attendant advising him to watch her, and have her placed under fresh certificates, but she declined to see him again. On the night of December 9th (that is, less than fourteen days after leaving the asylum) E. E. S— committed suicide on the permanent way of the Great Northern Railway in North London. Thus a report by a young and inexperienced justice of the peace outweighs the opinions of two experts, the family medical attendant, who had watched the case for months, and a fourth medical man, who signed the second certificate on admission. Surely this life was sacrificed through a defect in lunacy law!

Mental Conditions resulting in Homicide. By G. T. REVINGTON, M.D., Resident Physician and Governor, Central Asylum, Dundrum.[1]

IT is with great diffidence that I venture to address you to-day. I have not made any scientific discovery, and in my own opinion it is great presumption to open a discussion on a subject of which I am merely a student, and on which my studies have not yet enabled me to form definite theories.

I had not much difficulty in making choice of a subject. You will all agree with me that mental conditions resulting in homicidal acts are very interesting.

In nine and a quarter years I have admitted forty-nine men charged with murder or manslaughter. I am not dealing with female murderers, as these cases are mostly cases of infanticide, and are of a totally different nature. I have included one case of attempted homicide, not in order to make a half-century of cases, but because the case is one of extreme interest, and throws a bright light on homicidal conditions.

The difficulties of investigating these homicidal conditions are very great. Generally the witness who knows the murderer best is his victim, and thus the most important evidence is lost.

I do not propose to trouble you with statistics, but I may point out, parenthetically, that wives are the commonest victims, then children, then parents and sisters, but (and I am afraid will be a great shock to you) I have as yet met no person

homicidal enough to kill his mother-in-law. Possibly such cases are considered by indulgent juries as justifiable homicide, and do not come under my care.

Another great difficulty is the shipwreck of the home that a homicide causes. The children are scattered far and wide, my letters of inquiry are unanswered, the patients are not visited, and in many cases I neither hear nor see a single soul who knows anything of the case.

But the greatest disadvantage of all is that I do not get these cases under my care until months after the crime. The homicidal fire has died out, and I have to study what I may call a mental cinder.

There is worse to follow. These homicidal cases do not benefit in prison. For one thing, they are supervised in a painfully ostentatious manner, as they are dreaded, and they are doctored by the habitual criminal. There is not, I imagine, much joy among convicts over one sinner that repenteth, but there is considerable joy over one sinner that escapes the fatal noose.

Every convict takes the homicide in hand, and each has a specific receipt for cheating the hangman.

I need not detain you further, gentlemen, on these points; I am sure you will agree that these cases should be placed under expert supervision while awaiting trial. You will agree, also, that the absence of the essential witnesses, the absence of visits from relatives, and the length of time that elapses between the crime and curative treatment are formidable obstacles to scientific study.

I take the case of attempted homicide first, as it is thoroughly worked out, owing to the wonderful escape of the intended victim. M. M—, æt. 38, married, two children, profusely alcoholic, thoroughly syphilised, feels himself growing prematurely old, while his wife remains sprightly and attractive, becomes suspicious of her, watches for indications that she is tired of him and wants a change, as he says.

Next follow hallucinations of smell and taste; the patient searches the room for causes, finds vapours rising from the floor, thinks the flower-pots are watered with noxious chemicals.

I need not describe further. You all know the class of case, and I am sure you feel that you did not come to Cork to listen

to what you hear every day in your own wards. In fact, our worthy President might very well say, having regard to the fine asylum that he superintends, that bringing poisoning cases to Cork is like bringing coals to Newcastle.

Now if our patient's wife had placed her husband under Dr. Conolly Norman's care, nothing would have been heard of homicide, nor, I venture to say, would M. M— have been regarded as suffering from homicidal mania.

But the foolish wife becomes alarmed and goes secretly to an even more foolish member of our profession, and together they concoct a plan of campaign that is painfully comic, and leads to tragic results. The great idea is to treat M. M— without his knowing anything.

The results are serious. Even the secret visits to the doctor become matters of gossip, and lose nothing in the telling. M. M— is more than ever confirmed in his suspicions. He also tastes the medicine in his food, and his delusions of poisoning become certainties.

Can folly further go? It can indeed. Coming home to his supper M. M— finds two teapots on the hob, one for him and one for his wife and children. He is not allowed to touch the latter. Even a sane man might begin to doubt such a wife. He openly challenges his wife and accuses her of being a wanton, and wishing to get rid of him. She is terrified and refuses to sleep in the same room. Many a woman has thus driven the last nail into her coffin.

But the edifice of M. M—'s madness wants a final touch, and gets it. The wife invites a male friend to sleep in the house to protect her and the children. Even the soundest intellect might now stagger before such an array of damning evidence, and what chance has the alcoholised and syphilised brain of poor M. M—?

