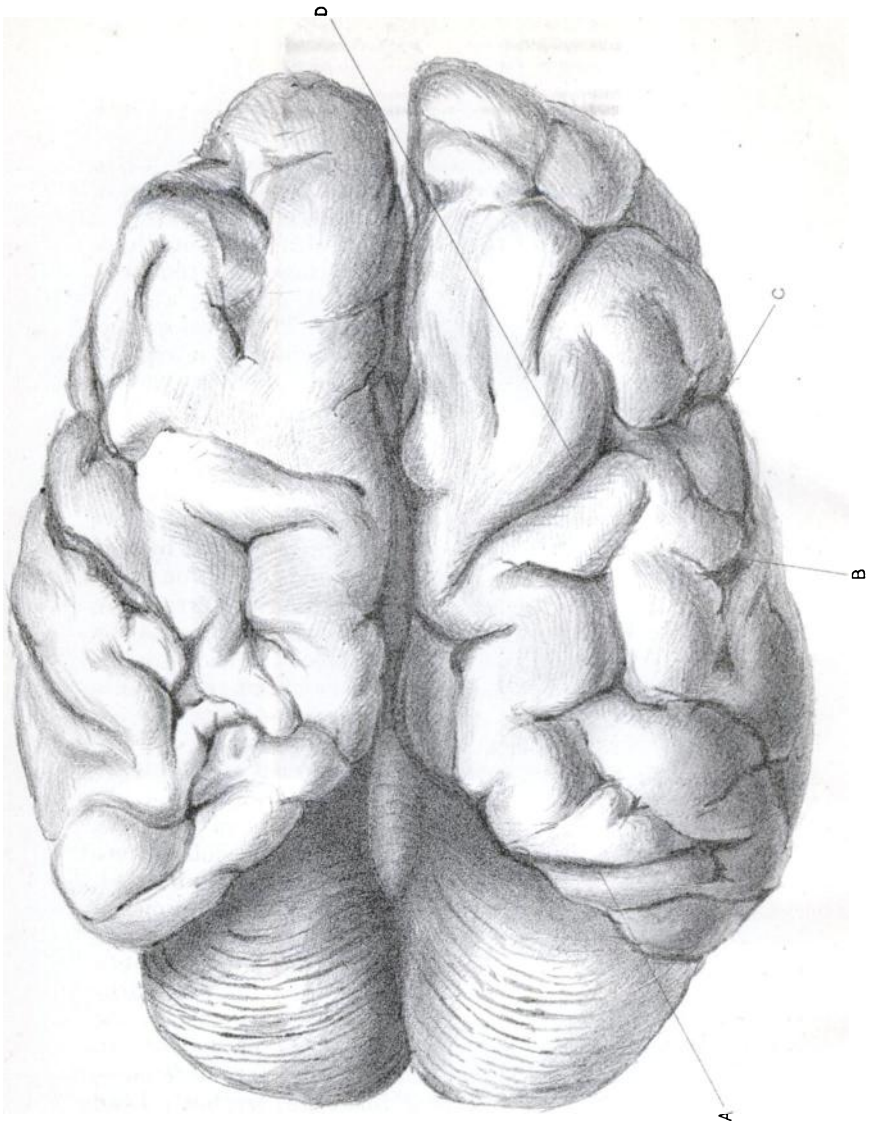
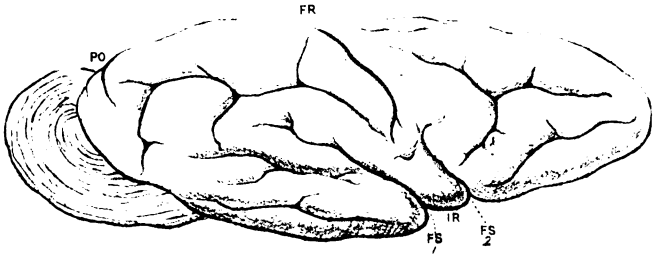
A Few Notes on Lunacy in France, suggested by a Recent Visit to French Asylums. By D. Hack Tuke, M.D., F.R.C.P. Read at the Annual Meeting of the Medico-Psychological Society, July 26, 1878.

