this time steps were immediately taken to give her rest and she passed through a milder attack of depression. I saw her the other day after over twenty years. She was well, and there had been no further breakdown.

I have met with some few cases in which a dream—generally one of horror—has preceded an outbreak of mania, the excitement and boisterousness having no relationship to the dread or terror of the dream.

Next, as to the dreams of those who are already insane.

The maniacal patient is very difficult to examine, and his accounts are not trustworthy. The melancholic generally has miserable dreams, but there is a most important exception. When a patient with mental depression begins to improve he dreams of home and happiness. I have often heard such a patient say—"I wish I did not wake at all: I was happy when asleep." Such dreams, as I say, almost certainly connote improvement and point to recovery. I would not give up hope of even a case of chronic melancholia if there were occasionally happy dreams.

Dreams do not represent one natural temperament. Hutchinson suggested that there might be reversions to ancestral habits in dreams, and that our floating dreams might really be memories of an arboreal existence of simian ancestors.

Dr. Hughlings Jackson has said: "Find out all about dreams and you will then understand insanity." Someone, I do not remember who, said that insanity was waking dreams and dreams were sleeping insanity. But enough of this; I have merely laid before you something to think about.

(1) A paper read at the South-Western Divisional Meeting held at Brislington House on April 18th, 1912.

The Varieties of Dementia, and the Question of Dementia in Relation to Responsibility. By ROBERT JONES, M.D., F.R.C.P.Lond.

THE questions I particularly desire to raise in order to ascertain the opinion of my fellow-members are three: (1) the actual meaning of the technical term "dementia" and the variety or varieties seen or met with as primary conditions; (2) the amount of "mental weakness" which this term connotes, *i.e.*,

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that exists compatible with responsibility or liability to punishment; and (3) the question whether there can exist such a condition as partial against complete insanity, and, therefore, also partial as contrasted with complete responsibility.

It is accepted both by the Statute Law and the Common Law that mental weakness may be such as to render a person not responsible for his actions, and in regard to responsibility there are three Acts which guide medical men and lawyers as to this condition. There is (1) the Act of 1800, Geo. III, 39 and 40, c. 94, which puts the question, "Was the person insane at the time the deed was committed?" and there is (2) the subsequent enactment, the "Trial of Lunatics Act," 1883, 46 and 47 Vict., which asks two questions and places two issues to the judge or the jury for consideration, *viz.*: (*a*) Did the person commit the deed or act? (*b*) Was he sane or not? It was pointed out to Lord Selborne, the eminent legal authority and the then Lord Chancellor, who introduced the Bill, that under this Act the accused may be both guilty and insane, *i.e.*, a person may be a criminal and liable to punishment and at the same time a lunatic and be irresponsible. Such a dilemma is said to have been foreseen and, quite intentional, with the definite object and purpose of appending some "condition" if a dangerous lunatic were acquitted on the plea of irresponsibility and then discharged. It purported the continued detention under supervision as a criminal lunatic of such a person. It is possible that a rich or a distinguished man, with some mental trouble, or what would be interpreted to be "mental weakness," might commit a capital crime and be acquitted on the plea of insanity and so be free. The friends might desire to have the care of him, and might refuse to have him placed under detention, so that it might be possible for the same or a similar crime to be repeated. This could scarcely happen in the case of a pauper or rate-aided person, as he would probably be certified and so legally detained. In order to defeat such a possibility the person acquitted, whoever he may be, could, under this Act, have conditions made in regard to his discharge or acquittal, and such conditions are not infrequently imposed by the Home Office under (3) The Criminal Lunatics Act, 1884, which defines a criminal lunatic to be any person who by order of the Secretary of State, or the Admiralty, is sent to an asylum for the insane. The rules

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for conducting cases of criminal lunacy were laid down by the House of Lords in 1843, in the celebrated McNaghten case, and in this case the question of irresponsibility on account of partial insanity was raised, and upon this plea the defendant was acquitted. Before 1843, Sir Edward Coke, Lord Chief Justice of England, one of the most eminent lawyers this country has ever produced, and at one time Speaker of the House of Commons, wrote, in 1625, *The Institutes of the Law of England*, in four parts, and in one of these he essays to divide insanity into four classes or kinds: (*a*) the idiot or *dementia a nativitate*; (*b*) mental weakness brought on by disease, thus anticipating our Lunacy Act, 1890, sec. 116 [c]; (*c*) forms associated with a lucid interval; and (*d*) those brought about by the person's own act, *e.g.*, drunkenness, *voluntarius dæmon*. Coke added: " When a madman is executed it is a miserable spectacle, against the law, as well as extreme cruelty and inhumanity, and can be no example to others." Sir Matthew Hale, fifty years later, in 1675, brought in the question of partial insanity. He divided the insane into two kinds: (*a*) *dementia naturalis* or *a nativitate*; and (*b*) *dementia accidentalis* or *adventitia*; the latter he again described as partial or total, and stated that an insane person may then be partially or only intermittingly insane, and Hale's "best measure" of distinction, or the criterion between partial and complete or total insanity, was the amount of intellect which would be possessed by a child of fourteen years —a method of comparison which Sir James Stephen later characterised as contrasting healthy immaturity with diseased maturity, and therefore obviously illogical and unsound.

