the habits were far from being of a serious or deeply-seated nature.

Patients come, or are brought to us for treatment, who think, or their friends think, that they will get well in a few weeks, or a month or two. Such ideas are utterly wrong, and it is practically hopeless *quoad* cure, that in such periods a good result can be achieved.

This sounds a hard verdict, and may, in cases of modest means, seem an almost insurmountable barrier. But which is worse, a few years' pinching, or a lifetime with such an incubus as a relative who is the victim of some such habit as we have above considered?

So important a truth does the writer consider it, that at the risk of monotony he repeats that in cases of insanity in its broad sense, in which the evidence of that insanity consists only of bad habit, and in which there is no evidence of pathological nervous change, there is fair hope that mental integrity may be restored by the application of the proper means, *provided a sufficiency of time for their operation be allowed.*

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*Recoveries from Mental Disease.** By J. G. Soutar, Barnwood House, Gloucester.

At these meetings we have an opportunity for resolving doubts by discussion, or it may be of only discovering that in confessing an ignorance which is not singular there is no great sacrifice of self-esteem. I am ready to accept either alternative as the result of our consideration of recoveries from mental disease.

The remarks which I have to make this afternoon are not written up to the title with which the secretary of this division has supplied me. A paper on "Recoveries in Asylums" might tempt one into byways where we had better not wander—might lead one into the foolish and futile course of instituting comparisons between the recovery-rates of different asylums. It is as well to avoid comparisons. I am a profound believer in the value of statistics, and I reject the cynical suggestion that they may be made to prove anything or nothing. Figures, however, can be effective only for the purpose for which they are com-

* Read at the Spring Meeting of the South-Western Division of the Medico-Psychological Association.

piled; when misdirected they become but vehicles for the conveying of false impressions.

The recovery-rate, as we all obtain it, shows what in the opinion of the compiler is the percentage of recoveries on admissions in the particular asylum with which he is dealing. That is all we are told. It is a bit of information, but it is, I think, an open question as to whether the information is of any real value. It is very evident that it gives no answer to the really important question, How many of the curable cases have recovered in any given asylum? It does not enable us to decide what residuum of chronic insanity remains as the opprobrium of our ineffective treatment. When we are taught how to procure figures which will give us information on this point, then those who disregard the common warning on this exercise may institute comparisons. Meantime a few puzzling questions remain to be solved. Prognosis must be unerring, and there must be no doubt as to what constitutes a recovery. The knowledge required for this is still, however, in the womb of the future. I think that we may therefore discard the discussion of that part of the subject, and rather for the purposes of correction and instruction submit ourselves to the salutary discipline of a review of our decisions. The result may be somewhat humiliating, but we come to bear the shock with greater equanimity when after repeated reviews of our decisions the fallibility of our judgment can no longer be doubted—even by ourselves.

It is, in my opinion, often a very difficult matter to decide whether a patient has or has not recovered from an attack of insanity. I find on review that I have again and again discharged as "recovered" patients who were not cured, and that I have discharged others as "relieved" who were really well. I do not know how to inevitably avoid such errors, nor am I very hopeful that any, except perhaps those who have had a limited experience of the insane, will undertake to provide us with a definite rule for our guidance. There are, of course, many cases where recovery is so obvious as to leave no room for doubt. Many other cases there are, however, where we have serious misgivings as to what our decision should be. We, for instance, find that a patient, from whom certainly all the grosser manifestations of insanity have passed, is, as his friends describe him, a different man from what he was before his illness. In such a case the often extremely difficult question arises as to whether the

change in mood or manner is indicative of permanent brain-damage, or whether it is merely the sane response of the organism to a terrible experience. Calamity in any guise operates on most of us to the modification of our moods, and it is, I think, only what we may expect to find, that many who have passed through an attack of insanity, with the knowledge of all that that means both in retrospect and prospect, should go back into the world vaguely, perhaps, yet undoubtedly altered men. We know that calamity influences the sane population in different ways. The ideal people become gentle and submissive—they can turn the other cheek to the smiter, others grow reserved, or sullen, or irritable, and some become reckless, and seek to find in gaiety and dissipation the grave of grief. Changes like these are what friends so often describe as having occurred in those who have been discharged from asylums. To me it seems that these are in many cases natural changes—changes compatible with perfect sanity, and not changes which are legitimately the cause of apprehension and dread, for recovery, whatever else it does mean, does not necessarily mean the re-establishing of that mental attitude which was characteristic of the individual before his attack. With the normal brain reaction to the new experience which has been added to the life of the patient we have now to reckon. It is not always easy justly to appreciate it, but it must not be ignored.