Having recently visited, and as regards some of them, re-visited many of the French Asylums, I propose to bring under your notice to-day, as briefly as possible, three or four prominent subjects of interest, which more especially attracted my attention. I shall not now attempt to describe the asylums which I visited, but merely to bring into as strong relief as possible those matters in which there is a difference of practice between our own country and France, either generally or in regard to the practice of some celebrated French alienists.

I was on this, as on former visits to the French Asylums, much struck with the number of hours during which the doctors soak their patients in warm water. Twenty-five years ago I witnessed the use of prolonged baths at the Salpêtrière, by M. Falret, the father of the present distinguished physician who bears this name. He eulogised the practice so much, that I hoped to be able to prove its utility in England, but the symptoms which I observed follow the use of the bath for even a period which the French physicians would consider ridiculously short—the exhaustion and the alarming syncope, had the effect on my mind of making me doubt the wisdom of employing this remedy. I am convinced now, however, that these alarming symptoms arose, in part at least, from giving a hot instead of a warm, or rather a tepid bath. The temperature of the French prolonged bath is usually only about 85° Fahrenheit, certainly not above 90°. So it is not likely to be so relaxing as a really hot bath is, after the first effect of stimulation has passed away. Perhaps, also, there is another reason why serious symptoms have appeared. On the occasion of my recent visit to Paris, I went to the Bicêtre, and on accompanying M. Falret in his round, I found that he, like his father and others, was strongly in favour of this method of treatment. I mentioned the dangers which appeared to beset the practice. He assured me that they were altogether exaggerated. "You do not feed the patient well enough while he is soaking," he said, "Do that, and warm water will not induce syncope." M. Falret could not give me any figures which would show the number of cases cured or relieved by this treatment.





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At one asylum the doctor remarked that he would not unfrequently order a patient into a warm bath during his morning visit, and that there he would remain until he made his visit in the evening. He did not believe that if the patient was properly watched there was any danger in such a course. In fact, the French physicians are astonished at the astonishment which English visitors experience when they see a patient in a bath, where he has already spent some hours, and has still some hours of soaking in prospect. But although a very long period is sometimes prescribed (subject of course to the effect produced), three or four hours are more common. I should state that some of the Paris doctors do not see any advantage in extending the time beyond four hours, and even admit that, in some instances, danger from prostration may attend the longer immersions which others employ.

I should state that, in many cases, I witnessed the patient in the bath without any force being employed to keep him there. In others it is necessary to cover the bath with a piece of wood in which an opening allows of the patient's head being literally "above board." Or a sheet of metal is used, or strong canvas, with the necessary aperture for the head. It may be objected that this is mechanical restraint. So it is, in the same sense as the wet pack, but I think it should be regarded in the light of legitimate surgical restraint, during an operation.

I may add that the opinion of Marcé was strongly in favour of prolonged baths, the use of which he says yields more positive and more constantly favourable results than any other system of treatment whatever—especially when the patient is young and vigorous, and is the subject of a recent attack of acute mania. He was, however, fully alive to the necessity of watching the patient constantly, and objected to prolonging the bath beyond four hours.

It will be seen, therefore, that some difference of opinion exists among the French physicians on this subject, but that this has reference not to the value of the remedy, but to the length of time to which the bath may be prolonged with advantage.

The wet pack *(drap mouillé)* is regarded with much favour by some French physicians in the treatment of insanity. I saw at the Salpêtrière a woman recovering from *Mélancolie avec stupeur*, whose recovery M. Voisin attributed to the employment of this doubtless powerful remedy. Her pulse tracings before and after the treatment were recorded, and

they showed a marked change. She was in the pack for half an hour at a time.