On the night of the attempted murder the watchful husband, supposed to be in bed, sees the male protector flit quietly from his wife's room. You will all remember that wonderful scene in Hamlet:

> "Now might I do it pat—
> And now I'll do it
> When he is drunk, asleep, or in his rage,
> Or in the incestuous pleasure of his bed;
> Then trip him that his heels may kick at heaven,
> And that his soul may be as damned and black
> As hell, whereto it goes."

Such were the thoughts of poor M. M—, though expressed in plainer but no less forcible language. Biding his time, he creeps to his wife's room with a hatchet.

The final result is that the wife recovers in a marvellous manner after every surgeon had given her up, the hatchet was buried in her brain, and M. M— spends the rest of his existence in that most unpleasant pleasure—the pleasure of His Majesty.

I have put this case so much from the patient's point of view that I must say that M. M— had really no cause for jealousy, and that his wife was a good though a misguided woman.

Now, gentlemen, have you not in your asylums many such cases? Do you regard them as suffering from homicidal mania? I am sure you do not.

I do not know whether your experience will agree with mine when I say that I have met many non-criminal delusional cases whose great regret was that they had not killed some one or other! I have heard them grind their teeth with fury when they thought of the opportunities they had lost!

Have you not many patients in whom the idea of revenge is predominant? Have you not many cases whose first action at liberty would be homicidal?

I have come to the deliberate conclusion that homicide is a potentiality in almost all cases of delusion and hallucination, and that whether the homicide occurs or does not occur is not so much a matter of a peculiar mental condition as a matter of environment, a matter of the length of time that elapses before safety is sought within the walls of the asylum.

I do not pretend to have investigated all my cases as closely as that of M. M—. I have done so as far as possible, but owing to the reasons already mentioned I cannot give you definite figures. I cannot say how many of my forty-nine cases come under the category, but I am convinced that if the loving wives, doting parents, and devoted sisters, victims of my homicidal patients, could speak they would tell us that they should have sent their murderer to an asylum months or even years before the crime was committed.

One fact that stands out before all others is the length of time that my homicidal patients were insane before they committed themselves. It is generally a question of years.

A considerable number have wandered from county to county, seeking refuge from persecution, wandered even from country to country,—a large number as far as America. Again I cannot give you definite figures owing to my information being so defective, and chiefly being founded on the statements of patients uncorroborated by other evidence.

Now if these cases had been originally or essentially homicidal the end would have come far sooner. It is absurd to call a case homicidal who, after five years' insanity, commits a murder. A large proportion of asylum inmates might commit murder if allowed to remain at large.

Proceeding to analyse my cases, I find one homicide due to epileptic frenzy, one to a similar condition occurring in general paralysis. These, of course, you will understand.

Five murders were committed by men suffering from congenital mental defect.

I have compared secondary dementia to a fire that has almost gone out, and congenital defect to a fire that has never been properly lit. To continue the simile, the act of murder in an imbecile is as if a parcel of gunpowder had got into the smouldering fire. An explosion results, but the fire does not light up. My congenital imbeciles may live to be as old as Methuselah, but I venture to say that they will never become homicidal.

In two cases the homicide was, so to speak, accidental. Both men wished to give a certain person a good drubbing, and went too far.

In another case a man attempted to rape an old woman of seventy, and incidentally, so to speak, killed her.

In one case a man, who had spent years in America amassing £200, committed murder to prevent himself being robbed.

In two cases patients heard a voice from God, saying, "To save yourself you must kill So-and-so."

In one, a thoughtful, very intelligent, and religious man, in dire distress, out of work and unable to get any, taunted to frenzy by the upbraidings of his wife's relations, deliberately killed his wife and two children. He was a man of very high character and sound morality, so much so that medical visitors refused to believe that such a man could have committed such a horrible crime. Yet this man often told me that it seemed

clear to him at the time that it was his duty to kill his entire family and then himself. He said that he could not explain how he could have taken such a point of view, but he always ended, " It was as clear to me as if it was written in the Bible." It is very hard for us, living in times of peace, to understand such a state of mind, but the men of Lucknow kept a last bullet for their wives, and the men at the Pekin Embassy were prepared to kill their womenfolk to prevent them falling into the hands of the Chinese.

My patient arrived at the same mental condition, but without the same dreadful reasons.

In two cases, at least, the murder was due to an illusion as distinguished from a true hallucination. In the first case, a man, whose delusions and hallucinations should have and did prompt him to kill his wife, sprang out of bed and killed his child, thinking it was a wild beast about to attack him. In the other case, a man whose father and family, including himself, had been visited and severely beaten by moonlighters, showed symptoms of insanity ever afterwards, and finally killed his father, mother, and two brothers; the house was described as shambles. When he was arrested he stated that he had killed some men who were attacking him.

