Or, if the first two years are averaged, and the same is done with the last two, the increase in first admissions will be from 656 to 1,110, that is, 454, which is an increase of 69 per cent. Now during this period the population increased in the whole State less than 35 per cent., so that the gain in first admissions was double the gain in population. Now observe further that the increase in *readmissions*, if the first two and the last two years are averaged, is only from 426 to 609, or 42 per cent., which is but little greater than the gain in population; from which I infer that the increase of insanity during the period, *beyond the ratio of population*, was mainly in the first admissions.

"I will not comment at present on the discharges without recovery, which in the 19 years aggregate 13,381, further than to say that about 3,500 of these were probably transfers from one institution to another; 1,900 were persons removed from Massachusetts by the State Board, and 1,100 were persons removed to town almshouses and other establishments, corresponding to the English workhouse asylums. This would leave 6,700 (nearly) who remained in the community of Massachusetts subject to readmission; while, applying the same reduction to the aggregate of readmissions, so far as it is allowable, the latter become 6,413 readmissions from the general community. It is to be noticed, however, that what are here called 'readmissions' are persons previously admitted to some other hospital *anywhere in the world*, so that they must include at least 500 persons who were never in any Massachusetts Hospital before. This would reduce the Massachusetts readmissions from the general community to about 5,900, or an average of 311 in each of the nineteen years, while the annual average of first admissions would be 893."

PART IV.—NOTES AND NEWS.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The Quarterly Meeting of the Medico-Psychological Association was held at Bethlem Hospital, on the 23rd February, 1887, the President (Dr. Savage) in the chair. Present: Drs. Robert Baker, T. W. Brushfield, D. Bower, H. Chapman, E. East, C. T. Ewart, J. E. M. Finch, S. Forrest, B. B. Fox, T. D. Greenlees, H. Hicks, W. M. Harmer, M. MacLean, J. D. Mortimer, James M. Moody, P. W. MacDonald, H. Hayes Newington, A. Newington, J. H. Paul, S. R. Philipps, H. Rayner, G. M. Robertson, A. H. Stocker, H. Sutherland, H. Stilwell, D. Hack Tuke, D. G. Thomson, T. Outterson Wood, E. S. Willett.

The following gentlemen were elected members of the Association:—G. Dickinson Symes, M.R.C.S., City of London Asylum, Stow, near Dartford; Rothsay C. Stewart, M.R.C.S., Ass. Med. Off., The County Asylum, Leicester; William Harding, M.B., C.M.Ed., Ass. Med. Off., County Asylum, Lancaster; G. M. Robertson, M.B., C.M., The Palace, Falkland, Fife; John Kennedy Will, M.B., C.M., Bethnal House, Cambridge Road, E.; Fred. W. Melson, M.D., Ass. Med. Off., Durham County Asylum, Sedgefield.

Dr. BAKER exhibited a model of a crib-bedstead which he had seen in the

Utica Asylum. He said that he had never seen such a bedstead in England, but he believed there was one in Scotland. In America, where, in company with Dr. Hack Tuke, he visited the asylums, they were very largely used, many of the superintendents there defending their use as being highly beneficial, especially in cases of restless senile dementia. The bed being made, the side is taken down for the patient to get in, and all being complete, the bed is closed up again, the lid coming over and fastening by a spring lock at the top. He (Dr. Baker) had seen one of these beds in occupation, and had conversed with the patient confined in it. It was very much like talking to a wild animal in a cage. The patient was, undoubtedly, in a very excitable condition, but when he asked her questions she said she was very comfortable, and, as far as he could learn, she was quite happy; so that in this particular case in which he witnessed it in operation, he did not think that the bedstead was doing any harm, and it might have been doing some good. He was not saying this with the belief that it would ever be used in English asylums. Anyone who had visited a country where restraint was used in asylums would come back with the feeling that, as a rule, for the body-politic, it was a mistake.

Dr. HACK TUKE said that Dr. Baker had forgotten to give his personal experience of the crib-bed. Having seen Dr. Baker himself enclosed in one at the Utica Asylum, New York, he should like to say that he looked quite as comfortable as the patient referred to had appeared to be. Dr. Gray, of Utica, who had now gone to his rest, had taken some little exception to the reference to this incident which he (Dr. Tuke) had made in his book on the American asylums, but what he had written was, of course, meant only as a joke. He might mention that he had been informed, on good authority, that the use of the crib-bed is now discontinued at this asylum. No one could say that there was any sin in using such a thing occasionally. Certainly not. But the cage-like appearance made it undesirable. In some cases of senile dementia it might no doubt be of use, and might do no harm, so long as the patient was not neglected. As showing how much a thing of this sort might be abused, he might tell them that at one asylum in America he counted fifty crib-beds, exactly similar to that now exhibited by Dr. Baker. A short time ago, however, he had received intelligence that this bed was no longer in use in this institution. In fact, the superintendent, who had not been many years in office, had not introduced them, but found them in use.