It is sometimes claimed as a necessary indication of recovery that the patient should recognise that he has been insane. I find, however, that I have been justified by the after-history of the case in discharging as recovered patients who to the last scouted the notion that they had ever been insane. It is, of course, impossible to penetrate into the minds of patients, and to ascertain their real belief on this or any other matter. They are just as inscrutable as the rest of us, and I have little faith in results obtained by what some call intuition, which is often merely a sonorous synonym for guessing. The fact is that many patients who have lost every trace of their mental disorder, men and women who are reckoned both intelligent and honest, do not admit, nay, even deny, that they have ever been insane; while, on the other hand, some patients who are still manifestly of unsound mind, especially when prematurely clamouring for release, recognise and admit that the necessity arose for sending them to an asylum. I know of no cases where this

recognition of his insanity—he calls it his past insanity—is so complete as in the case of the hopeless alcoholic dement compared with whose condemnation of himself the medical certificates form a mild indictment. I am thus inclined, in considering the question of recovery, to attach but little importance to the patient's admission or denial of his insanity.

Much more difficult questions await our solution when we ask are we justified, and under what circumstances are we justified, in discharging a patient as recovered who still adheres to some false belief which arose during the course of his attack of insanity?

I think that we are justified in looking upon some of these cases as recoveries. The following will illustrate and explain my view. A. B. had an attack of melancholia with delusions of persecution. On the day before he was discharged recovered he said to me, "I am very grateful for all that you have done for me, but I cannot understand why you permitted A"—an attendant—"to so cruelly ill-treat me one day in the garden." He asserted that the attendant had thrown him down in the garden—he showed me the very spot—that he had jumped on him and treated him violently, and that I stood at the porch close by looking on and encouraging the attendant in the assault. I assured him that no such incident had occurred in my presence, and that the attendant—about whose identity he was positive—never had charge of him. The patient replied, "I must, of course, accept your assurance, and try to dismiss from my mind what I frankly tell you seems to me to be the true and vivid recollection of an actual experience." This man soon after his discharge accepted an important public appointment, and he has for some years now performed the duties of his office with great efficiency.

I could quote other instances in which a patient has returned to fill his place and to efficiently discharge his work, all the time harbouring in his mind a false idea, which he did not entertain before his illness. Yet if a patient is well in other respects, if he has lost his depression or excitement, if he has recovered his natural interests and affections, if he is reasonably conformable to social laws, if he has regained his power for sustained and orderly mental effort, I do not think that his merely retaining an opinion or belief which sprung into being as the result of his insanity necessarily militates against his being dis-

charged recovered. If, however, this belief actuates conduct, and that conduct is of such a nature as to be antagonistic to the organised society in which the individual must live, then, of course, he cannot be discharged recovered. We retain, and rightly retain in our asylums, many patients of this type, and they form the comparatively sane elements in our community. In asylums they are safe; outside of asylums they would have the opportunity of translating into action ideas which are inimical to society.

It seems to me that while the belief in a false conception formed at an anterior date may be, often is of no importance, it is essential that the emotional state out of which the false conception arose should no longer exist. Here again, then, and so to speak, by another avenue, I reach the conclusion that recovery does not necessarily mean the re-establishing of the mental attitude which characterised the man before his attack. My belief is that there is to be found in the great majority of those who have passed through the ordeal of an attack of insanity some mental change, subtle and difficult to estimate though it may be. If, however, that change be not of such a nature as to unfit the individual for the society of his fellow-men or for the pursuit of his labours, we may, I hold, rightly discharge him as recovered. We can get no nearer than this to the appreciation of the sanity of anyone. A knowledge of ourselves and of others demands permission for the recognition of an infinite variety of mental constitution within limits only very vaguely defined.

How do recoveries, reckoned in this somewhat latitudinarian, but I do not think altogether unusual way, stand the test of a review? Let us see how far the decision "discharged recovered" has been justified by the subsequent history of the cases.

