## *After-care in Cases of Mental Disorder, and the Desirability of its More Extended Scope.*

By Dr. C. HUBERT BOND, Commissioner in Lunacy, and Emeritus Lecturer in Psychiatry at Middlesex Hospital. (1)

AT the request of the Council, and with your permission, I propose to lay before you this afternoon the following points for your consideration: firstly, the importance of organised after-care in cases discharged recovered or relieved from mental disorder; secondly, the lamentably small proportion of these discharged cases which are brought under the notice of those engaged in after-care; thirdly, the limitations imposed by the constitution of this Association in its practice of after-care; and lastly, certain suggestions—partly the outcome of conversations with your Secretary, Mr. Thornhill Roxby—with a view to increasing the scope of the Association's work.

### *The Importance of Organised After-care.*

It is indeed a singularly fortunate man or woman who does not know by personal experience, if not the necessity for, at least the balm-giving influence of, a period of rest and the recuperative effect after illness of a term of freedom from the cares of one's daily avocation. Nor, indeed, will anyone dispute that judicious after-care is not only one of the most potent promoters of full recovery, but also one of the surest safeguards against relapse, in by far the majority of the many diseases to which we are all liable. Such being the case, and if it is true, as has been written—and who will deny it?—that "Babylon in all its desolation is a sight not so awful as that of the human mind in ruins," how much the greater need that after-care should follow recovery, whether complete or partial, from such a catastrophe as an attack of insanity? The value of such has on many occasions, and especially at these meetings, been urged in far more eloquent terms than I can command; but I doubt not that you will agree that the circumstances which surround the origin of so many of our mental cases possess a dumb eloquence of their own that cannot be gainsaid.

Consider for a moment what these circumstances so com-

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monly are—very briefly, however, for to do so with any approach to thoroughness would involve an exhaustive survey of the many factors that take part in the causation of mental disease, and truly the "cause of insanity" is a hydra-headed complex. But these factors, numerous though they are, tend naturally to fall into certain groups, and it will be sufficient for present purposes merely to allude to the most important of them, entering into detail only with respect to the last group, and because the work of this Association is in practice so intimately concerned with it.

As part of, and probably the predominant partner in, this complex of factors, mention must first be made of what is sometimes termed a neurotic constitution or temperament; and it must not, indeed, be forgotten how very large a proportion of the insane enter on life's battle possessed with this handicap, and are thereby ill-equipped to withstand successfully the many stresses that may arise in the ensuing three score years and ten. Some of these stresses are inseparable from life's normal course, as, for instance, its several critical epochs, and, in women, the strain of maternity; other stresses, such as bodily illnesses and injuries, are in the nature of accidents; others are the effects of intemperance and excesses of various kinds; while still others—and they are legion—are mental in type, and include all the many shocks, worries, and anxieties from which only a very sheltered life is free.

Reflection upon the first of these factors suggests the desirability of "fore-" rather than "after-care"; and there can be no doubt that occasionally individuals who, as the result of their knowledge of the occurrence of mental and nervous disorders in their respective relations, have been able to recognise their own liability, have, by acting upon competent and judicious advice, succeeded in warding off mental and nervous breakdowns in themselves. Such examples of enlightenment in a difficult problem are, alas, only too rare, and we can but hope that, with the gradual education of the public upon this and kindred matters, they will be more frequent.

Meanwhile this Association has, at any rate for a considerable time to come, more than ample scope for its energies in concentrating its attention upon making smooth the difficulties and alleviating the distress which so often constitute the aftermath of an attack of insanity.

For, among the group of factors which are mental in type, especially in the class of cases which form the majority of those assisted by this Association, conspicuously stand loss of situation and inability to get work, with all their attendant hardships, so often culminating in more or less actual starvation. The disastrous effect of such privation can be to some extent realised when I tell you that, in the course of an examination of the records of 100 consecutive discharges on recovery, I found that a comparison between the patient's weight on admission to the asylum and that on discharge therefrom showed an average gain of no less than 18 lb. No doubt in a certain number of these patients the loss in weight which had taken place previously to admission was due to the mental illness itself: indeed, in some forms of recurrent insanity it is often taught that the keeping a watch on the body-weight and regarding any serious loss as an indication at once to obtain suitable treatment constitute a valuable means of warding off the threatened relapse. But apart from this evidence, a perusal of the history of these 100 patients, both as obtained from their friends and as related by themselves after recovery, makes it all too clear that, in an appreciable number of instances, loss of employment and consequent poverty with insufficiency of food had preceded the mental breakdown, and was undoubtedly one of the determining factors—sometimes apparently the only one—in bringing the patient to the asylum.