Dr. BRUSHFIELD said that he well recollected an engraving* of a crib-bedstead, very similar to that now exhibited, which was invented by Dr. Wood at Bethlem Hospital, for use in certain cases.

Dr. SAVAGE said he would take an opportunity of looking at it. Probably the remarks which he was about to make in his paper on strong clothing would apply to the question of the crib-bed. He had now to submit to them for their inspection two samples of material for strong clothing. Coarse reality did not look so well as a pretty little model, and when one came to look into these dresses the subject was rather repellent. Of course, if it were decided that no one in future should use strong clothing, the patterns now submitted might be sent to the British Museum, but he thought that some kind of clothing which would not readily tear might still be required, and the patterns before them might therefore be worth examination. The materials were of two sorts. One, which Dr. Hack Tuke had taken a great deal of trouble about, was specially made for the purpose at Belfast (Messrs Ewart). The result had been a material which was eminently satisfactory so far as strength and appearance were concerned. It was hoped at one time that the colour would last, but it was found on further experience that, although it washed better than many dresses, the colour did wash out before long. The second sample washed better, and was therefore, to that extent, more satisfactory.

Dr. SAVAGE then read a paper on the question "Whether there is ever sufficient reason for the use of strong clothing and side-arm dresses."

* See "Journal of Psychological Medicine," Vol. v. (1852), p. 395.

Gentlemen,—The first object of this paper is that it should be really practical in its bearings. We are, perhaps, usually too ready to discuss the political and more general aspects of our branch of the profession, neglecting the more domestic details. I think this is due to several causes, some of which will be alluded to in the following paper. As a rule each superintendent either inherits or develops certain principles of management, which he gets to look upon as perfect, because they are very rarely if ever met by perfectly unbiassed criticism.

The position of the superintendent is rather likely to produce dangerous self-satisfaction from his autocratic power, and his isolation. I write thus, as I feel the danger even in a large city with constant visitors, and I write it, further, because I feel that the paper has its real origin in such outside criticism. Sons returning to their parental home are in the habit of finding the quiet domestic habits old-fashioned; and in my asylum-life I have frequently found that old Bethlem students, having started in other spheres, when they return are in the habit of finding some faults with their early home. Of late, so frequently has the complaint been of the same kind that I found it necessary to ask whether it was not probable that I was wrong and old-fashioned.

The form of complaint was that they, in their new homes, never saw the use of strong clothing, and what I wish now is not so much to discuss the reasons for or against as to see what the alternatives are, and whether they are the best, for I pledge myself to follow that which I find to be for the good of the patients. I shall avoid going into the whole question of non-restraint, and accept as axiomatic that theoretically "non-restraint" is desirable, though in practice cases may possibly arise in which some mode of restraint has to be followed.

The next axiom I insist upon is that none of us would willingly give a powerful narcotic with no other object than that of producing quiet. I know here the practice differs widely, so that one superintendent's habit, I was going to say conscience, allows him to give a great deal of quieting medicine, while another allows none at all. Both are at fault.

It being granted, then, that much liberty and little depressing medicine be given, the next object must be to make the patients as comfortable as possible, and this involves making them as neat and tidy as one can, not alone for themselves, but for their neighbours as well, who may suffer by seeing others in discomfort or restraint.

As to dress, I think we should all prefer to have our patients dressed as nearly like their old selves as we can, but here at once we meet with difficulties, for the pauper patient may be happy in moleskin, while the refined person would look upon this as strong clothing.

First of all, as a question, I want to know what must be done with patients who persistently remove or destroy their clothes? I find, in

the latter case, the greatest difficulty is that the friends of patients in a hospital, having to provide the garments, complain very strongly if they are frequently called upon to replace what has been destroyed. They would be at once ready to go in for any amount of restraint to save their pockets. This is not unnatural. There being this difficulty, I find it easier and productive of better feeling toward me, and also toward the patient, by his friends, if I provide some clothes which are sufficiently strong to resist the ordinary destructive patient. In such strong clothing it is impossible, I think, to get anything like a good fit, and thus all such clothes approach the sack sooner or later; and, this resemblance is increased by the fact that though we have tried far and wide for all sorts of materials which would resist violence, easily wash, and yet retain a pattern, we have failed; so that without great cost, I fear, these dresses must look repulsive.

