those who have read M. Morel's numerous valuable contributions to medicine and the materia medica would expect to find. There are few more laborious workers than M. Morel. We think, with him, that peptones might be given with advantage to some patients; the practical remarks on this subject by the writer, and Sanders, of Amsterdam, will be found useful.

The Responsibility of the Insane in Asylums. By J. DRAPER, M.D., Superintendent of the Vermont Asylum.

This is an excellent practical pamphlet, and should be read in connection with Dr. Campbell's paper on "Complaints by Insane Patients." We regret that lack of space prevents our extracting some of Dr. Draper's remarks.

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

By T. W. MCDOWALL, M.D.

Annales Médico-Psychologiques, Nov., 1879—July, 1880.

Report on the Psychological Section of the Medical Congress at Amsterdam, September, 1879. By Dr. BILLOD.

In connection with the presidential address, Dr. Billod discussed the everlasting question of non-restraint, but without altering appreciably its position. He considers that French and English asylum physicians agree in theory, and differ in practice only in the extent to which they can do without restraint. Whilst acknowledging the organisation of English to be different from that of French asylums, he does not admit that it is better; they are only different. He comes very near the truth when he says—"Non-restraint consists much less in the abolition of means of restraint than in an asylum organisation which renders their employment unnecessary."

Dr. Billod visited five Dutch asylums without finding any patient restrained. How is this? He gives the following reasons:—

1. The patients being fed five times a day, are in a state of constant digestion—a condition tending to repose. 2. The excessive use of tobacco. 3. The character of the Dutch people. In England we are supposed to be able to do without strait-waistcoats, because—1. Of the large number of single rooms. 2. The superior character of our

attendants, and the authority with which they are invested, thus causing them to be held in awe and reverence by the patients. 3. It is a feature of English character to submit to authority, and to respect even its humblest officers. 4. Freedom is so characteristic of the nation, that we are only consistent in allowing all possible freedom to patients in asylums. 5. In the form of roast beef, beef-steak, animal food forms a large portion of the dietary. It, combined with ale, porter, produces torpidity rather than excitement.

In such questions a grain of fact is worth a pound of philosophical speculation. Dr. Billod is right when he says that the use of restraint is simply a matter of asylum organisation. Of this I had a crucial example during my visit to Denmark three years ago. On the island of Zeeland there are two asylums, and they are managed on entirely different principles. Both are conducted by thoroughly competent men, who devote themselves heart and soul to their work, and who carry out their ideas of right with great consistency. Yet the contrast between the establishments is surprising. At Roskilde, Dr. Steinberg carries out the practice of non-restraint, and as one walks through the wards and grounds, one is at once reminded of asylums as they are at home. Seclusion is rarely used, and restraint almost never. This asylum receives most of its patients from Copenhagen. The cases are largely composed of general paralytics and acute maniacs due to alcohol. An entirely different system of management prevails at Vortenburg, a large asylum for the rest of the island. The management is perfect in its way, but it is thoroughly French. If, on admission, a patient is excited and destructive, he is secluded and restrained until the excitement disappears. I therefore saw a patient in every single room in the asylum, and some had been in these rooms from a few weeks to more than 20 years. It must be stated that the single rooms are much better than those in English asylums—large, airy rooms, with windows in the roof. Across these windows it is possible to draw blinds to limit the amount of light admitted. Dr. Fürste found that the amount of light influenced the excitement; the more light the more excitement. There were strait-waistcoats in abundance. It must not be imagined that all this restraint and seclusion are employed to save trouble. They are employed on principle as the best method of treatment. The staff is large—one attendant to six patients—and the supervision by the superior officers thorough and untiring. Dr. Fürste spends far more time in the wards than any English superintendent I know—on an average ten hours a day; he is evidently popular with his patients, many of whom told me that they are very kindly and considerately treated. In spite of all this, I could not help condemning a system which locks up patients for years, and I can never forget the case of an old woman, an amusing chronic maniac, who had not seen the sun or a blade of grass for more than 20 years.

My Danish experience settled the matter to my mind. Without

denying the influence of racial and other difficulties, it is certain that there is no absolute obstacle to the adoption of the non-restraint system.

The next subject discussed at the Congress was—

Mental Derangement a Reason for Divorce.

The author of the paper, M. Van der Swalme, did not bring forward any novel views. He opposed the idea that incurable insanity afforded a sufficient reason to separate man and wife.

M. Van der Lith communicated a paper entitled

Is a Classification of Mental Diseases Necessary, and upon what Basis should it be Constructed?

He does not propose a classification, he only states how it should be set about. It is to be feared that, even availing ourselves of his suggestions, we are as far off as ever from a scientifically correct and practically useful classification of mental diseases.

On Katatony.

M. Donkerslout collects, under this name, a number of cases in which the chief symptom is powerlessness to act. This powerlessness he attributes to derangement of the part of the brain which presides over movement.

Katatony is not a separate disease, but is a complication of several, *e.g.*, catalepsy, hysteria, epilepsy, and melancholy with stupor.

Dr. Billod directed attention to the same subject in a paper on diseases of the will, published in 1847.