Now it is obvious that if the resources of these patients had been reduced to so low an ebb prior to their advent to the asylum, there can be little ground for expecting that fortune will have a brighter face with which to greet the discharged sufferer without the intervention either of charity or rate aid; the latter is mentioned because, under the existing Lunacy Acts, visiting committees of asylums are empowered to make a money allowance to a patient leaving the asylum under certain circumstances, to which reference will presently be made. Nor must it be forgotten that, even in those cases in which pecuniary distress or other adversity was not present, it by no means follows that on discharge from the asylum there will be the same freedom from adverse circumstances; because, as you well know, it is not infrequently only too true, either that an employer hesitates to reinstate an employé who has been absent owing to mental illness, or that the latter has been of such

lengthy duration as to have made it impracticable to keep the post open for the patient's return. In short, it may be stated that, apart from married women who have their homes to which to return, by far the majority of our patients in public asylums on their discharge therefrom are under the stern necessity of at once seeking for fresh employment—a quest which under favourable circumstances is sometimes difficult, but rendered doubly so if the would-be employé has to explain that his recent months have been passed in an asylum. Have we not in truth here all the elements required to establish what is termed a "vicious circle"? Small wonder that such a case, in the face of inability to obtain a livelihood, speedily relapses.

### *The lamentably small proportion of Discharged Cases which at present receive After-care.*

By a reference to page 120 of the *Sixty-sixth Report of the Commissioners in Lunacy*, it can be seen that every year there are discharged recovered, from county and borough asylums in England and Wales, something like 7,000 cases, in which women slightly preponderate. The degree to which these cases need pecuniary aid, relief in kind, or assistance in finding employment, no doubt varies in different localities; but I venture to assert that there is not one of them but would benefit by being followed up, counselled, and—in so far as necessities exist—befriended. I have reason to think, too, that such help is most acceptable and in the end most efficient and successful when given by a body organised as is this Association, and whose executive is detached from any public authority. In other words, I believe that discharged patients welcome visits and accept help from members of the Association's staff, whether honorary or paid, and learn to return voluntarily when in doubt or difficulty to the Association's offices, when they would not have done so had the visitor or almoner been directly connected with the asylum whence they had been discharged. That, at any rate, has been my experience of these cases, and a study of their subsequent history leaves me with a feeling of assurance that, in a gratifying number of instances, impending relapses were staved off thereby. To the cases already mentioned, others discharged recovered from licensed houses and hospitals for the insane might be added; but their number

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is difficult to estimate, as in a considerable proportion of them it would probably not be easy for the Association to proffer help, and in any case it is small in comparison with the 7,000 from county and borough asylums. Most of those present here to-day are in all probability familiar with the number of cases on whose behalf applications are year by year made to this Association ; but for the benefit of those who are strangers to its work I may remind you that, according to four of its recent annual reports, the yearly average number of applications for after-care is 380, in the proportion as to sex of about two men to three women. From the report before us to-day, we may take it that about *77 per cent.* of these applications are with respect to patients discharged from county and borough asylums, and further, that, of the number represented by this percentage, one-half are cases from the County of London asylums.

It is thus apparent that not more than one in eighteen discharges on recovery is brought under the Association's cognizance—a matter surely for deep regret, and towards remedying which it is gratifying to see that the number of local branches is tending to increase. Apart from three in or near London, actual branches at present exist only in the counties of Derbyshire, Essex (2), Kent (2), Oxfordshire, Somersetshire, Warwickshire (2) and Worcestershire (2), though mention should be made that some thirteen smaller districts each have a member of the Association who is good enough to act as honorary local secretary. It is, I feel convinced, only by persistent efforts on the part of everyone interested in this important work, and a refusal to be content until an active branch has been established for each local authority, either acting alone or in combination for lunacy purposes, that the Association can ever cover the whole ground of the work that lies at its door, and for which it is so admirably fitted. It is also, I think, highly important that, in the formation of these branches, the sympathetic interest of the medical superintendents, chaplains, other officers and members of committees of the asylums concerned should be elicited, and that they, and, if possible, their wives and such of their neighbours as will interest themselves, should be active members of their respective branches ; on the other hand, as already has been said, I believe it is better that the *personnel* of the executive, that is to say those who come in contact with the

discharged patients and their homes, should not be such as would necessarily remind the patients of their recent painful illness.