During the five years 1890-1895 we discharged from this hospital as recovered, 85 cases. I have been able to trace the history, down to the present time, of 73 persons. A careful consideration has led me to classify them as follows:—

I.—Those who soon showed such signs of mental unsoundness as to make it necessary that they should be placed under the care of others, those in fact who had not recovered.

II.—Those who, after leaving the hospital, showed signs of some degree of mental enfeeblement or peculiarity which,

while it did not prevent them from occupying their wonted place in society, rendered them unfit for carrying on with efficiency their usual occupations.

III.—Those who, for at least twelve months after leaving the hospital, showed no signs of mental infirmity to those around them, and were able to fully resume both their place in society and their usual occupations.

In the first class—those who soon showed such signs of mental unsoundness as to make it necessary that they should be placed under the care of others, those in fact who had not recovered—11 out of the 73 persons must be placed. All these persons within a month or two, some within a shorter time, showed undoubted signs of insanity, and although four out of the 11 have been able to live at home it is only because their circumstances are such as to make it possible for them to have the necessary attendance in their own houses. On a review of these cases I have no doubt that we had in several instances to deal merely with that temporary cessation of morbid manifestation which so largely prevails in some forms of mental disease. Other cases were undoubtedly examples of that asylum sanity with which we are all acquainted—those cases in which the routine life of the asylum shelters the patient from the buffetings which outside its walls fall on these unstable brains with disastrous results. These are the patients who, after one or two experiences of this sort, gladly make the asylum their home, thus securing for themselves that possession of their mental faculties which alone makes life worth living.

I shall be interested in another five years to ascertain if as large a proportion of those discharged recovered will then be placed in this class as must be so placed on the present review. I am not very hopeful that the result will be different, for although I now know that my decision was wrong I cannot see what other decision I could have come to at the time. In no case was it possible on discharge to set down any fact indicating insanity. I take it that these cases only disclose to us that not very distant view—the limit of our knowledge.

Class II.—Those who after leaving the hospital showed signs of some degree of mental enfeeblement or peculiarity which, while it did not prevent them from occupying their wonted place in society, rendered them unfit for carrying on with efficiency their usual occupations. In this class 13 of

the 73 persons must be placed. A few probably remain in this class because they are able to maintain themselves in comfort without being compelled to return to the occupations which they pursued before their attack. With necessity spurring them on they might perhaps reach a higher mental plane. These, however, form the minority of the cases. Most of them are incapable through some enduring disability of resuming their place as workers. Here is a typical case. A professional man who had done good, and very energetic work, had an attack of acute melancholia. His depression and delusions passed away. He returned home. He is quite cheerful, rational in his conduct, and keenly interested in everything. He has a desire to resume his work; there are no practical difficulties in the way, there is no loss of knowledge or skill on his part, but he has lost confidence in himself and he cannot be induced to make a start again.

To look upon persons of this type as being still insane is to restrict our view of sanity in an absolutely unwarrantable way. Their persisting peculiarity in mental constitution is within the limits which we daily meet with, and admit amongst the sane population. These then I reckon as recoveries, although not wholly satisfactory.

Class III.—Those who for at least twelve months after leaving the hospital showed no sign of mental infirmity to those around them, and were able to fully resume both their place in society and their usual occupations. Here may be placed 49 of the 73 persons. They have taken the place in the world and at their work which they occupied before their illness. These are satisfactory recoveries. It is true that seven of them have had another attack. Four of these have again completely recovered. One must now go into Class II.; one is still insane and another committed suicide at her home only a few weeks ago. Of the four who have died sane since 1890 it may be that one or more would, had he lived, have had another attack by this time, and certainly on a review of these 49 cases ten years hence it will be found that a considerable number of them have again been insane. This, however, is not the point at present. I have looked at these cases merely for the purpose of ascertaining in the light of their after-history what was the nature and quality of the so-called recovery.

The conclusion is this, that in about 15 per cent. it was not a recovery and ought not to have been so called; in about 17 per cent. the recovery was not wholly satisfactory, thus

leaving about 67 per cent. only of the recoveries in a period of five years to be reckoned as absolute and complete.