We have then got to this, that if strong clothing be used we at once get an unpleasant appearance introduced, and those superintendents who pride themselves on the outward look specially, are necessarily adverse to its use, and would do away with it altogether. In looking at the two sides I admit frankly that this strong clothing is often uncomfortable and irritating to the patients or their fellows, always unsightly, and some would say unnecessary.

What I have to say on the other side is that I do not consider that the slight amount of discomfort and unsightliness are worthy of serious consideration, if any greater end is attained by its use. I believe, however, that in using it I am able to give a greater amount of liberty, and this is my chief defence. Anyone who has been much about Bethlem must have seen many very contented, but eminently grubby, patients in strong clothing in our airing courts. They do just what they like from breakfast time till near dinner time, when they are washed and redressed. After dinner they are allowed once more to make a mess of themselves, if they like, and after tea they are usually quite ready for bed. I think these people, though not pretty objects, yet sleep better and eat better than if they looked prettier. Some will say we might attain the same end if we sent them walking round the grounds with two attendants for some hours a day. Well, I must say I do not like the look of the troops of such cases I have seen marching about like the wild elephant between the two tame ones, and I do not think the washing of clothes so costly as extra attendants.

But still more I think the freedom from control is the very best treatment. As a rule, of course, I admit there are some patients in whom we wish to break through bad, and establish new and good, habits, and in such it may be better to try the walking parties rather than the freedom of strong clothes.

We shall differ, I suppose, as to which is most irritating to the patient: the manual control, or the control by clothes; and each of us surely can decide separately which will serve best in different cases

without being angry because others do not quite agree with him. Strong clothing is needed, I think, in cases in which the chief symptom is the constant stripping; either you must have the constant, ever-watchful attendant, or you must have locked boots and locked gowns. Well, I again have an aversion to the rows of patients sandwiched with attendants on long forms. I should prefer to see the patient occupied, even in trying to get out of her things.

Each asylum must differ as to its needs, and, without for a moment wishing to speak apologetically, I must say that at Bethlem I believe strong clothing is, if not necessary, at least useful, and a saving of time, energy, and irritation.

First we have daily admissions of acute cases, in the earliest stages of their disorder; then, though we have a large staff of attendants in proportion to patients, we have an enormous area in which the patients have freedom to move. This means either more attendants than are really needed to control patients, or a greater crowding together of the insane. I think that we have in the very long galleries, with the scanty population, the very best means for curing the acutely insane; for, whereas we can have several groups of patients, each independently occupied, there is space for exercise as well.

To proceed, I consider that there are certain patients who must not only have strong clothing by day, but need also side-arm dresses at night.

Some will deny the necessity, and for those I have simply no answer, as I cannot manage without their use from time to time.

What is to be done with a case who will endeavour to gouge out her eyes, or for the man who wishes to emasculate himself? I do not think a man suffers any more from the restraint of a dress than that of four hands.

I claim the freedom, then, to use such restraint as I think will give the patients the best chance of recovery.

I know that restraint and its beginning is like wrath, and letting out of water. The danger is in the beginning it, the natural tendency of attendants being to do mechanically what will save them trouble. I would sum up, then, that in my opinion some such restraint as has been suggested may be useful, provided the higher restraint of the superintendent is constant over the attendants.

Dr. RAYNER said that he had received a letter from Mr. Rooke Ley (Prestwich Asylum), in which he wrote as follows:—

"Who proposes to defend strong dresses and other ingenious mechanical contrivances? I was under the idea that such appliances were things of the past, out of fashion, out of harmony with modern psychological opinion. Is their revival the outcome of the *scientific spirit* about which so much twaddle has been written and spoken of late? I am by no means opposed to restraint, when there is a purely medical purpose to justify its use, and then I stipulate that it shall be

used 'in camerâ,' in the privacy of a single room. To see a patient stalking about in a modified strait-jacket offends my taste."

Dr. HAYES NEWINGTON said that he probably used as little strong clothing as anyone, being able to substitute other means. The subject was a very difficult one, but he thought that Dr. Savage had looked at it in the right way. As regards Mr. Ley's letter, he should agree that their ingenuity should be shown in the direction of devising means of avoiding strong dresses, rather than in devising the construction of such dresses. There were, of course, many objections to using these distressing dresses, but still it did seem necessary sometimes to use them, however rarely. One additional reason for their occasional use was to deter patients, by the sight of them, from bad habits.