To extend some measure of after-care and supervision to every discharged patient, however desirable that may be, might possibly be considered as too much a counsel of perfection—probably rightly so at present, and until the necessities of those requiring help in money, kind, or in their search for employment, have been met. It is not an easy matter to gauge, even approximately, what this number is, and in attempting to do so I can only fall back on my own experience in the matter. Thus, I find that in the five years during which I was superintendent of the Long-Grove Asylum, some 700 patients were discharged recovered, and that of them there were exactly 100 instances on whose behalf I made application to the After-care Association, to which number should be added at least 55 other cases (notes of which I have) that were in more or less urgent need of help and which were otherwise dealt with. It was my habit at my final interview with patients, prior to recommending their discharge, to ascertain and enter in the case-book full details of the circumstances with which, apparently, they would be confronted on leaving the asylum. In every case in which difficulty in obtaining employment was likely to be experienced, or where there was a probability of financial straits, where, for instance, tools or a sewing machine, etc., were in pawn, or had been sold under pecuniary stress, or where the patient was without home or place other than the workhouse—in every such case the good offices of this Association were sought. In company with the other London asylums my committee, who were always most assiduous in placing a patient about to be discharged on the best possible footing, had at their disposal a grant from the Queen Adelaide Fund; it was usually their custom, in cases that the superintendent thought would benefit thereby, to make an order for the payment of £3 in respect of every patient for whom the help of this Association was requested. Mr. Roxby has been good enough to furnish me with a list of these 100 cases, with details of the procedure adopted in each instance, and the success or otherwise by which it was attended. I can only say that its perusal fills me with warm admiration for the painstaking efforts bestowed on each case, without which it is my convic-

tion that relapses would have been earlier and more frequent: in truth, with respect to some of the more unstable cases, I doubt if I could have recommended their discharge at all, had it not been that I had grown accustomed to being able to count on the helping hand of the Association on behalf of similar difficult cases. Therefore I gladly take this opportunity of expressing my personal indebtedness to the Association and my emphatic belief in the value of its ministry.

To return to the question as to how many patients are in pressing need of assistance at the time of their discharge, it would seem, if my experience is about what is usual, that the proportion is approximately two in nine, or a total of not less than 1,500 a year, of which we have seen that only about 380 are brought to the Association's notice. That a much greater number are not at least notified to the Association is to me a matter of much surprise. Perhaps the explanation is that its funds are known to be very limited, and that, were it more liberally endowed, asylums would be less timid in soliciting its help. There is, however, one direction in which asylum authorities have it in their own hands to provide at least a share of the cost of after-care, if the Association could in one particular alter its rules, and this brings me to my third point, namely :—

### *The Limitations imposed by the Constitution of the Association in its Practice of After-care.*

As doubtless most of you are aware, patients in institutions for the insane may be discharged either as "not improved," "relieved," or "recovered," and it is only upon the last group that this Association is permitted by its constitution to exert its function of after-care. Although there is reason to think that there are a limited number of those discharged as relieved who not only need, but are suitable cases for, the help of the Association, I do not propose to ask you to concern yourselves with them to-day. What I wish to remind you of is the fact that, prior to a patient being discharged as recovered, it is within the power of two members of the visiting committee, upon the advice of the superintendent, to allow the patient to be absent from the asylum "on trial," as it is termed. This is a most salutary and wise practice; because, as is so well known,

there is no sharp line between stable recovery and unstable convalescence. Also there is such a thing as "pseudo-convalescence," in which the mental symptoms of what is practically a life-long insanity are for a time in abeyance: in other words, it is much more easy to give a certificate of insanity than one of sanity. Indeed, of the multifarious duties that appertain to the office of asylum superintendent, it will probably be conceded that none is more onerous than that of deciding as to the propriety of recommending any given patient for discharge.

There can, in truth, be no doubt whatever that the practice of allowing patients out on trial is not only to their own advantage but also to that of the general public, to whom the knowledge of frequent and early relapses, in patients who have been fully discharged as recovered is a growing source of irritation and alarm, besides bringing some measure of disrepute upon the institutions concerned.

Moreover, there is another direction in which this procedure can be turned to the patient's welfare, and it is one which, I believe, it is only necessary to explain thoroughly to asylum committees for them to whole-heartedly adopt. For the section of the Act, under which patients are allowed out on trial, enables the Committee to make a money allowance to the patient, during such absence on trial, up to a sum not exceeding that of the cost of his maintenance in the asylum. It needs no argument from me to show what a boon that must be to the patient faced with the difficulties we have already discussed. The high value my colleagues unanimously attach to the course is borne out by the fact that it has been their custom for many years to include, in the returns to be annually furnished by asylums to the Board, a statement of the number of instances in which these money allowances were granted.

