Unverified Prognosis. By H. Hayes Newington, M.R.C.P.

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In none of the more practical aspects of insanity, with the exception perhaps of that of pathology, does the alienist stand at so much disadvantage with the other members of the medical profession as in the matter of prognosis. In diagnosis we have, as a rule, an easy task, though now and then cases arise in which it requires much thought to come to a determination whether some unhappy event is due to insanity or to crime. Again, in treatment we fairly hold our own, taking into consideration the complex nature of the organs and functions that are affected, coupled with the impossibility of direct examination and treatment of them. But in prognosis we are distinctly less sure of our footing, and it is unfortunate that this uncertainty is accompanied by a most pressing demand for accurate forecasts from the relatives of those who are placed under our charge. This pressure, no doubt, arises in chief from the necessity in nearly every case for modifying, either temporarily or for good, those circumstances, domestic, official, and pecuniary, from which the patient has been removed; but there is this further difficulty, that while in cases of general disease, other than insanity, the friends have some sort of knowledge and opinion of their own as to the probable result, gained from insight into similar cases, in insanity such clinical experience is denied them by the necessity for withdrawing patients from the observation of the public. They are thus almost entirely without guides of their own, and in consequence they come to lean more heavily on the doctor. The strain and responsibility for error thus cast on us would be intolerable were there only the two eventualities of absolute recovery and absolute loss of mind; but, fortunately, there are many stages to fill up the huge gap between these two extremes, stages of partial recovery which allow of the restoration of the patient to various degrees of liberty and usefulness in the world. It is not too much to say that the problem of the future of the patient has to be faced never less often, generally more frequently, than that of treatment.

To prognosis, therefore, much attention has been paid in treatises systematic and clinical, and in detached papers, such

as the able one of Dr. Thomson, which appeared in the "Journal of Mental Science" of 1882. The author of the latter rightly states that general rules of prognosis are arrived at from statistics, plus the results of individual cases. I venture to add that the results of these general rules have further to be refined and adapted to practice in detail, by a close study of each case that refuses to conform to rule, and that a knowledge of what is normal must be complemented by experience gained from a search for the causes of abnormality. Such search into each case is most instructive, and tends to lift experience into a far higher sphere than that of a mere knowledge of figures. Prognosis, as a term, covers a large field, too large for the present purpose, and, therefore, it must be limited by cutting off all consideration of cases before they come to, and after they leave, the asylum. I shall deal only with what we are called upon to say about the prospects of those patients that we have under our charge as medical superintendents. Further, my object is to draw attention to some of what appear to me to be the principal causes of erroneous prognosis, and to illustrate them by cases as well as I can; and I shall assume that the errors do not arise from carelessness or bungling, but are such as everyone might be expected to fall into blamelessly.

If we take 100 cases consecutively, whether of all classes indiscriminately, or of some selected class, we know by statistics that a certain proportion will recover and that the remainder will not. If, again, we take the same 100 cases, and having made a prognosis of each individual one, follow it to the end, we shall find that our forecasts are not in keeping with the gross results; we shall find that a considerable number that we set down to the credit have passed over to the debit, the balance being made good to some extent by unexpected recoveries. In some cases it is possible to demonstrate a reason for failure, in others it can only be guessed at by analogy with these successful demonstrations, while in the remainder neither demonstration nor analogy will afford a clue.

To bring as much order as possible into the treatment of such a wide subject, I shall follow the course of a case, commencing with the history and tracing it onwards; for in every stage there are opportunities for the introduction of errors, which will contribute materially both to the wrong formation and the non-fulfilment of prognosis.

The history-stage of a case abounds with pitfalls, so much so that one is never surprised at some untoward and hitherto unknown fact turning up in the course of it, which would obviously have modified the opinion formed at the outset. We have to contend with intentional suppression, misappreciation, forgetfulness of, and non-acquaintance with, material facts; we are never sure what more is behind that which is told us, and we have to place a liberal discount on most statements.