Dr. S. R. PHILIPPS said that he had had the honour of opening the last hospital for the insane, and his experience there was that restraint, more or less, was absolutely essential; partly from the reason suggested, that friends were unwilling to pay for the expense of new clothing, which must fall upon them if the hospital funds were limited, and partly because they had so many suicidal patients. He had several attendants who sat up all night, but they had at the present time two ladies with whom no two nurses were willing to sit up unless there was some sort of restraint, such as a jacket or other dress. In the daytime, with ladies, a shawl of loose and simple texture thrown lightly round the jacket took off the disagreeable effect. With gentlemen it did not so much matter, and in some cases an example might do good as a deterrent. Speaking of the crib-bedstead, which was on all-fours with the subject of Dr. Savage's paper, he said he had under his charge an old lady for whom that bedstead would be invaluable, as, although an attendant sat up with her, it was almost impossible to keep her in bed unless she had a jacket on.

Dr. FOX said that the question was very interesting, but, as an asylum superintendent, it seemed to him that one was almost without an alternative. The test which he might propose with regard to the justification of restraint would be, if they could find any asylum in England which entirely disused restraint, and took a fair average of acute cases—and to compare the results of treatment in that asylum (proportion of cures and so forth) with any other asylum under like conditions which used the ordinary modes of restraint. He was bound to say that, until he was satisfied that constant struggles with attendants and seclusion in rooms did not do more harm than wearing a garment of a particular texture or cut, so long should he continue to make use of strong clothes. Would not a man walking with attendants on each side of him be more likely to struggle with those attendants than he would be to struggle with a mechanical contrivance which he must feel was his master for the time being? His own experience had taught him that any manual restraint, or physical encounter with attendants, not only did very great harm, raising difficult relations with those with whom, above all others, patients should be on good terms, but also, in many cases, aggravated maniacal attacks. It was much better to let a patient be clothed and run about and have his liberty than let him have constant struggles, and he believed that an asylum adopting Dr. Savage's practice would have a much better record to show than an asylum which shut up its destructive patients within four walls all day long, and never let them go out without an attendant on each side of them. Referring to the crib-bed, he said that in the early years of the present century—about 1810—there was in use at the asylum with which he was now connected a much ruder contrivance, in the form of a padded box which slipped up and allowed the patient's head to move freely. The tradition remained that the patient always spoke gratefully of that treatment, but of course it was handed down as a curiosity, and he should be very sorry to see any such mode of treatment introduced now.

Dr. MOODY said that, having been an assistant medical officer under Dr. Brushfield, he had been taught to use restraint as little as possible; in fact, he thought that the only restraint used at Brookwood during his six years there

was in one case for surgical reasons. At Cane Hill he found no need for it, and his recovery rate was 47 per cent., with few accidents. In certain cases strong clothing was necessary. He found that the moral effect was very good, for when it was put on for a short time the other patients laughed the wearer out of his habits.

Dr. BRUSHFIELD said that he came simply as a spectator and not as a speaker, but, as he had been asked to say a few words, he might say, in the first place, with respect to the paper, that he thought it was one of a class of papers which would do very great good to the Medico-Psychological Association, especially in the way of exciting discussion. He thought that such a paper was rather new in the annals of the Association. Certainly, in past times, they had papers on mania and acute forms of insanity, but not papers of the sort now under discussion. No one could have heard Dr. Savage's paper without coming to the conclusion that he had made out a very good case for the use of strong dresses in certain classes of cases—recognizing it as an exceptional form of treatment. In his younger days (which took him back to Dr. Conolly) one of his first superintendents was a regular "restraint man." The number of dresses was wonderfully large, and he (Dr. Brushfield) attributed it to the principle of restraint being then in vogue. Directly he became superintendent he abolished a very large proportion of the strong clothing, finding that by giving more liberty in the wards and airing-courts there was far less need for it. Strong clothing was certainly very unsightly, but this was due partly to the circumstance that, as a rule, it was not made for the individual, but for the class, and if any patient required it the stores would be ransacked for the best-fitting garment that could be found. It should not, moreover, be forgotten that it was not used *per se*. It should be rather superadded to than replace common clothing. He (Dr. Brushfield) had certainly very rarely had cases of acute insanity requiring such treatment. His custom had been rather to order it for *chronic* cases. While a superintendent might be driven to use strong clothing, it did not follow that the patient should continue in that clothing for any length of time. He should be tried with ordinary clothing again and again. He recollected that at Hanwell the patients used to be taken to the store and allowed to choose their own dress, which was a very good plan. Wearing strong clothing gave a larger amount of liberty, if the patients were out more in the sunlight, and were thus able to enjoy exercise and digest their food better. It was frequently a remedy to use instead of employing opiates and seclusion.