Speaking of my own patients, I think I may say that there was no case in which, if it were feasible to recommend a period of allowance out on trial with a grant of money prior to full discharge, that plan was not adopted. It, however, implied that the patient had a home with either relatives or friends to which to go; and there were unfortunately quite an appreciable number not so blessed, in whose cases it was, therefore, necessary to forego "trial," and to discharge them as recovered to the workhouse. Again and again I had cause to wish that the Association was able to receive such cases

"on trial" into one of their cottage homes, on the understanding that the patient would pay to it the weekly allowance which I knew the Committee would grant. I believe very strongly that if it be possible for the Association's rules to be modified to permit of this, a most useful reform would thereby be effected.

### *Summary.*

The following are the conclusions, or rather suggestions, to which the foregoing remarks are intended to lead up, and which I venture to commend to your consideration:

(1) That while all cases (which as regards public asylums in England and Wales number about 7,000 annually) that have been discharged after undergoing treatment for mental disorder must of necessity benefit by suitable "after-care," there is an appreciable number of them (at least 1,500 a year) for whom it is not only highly desirable, but also urgently required, and of which number only about one quarter at present are assisted by this Association.

(2) That "after-care" for the latter, besides being called for on humanitarian grounds, may, by reason of its preventive power in respect of relapses, be fairly regarded as economically worthy of generous support.

(3) That to be effective, "after-care" must be organised and, as regards its executive, it should, as at present, be in the hands of those experienced in this particular branch of eleemosynary work.

(4) That its organisation should aim at the establishment of branches of this Association, which, although probably not corresponding in number to the public asylums, should at least be as many as there are local authorities either acting alone or in combination for lunacy purposes.

(5) That, as a preliminary step, inquiry should be made of medical superintendents as to whether they would see any difficulty or objection in notifying the central or, when formed, the local offices of this Association, of the intended discharge or allowance out on trial of any of their patients, having, of course, satisfied themselves that each such patient is willing that his (or her) name and other necessary particulars should be communicated.

(6) That it would facilitate the work of "after-care" if the rules of the Association could be so far modified as—

(*a*) To permit its executive to commence such work, in any case in which they see fit, during a period while the patient is away from the asylum "on trial," and—

(*b*) To permit further of such patient (or patients) being received while out "on trial" into one of the Association's cottage-homes.

(7) That visiting committees of asylums be urged to take advantage more frequently of section 55 (1) and (2) of the Lunacy Act of 1890, whereby patients who appear to have recovered may, instead of being at once fully discharged, be allowed out "on trial," and may, during such period, be granted an allowance not exceeding the cost of their maintenance in the asylum. It is with confidence asserted that this practice, which is habitually adopted by certain committees, is of the utmost value to the patients, and that by its adoption, early relapses—so vexatious and dispiriting to the authority concerned—are materially prevented.

This would enable such patients to pay a weekly sum to this Association, which would rather more than half meet the Association's pecuniary necessities with respect to those patients temporarily boarded in its cottage-homes.

(8) And lastly, notwithstanding such contributions as just mentioned, it is obvious that to enable the Association to extend its scope as indicated, its available funds must be considerably augmented, and it must be able to count upon a sufficient annual income.

[1] Being a paper read at the Annual Meeting of the After-Care Association, February 25th 1913.

### Discussion.

Sir James Moody (Chairman) said he was sure all who were acquainted with the subject would agree with the conclusions drawn by Dr. Bond. The points which had specially appealed to him were, first, the need of discharging more patients on trial into the care of the Association. This he recommended more and more in his own asylum, but sometimes, although he knew a case would benefit by a trial, he was unable to send the patient out on trial because in that case the Association could not give any help. Such cases had to go to the union, where they took their discharge, frequently returning to the asylum in a short time. Secondly, he wished to know whether it would be an infringement of the Lunacy Laws if cases on trial were sent to our cottage homes.

Mr. Trevor (Commissioner in Lunacy) explained that Dr. Bond's proposal did not involve any infringement of the Lunacy Laws as to illegal charge, as the patient would remain certified and on the books of the asylum.