The question I am bringing forward for your opinion is how we are to class certain senile cases of physiological decay, those who appear able to manage their property, to dispose of it, who have no delusions or hallucinations, who can name their beneficiaries, and who realise the amount and extent of their property, yet whose moral conduct leads them into social, domestic, and sometimes into criminal trouble. They become indecent and expose themselves, make improper overtures to young people, neglect their person and become deficient in self-control, so that their present conduct may become totally different from their former behaviour; where in such cases does irresponsibility begin and responsibility end? Let me quote some cases. I had a patient who for nearly twenty years

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worked in a Government office, but who had suffered from painful aural hallucinations, so that his friends had to place him under my care. By demonstrating the falsity of his belief and reasoning with him, and so gaining his confidence, he was able by degrees to realise that these voices were imaginary, and he was sent back (still suffering from the voices) to complete his time for a pension, which he did. A lady was brought to me (about the period of her climacteric) suffering from the mistaken idea that she was constantly being advertised for in the agony columns of the daily papers, which she repeatedly answered, and she became a source of great anxiety to her friends. In all other respects she was well, and could often see the falsity of her wandering and amorous thoughts. A man discharged from Claybury Asylum "with voices," apparently very sensible, went to Glasgow, where he succeeded in getting an appointment in an Insurance Office, but frequently wrote uneasy, not to say threatening, letters about the "influences" and "voices," yet was able to pursue his avocations satisfactorily. Numerous cases of obsessions, beliefs, "influences" and irresistible impulses, mental "tics," occur to all of us, as well as cases of commencing mental weakness, cases which cannot be described as actually demented or really insane, yet which are partially right and partially wrong. I should like to know the views of my fellow-members about this class, for I am often exercised about them, especially in the state of commencing, or the early stage of dementia.

The second point is as to the line of demarcation between responsibility and irresponsibility. This is often most difficult to delimit, and one naturally has to ask oneself, "Can a person be deprived of self-control while the other faculties are sound?" We know the mind is stated to act as a whole; the whole mind thinks, the whole mind feels, and the whole mind wills; yet we know the mind may be analysed into component parts or elements, such as cognition, or ideation, imagination and perception; feeling, or the emotional tone; and the will, or the conative faculties; and it is possible, I believe, for one of these elements of mind to be affected while the others remain normal or nearly so, so we may have a partial delusion, suicidal insanity, or a monomania, and thus a partial as against complete insanity. We know there are many patients who can speak "rationally enough" about subjects other than those

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connected with their delusions. It is well known that "partial" insanity does not relieve the offender or the criminal from punishment, but it should be used to mitigate the penalty, and I believe this is not infrequently the case. I am aware the argument is now used, and was put forward by Lord Cottenham many years ago, that there is no partial insanity, that no one labouring under a delusion could be aware that it was a delusion, for if aware of it there could no longer be a delusion, but we meet with cases in which cognition is perfect and feeling-tone is normal, but there is deficient conation or will-power. The history of this controversy, as pointed out by Dr. Dupré in a recent paper, dates back to the days of Pinel, who in 1809 described the form *manie sans delire* as a partial insanity implying a perversion of the instincts, whilst the reasoning faculties and feeling or the senses were unaffected. He referred to the affection, amounting to alienation, of some of the individual mental faculties. Benjamin Rush, in 1812, described a partial insanity under the title of "derangement of the moral faculty" and associated this with a defective organisation of some part of the brain occupied by the moral faculties. Pritchard, in 1835, sought to describe a partial form in his *Moral Insanity*, the moral dispositions, for example, and the inclinations of temperament being abnormal, whilst there was no impairment of the faculty of perception or of the reasoning. Esquirol, in 1838, also supported this view. Morel, in 1860, described an instinctive insanity of this type—a delirium or wandering of the emotions or the will whilst there was an apparent preservation of the intellectual faculties. Falret, in 1866, after proclaiming the unity of all forms of psychical activity, yet acknowledged the existence of a partial affection of some of the faculties of mind: acts, for instance, might be unnatural, perverted or wrong, whilst there is full intellectual appreciation of their wrongness—they were the acts of "reasonable lunatics." Maudsley has also contributed authoritative comments upon this question of partial insanity and consequently of partial responsibility.