Dr. HACK TUKE was bound to say that, looking back some forty years, he could remember asylums in which the abuse of strong dresses at that time was very marked, and the effect very unpleasant. Since that period he had been much gratified to see the improvement in this respect, and therefore, without at all condemning their use, he might say that he thought that in visiting asylums the large resort to strong dresses would strike one unfavourably in estimating the character and management of a given asylum. If, on the other hand, one went to an asylum where the use of strong dresses was small, and they were made as neat as possible, where the patients were at the same time well looked after by attendants, and where there was not over much grovelling on the ground in the courtyards, one's opinion would be more favourable than in regard to those asylums where patients in loathsome strong dresses might be seen roving and raving about of their own sweet will in the galleries or airing-courts all the day. Besides, patients in strong dresses are often in seclusion also. It was certain, at all events, that strong dresses might be abused. One thing certainly puzzled him: where no strong dress was used it might be supposed that the proportion of attendants would be much greater, and the amount of seclusion much larger. Now, in regard to Prestwich Asylum, he had once visited it with great pleasure, and he had the impression that the percentage of attendants was not extraordinarily large, and that seclusion was not more resorted to than in other asylums. He was rather at a loss, therefore, to understand how Mr. Ley could do without strong dresses, and yet not have a larger number of attendants to look after the patients to keep them in order.

Dr. RAYNER said that it was to be gathered from Mr. Ley's letter that he used strong dresses, but objected to their use while the patient was about, saying they should be used *in camerâ*.

Dr. HACK TUKE thought he remembered that in going through Mr. Ley's asylum he saw scarcely any patients either in the airing-courts or in seclusion in strong dresses, and yet Mr. Ley had, as he believed, no more attendants than were required elsewhere. In regard to the patterns of the strong clothing material, that from Belfast was from Ewart's extensive manufactory there, who had, at his suggestion, taken great interest in the production of a satisfactory material. Fresh samples, which, it was hoped, would wash better than those first tried, were now being tested by the Steward of Bethlem Hospital, who was a little conservative as to the past, and sceptical as to the future. He had informed him to-day that he thought the new patterns were more likely to succeed than the old ones, but he was not altogether satisfied yet. He (Dr. Tuke) was at the Dublin Asylum some few days ago, and the medical superintendent, Dr. Conolly Norman, had found that the dress in use there, of which he now showed a sample, did not wash well, though it was very neat. Dr. Norman had at the present time 580 female patients under care, and only four had strong dresses. Many were of an excited class. The other patterns which he exhibited were mainly from Dr. Deas, who spoke strongly of their washing quality. They did not seem, however, to be very strong in texture. He (Dr. Tuke) did not dissent from the view expressed in Dr. Savage's paper, that strong dresses should occasionally be used, and it was for that reason he desired to see them, not of the ticking material and looking like a sack, but with a neat pattern, and easily washed. He was not speaking of the strait-jacket, but simply of dresses of very strong material, for these were distinct subjects, and ought not to be confounded together. The latter, in fact, would lessen the necessity of resorting to the former.

Dr. RAYNER said he could have wished that Mr. Ley, or some gentleman present, could have given them some information as to the best mode of avoiding the use of strong dresses, and overcoming the habit of destructiveness in patients. To some extent, strong dresses were not avoidable. Even Mr. Ley acknowledged that he must use them under certain conditions. They were all agreed that they should be used as little as possible, and they must also agree that there were cases in which it was very difficult to break through destructive habits. At Hanwell, he had two or three cases at the present time which were chronically destructive. One man had periods of destruction. The cases he referred to were old cases, which had come to him second-hand. He had tried his very best to break them of the habit, but without success. He had frequently found that in cases of this sort great attention to health would be successful. Sometimes improvement could be effected through nutrition—making them fat. In other cases—the most numerous class—ill-looking individuals, with no capacity for fat, something had been done by putting their energies into the best directions. He had, however, at that time an imbecile he could neither get fat nor in any other way break of his destructive habits. This patient had been put under special care, but, in spite of everything, he would, whenever he had the slightest opportunity, destroy his clothing. It had not been possible hitherto even to make a break in his tendency. In acute cases of insanity, the use of strong clothing might be absolutely necessary, and he quite agreed with Dr. Savage that it was much better to let the patient get into any amount of dirt rather than keep him living in a close room. Sometimes a patient might get out too soon, but, as soon as a patient was fit to get out of doors, it was much better that he should go out in a strong dress than remain some time longer in a single room because it was thought to be discreditable that he should be seen in strong clothing.