From a review of even the few cases with which I have been dealing, there arise many other interesting considerations, but I shall now advert to only one of these. We all value highly as an indication of satisfactory recovery that improvement in the general health of the patient which is indicated by an increase in weight. I find that the average increase in weight between the date of admission and the date of discharge in these 73 persons was just over 12 lbs. In some there was no increase at all, while in others increases ranging from 2 to 38 lbs. were recorded.

I note the fact that amongst those whom I have placed in Class I.—those who had really not recovered—unaccounted for fluctuations in weight occurred in some, in others there was no increase, and in two there was an actual loss of weight between the date of admission and the date of discharge.

This improved condition of our patients which we can weigh and estimate and represent in figures, and which is so intimately associated with their mental improvement, is reached along those lines of general medicine, the practice of which carries us outside the range of specialism in its narrow and restricting and invidious sense. This is not, I know, the opinion of some outside our ranks, to wit—for example—those distinguished physicians who constitute the British Gynæcological Society. It is on record that at a conclave of these gentlemen to whom the iniquity of specialism is particularly abborrent, it was declared on June 11th, 1896 (*Lancet*, June 27, 1896), by one member, that "he regarded Asylum Medical Officers as the most absolute of the profession, and once a woman was placed in an asylum she was likely to stay there;" by another that "as a rule"—it was kind to make some exceptions—"as a rule no one knew less of the gynæcological conditions of the insane than the medical attendants in asylums." Why this onslaught on us? Because we are supposed to be ignorant of, what they so learnedly discussed—the psychological consequences of suppressed menstruation. In the treatment of our cases we do not confine our investigations even to this important function. A review of recoveries, a reference to case-books, shows that we recognise the fact that in the great majority of cases the restoration of mental health has followed in the train of persistent efforts to restore the function of some organ other than the brain. In many cases of insanity

we have but a manifestation of a primary disorder in the alimentary tract, or of an abnormal state of blood, of a failure, perhaps a remediable one, in the circulatory system, of defective emunctories, of faulty working in the organs of reproduction. In fact every system must be examined and re-examined with minuteness and care, and all the resource of our art must often be expended in the treatment of organs far removed from, yet directly or indirectly operative on the brain.

There is nothing new in this. In every asylum in the land this is now recognised as the cardinal truth underlying the treatment of insanity. Without this the discipline, the ordered life, the appeals to our patients by pleasing externals, by attempts to arouse dormant interest, by encouragement, by warnings and often by frank explanation—all invaluable aids in treatment—would be of absolutely no avail.

Not the least satisfactory and hopeful conclusion to be drawn from a review of a list of recoveries is that most of them are undeniably the result of definite medical treatment, they are victories of the physician over disease. It is the recognition of this fact which keeps alive amongst us that true medical spirit which, particularly in our work, must ever be less daunted by difficulties than encouraged by success.

Discussion.

The CHAIRMAN (Dr. Maury Deas) said he rose to express their thanks to Dr Soutar for his thoughtful, suggestive, and practical paper, and also as one who had been placed at the head of the meeting to express a few thoughts. There was no doubt that the question of recoveries was one of a very vague and unsatisfactory character as usually dealt with in statistics. But he thought they were to blame themselves to some extent, because it would be rather a good thing if it could be managed strictly without those elaborate statistics, of which Dr. Soutar spoke as one who knows, if the word "recovery" could be eliminated. He did not believe anyone could say that a case was absolutely recovered, or define what recovery is. If one had brought persons to such a condition of improvement, one should be able to say to their friends, "I don't say they are recovered, but they have such mental stability that they are able to face society and the world again." He was rather surprised that Dr. Soutar did not allude to the great importance of the test of discharge. He did not know whether he (the Chairman) was exceptional—he did not suggest he was—but as a matter of fact he had very rarely discharged a patient absolutely. He adopted a system of probation. He thought that if a man could face the rough and tumble experiences of life that was the best test of recovery. He was inclined to think that if Dr. Soutar had adopted some such means as he himself had, that some of the failures to which he had alluded would not have become failures at all. They all knew that insanity had a tendency to relapse. His course, therefore, was to place a patient on probation, and let him understand that he was on probation, to see how far he could stand the turmoil of this world. Then as to another point to which Dr. Soutar alluded, he (the Chairman) thought it was a very difficult thing to say what patients are curable, or what incurable. Of course

there are cases in which there was no difficulty; but he was sure they had all been deceived in regard to cases, some of which they had classed as incurable, but which had recovered, and in others which they had said would recover, but yet had not recovered. The last thing consequently they should say was that a case was incurable while under care, for even the apparently most hopeless patients sometimes gave them experiences of surprising recoveries.