The term "dementia" is popularly and legally used as synonymous with insanity, but technically this is not correct. Dementia connotes those states of mental weakness which occur in persons who have previously been in full and complete possession of their normal, or of the average, intellectual faculties. The term thus excludes cases of idiocy, imbecility

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and feeble-mindedness. These commence at birth or from an early age, and are described usually as cases of amentia, *i.e.*, high or low grade according to the amount of mental defect present. The term "moria" is often used, especially in American medical literature, to describe the slighter forms of congenital weakmindedness, which do not amount to imbecility or idiocy. There may be no difference between amentia and certain stages of dementia, either in quality or the quantity of mental reduction, but amentia applies exclusively to congenital cases, whilst dementia applies to those cases whose mental weakness is acquired later in life. It is the difference between the bankrupt and the very poor or indigent; both "have not," but one "has had." A further difficulty—and this is a point I particularly desire to emphasise —is to fix the line of demarcation in dementia between the amount of mental weakness consistent with responsibility and that which may be technically the dementia of insanity; the difficulty there is, for example, in distinguishing between the mental weakness of old age, which is physiological dotage, and that amount of dementia which is pathological and which is compatible with irresponsibility for criminal acts, or that form of dementia, also pathological, which is seen to follow repeated attacks of mania, melancholia, or diseases known as gross brain or arterial lesions. The actual commencement of dementia is to me always difficult to determine. I may see a patient one day and describe the case as chronic mania or melancholia, and my colleague may see the same case later in the day and describe the case as dementia. From the above remarks it will be seen that the actual delimitation of physiological and pathological dementia is of great importance from the medico-legal standpoint. As to the forms of this variety of insanity, we know dementia to follow or be associated with severe arteritis, which is the most frequent pathological condition connected with senile decay. It is also the termination of mania and melancholia, but not to any great extent of alternating insanity, or of monomania, often called paranoia, although it would generally be true to state that dementia is the natural termination of all varieties of insanity. It is especially the sequel of long-continued epilepsy, whether of the *petit mal* or the *grand mal* variety, for it is a question of repetition of the fits rather than of their severity. Dementia is the invariable

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accompaniment of general paralysis, some forms of tabes and of chorea, especially the senile form, Huntington's chorea, and it may be the direct result of certain toxins—often described as racial toxins, *viz.*, alcohol, lead, and syphilis. It occurs as the consequence of the organic destruction of the brain by cysts, hydatids, pachymeningitis, or tumours when there is frequently dulness, stupidity, and hebetude. It is also known to follow injuries to the head, and it may result from hæmorrhage, embolism, or thrombosis with cerebral softening, but as a primary condition I am of opinion that there is only one form, which is characterised by heedlessness of person or of surroundings, in which the sense of personal vanity and of ambition dies, "unemotionalism" rules, and there is a shedding of mental acquisition and intellectual power in the reverse order of their acquirement; the gregarious feeling dependent upon instincts of association and social feeling disappears, and those who suffer from this form of mental weakness may well be described as mental cripples. They certainly need the "minds" of others to buttress them or to prop them up, and their mental impairment varies from a slight loss to gross degeneration, *i.e.*, from slight heedlessness or indifference to complete mental apathy. I need not recapitulate the symptoms nor their mode of onset before such a society as this, but the ways of these persons eventually become so strange and their conduct so odd and different from that of their past, that their friends and relatives consider them to be unendurable, and it becomes obligatory to care for them elsewhere than in the domestic circle. Some of them tend to wander aimlessly, and thus may come under the cognisance of the police. Others in their impulses, owing to loss of higher control and the prominence of lower or animal characteristics, may commit dangerous acts by their selfishness. When they demand the best and fail to get it they may, and do, show violence, and sometimes they appear in the criminal courts in consequence. How far is one justified in considering such cases when in the early stage of their disease, to be irresponsible, and is it possible by any combination of symptoms to state: "Here ends responsibility and here begins conduct which is irresponsible, and therefore not punishable"? Can the "partial" condition of such dementia be brought forward as a mitigation, if not an exculpatory plea, as regards punishment?

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I invite the views of my fellow-members on these points, which must be of supreme interest to society as well as to forensic medicine.

DISCUSSION,

At the Quarterly Meeting held in London on May 21st, 1912.

Communications by Sir THOMAS CLOUSTON and Dr. MERCIER were read by the Honorary Secretary.