Hereditary predisposition is peculiarly open to these difficulties. But very few relatives have either the moral courage or the necessary knowledge to fully supply what is admittedly a most important item. We know from statistics that heredity by itself is slightly in favour of recovery from any first, second, or even third attacks; but we also know from experience and reasoning that on the closeness or directness of that predisposition much depends, and that in doubtful cases the scale would be turned the wrong way, in our opinion, by a knowledge that a parent had laboured under insanity, while we might not take much notice of an insane cousin.

Some time ago a young lady, particularly bright and intelligent, consulted me about her brother. I asked the prescribed question as to heredity, and, as usual, I was told that she knew of none, and that she wondered where it could have come from. In the course of further conversation on indifferent subjects, she quite artlessly told me that their father had committed suicide abroad; but the act was due, she said, to a fever from which he had suffered. Further questioning convinced me that he had suffered from melancholia as well. The patient himself was paralytic, though only 30 years of age. As from a distinct history of syphilis and a blow on the head, it was possible that the insanity was acquired, the case, though grave, was not without hope on its own merits; but the history as revealed, adding predisposition to acquisition, reduced the hope to a minimum, which the subsequent course has justified.

More important than mere directness is a history of the actual existence of insanity in either parent at the time of the procreation of the patient. It is difficult to arrive at this knowledge, but when it has been obtained it is of great value. In a case of the insanity of adolescence, in which form heredity is an usual factor, while close heredity is a grave element, I was told that there was no predisposition.

From the course of the case, I was for a time quite hopeful of recovery, but further on it became known to me that at the time of the conception of the patient the very parent who had given me the history had been "peculiar," and had several epileptic fits. The real nature of the affection, which was only of short duration, was never realized by my informant, and it was brought to my knowledge by accident. But it completely reversed my opinion, and the patient died insane.

I have lately been able to work out a family history, which, as usual, notwithstanding its importance, was concealed from me at first. As it is interesting from other points of view beyond the one that I am dealing with now, I give it at some length. The patient is a lady, 58 years of age; a suicidal, querulous melancholiac, who has at times been violent and has given much trouble. Her father was an only child. He drank hard, and died of apoplexy; aged 65. The paternal grandfather died of softening of the brain, and this grandfather's brothers were fast and rackety, one committing suicide while insane. We get three elements of predisposition here: one indirect of insanity, the other two —drink, and neuroses other than insanity—more direct. The patient's mother was also an only child, as, indeed, was the mother's mother. There was consumption in the mother's family, though she was not phthisical herself. Here was a fourth element to start with. The father and mother, being both only children, proceeded to restore the balance by having 17 themselves, two of whom were still-born, the patient being the youngest of all. In these 15 living children the drink-element showed itself in six of the seven sons; the tendency to neurosis declared itself by two sons dying with paralysis, one facial, the other creeping; while the consumption was carried on in three of the daughters, the patient herself being phthisical. But all the elder 14 escaped the insanity, and it seemed as if our patient would also have escaped. In her case, however, fresh *direct* predisposition came into play; for while she was *in utero*, her mother, being 47 years of age, became seriously insane, having homicidal impulses and pyromania, though after some years she recovered, and died sane. It is possible that the patient might have followed her mother's footsteps to recovery, were it not for the difference in their respective gestations, and the opinion that I formed turned mostly on that. I should add that though the 14 brothers and sisters have all

themselves escaped the indirect predisposition to insanity, yet it has reasserted itself in their children, two of whom are insane. Yet, again, the tendency to extinction of the race, shown by the father, mother, and grandmother being only children, retarded, as it was for the time, by the numerous family, comes to the front again in the next generation, for of the 11 who married there have only 28 children been born, and of these no less than 18 are already dead.

Hardly second in importance to the history of heredity is that of a *group including the temperament, disposition, instincts, and habits* of the patient as he was before he became insane. Correct information as to this is very essential in making a prognosis; not only as supplying often a key to the causation and nature of the attack, but as also affording some means of estimating how far the brain mischief has gone. And, again, it is often of service in judging as to how far recovery has taken place. It is very hard to get this information truly; for relatives frequently fail to see important points that are patent to all others, and they are prone to suppress, minimise, or explain away what is disagreeable to themselves. For instance, we may be told, as I have been told, that a man had a sweet disposition, and was never angry unless he was put out, which may have been true; but it may also be the case that the man was for ever being put out by trifles, and was really in a chronic state of ill-temper. Again, we may hear that he has been a model husband and father, while he has been keeping up another establishment in secret.