Dr. Helen Boyle said that the only possible discussion of the paper was

applause. She herself was particularly interested in the "fore care" of patients. She pointed out that the work of the Association did not get known, as those who benefitted by it were least likely to talk about it. She thought the Association did a useful work in educating the public in regard to insanity. She also suggested that the name of the Association led to confusion with other "after-care" associations.

Mr. ROXBY replied that this point had been considered, and that the full title was always now used.

Dr. LORD said that the position of the London asylums was admirably summed up in the paper. He was surprised at the very small number of applications made to the Association as compared with the number of cases discharged. Others perhaps, acted as he did. He personally did not make many applications to it because of the bad moral character of many of those discharged which would be an abuse of its funds and at the same time ineffectual. In every possible case otherwise, he asked the Association's assistance and recommended the usual grant of £3 and equipment. He felt sure that if the work were extended to cases on trial it would prove of much greater service than at present. They had heard of "fore-care" and "after-care" but patients' recovery was often prevented by anxieties as to how things were progressing at home. In destitute cases it was very desirable that some association should supervise the homes during parental detention. It would be of immense advantage in getting the patients well.

Dr. BOWERS spoke of the proposed extension of the work, saying he had had experience from two points of view: first, as a member of the Council of the Association, where he had seen applications brought forward and refused because the word "recovered" had not appeared on the certificate; and, secondly, as a member of the committee of a county asylum, where he had felt much hampered in recommending cases for discharge on trial because these cases could not be taken by the Association.

Dr. PERCY SMITH said that the Association was at present doing as much as it possibly could with the funds at its disposal, and that a large increase would be necessary before it could undertake the care of those discharged on trial. Personally he thought that this work should not be undertaken by a voluntary association, but that each asylum should have a convalescent home to which patients could be sent for a period of probation, and which should be supported by the rates. The expenses would be greatly increased by this extension of the work, as these cases would have to be under special observation and supervision, and might have to be returned to the asylum at once. He pointed out that the Chairman had spoken of cases being sent out to the care of the Association. At present this was not the case, but patients sent out on trial would be sent out into the care of the Association or of the person to whose house they were sent. There was also the question of who was to sign the certificate of recovery. Considering the legal and medical expenses which such an extension would involve, he did not think the Association would be able to deal with trial cases unless it could show a large increase in its funds and in its staff.

Dr. RAYNOR, having thanked Dr. Bond for his paper, said that, of course, the present funds were very insufficient for an increased number of cases. If these cases were taken, quite a different kind of expenditure would be needed, and quite a different kind of home, as many who would take recovered cases would not be willing to receive cases on trial if they thought there was any danger of relapse. There were great difficulties in the way, and unless the present income was largely increased, they could not be overcome; but he thought it would be a great assistance to the medical superintendents, and of the very utmost benefit to the patients themselves, if it could be done. He was sure the Association would consider all that Dr. Bond had said in the most sympathetic manner, and if it were possible to do anything in the direction he had so ably suggested, he was quite sure they would do it.

The BISHOP OF CROYDON said that he was very much struck by the suggestion of the extension of the work of the Association, and if it was hampered by financial stress, he thought it would be most desirable that the Government should be pressed to subsidise such an institution.

Miss HUMPHRIS asked some questions about asylum procedure, which were answered by the Chairman.

Mr. ROXBY said he had talked the matter over with Dr. Bond, and sincerely hoped the Association would try to do more than it had done in the past, if not by taking cases on trial into the homes, at any rate by visiting them while on trial. A large number of applications were received from cases on trial. These cases go to the workhouse, or board with their friends for a time while their allowance is continued. When their allowance comes to an end, the friends frequently say they must get rid of them, and the cases finally relapse. If these cases had been under the care of the Association from the day they left the asylum, he believed that many of them would not have relapsed. As regards the money question, he believed that if the Association were doing more, it would get more money. Again, if all the asylums would give an adequate money allowance to cases on trial, this could be handed to the Association and would be a great help in meeting the extra expense. Some of the homes were doubtless unsuitable for the reception of trial cases, but others were, such as those under trained mental nurses. He considered it would be desirable to work more on the county system, and that the medical superintendents might do much by bringing the work of the Association before their Committee, which included a large number of influential people. In his opinion it would be much better to help hopeful cases on trial than recovered cases who had been out several months and were on the point of a breakdown. He sincerely thanked Dr. Bond for his paper, which he hoped would be the means of the Association's doing a great deal more work than it had done in the past. In conclusion, he asked all those who would be willing to hold a meeting on behalf of the Association to give in their names.

