhood, and the gray matter of lower specific gravity than in any other cases of insanity.

5.—Tubercle is not more frequently found in the nervous centres among the insane than among the sane, and when found it does not, in all cases, or even in the majority of them, produce any symptoms, and is not connected with any particular form of insanity.

6.—Tuberculosis of the peritoneum is not more frequent among the tubercular insane than among the same class in the sane. In the former it is more frequently associated with melancholia and monomania of suspicion than ordinary tuberculosis of the lungs.

7.—The average age at death of the cases of tuberculosis is about three years below the average age at death among the insane generally; and the average age of those in whom much tubercular deposit is found is five years below the general average.

8.—The proportion of the tubercular who had had previous attacks of insanity is about the same as among the insane generally.

9.—There is hereditary predisposition in seven per cent. more of the cases of tuberculosis than of the insane generally.

10.—Monomania of suspicion is the "symptom" of insanity in which tuberculosis is most frequent, and general paralysis stands at the other end of the scale that marks the frequency of tuberculosis in the different forms of insanity; mania stands next to general paralysis, and melancholia to monomania of suspicion; while the tendency to dementia in all forms of insanity is greater among the tubercular than among the non-tubercular. A majority of the cases of general paralysis and mania die non-tubercular; a majority

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of the cases of melancholia, monomania, and dementia exhibit proofs of tuberculosis before death.

11.—In all the cases of general paralysis who were tubercular, the disease had commenced with depression.

12.—In a certain number of cases (about one-fourth of all those in whom tubercle was found) the insanity is of such a peculiar and fixed type, that it may be called "phthisical insanity." In all those cases the phthisis is developed so soon after the insanity, that tubercles must have already formed in the lungs, or a strong tubercular tendency been present, and about to pass into actual tuberculosis when the insanity appeared. We know that the chief characteristic of tuberculosis is an impaired energy in the nutritive processes, and as a badly nourished bone becomes carious or necrosed for slight causes, or a badly nourished skin becomes subject to parasites, so disordered action results in those imperfectly nourished brain-cells, from causes which would not be felt in a healthy brain. It is not the enfeebled nutrition directly, so much as the perverted action to which the enfeebled nutrition predisposes, that produces the insanity. The peculiar mental state, the incurability of the insanity, the appearance of the brain after death, and its lowered specific gravity, all point to such a cause for the derangement.

13.—There is a special relation between deep melancholia, with long-continued suicidal tendencies and refusal of food, and *lung disease*—either gangrene or tubercular disorganization.

14.—There are a few cases in which the insanity is only a kind of delirium occurring during previously developed chronic phthisis, and soon passing off.

15.—The prognosis is most unfavourable, if tuberculosis occurs in any case of insanity.

16.—Half the cases of tuberculosis die within three years after the commencement of the insanity.

17.—There is no proof that the "morbid influence of the pneumogastic nerve" has anything to do with the tuberculosis in cases of insanity.

18.—Long-continued insanity does not tend to the development of tuberculosis more than to the production of other diseases.

19.—Phthisis is entirely latent in between one-third and one-fourth of all the cases among the insane, and in almost all the others it is latent for a considerable time. This latency is most frequent in general paralysis, in which the majority of the cases of phthisis exhibit no symptoms whatever.

20.—There are very few cases where the commencement of

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insanity benefits the phthisis, but in a few, where the phthisis is very chronic, an attack of insanity may be followed by the permanent disappearance of the phthisical symptoms, or attacks of mania may alternate with symptoms of phthisis. In by far the majority of such cases, however, the phthisical symptoms are merely masked, while the deposition of tubercle goes on.

The Morbid Psychology of Criminals. By David Nicolson, M.B., Medical Officer, Her Majesty's Convict Prison, Portsmouth.

(*Continued from Page* 409, *Vol.* XIX.)

The Special Delusions of Prisoners.

Having made ourselves acquainted, in a measure, with the more rudimentary perversions to which mental operations in prisoners are liable, we shall be the better able to enter upon a consideration of those more advanced perversions which establish themselves at the expense of the healthy exercise of a reasonable intelligence, and which induce behaviour so eccentric or obstructive as to necessitate medical interference. These latter I propose to deal with under the general term of *delusions;* not being always careful to discriminate between a "delusion proper" and a hallucination; for, after all, what is a hallucination in its outward manifestion but a delusion credited (upon grounds not always well established) with some relationship to the organs of sense.

The delusions met with among imprisoned criminals are of two kinds; the *ordinary* and the *special.* By ordinary delusions I mean those to which prisoners, in common with all human beings, are liable. In number and extent they are inconceivable, as they lie beyond the confines of reason and healthy imagination. Although I may have occasion to make remarks which are applicable to ordinary delusions, they are in themselves beyond the subject at present in hand.

The *special* delusions of prisoners to which I am desirous of drawing attention may be defined as those delusions which arise in connection with the peculiar circumstances of prison life, and which are referable, more or less, to those circumstances. They are special rather as to the frequency than as to the exclusiveness of their occurrence in prison; for it is not to be maintained that delusions of a kindred nature may not occur in the outer world.

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