Dr. PERCY SMITH supposed they would hardly ever eliminate the personal element in cases that recovered. They saw a good many asylum reports in the course of a year, and, no doubt, some cases returned "discharged as recovered," where he should say "relieved." As to patients not recognising that they had been ill, he said that as to such cases when their conduct was normal he generally discharged them as relieved, not as recovered. Alluding to cases of asylum sanity, he mentioned one, of a lady who had been in Bethlem for four years, whose conduct was apparently normal. Yet there was something at fault which made her break down when she was sent out. At last the exigencies of the renewal of the reception orders under the Lunacy Act obliged him to send her out; but in a week's time she was brought back again. He considered this one of the blots in the enactment (hear, hear).

Dr. BENHAM said that in his interesting paper Dr. Soutar did not allude to the time when patients might recover after having been under treatment. He thought that those who were accustomed to large asylums, where they could not give as much attention to patients as they might in smaller ones, knew cases, quite harmless, which had been settled in wards with chronic cases, and in which after a time great amelioration occurred. He considered they kept such cases as these rather longer than was necessary. He mentioned three cases (one of whom was in the asylum for 16 years) which he himself had ultimately discharged, and which were all doing well in life. He contended that such experience made it well for Superintendents to look round their wards and see what they could do in discharging patients fit to go out. He rarely discharged patients on probation; he preferred to keep a patient till he could say that the patient was ready to face the world. With regard to recoveries he did not think the point of epileptics had been touched on that day. They sometimes got better, and it was a serious question whether they should be discharged. He sometimes discharged epileptics, but he always insisted on waiting for a period of one or two months to watch if the case kept well, rather than make a premature discharge. As to the question of increase of weight in patients, recovery could not be estimated by this alone. It was a bad sign if a patient's weight increased without there being some improvement mentally.

Dr. BATTEN, as a general practitioner, said that he wished he had had some of this special experience. He had listened to Dr. Soutar's paper and the discussion following with a great deal of interest, and his feeling was somewhat of pain and sorrow that he could not find in their specialised branch of the profession that amount of hopefulness that characterised the branch he belonged to. He thought he might say for himself and Dr. Oscar Clarke, who was present, that they generally at the first saw whether they considered their cases curable, and that at the end they did send out a very large proportion of them cured. While admitting that there was a large amount of specialism necessary, and that patients ought to have the benefit of this knowledge and skill, he was not sure that the sharp line that came between their branch and his branch of the profession was altogether wise. He trusted that the two branches would be able to bring themselves more closely together. At the present time he was feeling acutely the case of a female patient of his, and he recognised that with the skill and knowledge which the specialists could bring to bear on her case she might have a better chance of recovery, but that this girl would in consequence be labelled all through life as having been in an asylum, he could not help thinking that the day ought to come when their specialism should only be an increased knowledge in the general profession, and that such a case as he had

mentioned would be treated without leaving the stigma of having been in an asylum behind. He should like to see, if possible, all classes of nerve disease have the benefit of the higher skill and better knowledge of the specialists without the cases being labelled as at present. Whether he was too hopeful in thinking that the day would come when the public would recognise this, he did not know, but he thought it ought to come, and speedily too. It seemed to him that the day could only come by inviting, as the Division had done that day, some of the heathens from outside to meetings such as this one, so as to bring about increased and fresh confidences between them for the greater advantage of the public.