Dr. BOND said he felt very gratified by the extent of the discussion, which had more than repaid him for any time he had spent in preparing the paper. But it had also revealed one or two misunderstandings which he would like to straighten out. In the first place it would seem that, in the minds of some, there was a marked and important difference between the mental state of a person discharged as recovered and that of another away from the asylum "on trial," and that more serious risk was incurred in receiving from the asylum a patient "allowed out on trial" than in receiving one discharged as recovered. While in a very few cases and in exceptional circumstances that might be true, the members of the After-Care Association might rest well assured that superintendents, who favour and frequently practise the system of allowing patients out "on trial" prior to their full discharge as recovered, do not have recourse to the procedure with any prematurity or with a view to hurrying their convalescing patients out to make room for others, but solely with a view to doing the best they can for the patients concerned, and to enable them, with this aim, to immediately recall their patient in the event of information being sent that evidence of relapse was being shown; whereas, if such a patient had been discharged as recovered, he (or she) could not resume asylum treatment until the full process of recertification had been gone through. In other words, there was practically no medical difference between a patient discharged as recovered and another sent out "on trial": the one was not more likely to relapse than the other, and the technical and legal difference that did exist between the two was to the advantage of the employer or supervisor, in that after despatching notice—by telegram if necessary—to acquaint the superintendent of the existence of symptoms of relapse, he could be sure of the patient's prompt removal. The other fallacy or misunderstanding was a belief entertained by some that the person receiving a patient "on trial" was in the position of a "holder," and was legally responsible for his custody and safety during the period of trial. This was not so, although it was a fact that asylum authorities generally interviewed the relatives about to receive such a patient, and, verbally or by printed instructions, impressed certain advice suitable to the case upon them; but the relative or person receiving the patient assumed no legal responsibility, and during the trial period the patient was a free agent. The clearing up of this second misconception had a bearing on the question that had been raised as to the legality of adopting certain of the suggestions put forward in the paper, upon which question Mr. Trevor had been able to reassure the meeting. Mention had also been made of the desirability of visiting patients on trial: he (Dr. Bond) did not consider that this should be done by people connected with the asylum, as during this period it was expedient to ensure an entirely non-asylum atmosphere. With regard to applications from provincial asylums, he would deprecate as

unfair to London the systematic sending of such cases to be dealt with by the metropolitan (or central) office of the Association; and this objection in his view emphasised the necessity for establishing thoroughly organised provincial branches. A suggestion had been made in the course of the discussion that public asylums should provide convalescent homes in the country or at the seaside, and that the period of trial might be spent there, London with its several large asylums being taken as an example, whence such a movement might well be looked for. In fairness to the London asylums he would, however, point out that in the majority of them there existed in their grounds entirely detached villas or houses, admirably adapted for convalescing patients, through which practically all patients passed prior to their discharge, and which were administered on the open-door principle. But greatly as he believed in their value, in no way in his opinion could residence in them take the place of a period of "on trial" spent in an environment entirely unconnected with the asylum. Besides, it would leave unfulfilled the main objects of his anxiety to see the Association free to render help to patients while on trial, namely to enable employment to be found for patients prior to their full discharge, and to provide a means whereby the necessary funds would be available for the critical first few weeks.

Dr. MACARTNEY, in proposing a vote of thanks, pointed out the difficulty of segregating the cases in their homes.

The vote of thanks was seconded by Dr. OGILVY, and carried.

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## *Emanuel Swedenborg: A Study in Morbid Psychology.*

By HUBERT J. NORMAN, M.B., Senior Assistant Medical Officer, Camberwell House.

"LET us examine," says Swift, in his "Digression concerning Madness" in a *Tale of a Tub*, "the great introducers of new schemes in philosophy, and search till we can find from what faculty of the soul the disposition arises in mortal man of taking it into his head to advance new systems, with such an eager zeal, in things agreed on all hands impossible to be known; from what seeds this disposition springs, and to what quality of human nature these grand innovators have been indebted for their number of disciples; because it is plain that several of the chief among them, both antient and modern, were usually mistaken by their adversaries, and indeed by all except their own followers, to have been persons crazed or out of their wits; having generally proceeded in the common course of their words and actions by a method very different from the vulgar dictates of unrefined reason; agreeing, for the most part, in their several models, with their present undoubted successors in the Academy of modern Bedlam . . . Of this kind were Epicurus, Diogenes, Apollonius, Lucretius, Paracelsus, Des Cartes, and others; who, if they were now in the world, tied fast, and separate from their followers, would, in this

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