Twelve cases I am unable to classify owing to want of information and the utterly demented condition of the patients when coming under my care.

The larger proportion of my fifty cases are now disposed of; the exact number I cannot give you, as so many cases must be reckoned as doubtful.

Before coming to consider the cases that might be regarded as homicidal, I may give you the following statistics, asking you to remember that I am giving you figures that represent cases definitely ascertained, and that I am convinced that such figures are in every case far below the true figures owing to want of information:

In ten cases a very definite history of insanity was obtained, this is equal to 20 per cent., and with fuller information the percentage might, perhaps, be doubled.

Ten of the fifty cases were actually under the influence of acute hallucinations at the time of the crime, ten of the cases were in a state of acute frenzy, the raving madness of the older authors. Five cases had been previously confined in other

asylums, and twelve cases were under the influence of alcohol at the moment of crime.

I have no doubt that all these figures are far below the truth, could it be ascertained.

I have detained you so long, gentlemen, that I fear I must leave the full discussion of these possible homicidal cases to a future occasion.

You will, of course, understand that the above figures overlap, and that many presented a history of insanity or drink, a personal history of drink, and were also in an acute frenzy and under the influence of hallucinations.

In one case I can point to a clear case of homicidal impulse. The patient was drinking and suffering from hallucinations. He graphically describes how he lay in his garden, hid amid the cabbages, listening to voices telling him that his nephew was plotting against him, intending to kill the entire family and get the farm. One day the nephew came to borrow some agricultural implement, which was stored in a loft. The patient procured a ladder, and held it steady, standing at the foot, with, unfortunately, a scythe in his hand. As the nephew descended the ladder an overwhelming impulse seized the patient, and he made a stroke with the scythe, almost decapitating his nephew and killing him on the spot.

I questioned the patient most carefully and many times as to the nature of the impulse. There was no definite idea of killing his nephew, no thought of preventing him from killing the family, it was an impulse to strike a blow, a wild whirling impulse to strike, regardless of consequences.

I have under my care at the present time three cases subject to similar impulses. These impulses occur at irregular intervals and result in assaults.

Previous to admission one of these men assaulted a policeman he had never seen before, attacking him with a scythe, and wounding him severely. Another killed a fellow-patient in a district asylum without any provocation, and the third was an ordinary case committed for larceny, who did not develop impulses for some years.

Now these are four cases of pure impulse, but after careful study of the conditions I am forced to the conclusion that there is, strictly speaking, no evidence that the impulse is homicidal. There is no attempt to get hold of some implement, the blow

is not aimed at a vital part, it is a blow of the fist, or even of the open hand. I have spent many hours trying to elicit the exact idea that was in the patient's mind when he struck the blow. In one case this is easy, the patient becomes quite calm in a few hours. When asked why he struck his victim, he says, "I don't know, I had no reason, I know I was wrong, but I could not help it." I have taken great trouble to find out whether there was the vaguest wish to hurt any one or any definite sensation of satisfaction at having struck the blow. The answer is always in the negative. The other two cases are much more difficult. After each assault they are, of course, placed in seclusion and visited by the medical officer on duty. They are always sulky and sullen, decline to answer questions, refuse to meet one's eye, and hide their heads under the bed-clothes. Their faces are flushed, the brain is evidently working at high pressure, and their self-control is on the point of breaking. One is reminded of a horse that is about to bolt, and is hard held. These two patients always utter short, abusive, and threatening sentences, and express a great desire to be alone, and, undoubtedly, if I did not prudently clear out, there would be a sudden mad rush, and some one might get hurt. I have frequently delayed longer than usual, and asked further questions with the view of studying the mental state. The result is that the patient's excitement increases rapidly, the limbs quiver, the body bends like a wild beast's for the final spring. Well, then, gentlemen, it is time to go. As the door is shut I often say, "There is an exact picture of the mental condition that results in homicide." This interesting condition lasts for weeks and even months,—in one instance for five months,—and during this period I could, at any time, have created a homicidal mental condition.

But this is a sort of mental vivisection which I am sure you will agree with me should not be practised, even in the interests of science.

Even for the sake of making my paper less uninteresting I dare not try experiments by giving these patients opportunities of using implements or weapons,—I might not be here to-day if I did. But can any one doubt that these patients would use any weapon that happened to be in their hands? and then the verdict would be homicidal mania.

After all, mental degenerations may be regarded as rever-

sions to the type of our savage ancestors. The carnivora are not mammacidal, they kill to eat.

The impulse to strike that these four cases feel may, perhaps, be best compared to the wild rush of nerve-force which hurls the tiger on the bullock's neck.

And now, gentlemen, I will conclude by briefly referring to the remaining classes of mental condition, the eight cases of acute frenzy, the twelve cases of alcoholic influence, the ten cases of acute hallucinations, and ten cases in which there was undoubtedly an absolute break in the mental continuity—a mental blank. These latter remember a certain action at a definite time, and their next recollection is their arrest, or they may not, as they say, come to themselves until they have been some time in prison.