I may say that M. Voisin is one who does not employ the prolonged warm bath so long as many do, but fully believes in its efficacy in calming excitement, lowering the temperature, and inducing sleep.

Another point in regard to treatment I will now refer to, and that is the use of hypodermic injections of hydrochlorate of morphia in the large doses I found M. Voisin employing in his practice at the Salpêtrière, where he showed me patients under the influence of his favourite remedy. M. Voisin is of opinion that the cases in which the most strikingly beneficial results are obtained, are those of melancholia, with or without hallucinations; and maniacal excitement "without congestion." He holds that it is very dangerous in congestive and inflammatory conditions, or where the arteries are atheromatous. He would not think of using it in general paralysis, epileptic insanity, or, in fact, wherever there is reason to suspect organic lesions or active inflammation. He has recorded a case in which, mistaking its nature, he produced very alarming symptoms by the administration of this drug, namely, cerebral congestion and loss of consciousness.

In the cases suitable for this treatment, M. Voisin finds that there is frequently neuralgic pain (especially with women) in some part of the body, the head, chest or stomach, which is closely connected with the mental disorder, and is easily removed by morphia. One of his (female) patients suffered from neuralgia under the lower jaw, and this appeared to M. Voisin to be connected in some way or other in the patient's mind with the desire to commit homicidal acts. She was subject to frightful attacks of passion. Two injections of morphia were followed by recovery. In the same way, he believes that neuralgia may lead to the idea of being persecuted.

As to the dose employed by M. Voisin, he says that five or six centigrams ($\frac{3}{4}$ grain) daily, suffice for mild excitement connected with delusion or hallucination—beginning with $\frac{1}{25}$ of a grain—but that for a condition of intense excitement, it is necessary to raise the dose till it reaches 13 centigrams (2 grains). These doses produce a calm; to cure the patient, much larger doses must generally be used, namely, 20, 30, 40 centigrams (3 to 6 grains), and even in some instances as much as a gram (15 grains) in the course of the day.

As regards this maximum, and doubtless exceptional dose, I can only state what M. Voisin has informed me. It

need not be said that there is no difference between French and English of hydrochlorate of morphia. The view appears to be that the system becomes gradually accustomed to the drug. It may be questioned whether the solution is all absorbed. Putting aside, however, the very large doses, the fact to which I wish to draw attention, is the allegation by so able an alienist as M. Voisin, that the hypodermic injection of morphia does effect a cure in many cases not benefited by other remedies.*

Under this treatment, patients, it is alleged, will sometimes recover in a few days, and M. Voisin says he has been driven to these seemingly dangerous doses from his failure in this mode of treatment by employing too small ones, and allowing himself to be frightened by the violent vomiting of the patient. He certainly acts more heroically than the superintendents of English Asylums would like to do. They would stand in awe of a Coroner's Inquest!

At Bethlem Hospital, where any new remedy is likely to receive a fair trial, I have seen a number of cases treated by this method, and while the results have been various, and in some instances disappointing, decided success has been achieved in others. Dr. Savage has found this treatment to be more useful in melancholia than in mania, especially in its active and simple form, the benefit being greater in women than in men, and in older and climacteric cases than in the young. He did not exceed 2-grain doses, in consequence of the vomiting and other disagreeable symptoms which were produced. In several cases where the administration of morphia by the mouth entirely failed to benefit, the subcutaneous injection was immediately followed by good effects.

So much for prolonged baths and the subcutaneous injection of morphia.