Dr. SAVAGE, in reply, said that he fully realized the advantage of having more than one course open in the treatment of patients of destructive habits. To say continually, "No restraint! no restraint!" would be to imitate those people who, not having very strong faith, repeated the Creed constantly. It

was necessary, however, to remember what restraint had meant in times past, and he felt a certain danger in approaching such a subject as he had done that day, lest, by so doing, he should loosen the better feeling which now prevailed in regard to it. Undoubtedly, enormous harm had been done in the past. There were still patients in Bethlem who could tell of a time when on Saturday night a patient would be chained to a pallet of straw, and there left with a cruise of water and a crust of bread till Monday morning. He need hardly say more than that he fully appreciated the criticisims and suggestions which had been made. He regretted the absence of Mr. Ley, with whose remark that strong clothing was bad taste he could to some extent sympathise, but when Mr. Ley went on to say that it should be used only *in camerâ* he must disagree. He could agree with Dr. Rayner as to not stirring up a patient too soon. It was a disease, and could not be talked into order. The first treatment should be a certain number of days in a padded room. The patient would make a nice mess, but would very likely eat well and sleep well, and at the end of a certain period the patient went out of doors in strong clothing. He quite agreed with Dr. Hayes Newington as to the effect of strong clothing looked upon as a "bogey" dress. Patients frequently had to be treated as children, and a "bogey" dress mightfrighten a patient into self-control.

Dr. PERCY SMITH read a communication on "The Results of an Epidemic of Typhoid Fever in the Insane." (See "Clinical Notes and Cases.")

Dr. SAVAGE said that the paper just read was one in which he, of course, felt deeply interested, but, unfortunately, in one respect it did not bear much discussion. It was a most lucid description of what had occurred. The success in the cases which Dr. Percy Smith had modestly attributed to nursing, was largely attributable to Dr. Smith, and certainly the care with which the cases had been recorded made them standard cases. It was an extremely interesting question, why, under certain conditions, should fevers effect cure or facilitate recovery, whereas in other cases they did not do so at all. Of course, there were the dogmas which he had laid down in his Presidential address, and which would seem to show that except in cases in which organic disease of the brain did not take place, they could not expect events like fever to do any permanent good. He had never yet seen a case of general paralysis benefited by fever. He had seen one or two cases of general paralysis attacked by scarlet fever or small-pox, but he had never seen any definite gain. The only case he could cite in this connection was where improvement in a general paralytic case followed immediately upon the development of an enormous carbuncle, and it seemed to follow that, as a rule, improvement only occurred in the so-called functional or emotional instances. In one of the present month's medical papers, there was a paper on anti-pyrin. It was stated that this was not only good in cases where the temperature was high. He should be inclined to try it in some cases of delirious mania. The only real point of encouragement in their recent troublesome experience at Bethlem was that good had come out of evil. They had gone through a great deal of trouble and anxiety, but they had got the drains put right, at any rate for the present.

Dr. HACK TUKE referred to the cases reported by Dr. Colin M. Campbell as having recovered at the Durham Asylum, which he had always thought of great interest. He said that there was in the early experience of the York Retreat a striking case which had been placed on record in the history of that institution. Dr. Maudsley had thought it of sufficient importance to employ it as an illustration in one of his works. It was another proof of the influence of fever on the insane This case was one of fatuity or dementia, in which a young woman for a time recovered her mind entirely, and then, when the fever passed away, the insane condition returned. The practical lesson seemed to be that as we were not warranted in giving patients fever, or in having bad drainage, counter-irritation in some cases was useful, and ought to be tried. Why it was useful in some cases and not in others, in which there was no more evidence of organic disease, it was impossible to say.

Dr. FOX quoted a case of a man undoubtedly suffering from brain disease. He had not only all the symptoms of general paralysis, but they were able to watch the conditions of his gradual declension. He had a well-marked attack of pyæmia. His friends were summoned to see him die, but they stayed long enough to see him walk across his room, and well enough to be a certain pleasure to them, and to have regained a certain amount of mental power. There was no doubt that to a great extent enormous improvement for a time in this case of general paralysis did follow a very well-marked attack of pyæmia.