Sir THOMAS CLOUSTON: The term "dementia" should only be used to indicate incurable non-congenital conditions of enfeeblement of mind. Any other use of it leads to confusion and misunderstanding, and is also practically very inconvenient. To the student beginning the study of psychiatry such misuse is especially misleading; new names should be devised and used for "acute dementia" and "dementia præcox." *Classification.*—The great and dominating kind of dementia is the secondary or "sequential" form of the disease. That form covers five-sixths of the incurable insane. It is the most terrible and frequent sequel of Kraepelin's dementia præcox and my adolescent insanity. It is the type of all the hereditary forms of mental disease; it is an altogether unique brain condition; it is the great reversionary condition into which the brain cortex devoted to mind is liable to fall. I am now convinced that all the preliminary symptoms in adolescent insanity and dementia præcox are mere preludes and parts of secondary dementia. It affects all the higher mental faculties, though more in one case, less in another, no doubt. I cannot conceive any classification of mental diseases in which it does not form an essential part, and cannot imagine any other term to take its place. The other forms of dementia are the toxic, the senile, the paralytic, and the general paralytic, but being one phase of the progressive cortical destruction in general paralysis I should like to see its use discontinued in connection with that disease.

Dr. MERCIER: I have always understood dementia to mean any degree of deterioration of mind, whether temporary or permanent, and whether associated or not with active manifestations, such as delusions or disorderly conduct. In short, I have considered it to mean literally that the demented person is unminded, or deprived of some portion, or in some degree, of his mind, especially of his judgment and intelligence. I think there are great advantages in thus understanding the term, but I recognise, as I did not always recognise when I used it in this sense, that the meaning attached to it by other people is so widely different that when I use it in this sense I seem to them to be talking nonsense. The Scottish members of this Association mean by dementia a state of things in which a large portion or degree of mind is irrecoverably lost. They strike out from my concept of dementia all those in whom the defect of mind is slight, all those in whom it is accompanied by active manifestations, and all those who do or may recover. To them dementia means deep, irrecoverable and passive dementia, and any weakening of mind which is slight, is temporary or is accompanied, and especially if it is observed by active symptoms, is outside of their concept of dementia. By "dementia" they mean, in short, if I understand them aright, the condition of the "chronic dement" of asylums. Others, again, still clinging to the "chronic dement" as the type of dementia, and recognising that the chronic dement is liable to occasional outbreaks of violence, would admit occasional active manifestations into their concept of dementia, but would exclude and call "mania" those cases in which misdirected activity in conduct forms a preponderating or a large element in the symptoms. They would also exclude those in whom there is an element of positive mental symptoms, such as delusion, and neglecting, or perhaps overlooking, the negative element of weakness of mind, or defect of judgment, or lack of intelligence, whichever we please to call it, would call such cases chronic delusional insanity. The prevalent use of the term "dementia præcox" to characterise cases, many of which entertain delusions, some of which recover, and most of which present disorderly conduct at some time in their progress, tends to confuse and break down these restrictions, and to extend the term "dementia" so as to include any and

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every case of insanity. In thus extending the scope and ambit of the term, I think the users of it are clinically wrong, but abstractedly right, that is to say, while denying that there is any natural clinical group of cases that can properly be brought together under the title of "dementia præcox," I hold very strongly that in every case of insanity there is some loss of judgment, of intelligence, or of moral rectitude which justifies the title of "dementia" in the sense of weakening or defect of mind. The use of the term "precocious dementia" implies necessarily that in advanced life dementia is the rule, and that in cases denominated precocious this invariable decay has set in earlier than usual. Although, no doubt, many of the people who live to extreme old age do become enfeebled in mind, yet there is no such invariable rule as the term "precocious" implies, and, speaking without a statistical basis, one can only say that it is probable that more persons above the age of eighty are unimpaired than are impaired in intelligence. The term "partial," as applied to dementia, may be understood in either of two senses. It may refer to the degree in which the whole of the faculties of mind are impaired, or it may refer to the several faculties as being impaired singly, the others remaining intact. In the first sense the term "completely demented" is not infrequently used, but a moment's consideration will show that if a person is completely demented, if, that is to say, the whole of his mind is lost, he must be totally unconscious, and therefore, although the term is accurate when applied to coma, it is inaccurate if applied to any loss or defect of mind short of coma. Any person who is demented to a less degree than this suffers from partial dementia. In the second sense, the term "partial dementia" raises the questions whether (1) any one or more faculties of mind may be impaired while the rest remain intact; and (2) whether, if this does not occur, one or more faculties may be impaired to a graver degree than others. The occurrence of aphasia conclusively settles, to my mind, the first of these questions. In aphasia that part or faculty of mind that is concerned with the correct use of words is impaired, without, as far as can be ascertained, any sensible impairment of any other faculties beyond those that are concerned with the correct use of words. This single case is enough to establish the position, but if other cases were needed it would not be difficult to adduce them. *Folie du doute* is one; loss of memory for other things than words is another. Responsibility, that is to say liability to punishment, is determined by the same rules in clinical dementia as in other cases of insanity. Finally I desire to emphasise once more the existence in every case of insanity of the negative factor as well as the positive factor. It is in such cases as clinical dementia and stupor alone that the negative factor, being but little complicated with a positive factor, is recognised. In cases of systematised delusion, of acute mania, and so forth, the positive factor is so prominent that it is usually forgotten that there is any negative factor at all. But from the broad philosophical point of view the positive incidents are mere accidents. The material factor in the case, the factor which gives it all its significance, is the negative factor, the loss of faculty which allows, by loss of control, the positive factor to occur. What is important is not the delusion, but the loss of judgment that would prevent the delusion from being entertained. What is important is not the outrageous conduct of the maniac, but the loss of inhibition of conduct that allows the conduct to occur. These losses are what I mean by the unminding, the deprivation of mind, the ***dementing*** in a literal sense to which I attach the term "dementia."