I should have been almost glad to pass over the question which still rages with no slight force between ourselves and the majority of alienists of other countries—I allude, of course, to non-restraint—because I feel there is much danger of our judging the excellence of treatment abroad by one narrow test, instead of taking a broad survey of the whole

* Since this paper was read, the writer has had the opportunity of asking M. Voisin whether these apparently improbable doses are correct, and he assures him that there is no error. A dose is generally given twice a day, at 9 a.m. and 4 p.m. In several cases half a gram has been given at once, and in one case at least, one gram twice a day. One of the patient's arms at the Salpêtrière presented a large swelling at the seat of the injection. The solution used is 1 of the salt to 30 of water.

system pursued, and there is also the danger of criticising foreign modes of treatment, as if ours was necessarily the wisest and the best. Such a course may well excite the annoyance of our *confrères* whether on the other side of the Channel or the other side of the Atlantic. There is undoubtedly an advance in the adoption of the non-restraint system in France. Among the large asylums, it is, for example, warmly adopted in that near Toulouse, under the superintendence of Dr. Marchand. Here I found between 800 and 900 patients, and I only saw one woman, a case of general paralysis, in a camisole, for what may be called surgical reasons. I have often heard it said as a reason for the use of restraint in France, that the French are more excitable than the English, but the authorities at the Toulouse Asylum demur to this being the case, and they are of opinion, like ourselves, that restraint usually increases the excitement. Dr. Pons has done good service at the Nice Asylum, where he found, when appointed, some of the patients chained.

Again, at a new asylum at Aix, with 627 patients, I only saw one man in restraint. On the other hand, at the Pau Asylum, out of 253 female patients there were eight women in camisoles, three of whom were also in restraint chairs. I was told that the average number was six in the day and six or seven at night.

At Charenton, where there are about 560 patients, I saw six or seven men in camisoles, and in the division for the women I counted six in camisoles, and four restraint chairs occupied by patients fastened to them, two being camisoled also.

There appears to have been here no progress, but the reverse, in recent years, in the matter of non-restraint, seeing that when I visited Charenton, 25 years ago, I then found only one male patient in a camisole, and in the refractory division for the women, four patients camisoled and strapped to restraint chairs, and one walking about in a camisole—making a total of 6 in 1853 and 14 in 1878. This is the more to be regretted when Charenton is a State asylum, under the immediate authority of the Minister of the Interior, intended, it is expressly announced, to be a model to other asylums in France. My impression is, however, that it has more occasion to be itself taught by some of these.

At the Salpêtrière and Bicêtre, a quarter of a century has certainly seen some change for the better in the number who are restrained, though this is still considerable. At the for-

mer M. Voisin strongly contended in favour of the camisole, and appealing to one woman whether she disliked it, obtained the reply that she did not. I ventured to ask him whether, when he visited the asylums in England in 1874, he was not convinced of the superiority of the English method of treatment? He said he was not; that, on the contrary, he believed that the patients in our asylums not only had their ribs broken much oftener than in France, but frequently got pneumonia from being allowed to throw their clothes off in the night. He maintained, also, that he had found mechanical restraint employed in English asylums, and that, notably, in one of large size, where he had seen a patient in a seclusion-room "fastened from head to foot like a sausage."

When I visited M. Billod's admirable institution at Vaucluse, I saw six men out of 48 refractory patients in camisoles, of whom three were also in seclusion. Among the women there were four so secured, and I was informed that the average was four or five. As I am now only stating facts about restraint, this is not the place to speak of the many excellencies of this asylum. I hope to do so at a future time.

Brierre de Boismont, now 80 years of age, who forms one of the few links remaining between Pinel and the present generation of medical psychologists, is not a convert to the non-restraint system, and says now what he has said before: —"To go from one extreme to the other is to prepare for ourselves a bitter deception. Philanthropy," he says, "has in this way made itself ridiculous; excess, in everything, is a fault. This is a maxim," he adds, "to which we cannot too strongly recall those who burn with love for the public good." And yet it must be confessed that philanthropy, in spite of its seeming but generous excesses, has many a time removed abuses and inaugurated reforms which otherwise would never have been effected.

M. Magnan strives hard at St. Anne's (Paris), to limit the use of mechanical restraint within narrow bounds, and when I went round with him he severely reprimanded one of the attendants for having secured the legs of a male patient in addition to his arms.