Dr. MOODY said that he could recall sixteen cases of typhoid fever, and in many of them a marked improvement took place, and was permanent. He also remembered a case of pneumonia, where the patient had been in an asylum fully a year. The patient quite recovered. There was also a case of general paralysis in which the patient showed a marked improvement after an ulcer of the leg, and he (Dr. Moody) was so impressed with this that he put large blisters on to keep it open.

Dr. HAYES NEWINGTON said it was quite possible that the mental disorder frequently resulted from the effects of retention of abnormal material in the blood. He could quote a case where the patient gradually got more silly, becoming water-logged, and getting those heavy, stuffy features which one sometimes saw. At length, to his (Mr. Newington's) great alarm, it was found that the patient had passed a large quantity of blood, but from that time he was quite a different man. He began to write letters, and improve in many ways. Next time that patient got into a similar state it would perhaps be desirable to try the effect of bleeding him.

Dr. PERCY SMITH said that he had referred to Dr. Campbell's paper alluded to by Dr. Hack Tuke, and he found that out of twenty-one cases, at least four, appeared to have commenced mental improvement during the course of the fever which proceeded to ultimate recovery, and there was marked improvement in other cases.

SCOTTISH MEETING.

A Quarterly Meeting of the Medico-Psychological Association was held in the Hall of the Faculty of Physicians and Surgeons, Glasgow, on the 10th March, 1887.

There were present Dr. Wickham (Newcastle), in the chair, Dr. Campbell Clark (Bothwell), Dr. Clouston (Edinburgh), Dr. C. M. Campbell (Murthly), Dr. Dodds (Montrose), Dr. Carlyle Johnstone (Melrose), Dr. Keay (Maribank), Dr. Ireland (Prestonpans), Dr. Blair (Lenzie), Dr. Alex. Robertson (Glasgow) Dr. Rutherford (Dumfries), Dr. Skae (Ayr), Dr. Yellowlees (Glasgow), and Dr. Urquhart, Secretary.

Byron Bramwell, M.D., F.R.C.P. Ed., 23, Drumsheugh Gardens, Edinburgh, was elected a member in conformity with the Rules of the Association.

The minutes of last meeting were read, approved of, and signed by the Chairman.

The SECRETARY gave notice of the regulations respecting the Prize Dissertation and the examination for the Certificate in Psychological Medicine to be held in Edinburgh in July next. He also intimated that the Gaskell* and Elliot Funds are not applicable to Scotland.

A letter from Dr. Conolly Norman regarding the forthcoming British Medical Association Meeting in Dublin was laid on the table. It was resolved to hold a meeting on some convenient day next summer at Aberfoyle, or some such place, where the insane are boarded out in considerable numbers.

* The examination is restricted to England, but Candidates who have passed the Pass Examination in Scotland or Ireland are elegible.—[EDS.]

A letter of apology for non-attendance from Professor Gairdner was read by the Secretary.

Dr. YELLOWLEES read a paper entitled "Moral Perversity or Insanity?"* It set forth in graphic detail the life histories of two young men.

Dr. WICKHAM said that he happened to have had personal experience of a case very similar to the first referred to by Dr. Yellowlees. It was a lad who came to the Newcastle Asylum with a circumstantial story of his being an adopted son of another asylum superintendent. He kept the youth for a day or two, when he proved a clever musician and an amusing story-teller. On his departure, however, he found that he was the son of a patient born in the asylum from which he said he had come, and that he had been going the round imposing on other people, had afterwards been placed in a reformatory, and ultimately completely disappeared.

Dr. C. M. CAMPBELL then read a clinical study of a "Case of Moral Insanity" (see "Clinical Notes and Cases").

Dr. IRELAND said that the expression "moral insanity" suggested a doctrine that he thought it would be difficult to uphold logically. Were morals intuitive or utilitarian? Utilitarians considered it was the best plan of life for a man to behave in a moral manner, that it was to his best interest to do so, and hence morality was an intellectual exercise, and the man who behaved so badly as to be brought into an asylum would be a grossly stupid person. There were cases, no doubt, where moral perversity was much more marked than intellectual deficiency, but so far as he knew there was no case where there was not some intellectual weakness, or if not that, there was a deficiency of the will power. He believed that all such cases, when carefully examined and analysed, showed such intellectual deficiency. Dr. Yellowlees, for instance, recorded that "C. S. A." got fifteen overcoats from a tailor "because he was going to Africa." That was surely a proof of intellectual weakness. A man might be moral as the result of training, as the result of holding certain theories, or as perceiving proper conduct to be to his best advantage. If those failed to control him, there must be a mental deficiency; his mental system must have a flaw in it.