Dr. Hayes Newington said that this question was one on which he had formed somewhat decided opinions many years ago, and the papers now read focussed very well a difficulty which had arisen of late years as to what was included in dementia, and especially as to what was meant concerning the recoverability from, or curability of, dementia. Sometimes he had had the misfortune to find himself in strong opposition to Dr. Mercier, but in this instance he was strongly with him. The most important element from the clinical point of view was as to whether a dement would get well or not. Members would recollect the discussion which ensued when Dr. Robert Jones read a paper some time ago on "Dementia Præcox"; members got into controversy on the question whether the term "dementia" could properly be applied to a curable condition. Some said that certain cases of dementia præcox did get well, but Sir Thomas Clouston said if they did get well they could not be cases of dementia præcox. It was all very well in the old days, when alienists had separate bags into which one could put cases of melancholia, dementia, general paralysis, and he believed some people would go so far as to

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include moral insanity and monomania. The more one tried to specialise the term "dementia" the more one departed from the view that dementia was not a disease, but a diseased condition. One might just as well try to classify anæmia, or fever, or any other general condition. No one wished to describe a case as one of tuberculous anæmia, yet such a description could bear a resemblance to the effort to make a classified disease of dementia. He thought the time must come when they must make up their minds whether dementia was curable or not. He repeated now what he had said once before when Dr. Jones spoke: it was all very well to try to patch our English classification with German cloth; it could not be done. The German classification was doubtless very scientific, but whether it was useful practically was quite another question. British alienists had got their own classification, but it would be impossible to continue it if they were going to take a term out of the German classification and apply it to English cases. If that were done there was sure to be confusion sooner or later, and it would be a very great step if this Association, or some body representing psychiatry, whether in this country or for the world generally, would meet and settle that question once for all, namely: Is dementia to be used in the sense of a disease, and an irrecoverable one? He believed that there would be no accepted classification until that was settled.

Dr. ROBERT JONES asked that he might say a further word in order to fix the discussion. The question was not one of terminology only. What he meant was that there were certain kinds of cases in fully developed adults which exhibited weakness *ab initio*, and one wanted to define those cases and give them a name. In them there was, from the first, a weakening of the mental powers, and he maintained that that weakening was irregular in its incidence and course. It might affect cognition, or feeling, or the conative faculties, but certainly there was often to be noticed a gradual weakness proceeding down to absolute irrecoverability and complete loss of mind power, which was called dementia. What he wanted to focus in the discussion was that there existed such a condition—he was not discussing ætiology, it might be due to a toxin, or stress of some kind producing various toxins—a mental state in which one or other faculty seemed alone to be affected. He called it partial dementia, and asked whether the person so suffering was responsible. Was there a gradual weakening of mind power, attacking one of those unanalysable mental qualities first and leaving the others unimpaired? He gathered from Dr. Mercier's contribution that such was possible.

Dr. YELLOWLEES wished to express the great satisfaction with which he had listened to the paper. He did so because he agreed most strongly and emphatically with what Dr. Jones said about primary dementia. He was quite clear in his own judgment that primary dementia was a condition by itself, and that it began in mental enfeeblement, not only in one of the mental areas, but in all of them more or less, though no doubt it was more pronounced in some than in others. He also believed that that mental enfeeblement was a gradual, progressive and hopeless condition. That was his distinct conviction about that group. But other conditions were continually being mixed with it. Kraepelin called a number of things primary dementia which did not come at all under the interpretation which he, Dr. Yellowlees, had all his life put upon those words. He believed that that primary dementia was a very definite continuous degradation of mind. It might, for a time, seem to stop; one week the patient might be more bright, pleasant and workable than another week, but the general trend was downwards; it might seem slow, and to go on with uncertain steps, but in his judgment it always went on to final and complete mental enfeeblement. That was totally different from using the word "dementia" as he thought it ought not to be used, for conditions such as one saw constantly after an acute attack, when a man was sluggish, inert, and had not come to himself, but was confused. That might be called temporary dementia, but he believed it to be a wrong use of the word "dementia." The latter term, to him, conveyed a condition of mind from which there was no recovery. It was a gradually deepening mental degeneration. As to partial responsibility, there also he found himself in accord with what Dr. Jones said. But he took the practical view, not so much as to partial insanity, as with regard to the partial responsibility which he had always believed insanity often implied. Of course, that was only another aspect of the same thought. He did not know whether there had been in England such definite cases of recognition of partial responsibility as they in Scotland had had. But in the latter country again and again there had arisen the question of