Other matters were discussed, but they are not of sufficient interest for English readers for further space to be devoted to them.

On Claustrophobia. By Professor Ball.

We have long been familiar with the condition Agoraphobia; a very analogous, though apparently totally different state is Claustrophobia, the fear of closed spaces. Under different names this symptom of mental derangement has been described by Prof. Verga, of Milan, Dr. Meschede, and Dr. Raggi, of Boulogne.

The first example of this condition, given by Dr. Ball, is so typical, that I reproduce it in almost his own words.

In March, 1875, he was consulted by a young foreigner of the upper classes, who presented, after an attack of gleet, a typical example of the mental condition, described by M. Legrand du Saulle, under the name of *délire du toucher*. There was no sensorial delirium present, but, in consequence of the misfortune to which he had exposed himself, he had so continually thought about the inconveniences of all impure contact, that there had resulted such exaggerated scruples as to deserve the name of delirium of cleanliness.

At first he thought it wrong to touch a door handle, because possibly dirty hands might have left their mark on it. Even this indirect contamination appeared to him unbearable. Shaking hands was even more offensive, and to avoid doing so he always wore gloves. Soon the same disgust extended to all kinds of contact with any part of his body. On getting out of bed he immediately put on slippers, to avoid touching the carpet on which so many persons had walked, and so on. He was constantly washing himself. He stated that all contact gave rise to a peculiar sensation, as if his fingers had touched a sticky body, and this imaginary sensation disappeared whenever he applied even a few drops of water—a conclusive proof that his derangement was purely mental.

At Dr. Ball's second visit, another and entirely different symptom had made its appearance.

At various times—but chiefly during the night—he was seized by a sudden terror of being locked up alone. In whatever room he might be, he insisted on the doors and windows remaining open. If he were in company this feeling lost somewhat of its intensity, and in deference to his visitors he allowed the doors to be shut. But during the night his condition was much worse; he required his bedroom windows always open. He also forbad the servants to shut his room door, and even that leading to his rooms. More than once he got up during the night to make sure that his orders were carried out. At last, seized by an irresistible restlessness, he sometimes was impelled to descend into the court and even open the front door, in the middle of the night, to wander about the streets until daybreak.

At such times he declared that he experienced a constrictive agony, like what one would feel in creeping along a passage which gradually narrowed, until squeezed against the walls, one could neither advance nor retire. At this point, in a state of extreme terror, he rushed out of the house, unable to endure longer such frightful torture.

On a Secondary Symptom of Melancholia and its Treatment.

By Dr. Hildenbrand.

Starting with the well-known statement that, as we are ignorant of the diseased processes in the nerve centres in cases of mental derangement, we must direct our treatment to the removal of the coexisting symptoms, *e.g.*, insomnia, anæmia, &c., the author explains that he desires to direct attention to one of the most common symptoms of simple melancholia, the disturbance of respiration and circulation due to the condition of the brain.

It is believed that the arrangement of the veins within the cranium is such as to favour venous congestion, but that this tendency is counteracted by the expansion of the chest in inspiration. In the melancholiac, disorder of the cerebral circulation is evident. He has a great aversion to movement; his muscular system is enfeebled; the heart has partly lost its force, and respiration, which normally is as 1 to 3,

is not more than 1 to 5. It is, besides, incomplete, and the oxygenation of the blood imperfect, whence the blueness of the lips and coldness of the skin. Inspiration, being as small as possible, no longer acts by withdrawing the blood in the cerebral sinuses.

The melancholiac suffers from all the consequences of incomplete oxygenation; a slow asphyxia, and disorder of nutrition of the nerve centres is the result. Sleep is absent or unhealthy, and soon general nutrition is impaired.

In the opinion of the writer the disorder of the respiration and the consequences on the cerebral circulation are factors which deserve attention. No doubt they are secondary in time and importance, but they notably aggravate the original disease.

It is therefore necessary to make the melancholiac breathe. This may be done by work, exercise, and forced inspirations. It is stated that, as the result of the latter, the skin immediately loses its bluish colour and becomes clear.

One case was submitted to this form of treatment, and the account given of her progress is not such as to tempt any one to adopt it.

Mental Medicine throughout the Ages.

This admirable address was delivered by Dr. Ball, as the first of his lectures on mental diseases. Its matter, though not new, is well arranged, and is intended to teach the lessons summarised in the following paragraphs :—

Firstly, respect for the ancients. It is only by accurately estimating the difficulties of the subject, that we succeed in appreciating their efforts, and the immense services they have rendered us.

Secondly, the cultivation of clinical observation. Do we not see in every age great observers who have studied mental disease, and leave imperishable pictures which will remain eternally true, whilst time has dealt justly with the different theories which have in turn disputed for pre-eminence. Strive to observe well; before everything be clinical observers, and thus you will be the legitimate successors of Esquirol and Pinel.

