The Insanities of Decadence. By GEORGE A. RORIE, M.B., Senior Assistant Medical Officer, Dorset County Asylum.

THE last time I had the pleasure of addressing a meeting of this Division the subject I discussed was the different forms of insanity met with during the period of adolescence, and it was suggested that it would be interesting to investigate the cases at the other end of the scale—that is, those connected with the incidence of decay and old age, and to compare them with the previous cases.

Looking back at the adolescent cases one noticed the common forms of mental disorder met with were: (1) cases of simple mania and melancholia; (2) recurrent cases; and (3) the cases of acute or premature dementia; and a noticeable point was the frequent occurrence of tuberculosis as a cause of death. In using the term "Insanities of Decay," I am referring only to the insanities associated with the oncoming of old age and do not include all cases of general paralysis and dementia præcox, as has recently been done.

On turning to these senile cases, the first thing to fix was the period of life when old age was to be recognised as a factor in the case—as with the analogous question in the adolescent cases this was rather difficult to settle—but looking on the climacteric as a first indication, I took 50 as a starting-point in both sexes; no doubt by doing this many cases of insanity associated with the climacteric have been omitted, especially among women, but it was the most convenient plan to adopt.

Fifty may appear a very early age for old age to set in—if we except the remarks attributed to Dr. Osler—but besides the climacteric cases one finds several cases of true senile dementia, which is of course one of the most hopeless of the mental disorders of this period, starting at 50 or soon after and accompanied by all the usual bodily signs of senility such as grey hair, etc. Senile insanity has been divided into three kinds: (*a*) those cases in which there is no dementia; (*b*) those cases in which there is dementia accompanied by the psychoses; (*c*) those in which there is organic brain disease; while climacteric insanity is also separately described—the majority of cases being melancholic in type. As the ages vary in one description from 35 to 70 it must be difficult to make

an accurate diagnosis in such cases unless the history is accurate, and that is unfortunately uncommon ; in the opinion of others senile insanity should not be separately described and classified, so it appeared the best plan to group the above, as they are intimately associated, and consider them together.

A series of cases was collected of both sexes from the starting-point of 50 years of age on admission, and they were divided up according to age into five-year groups—thus 50 to 54 was the first, 55 to 59 next, and so on.

Taking the cases as a whole and comparing the males with the females, one is at once struck by the prevalence of previous attacks and recurring cases among the females as compared with the males—the real recurring cases being markedly more numerous among the women—a point also noticed when the adolescent cases were dealt with.

As to the forms of insanity, these can be roughly divided into mania, melancholia, delusional insanity, and dementia, while there are other cases met with best described as partial dementia. One also meets with cases of general paralysis—up to and over 60—senile epileptic insanity and imbecility, the latter including cases of mental defect which did not show other marked symptoms till now.

Taking the cases in periods of five years onwards from 50, the percentage of admissions was much the same in both sexes and was roughly 25, 20, 15, 14, 12, 10 for the first six periods, though more women were admitted at the earlier ages and fewer in the more advanced—probably due to the earlier climacteric in women. There is then a continuous decline in the admissions as the age advances and no marked period where one could state that senile insanity predominated. When the form of mental disorder is examined—taking the first four periods, that is 50 to 70—one finds that melancholia predominates in the first two, *i.e.*, 50 to 60, and especially between 55 and 60 in both sexes—mania coming next, though the largest number of the cases of delusional insanity is in both sexes found in the first five years. After 60 melancholia and mania are about equal for a few years, and then these diminish and the number of cases of dementia increases ; an interesting point, however, is that cases of delusional insanity without marked dementia are occasionally met with starting in the most advanced years.

Of the total cases about one third of the men were cases of melancholia and rather fewer of the women. This predominance of melancholia in the earlier years particularly is very much what one would expect ; the climacteric is recognised as having a marked effect on the whole system, leading to a changed aspect of life—so well described by Dr. Clouston—and giving a tendency to depression, often to suicidal tendencies, to the development of suspicions and delusions, and to the development of delusional insanity.

If we take melancholia as being most important, we may first note that the term melancholia is restricted by Defendorf to the cases of depression occurring at this period.

The cases here show the following characteristics : The incidence is usually gradual—if a full history be obtained—the general manner and behaviour of the patient are changed—he is dull, irritable, and the feeling towards relatives changes ; there is a loss of self-confidence on the part of the patient ; he feels unfit for his work, and this is followed by a loss of self-control shown by the various impulsive acts met with, the suicidal impulse being common and a homicidal impulse not uncommon. There is often an increase in the sexual feelings even in these depressed cases, and one often hears patients complain of the evil thoughts and suggestions which come into their minds.