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partial mental disorder being regarded by the judge as a reason for modifying the sentence on a person. The most striking case of all was that of a murder committed on the Goat Fell Mountain in the Island of Arran. There was no question about the commission of the deed by the man, and he was found guilty and condemned. For certain reasons, and especially because doubts as to his sanity had been expressed, the Secretary for Scotland appointed a Commission consisting of Sir Arthur Mitchell, Prof. Gairdner and himself to visit that man and report upon his condition. When they went to see the man in prison the hammering was going on outside for the erection of his scaffold, so no time had to be lost in sending in the report. Knowing the gravity of the case, the members of the Commission took very special and great pains over the matter, so much so that they resolved beforehand not to discuss with each other their first impressions of the case, but that each should put into writing his separate convictions about it, and then compare opinions. It was very singular that these opinions were found to agree almost entirely. Before giving their report finally, they sent for the man's relatives and for those who had been employed with him, and for his teachers. As a result they came to the definite conclusion that this man was not sane in the sense that ordinary people were. He had no delusions, but the nature of his inheritance and his history were such, and were so distinctly indicative of mental deficiency, that the Commission reported that, in their opinion, this man was not wholly responsible for his conduct, and therefore in their judgment he ought not to be fully punished as if he had been a thoroughly sane man. The result was that the man's sentence was commuted—not abrogated—and he was dealt with as a man not wholly sane. The execution was stayed and penal servitude for life was the sentence substituted. He regarded that case as an extremely important one, and as establishing definitely the principle of the recognition by law of partial responsibility, and therefore of modified punishment.

Dr. G. M. Robertson said Dr. Jones had asked the question whether dementia might be partial. He thought all the members would answer that in the affirmative. The position was very well described by a simile which their old teacher, Sir George Savage, used to employ. He used to say that dementia was various, and that it was various in the same way as the ruins of a house might be. In one case the house might be destroyed by an earthquake, in another it might be destroyed by fire, and in a third event it might simply fall into decay owing to neglect and age. And, Sir George said, the mind might be similarly destroyed: in some cases absolutely, in others to a less extent, and in still others it might show slight signs of decay in some of its functions. And he went on to add that as there were different classes of houses, so there were also different classes of minds. That put the whole matter very clearly. There could be no doubt that there had been much misunderstanding and futile discussion with regard to the employment of the term "dementia." Dr. Jones had just stated that the Scotch held a particular view of dementia; but the Scotch were in very good company in that respect, because some of the best alienists in France held the same view. It had been pointed out that dementia was not a disease at all, for in disease one found progress, whereas in dementia there was no progress whatever; there was the result of the scarring. It was a terminus, not a condition of disease. And he thought British alienists had been very much handicapped by not having in the language a term for the condition in which the dementia developed. A number of years ago Spitzka, of New York, described a condition which he called "primary mental deterioration," and it occurred to him, the speaker, as a good description for the condition. It did not imply a dementia which was irrecoverable; rather it was a condition of mind in which there was a slow deterioration, but one in which repair might take place. The term "dementia præcox" had been very much discussed, and little more need be said about it by him. There was much to be said against the employment of the term, because these cases sometimes recovered. But the same argument might be used about general paralysis. He had a case which was seen by a distinguished neurologist and himself, and the diagnosis made was general paralysis. Yet he had no symptom of general paralysis, so that the name would seem to be a misnomer, in the sense that it was described as being general paralysis when there was no paralysis. But it was well understood what was meant, and ultimately the man was paralysed.

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So also one knew what was meant by dementia præcox, and it did not much matter that it was a wrong term.