Of course, a large number of patients claim to have been in the condition of mental blankness, or rather of separate mental existence, but in only ten cases am I satisfied that this was so. These forty cases represent only twenty-seven individuals, three cases having been in a state of acute frenzy, mental blankness, and under the influence of drink, two cases having been under the influence both of drink and hallucination, and six of the twelve alcoholics were undoubtedly in a state of mental blankness, and two at least of the alcoholics having been in a state of acute frenzy, though not under the influence of hallucinations.

This disposes of the twenty-seven individuals. The ten hallucination cases I cannot regard as homicidal, for I believe that any hallucination case is a potential murderer, and if not under treatment would sooner or later become one. I do not forget those rare cases in which exceptional men recognise that they suffer from hallucinations, and can be regarded as sane.

I recollect that my friend, Dr. Savage, had one such case under his care, and discharged him as sane.

Of my twelve alcoholic cases, in nine mental disease undoubtedly caused the recourse to drink, in one case acute alcoholism, and in two pronounced chronic alcoholism caused the crimes.

I do not think that much will be gained from the study of advanced alcoholism. I have formed my opinion entirely from the study of a few cases of early alcoholism I have met in

private practice, and I have also formed the habit of studying certain of my friends, who, I regret to say, are slightly alcoholic without in the least knowing that they are so.

Now what is the one prominent change which I have observed in early, slight, but habitual alcoholism?

It is a slight loss of self-control, a shortening of temper; in a word, a certain explosiveness. The patient's mental balance seems to be hung on a hair trigger, trivial things that would not have ruffled the sunny surface of his good temper now cause deep submarine explosions. The poor wives and children of alcoholics will bear me out in this. I often compare alcohol to the fulminate of mercury which explodes the comparatively harmless material which fills the shell.

In nine of my alcoholic homicides drink was the result of mental disease, not its cause. I do not believe that the forms of mental disease due to alcohol are more homicidal than diseases due to other causes, but I believe that the effect of alcohol on a diseased brain is to increase the danger of explosion, to increase the tendency to homicidal action.

To conclude, I have not referred you to a host of foreign writers, whose dicta seem to gain in dignity because written in unknown tongues. I have told you a plain unvarnished tale of my humble studies. I have read what I fear is a sketchy, diffuse, and discursive paper, and I leave you to draw your own conclusions. My own I will sum up in a word.

I believe that my homicidal cases do not suffer from any peculiar forms of mental disease. I believe that most of them are not criminals in any sense of the word; I maintain that the crime is, in practically all my cases, an accident in the mental disease, not its essential or its typical outcome. I am convinced that you have all under your care hundreds of potential homicidal patients. That they did not commit murder is, in my opinion, a lucky accident due, shall I say? to the grace of God, or to the caution of timorous and unloving relatives.

None of my cases lead me to believe in such a thing as homicidal mania, a ravenous lust for blood, a brutalised craving to take life simply for the sake of taking life. I believe that ordinary motives such as jealousy, misery, acute fear, acting on morbidly active emotional conditions, are

responsible for the lengthy list of murders which I have brought under your notice.

I have attempted to enter into the inner temple of my patients' minds—I fear I cannot call it a holy of holies—and to tell you what I found there, and I say definitely that it is not the homicidal idea that dwells there.

(1) A paper prepared for the Annual Meeting of the Medico-Psychological Association held at Cork, July, 1901.

Clinical Notes and Cases.

An Abnormal Brain of Excessive Weight. By JOHN SUTCLIFFE, M.R.C.S., L.R.C.P., Assistant Medical Officer, Manchester Royal Lunatic Hospital, Cheadle; with Pathological Report by SHERIDAN DELEPINE, M.B., Professor of Pathology and Director of the Pathological and Public Health Laboratories in the Owens College, Manchester.

MR. B—, an accountant æt. 37, was admitted into this hospital on February 6th, 1900, suffering from epileptic mania. That there was insanity or other diseases of the nervous system in his family history was denied, but his brother was said to be very eccentric and to take too much to drink. There was also a suspicion that another brother died of some mental or nervous disease. The patient was married at 21, and his wife had had four children—no miscarriages; the eldest and third are alive and in good health, æt. respectively 16 and 12; the second died at 2½ years and the fourth at four months, both in convulsions. He was always excitable and masterful, and latterly had been very quarrelsome; he had always been a sober, steady, hard-working man and a good and kind husband and father. He had built up a good business as an accountant and estate agent. He had had good bodily health generally until five years ago, when he had an ischio-rectal abscess followed by a fistula, which was cured by operation. When he was a boy a brick fell on his head and caused a contused wound, the scar of which is about one and