These patients feel this loss of control and struggle against it. They often put the above ideas down to the Devil and pray to resist the Devil who suggests evil acts, suicide, and the desire to kill their children—often the ones they like most. Another sign of this loss of control is the screaming and almost hysterical attacks met with in some women.

The evil thoughts and suggestions above mentioned may pass into actual hallucinations of hearing, though these are most marked in the maniacal cases. As the patients become worse delusions develop, often referring to themselves, and are anxious in character—they believe a heavy debt is hanging over them, that bailiffs are in the house, that something awful is to happen to them, that their children are to be killed or burnt, while the familiar unpardonable sin is usually prominent. The delusions also often refer to the body and especially to the bowels. The bodily health is usually weak. Occasionally the disorder starts suddenly by suicidal attempts, but usually its onset is found to be gradual.

The causes given are usually various, worry being common ; hereditary predisposition is generally found in these melancholic cases.

The prognosis is fair, about 52 *per cent.* of the women recovering and about 31 *per cent.* of the men ; the women appearing to recover more quickly than the men—the duration varying from a few months to one or two years.

The maniacal cases present the well-known symptoms of noisy chattering incoherence, mistaken identity, great restlessness, and a loss of all ideas of their position ; they are restless and noisy at night, refuse to dress, and are destructive and violent at times ; hallucinations of sight and especially of hearing are commonly met with, and also fleeting delusions, and under the influence of the latter suicide is sometimes attempted. The most severe of these cases have been separately described as senile delirium.

They are most troublesome cases to deal with and are often in a very weak state of health and occasionally quickly die, but in spite of this the recovery rate is higher than in the melancholic cases, the rate being higher among the women again, but this is to a certain extent discounted by the tendency to relapse. Cases of recurrent mania starting in early life are of course met with during this period, but several cases of recurrent mania occur which start about 50, an example of which is an old lady, who started at 55 and had five attacks between that and 63, from each of which she recovered perfectly, the symptoms coming on rather quickly and being acute.

Besides these there are cases, half way between mania and melancholia, of confusional insanity and here described as partial dementia ; the cause in these cases is often shock from an accident or injury, such as a blow on the head, though alcohol also figures as a cause occasionally. The symptoms resemble those of concussion of the brain, only much prolonged —confusion, listlessness, and loss of memory, and they are more favourable as a rule.

Looking now at the delusional cases they appear to be more common among women than men ; the largest number of admissions is found in the earlier years, and they decline rapidly afterwards. They are usually marked from the first, though possibly some of the melancholic cases may develop

into this class; they are unfavourable as to recovery and hereditary predisposition is often found.

A certain number of marked cases are met with in the most advanced years and are characterised by the fixed and very absurd character of their delusions; these are usually of persecution to an extreme extent and are often expressed more or less incoherently, *e.g.*, that the patient is the daughter of the second God, has two bodies, one in a home down under, is troubled by witches, spirits, policemen, is a beast, is to be made into tinned meat, swallow elephants, etc. Hallucinations are very marked and appear to affect all the senses, the result being that these patients are often very noisy—scream and beat the doors of their rooms at night; the personality as a whole is much altered and they are usually irritable, abusive, and disagreeable. There is frequent variation in the severity of their symptoms. These probably include the cases described as presenile delusional insanity.

As to the cases of dementia there is not much to say; in some cases the condition is little more than the normal mental state in old age; it is met with in a severe form coming on gradually after attacks of the more acute disorders, but there are also cases of dementia which in the depth and extent of their symptoms resemble the cases of dementia præcox or the dementia of general paralysis. This form may start at comparatively early ages and more or less rapidly get worse, the dementia always deepening. One often finds that marked organic disease of the brain exists.

As regards treatment there is nothing particular to mention. The causes of death show great variety, but phthisis is uncommon. Organic brain disease and cerebral hæmorrhage are common, as also are heart disease and congestion of lungs, while cancer is not uncommon.

In considering these cases of mental disease, I have endeavoured to determine whether the various groups exhibit distinctive symptoms. One is struck by the marked prevalence of melancholic symptoms about the climacteric period, though I think it very doubtful whether the term melancholia should be restricted to these cases. Other interesting points are the greater recovery rate and the tendency to relapse and recur amongst women, the delusional cases amongst the aged, and the occurrence of acute symptoms in some imbeciles and epileptics at this period.