Dr. MACDONALD said he had only one or two observations to make. The apparent difference of opinion between their Chairman and Dr. Benham was, he thought, easy of explanation. While he quite agreed with the advantages accruing from discharges on trial, he was not at all sure that this special method was the best to be adopted in connection with County or Borough Asylums. He said that for some considerable time the course adopted at the asylum with which he was connected had been to recommend patients early, and not to discharge them for several weeks after in case of any break down, and he was glad to say that this course of action had so far given most satisfactory results. In the course of the discussion no reference had been made to the serious and great responsibility incurred by Superintendents in recommending patients for discharge before they were thoroughly satisfied as to their return to mental health, and he did not think that they could be too careful in recommending cases for discharge. They were all fully aware of the ready desire on the part of the public to attribute blame to the asylum authorities, and in particular the Superintendent, when an old friend in the capacity of a patient has committed some horrible crime. As Dr. Deas very well knew, he may have no difficulty in sending out cases on trial, because they invariably return to comfortable homes, but alas, it is very different and otherwise with many of the cases discharged from County and Borough Asylums. And unless there should happen to be a charity fund from which recent discharges can be assisted, or unless the asylum authorities have granted an allowance in accordance with the Act, it is not desirable to discharge cases on trial. He had listened with great pleasure to the remarks that had fallen from Dr. Batten, and could assure him that one of the main objects of these divisional meetings is to draw within their membership more of the general body of practitioners, and to remove much of the supposed differences in ways and methods. Would that the general public followed his sound advice and classed them as ordinary medical men, engaged in treating an ordinary disease, but with special advantages and the special methods and means at their disposal.

Dr. ALDRIDGE mentioned two cases which he had discharged on trial, and which had to come back to the asylum. In continuation orders they had often to stretch a point. With regard to what fell from Dr. Batten, he said this was an exceedingly serious consideration. Medical Superintendents were exceedingly anxious to do what they could for outside cases, and they were often appealed to. But their difficulty with patients requiring discipline was that there was no intermediate place to which they could be sent in which they could get treatment similar to that in an asylum without the opprobrium of asylum treatment or certification. Cases of that kind were exceedingly depressing to be consulted about.

Dr. SOUTAR thanked all for the very kind way in which they had received his paper. The criticism had been more appreciatory than depreciatory, and therefore he had not much to reply to. Of course many points of great interest had been raised by the various speakers. It was impossible in a single paper to deal with all of them. The Chairman and others had referred to trial on probation. He omitted to refer to this point, but not because he did not resort to trial probations. In his opinion this was an invaluable test, provided it was certain you could send a patient back to surroundings quite

as good as those he left in an asylum. That was a difficult matter from pauper asylums, but it did not exist amongst private patients. Every now and again cases occurred in which improvement happened up to a certain point and there they stuck, and yet when they were sent home recovery was effected. Many owed their recovery to the fact that they were sent out on trial. He was delighted to hear Dr. Batten—they in this district always were. He did not altogether agree with certain of Dr. Batten's remarks, but he might be mistaken as to the drift of them. The asylum doctors had no desire to be marked out from the general physicians; their desire was to be recognised as general physicians. He thought in his paper he laid considerable stress (thus showing they were not quite so hopeless as considered) on the fact that their recoveries were the victories of the physician over disease. It was, of course, absolutely impossible to treat their patients in their own homes. Until the general public began to recognise that there was no more disgrace in being treated in an asylum than there was to be treated for, say pleurisy, by Dr. Batten in the infirmary, they (the specialists) must continue to do everything they could to break down the feeling now existing. (Applause.)

Housing the Insane. By H. Rayner, M.D., Lecturer on, and Physician to the Out-Patient Department for, Mental Diseases at St. Thomas's Hospital.

Under the term "Housing the Insane" I wish to bring before you for discussion the various plans that have been adopted of providing for the insane in asylums, colonies, homes, &c., the extent to which they are practicable, the medical supervision they necessitate, together with the size and form of institution which might result from their combination.

The number of lunatics housed in County and Borough Asylums in England and Wales has increased from 15,844 in 1859, to 63,957 in 1896. The increase since 1892 has been 8,448, giving an average of more than two thousand per annum. The housing of these patients in asylums costs from £150 to £250 per head, so that the mere monetary question is one of considerable public interest.

Its importance is recognised by the fact that the London County Council has appointed a Committee to consider the whole question of dealing with the insane, and I think this Association would be neglecting a public duty if it omitted to discuss, and if possible to formulate its opinions on this subject, in regard to which no other body of men in this country can have had equal experience.

The provision of accommodation for the insane has been hitherto too much a question of local expediency, and few counties can be said to have followed the lines of a definite consistent plan, based on skilled forethought. The result has been, it is to be feared, that experiments of a vast and costly character have been undertaken, in regard to the