Dr. SEYMOUR TUKE asked Dr. Yellowlees whether he had followed up the case of the man of whom he spoke; and if so whether he had become incurably insane, or whether he had recovered. He had a curious experience of the same kind not many years ago. He was called in to see a lady who was being prosecuted for ill-treating a young maid-servant. He was called in at the last moment as the trial was to take place next day. He had great difficulty in finding anything the matter with the lady, as she answered questions and seemed to know what she was doing. She was aware of her position and what was going to happen. He discovered, almost by accident, that she had been suffering dreadfully from insomnia, and she had one or two delusions. He went to her counsel and told him there was a grave excuse for the lady's conduct; to all appearances she knew what she was doing, how she was going on, and the consequence of her act; yet, in his opinion, she had commencing degeneration of mind, and circumstances pointed to a progressive deterioration. Counsel thanked him very much, and said he would do the best he could, but that he was afraid it was rather too late to do anything. She was sent to prison for three months. Her condition was reported to the doctors, she was placed in the infirmary for the whole time, and she was not treated as a prisoner but as a patient. She was taken from the gaol to the asylum, and she had never been mentally sound since. In a lesser way that was a case of partial responsibility recognised by the authorities. With regard to dementia he recalled the case of another lady. There was very little that was abnormal noticeable about her, but her people said she was becoming careless and unable to manage her banking account, and was not taking proper care of herself. She was also afraid of being run over. The lady was brought to him for confirmation of the opinion which had already been expressed about her, namely, that there was nothing the matter with her. But he formed the opinion that her mind would deteriorate, and he gave an unfavourable prognosis. The doctor who brought her was astounded at this, and said he had been to one of the greatest authorities in London, who had assured him there was nothing the matter. He, Dr. Tuke, told him he must disagree with that opinion, as there was every reason to fear mental deterioration. About two years from then the lady died absolutely demented.

Dr. YELLOWLEES, answering Dr. Tuke's question, said that the man of whom he spoke was still undergoing penal servitude in Peterhead, and he was recognisedly so insane that the authorities dare not let him out. He desired to add a word as to the cases of primary dementia which were said to recover. He felt certain that those cases were not true cases of primary dementia, but were rather instances of anergic stupor. The stupor might be so bad that the patient would be not only unconscious of what was said to him and unable to reply, but would become heedless of Nature's wants. He would also refuse food, and have to be fed by tube; and altogether seem as unlikely to recover as a case might well be. And yet such cases were known to make excellent recoveries. That was a distinction between a stupor which was a temporary condition and primary dementia, which latter he held to be the commencement of hopeless gradual enfeeblement. Secondary dementia was marked by mental enfeeblement also, but it was brought on by former acute attacks of insanity which had landed the patient in this hopeless condition. Another type was the dementia of ordinary organic paralysis. No one would think of confusing those cases with those he had been specially referring to. The term ought never to be used in connection with general paralysis at all, because dementia was one of the features of the paralysis. The dementia following hemiplegia was a different thing altogether. To summarise, primary dementia he held to be by itself, and in itself, irrecoverable, and that the cases in which it was said to recover were really cases of temporary anergic stupor.

Dr. CARSWELL (Glasgow) desired to make reference to one or two matters which had occurred to him while hearing the very interesting and suggestive remarks of Dr. Jones. In the first place he would like to say a word in defence of their reputation at Glasgow. They knew the case of the man to whom Dr. Jones referred, and he, the speaker, had had him through his hands several times, so his insanity was recognised in Glasgow as soon as he came their way. The difference was that in Glasgow he was not put into the asylum. He was treated in the observation wards