Lastly, scepticism ; and by this I do not mean that morbid disposition of mind which makes us receive with foolish ridicule all new ideas, and which would ultimately become more hurtful to the true interests of science than the most childish credulity. I mean by scepticism that negative virtue which consists in never accepting a fact without verifying it, an idea without examining it, and which teaches us never to yield until compelled by the weight of proof. Then, but not till then, we yield, with the conviction that we have not succumbed to the allurements of the imagination, but have submitted to truth alone. Through subjection to such discipline, we run the risk of never marching at the head of our age; but we have at least the advantage of never mourning over those hypotheses, whose blossoming is so rapid, and whose life is so ephemeral.

On Certain Acute Secondary Visceral Lesions in the Insane.
By Dr. E. Dufour.

In a paper in the "Annales Médico-Psychologiques," for July, 1876, Dr. Dufour showed the existence of numerous secondary visceral lesions in certain cases. Now experiments by various physiologists have proved that these lesions can be produced at will in animals by pricking or tearing certain regions of the brain, such as the peduncles, &c., in which irritation by foreign bodies causes various disorders of the pleuræ, lungs, liver, kidneys, stomach, intestines, &c. Further, some facts seem to prove that the same changes may follow mechanical irritation of the *periphery* of the cerebral organs. Are these results due to a direct action, or to transmission to the central nuclei? The question is difficult of solution, but the fact remains. Do not the phenomena of *émotivité*, which have their seat in the cerebral cortex, react in the same manner upon the splanchnic organs.

Cases have been recorded by Charcot and others, in which hæmorrhage, or congestion of the lungs, kidneys, &c., was consecutive to cerebral changes. In paralytics death is frequently due to pneumonia. One sees it occur, says A. Voisin, without known cause in patients who are confined to bed. That unknown cause consists in the various modifications of texture and circulation in the brain, which are peculiar to general paralysis. Remote organic changes also occur in epilepsy and the vesaniæ. Dr. Dufour claims that in his paper of 1876, he demonstrated their existence in the chronic state; their connection with cerebral disorders was deduced from their great frequency in lunatics; but this conclusion as to their origin was wanting in that clearness which can alone result from careful experiment, or observation of acute cases, in which the relations of cause and effect are more tangible than in the complexities inseparable from chronicity of diseases.

Of the ten cases reported in detail, it is unnecessary to give the particulars. Except the first, they are such as occur in the experience of every asylum physician—cases of general paralysis and epilepsy, in which congestion, inflammation and sanguineous extravasations are found in the thoracic and abdominal viscera. The excepted case is, however, one of much interest. The patient was a chronic lunatic, and died instantly from a kick on the head by another patient. At the post-mortem examination, extensive effusion of blood was found over the larger portion of the cerebral surface and in the ventricles. Under the pleura several extravasations were found, varying in size from a sixpence to a shilling, and penetrating into the lung tissue. Minute punctiform ecchymoses were found in the stomach and small intestines. The liver was congested, and under the capsule was one considerable blood tumour.

This case is considered to demonstrate the correlation existing between lesions of the splanchnic organs and cerebral changes, but

unfortunately the multiplicity of the latter prevent us from allotting to each its due share.

The writer is careful to state that he makes no pretensions to originality in his observations. In correlating apoplexies, pneumonias, and other visceral changes similar to those he has described with cerebral disorders, he desires to point out the close connection which unites them to the ordinary pathogeny of lesions of the splanchnic cavities of cerebral origin; whilst our predecessors appeared to see in them chiefly the results of mechanical compression during the crisis. It is well known that in animals these pulmonary ecchymoses and apoplexies occur even when the chest has been opened; they therefore cannot be solely the result of the convulsion, as Delasiauve has said.

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2. *German Retrospect.*

By W. W. Ireland, M.D.

Hemiopic Hallucinations.

Dr. A. Pick (in the "Jahrbuch für Psychiatrie," ii., 1, quoted in the "Centralblatt," 1 April, 1881) records the hallucinations of a man of 28, afflicted with delusions of persecution and grandiose ideas. He imagined that he heard reproaches poured into his ear. A lady followed him with her endearments. He was electrified, magnetised; he saw shapes and visions, such as a burning house. He often heard a voice on the right side. Sometimes it disappeared as he put his finger into the ear, but then it passed to the left ear. He had hallucinations of sight, which affected only the right eye. They appeared generally in the evening, when his eyes were shut, but sometimes after awakening. These hallucinations disappeared when he opened his eyes. He often saw portions of figures, heads, or feet, generally the upper part of men, or objects which were sharply defined off against a dark ground. There was found to be a broad spot in the right eye, where sight was deficient, without any positive lesion. Dr. Pick places the seat of the lesion in the inner side of the left optic tract, behind the chiasma of the optic nerve. He observes that if the lesion had been nearer the cerebrum the defect of vision would have affected both eyes.

Nerve-Stretching in Facial Neuralgia.

Dr. Julius Janny ("Centralblatt für Nervenheilkunde, 15 Februar, 1881) records the case of a woman forty-four years of age, the wife of a day labourer, who suffered for two years from tic douloureux of the right side of the head. Thinking that the pains proceeded from the irritation of the teeth, she got them all extracted, but they became worse instead of better; and at last the neuralgia came on in such fearful paroxysms that her life became unendurable. It was found