But in any case we expect to find, and do find, more or less, alteration in many respects when mental trouble comes on. We must not accept the fact of an alteration without looking well beneath the surface to see how far it is real. I use the word alteration rather than change, for what we do find may be less of a real change than an alteration by way of diminution or exaggeration of the previous habit of mind. And this is important; for without going so far as to say that complete change of disposition, etc., is invariably a more hopeful sign than a morbid exaggeration, I will say that it is far less easy to bring back a patient from exaggeration than to lead him to give up what is only a recent acquisition. And I think that reasoning supports this view. Exaggeration can be brought about only by the lessening of control and reflection, and can be remedied only by a corresponding restoration of these, which are just the two ele-

ments that are most wanting when the disease is established. Again, if a patient's disposition has been completely changed, it is probable that this has occurred more or less rapidly: he may have the recollection of a former happy state, with which he can compare his present one. And, still more important, if he can be brought near the edge of the pit into which he has fallen, and be induced to endeavour to extricate himself, he finds sound ground on which to step out. On the other hand, where the insane is merely an exaggeration of the sane habit, the reverse is the case. Most probably considerable time has been taken to effect this; the reflection on the past offers but little help, and the patient has beforehand destroyed that sound foothold without which he cannot hope to drag himself out of his trouble. Alcoholism in ordinary life, and religious insanity in our domain, afford good examples of what I mean. The latter I will therefore take as an illustration.

I have two patients in view. Both have been actively suicidal, and in both religious despair has been the chief element. The first has been brought up from her childhood in the very gloomiest views, in that form of so-called religion which allows the holders of it to ascend to their heaven only over the lost souls of other beings. She herself has been so tinged with this morbid conviction that when misgivings as to her own future safety entered her mind she lost heart, and has gradually tumbled back into that place of torment which, in preparing it for others, she has made a fearful reality for herself.

The second has, during her illness, been more actively suicidal, and more self-accusing than the previous lady. But as the daughter of a clergyman, she has been brought up in a brighter faith, and her trouble, which in itself is a direct change to her, has come more rapidly. She has the recollection of what was previously a happy time, the hope of regaining which affords a healthy stimulus. No one can doubt which of these two has the better chance of recovery.

I have another patient in view, who had paid great attention, so I was told, to religion, and in whose early symptoms were evidences of this. She saw visions, heavenly and the reverse, and she raved Scripture. However, I found out that she had married a clergyman a year or two before, and that her devoutness was then assumed, so really her religion and its manifestations were merely passing elements in, and not factors of, the insanity.

In some cases a direct change of habit, etc., on the invasion of insanity is followed so quickly by restoration, that it appears to be the direct antidote to a previous condition which had become morbid. Such is the case of a lady who for several years past has come to us for about three weeks soon after Easter. She is very advanced in her religious views, praying through Lent, and fasting also in season and out of season. She then breaks down, and has an evanescent, though sharp attack of acute mania, in which she rushes about laughing and chattering, wild as a hawk, and the very reverse of devout. This passes off, and leaves her in her normal condition. I have but little doubt that this is the true medicine, sharp though it be, for the effects of the strain that she puts on herself, and that were it not for these attacks she would probably pass into obstinate melancholia.

Sometimes we are left in ignorance of *previous attacks of insanity*. These have, of course, a considerable bearing on a present attack, giving, as it were, the line of prognosis. But it is a more serious thing not to have information of the *pre-existence of some of the graver bodily diseases*. This remark applies especially to the various neuroses other than insanity.

