in focal infection, endocrine organs, the exploration of the unconscious, the cravings of the autonomic apparatus and other theories and ingenious modes of reasoning. But the sincere enthusiasm of devoted disciples tends to a singleness of purpose which detracts from the scientific worth of the massed results. Correlation between the various findings seems necessary to arrive at a true conception of the ætiological factors, and a final analysis may show a multiplicity of causes of mental disease—a non-specific ætiology.

In general medicine the pathological conditions which can be described as specific reactions are very limited, and even in such diseases as tuberculosis, syphilis, typhoid and malaria the unconditioned specificity of causation cannot be granted. The processes which lead to the development of any morbid condition are immensely complicated, and disease is almost always a culmination of a long series of detrimental or destructive conditions which eventually become sufficiently strong to break down the barriers of natural and acquired resistance. So, too, with mental disease, and the study of its causation should be approached from many angles. Of particular importance is the chronological order and times of occurrence of the various stresses and strains which assist in the final breakdown.

Brief histories of fifteen cases are given in which heredity, personality, somatic and psychogenetic factors are brought into the field of inquiry. In any particular case one of these factors predominates, but the others have some bearing and should not be lost sight of, and a check placed on the tendency to regard every hypothesis as an incontrovertible fact.

A non-specific conception entails the most advantageous therapy in the present state of our knowledge, for pathological and psychotherapeutic measures do not exclude each other. Once we know, if only approximately, the various conditions on which a psychosis is based, we may be able to exclude some factors, sufficient to allow the patient's resistance to cope with the remainder and restore him to mental balance. A. WILSON.

*The Ætiology and Clinical Characters of Certain Fugues* [*Sur l'étiologie et les caractères Cliniques de Certaines Fugues*]. (*Ann. Méd. Psych., November*, 1923.) *Dupouy, R., and Schiff, P.*

In certain cases of fugue the ætiology is easy to ascertain, as in hypomania, alcoholic confusion, uræmia, etc. In other cases the diagnosis is more difficult. The authors describe four cases and point out certain symptoms common to them all. They lay stress upon the fact that there is a great degree of individual emotion, the patients showing irritability of a vago-sympathetic kind. Thus in all these were vasomotor and secretory reactions, weeping, blushing, dermographism, cold extremities, goose-skin. There was a marked oculo-cardiac reflex and intense reaction to drugs. It is in such people who feel intensely all the emotions of ordinary life that fugues occur; they cannot use their reason or will to overcome affective impulses. There is a sudden supremacy of an emotional

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state. There are divers reasons, such as diminution of psychic resistance by depression, exasperation by a sense of inferiority, or acute crises of anxiety, doubt or discontent. In all cases a period appears where the profound tendencies of the invalid get the better of such superficial ideas as education has inculcated. It is following such an invasion of the conscious by the unconscious that fugues occur. It is as manifestations of the unconscious that fugues should be regarded, and this whether amnesic or not, or conscious or not. Whether or not the affair is conscious once the fugue begins the actual motive remains unknown to the subject. Fugueur's never have complete memory. There is always some obfuscation, some fogginess of consciousness in the beginning; in all there is some automatism. Why certain individuals have fugues while others, equally debilitated, psycho-asthenic and affected by the same difficulties have not, is because in the former there is a particular constitutional element. There are many ways of flight from the everyday life. The hysteric reacts by flight into illness, the schizophrenic by flight into an imaginary world of his own. These are purely mental flights, motionless so to speak. Others make their flight in walking; their mental flight is a motor flight. Why should their unconscious reveal itself thus and not under any other form but ambulatory automatism? It is because of the constitutional element. There may be a hereditary tendency: such people have adventurous ancestors, nomads to whom a change of country was essential.

Clinically there were two great classes of fugues, the repulsive and the propulsive. The repulsive fugues are impulsions more or less irresistible and conscious where the emotion tries to shun the place where it occurred, as in alcoholics, the anxious, the confused and the persecuted melancholic. The propulsive fugues are those which proceed to a peace determined by a mental upset, imperative hallucinations, or hypomania. The two motives may exist in the same subject, but the presence of a propulsive fugue to a definite goal is a response occurring in those to whom the fugue is an ordinary instinctive act.

A point of importance is what is the degree of irresistibility of the fugue? A fugue is the result of two factors—the power of the driving force (hallucination, emotional shock, anxiety), and the diminution of the psychic control (drunkenness, organic dementia, senile dementia, mental defect, constitutional instability). These two factors vary inversely. Thus clinically also one is obliged to adopt the idea of constitution. Alcohol acts in a double sense, exalting the latent impulsiveness and lessening the voluntary control. The consciousness of the fugue varies from the total unconsciousness of the dement up to the almost entire consciousness of the capricious unstable person.

There is always a more or less definite and passing phase of obfuscation. That is why the conscious factor cannot characterize a fugue, and in particular cannot differentiate between the two great clinical types that the authors term the psychasthenic fugue and the ambulatory automatism claimed by some to be epileptic.

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The fugue of the psychasthenic is seen in emotional subjects. Easily impressed and upset, scrupulous, obsessed, having phobias, showing easy fatigability of mind and muscle, these subjects are dominated by their emotions, and the anxiety which is born in them by a traumatic or emotional shock incites them to flee. On the other hand, alcohol, which they take to "buck themselves up," causes certain hidden, subconscious desires to emerge, notably sexual ones, and the fugue which is primarily a defence reaction becomes secondarily a pursuit or an aggression. These psychasthenics frequently complain of headaches of various kinds, especially in the morning or after meals, and this is due to gastric and intestinal atony, and is not to be confounded with epilepsy. The emotion and alcohol together cause amnesia, and the fugue they cause will be partly amnesic, thus again risking being confounded with epilepsy. If the anxiety be great or the alcoholism has proceeded to drunkenness, the unconsciousness may be almost total and the state like that of confusional automatism. During the war such fugues were common, and were accompanied by almost total amnesia, sexual attacks and murderous aggressions.

As for the ambulatory automatism, the authors state that there is no proof of this being epilepsy, and they have never observed such states in epileptics, of whom they have had many cases. The real epileptic during a fugue is disorientated, disorderly in appearance, restless, perhaps terrified; he runs, he falls, he soils himself, he satisfies his wants anyhow and anywhere. He responds to questions with difficulty, or capriciously or unintelligibly.

He is excited, gesticulates, and is often hallucinated. Psychic epilepsy terminates in sleep analogous to the coma which follows a fit.

The great fugue, on the other hand, is quite different. Here the patient is composed, quiet, orderly. He does not show the agitation, precipitation, or anxiety of the confused and hallucinated. He appears to live a dream. His responses are easy to obtain and appropriate. He acts, walks, and satisfies his daily wants without attracting attention. These patients dress, move, take their food, urinate, and lie down automatically, but correctly, showing no particularly intense emotion. They do not show the tendency to sleep as epileptics do. They resemble more the sleeper than the anxious person. Hence the authors conclude that they are related to somnambulists. Some show a family history of this disorder. The ambulatory automatism of these persons is not epileptic, but is a *vigilambulism* analogous to somnambulism, and closely allied to, if not a form of hysteria. W. J. A. ERSKINE.

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## 4. Sociology.

*Observations on Exhibitionism.* (*Lancet, August* 23, 1924.) *East, W. Norwood, M.D.*

In this paper Dr. East points out the importance of sexual offences, not only as regards the offender, but also on account of the results which may accrue to the victim of the offence. The

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