M. Magnan objects strongly to the ordinary camisole, which, he says, forms a part of the arsenal, not of asylums only, but even of ordinary hospitals. He points out that it interferes with the breathing, that it produces excoriations, and sometimes by its pressure lays the bone itself bare, and

causes (for example) necrosis of the olecranon. When camisoled in bed, for which he cites Pinel's authority, worse ills may befall the patient. The disciples of this great master have, he says, only too closely followed his directions. The respiration is chiefly abdominal, from the extreme pressure on the chest; in his distress the patient throws out his legs on all sides; his assiduous attendant then secures these to the bottom of the bed; the abdomen and knees are also strongly compressed; the result being that the unfortunate lunatic is asphyxiated. The swollen neck is strangled by the rigid border of the camisole, or the larynx is seriously damaged. M. Magnan says it would be no exaggeration to affirm that the majority of patients who die in restraint, owe their death to the pressure exerted by the camisole during the night. To remedy this evil M. Magnan has invented a strong dress, which he considers ensures perfect mechanical restraint without any of the disadvantages which attend the use of the camisole. *(Illustration shown.)*

I need not, however, describe M. Magnan's dress for a violent or mischievous patient, in detail, as I imagine it is likely to meet with the same fate at your hands as a strait-waistcoat did the other day which a woman was hawking about London and brought for sale to St. Luke's Hospital.

Holding the views which I am sure every one in this room holds in regard to the nature and amount of the restraint I have described as being employed at Charenton and some other asylums—whatever differences of degree there may be amongst us as to extreme views of non-restraint—I think we cannot do otherwise than hope that the frequency of restraint will before long be greatly reduced, if it is impossible to hope that it will be altogether abolished, and that the mischievous restraint chairs *(à siége percé)*—the survivals of the *ancien régime*—will cease ere long to be employed.

My own conviction is that no one can visit the Continental asylums, to the excellent organization and management of a large number of which I bear willing testimony, without being confirmed in his attachment to "the English system"—by which I do not understand one which obliges a medical superintendent to commit the absurd inconsistency of putting a moral strait-jacket upon himself, in saying that under no conceivable circumstances will he employ a strait-jacket for a patient. By "the English system" I understand the exclusion of mechanical restraint as a *necessary* part of the treatment of the insane—a position the exact opposite of

that which obtains in the majority of the French asylums, where it is regarded as *indispensable.*

I could, had time permitted, have commended much that I witnessed in France, and dilated on many other points of interest suggested by my visit to the asylums of that country, from the medical superintendents attached to which I received the most courteous attention, but here I must bring my observations to a close, which are necessarily of a much more limited and imperfect character than I could have wished.

Homicide by a Somnambulist. By D. Yellowlees, M.D., F.F.P.S.G., Physician-Superintendent, Glasgow Royal Asylum.

Somnambulism and the conditions allied to it have always attracted peculiar interest, probably because most men have felt that common sleep, although so familiar, is yet a wondrous and solemn thing, and full of mysterious possibilities for each of us. Cases of somnambulism have naturally lost nothing when reported, the observer and the recorder being alike liable to enhance rather than lessen the mystery. The wholesome scepticism which now prevails as to the truly involuntary character of many nervous disorders was formerly less common. We know that some patients will subject themselves to constant suffering and discomfort, or will practise the most patient and painful imposture, for no conceivable object save to be exceptional or to attract attention; and there is no want of charity in suspecting that in some cases the somnambulism was but hysterical simulation or morbid malingering.

The interest is, therefore, great which attaches to a case where the condition was so extreme as to lead to a capital crime, yet so unquestionable that the plea was sustained without hesitation, and the prisoner adjudged blameless. The fatal occurrence was simple and tragic. On the night of April 9th the accused was asleep in bed with his wife and their only child, a boy of about 18 months, of whom he was passionately fond. About 1 a.m. he saw a wild beast of some kind rise up through the floor and jump on the bed to attack his child. He seized the animal, and dashed it against the wall or floor to destroy it. His wife's screams recalled him to himself, and he found to his horror that he had seized and fatally injured his child.