Some years ago a lady was admitted suffering from melancholia of the ordinary religious type. She was very gloomy, thin and yellow, and had made two serious attempts at suicide. Ordinary treatment improved her, and she seemed to be in a fair way to recovery, her friends being led to believe so. But after getting to a certain point she seemed to become stationary, and remained so for some years. One day she had a severe epileptic seizure, followed shortly by another. Careful inquiry revealed the fact that nine years before, while she was standing on a friend's doorstep, she fell insensible, and must evidently have had an epileptic fit then, though the relatives had never recognised its nature, and had indeed forgotten the fact until it was recalled to their recollection by the later seizure. One or two more fits have followed at lengthened intervals, and the cause of the non-recovery stands declared.

The *causation of an attack* affords quite as many opportunities for error as any of the foregoing. In fact, it is not too much to say that, as regards some of the assignments of cause in the admission papers, we had far better be without them. No assignment is better than a wrong one, so easily can we be put on the wrong track. Without doubt,

unless we have accuracy here, we cannot approach accuracy in forecast. As an instance of this, a gentleman was brought to us in the following condition:—He was gloomy, reserved, and silent, somewhat vacant in expression, with the appearance of being beaten down by trouble. He was obstinate, disinclined to eat or move, quite heedless of the calls of nature, and weak in body. Trouble was given as the cause, and there was a history of a fall on the head. He improved slowly up to a certain point, but never lost his gloom. The prognosis, though guarded, was not altogether a bad one. But in a little time it came to my knowledge that not only had he had the trial of losing his worldly goods, but that he had done so under shameful circumstances. He had the misery of seeing his family brought near to penury by his own misconduct, and was altogether deprived of any hope of being able to rehabilitate them by his future exertions. In my opinion it was just this addition of shame and self-recrimination that made his case a hopeless one.

Having got as near the probable cause as we can, we have to consider both the validity and the nature of it. It is obvious that if a given cause produces mental disturbance out of proportion to its importance, then we must look farther again and expect to find contributing elements such as heredity, mental worry, bodily disease, drink, etc. And we can go so far as to say that an inadequate cause is insufficient in itself to form a foundation of prognosis. But when we do get an adequate and true cause we obtain from it substantial aid. It is to be remembered that a cause does not exhaust itself in the work of developing insanity. It may be destined to last out the patient's existence. For instance, if a person loses a relative, that loss may be very sharp for the time, but in the natural order of things it tends to wear itself out. Again, if a person becomes insane through bankruptcy or loss of money, the same occurs; but there will probably be difficulty in healing up the wound in proportion to the difficulty in remedying the misfortune. But if, as in the last case, the cause be an ever present one, then the chances are much against the patient. I will give an instance of this: A lady came to us labouring under melancholia. There was no particular religious element about the case, the chief symptom being a beaten, cowed condition associated with the digestive derangements usually seen. The history that I had with her was that she had been in-

sane twenty years before, from which she completely recovered, and had been quite well up to forty, her age at the time of admission. It was supposed that she had worried herself into this condition, but no particular cause of worry was suggested. The prognosis was good, and, indeed, she improved a little. Later on I got further information from a private source. It appears that her present husband courted her when she was quite young, and she returned his affection. But her father, evidently with good cause, refused his sanction, and the pair were separated, the lady thereupon becoming insane. Some years afterwards the father died, and she being a free agent, married her former suitor, who held a very good position. But his principles were anything but desirable, and he turned out to be a confirmed drunkard, so much so, that in the midst of comparative opulence it was necessary that she should keep the purse so strictly that he had to come to her for money to get shaved with, for which operation he had not sufficient steadiness himself. Here we have a powerful cause, slow but sure in its action, and quite likely to outlast the patient's chance of getting well. She continued for some time further under our care, but made no more advance to recovery.