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and thus was tided over the exacerbations of his trouble. In the intervals this man had been able to earn his living. He understood the main point of the present contribution to be the question of responsibility. And it was very important in the connection which Dr. Jones had brought it forward. He was willing to take up the position as Dr. Jones left it, namely, that there were certain cases which presented difficulties in diagnosis, and occasionally caused serious questions of responsibility to arise in the early stages, and that these were cases which for the most part went on ultimately to dementia. What was the state of the law, and what opinions ought to be offered by alienists in connection with cases of that character? He understood that to be the position taken up by Dr. Jones and the question he wished to raise. Dr. Yellowlees had very instructively cited a case which had some bearing on the point. But it had to be remembered that the remission of sentence in that case was due to the exercise of the Royal prerogative. In that case the question of insanity was never before the Court. Indeed, not only was it not before the Court, but it was actually considered and repudiated by the defence. It was not until the young man was found guilty and sentenced to death that, on reviewing the evidence as it had been given in Court, he, Dr. Carswell, took it upon himself to present his view of the man's probable mental condition to the man's solicitors. They replied that all that he submitted had been considered, and they had decided that it was unsafe to plead insanity in the case. However, he, the speaker, ultimately sent his views to a leading Glasgow newspaper, with the result that the Commission of Inquiry referred to was appointed. The subsequent history of the case proved that the man had been, and still remained, insane. His sister was insane, a maternal aunt was insane, and so was his mother's cousin. But apart from the exercise of the Royal prerogative the law in Scotland had been very definitely stated. It had been repeatedly stated in important cases in Scotland to this effect: that where evidence had been given which led a jury to believe, as reasonable men, that there was reasonable doubt as to the state of a prisoner's mind, although they were not convinced that such prisoner had been proved to be insane, it was open to the jury to reduce the charge from the more serious to a lesser one. As far as he was aware, the history of that development of the law was somewhat interesting. He believed that the earliest record of it was a case which was tried at Inverness as far back as 1866 by Lord Deas, who had the reputation in Scotland of being 'the hanging judge." He was certainly severe, and unwilling to admit fancy pleas in mitigation of crime. A case came up in which delirium tremens was proved, and that judge laid down the law that if the jury was satisfied that the accused was in a state of delirium tremens, though they might not consider it to be insanity, they were entitled to bring in a verdict of culpable homicide or manslaughter. Subsequently that dictum had been expanded, and the late Lord Kinross, Chief Justice of Scotland, and Lord Maclaren, had tried at least three cases of the kind. One was in Aberdeen about twenty years ago, where a man had committed murder, and had followed one person after another and shot at them. No medical man would say the man was insane. Lord Maclaren said that if the jury had reasonable doubt they were entitled to reduce the charge to culpable homicide. This they did. There was also a case of infanticide, where a similar ruling was given by the same judge, and a verdict was returned in accordance with that advice. Lord Kinross laid down the same ruling in a case in which an attendant, an old soldier, shot Prof. Stevenson Macadam. The law was explicitly laid down that although no evidence had been given that this man was, according to medical opinion, insane, still, if the jury entertained reasonable doubt they were entitled to reduce the charge to one of culpable homicide. There was another case, which occurred a few years ago, and he had left it till the last because it bore directly on the point raised by Dr. Jones. It was that of a young man, a Jew, who was tried for murder. The facts were perfectly plain. He had been forbidden the house of his sweetheart by the girl's father, but he had entered the house surreptitiously one morning early and shot the girl dead in bed. There was no proof of mental disorder. His age was only twenty-one. There was proof that earlier in life he had suffered from a distinct nervous breakdown, and evidence was given to the effect that although there was no evidence of acute insanity, there was very reasonable doubt as to this lad's state of mind, and Lord Maclaren, who tried the case, again laid down the law in that sense, and the jury found that he was guilty, not of murder, but of culpable homicide, and he was accordingly sent to penal

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servitude for life. This lad is now in the criminal lunatic department, acutely insane. So that in a very few years the potentiality had developed into the actuality. There was no doubt that the lad was now a lunatic, and that he had been already so at the date of the crime, but in the early and incipient stages of what was probably dementia præcox. The law in Scotland was clear as laid down by the judges. There was no Statute law on the subject, and the judges in Scotland in recent years had taken that humane and, as it was believed, enlightened view, which in its results left the person under the observation of the medical officers of the prison, who could deal with any subsequent developments.

Dr. ROBERT JONES said he would not detain the meeting further with a reply, but desired to express his cordial thanks for the comments which had been made, and for the attention with which his contribution had been received. In this country partial insanity was not an exculpating plea for punishment; such a plea was not recognised, but he agreed with Dr. Yellowlees that such might be advanced as a reason for modifying the punishment.

An Investigation as to the Therapeutic Value of Thyroid Feeding in Mental Diseases. By RICHARD EAGER, M.D.Aber., M.P.C., Senior Assistant Medical Officer Devon County Asylum.

THE history of the use of thyroid extract in insanity dates back to the year 1893, when McPherson (1), of Larbert Asylum, reported a case of myxœdematous insanity which recovered from both the myxœdema and the mental disorder under its use. Its use in cretinism has also met with much success. My investigations, however, are confined to its use in mental conditions not associated with myxœdema or cretinism. In 1894 McClaughey (2), of the District Asylum, Maryborough, reported two cases as improved, and in 1894–5 McPhail and Bruce's results (3) and observations of treatment were published in detail. The publication of their results and their belief that "in thyroid feeding we possess a valuable addition to our armamentarium in the treatment of certain cases of insanity" incited many other alienists to test its efficacy. Besides Clarke, Brush and Burges in America must be mentioned Mabon and Babcock (4), who give a review of the results obtained in 1032 collected cases of insanity from twenty-four different observers, and who show that 23·9 *per cent.* recovered and 29·4 *per cent.* were improved. They also report on a further use of thyroid on sixty-one cases at the St. Lawrence State Hospital.

Dr. Bruce has so far published the largest number of cases, namely eight-seven, and obtained a recovery rate of 42·9 *per cent.* with 21·9 *per cent.* improved. He was first led to try the

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