The *duration of insanity before admission* has such a well-known influence on prognosis that it is an element that has to be carefully inquired into. It fortunately can be determined with a fair amount of accuracy, though occasionally there is some difficulty in separating the prodromata from the overt symptoms. But one or two cautions are necessary. Firstly, when we consult statistics, such as are afforded by No. VII. of this Society's tables, we see that the duration is calculated up to the admission into the asylum. But in applying these tables to individual cases of our own, we must not render the term admission too strictly. The admission into the asylum may only be a phase in the treatment which has been begun most actively elsewhere. To take a not uncommon case: Last year a young lady was admitted by us who was suffering from acute mania; the duration between her first seizure and her coming to us was six weeks, but within one week of the symptoms showing themselves she was at home under very energetic treatment, with competent advice, consisting of nurses, strong sedatives, restraint, and seclusion. The real duration before treatment was therefore one week, not six. Of course, in such a short case, much difference would not be made, but in a long case of melancholia a con-

siderable misapprehension might arise. Secondly, it is not sufficient to ascertain the duration of the disease as a whole. It is necessary to find out how long symptoms, or sets of symptoms, have existed in relation to each other. This necessity has pressed itself on me recently. A young married lady, who on admission had no very urgent symptoms, had done some foolish and dangerous things, and had therefore to come under care. It was a puerperal case originally, the first symptoms of excitement coming on a few weeks after her child was born. She suffered from severe metritis. The excitement passed off, and she began to regain strength. But she did these silly things, and for no very good reason. It soon appeared to us that she had aural and other hallucinations. The prognosis then very much turned on the question of whether these grave symptoms were part of the acute disease, or whether they had been developed when the acuteness was receding and the bodily health was being re-established. Had the latter been the case, I should unhesitatingly give but a poor opinion. As it is, there is clear evidence that they have been present from the first, and therefore I look on her case much more hopefully.

In the history of the attack itself no very special risk suggests itself to me beyond that of having the mind overloaded by a mass of useless facts. The informants have a great knack of telling one a long story, the whole of which perhaps establishes one real fact only, while valuable information may be thus excluded.

In passing from this division of the subject, I must mention that occasionally a correct history is a source of positive embarrassment. The history may contra-indicate a condition which is sufficiently apparent clinically. As an instance: A patient was with us last year who was clearly a general paralytic, and condemned as such by several competent judges. The leading symptoms were busy activity and great earnestness, much talk of riches and lucrative speculations, dirty habits, somewhat unsteady gait, and marked inequality of the pupils. The speech was not much affected, and there was but slight fibrillar unsteadiness of the tongue. The facial muscles, though unsteady, were not so to the usual extent. He improved, and eventually left us for domestic treatment, under which he continues in a most satisfactory condition. Nevertheless, there is only too much ground for being certain that it is a case of general paralysis, whether it be of syphilitic origin or idiopathic. But the

history does not tally with this at all, for it appears that twenty-five years ago the patient had an undefined attack of mental trouble, which his father, a medical man, feared would go on to insanity then. Again, some four or five years ago he was excited over business matters, and of late years has never been of the same calibre as before. The inequality of the pupils has apparently but little to do with his present disease, for it was noticed years ago, and he has worn glasses of different powers to accommodate this condition. Again, his mental state is only an exaggeration of what it was formerly. He has good right to talk of his riches, which are considerable, and activity in scheming has been his forte and the source of his wealth. His habits, especially of late years, have not been very tidy; he has allowed his food to drop about his clothes, and a long-standing looseness of the bowels has contributed to other sources of uncleanliness. In fact, there is not one of the leading symptoms that can not be traced far back into the past; too far to be consistent with what is accepted to be the ordinary history of the disease.

(*To be continued.*)

Exaltation in Chronic Alcoholism. By Bonville Bradley Fox, M.A., M.D. (Oxon), Brislington House, near Bristol.

(Read before the Medico-Psychological Association, May 6th, 1884.*)*

During the last four years, as medical officer in an asylum sufficiently populous to offer a fairly wide field for study, but not too large to prevent each individual case from receiving its own share of investigation, no subject has attracted me more than the occurrence of delusions of exaltation and optimism in the Insanity of Chronic Alcoholism. And this mainly for two reasons, viz., the divergence of opinion of good authorities as to the frequency of the association of such ideas with this particular class of insanity, and the difficulty which not seldom attends the accurate recognition of their true character and import. If in this paper I can report the salient features of these cases, they may, perhaps, have an interest to others to whom they present no difficulties in diagnosis; and if the inferences that are drawn from them seem occasionally to deviate from those of writers of experience, it must be remembered that the cases are too few to