Dr. ROBERTSON agreed with Dr. Ireland that in cases of moral insanity some intellectual defect could be almost always ascertained—in his own experience he never failed to find such to be the case. The name "moral insanity" had often brought lawyers and doctors into conflict; and he would not advise anyone to use it in a court of law for his own comfort. He had noted the top-coats incident, and believed that it indicated intellectual weakness. The judgment in these cases was not up to the standard, and they therefore used the word "moral" by way of excluding the other faculties of the mind. He had generally found these cases, when occurring in youth, to be hereditarily predisposed to insanity, and was surprised that Dr. Yellowlees found no such tendency. He would lay some stress on the fact of the forceps having been used at the birth of one of the cases. Dr. Robertson went on to refer to cases of simple mania where there was not much intellectual derangement and scarcely any delusion, but merely mental instability and an inability to look at things in their proper light. In childhood this generally showed itself in erratic conduct, and in such children as had fits he often recognized a certain amount of perversity. Where there had been previous attacks of insanity a twist in the mental nature was often left—sometimes leading on to criminal actions, as in the case of Tierney. And, in conclusion, there were cases where the moral power was markedly deranged during a long preliminary stage of mania or general paralysis.

Dr. CLOUSTON believed that not many had set up moral insanity as existing absolutely without intellectual deficiency. He thought that the general opinion was that moral perversity, lack of self-control, impaired volition, and perverted moral impulse together constituted a case. The intellectual power would be such that the man, but for the moral perversity, would be regarded as a sane member of society. He might be a little deficient in intellect—all were

https://doi.org/10.1192/bjp.33.141.152 Published online by Cambridge University Press

a little deficient in intellect; he might be perverted volitionally—all were perverted volitionally; but the deficiency and the perversity would not amount to legal or medical insanity. The moral perversity constituted the essence of the case, and the only part that was really insanity. Looking at morality in a practical way, they found the moral sense a physiological brain quality, developed as the muscles were developed, perfected as the muscles were perfected yet differing in different individuals. Certain predisposed children were capable of development intellectually and morally to a certain extent only. Their brains did not seem capable of attaining to the finest moral sense which constituted the mind of the present day. They were only capable of development up to a kind of semi-savage stage in this direction, while their reasoning powers were as acute as those of other children. It had been long recognized that the moral powers were the first to go in an attack of insanity. Dr. Clouston referred at length to De Quincey and Shelley, whose intellectual abilities were far above the average, but whose moral qualities and volitional powers were twisted and perverted. He would regard Dr. Campbell s case as belonging to that class which Dr. Robertson had referred to, where the actual attack of insanity (probably in that case mild melancholia) had left a mental twist.

Dr. YELLOWLEES briefly replied. He had not used the expression "moral insanity," and did not feel bound to defend it. It was a term he rarely employed. He thought, however, that moral insanity was a brain disorder which took the direction of immoral developments, and that it might do so together with an intellectual disturbance by no means sufficient of itself to constitute insanity.

Dr. ROBERTSON read a paper on "A Case of Catalepsy with observations on the Mental Condition in the Cataleptic State."*

Dr. CLOUSTON referred to a case of catalepsy in a boy in whom that state supervened after an attack of convulsions. He said that he had often had what Dr. Robertson proposed to call cataleptoid cases, where any position in which the patient might be placed would be maintained for a considerable time. He described two kinds, where the patient would readily assume the attitude to which he might be moulded, and where the patient strongly resisted any change in the position assumed by himself. The question was, in the latter class, was the brain condition the cause of the rigidity, or was it owing to a delusion? The case he described was probably conscious during the whole time, but it would not be the same in every case. Its connection with epilepsy would rather point to a pathological condition, and he believed that many of them primarily owed their origin to a derangement in the convolutions.

Dr. URQUHART thought that there was very great difficulty in assigning cataleptoid conditions to the influence of a dominant delusion. His experience had led him to believe that, if a patient assumed a rigid attitude, it was most probable that he was under the influence of such a delusion, while, if he were plastic and could be made to assume and preserve attitudes, no such influence could be proved.

Dr. IRELAND believed that Dr. Robertson had proved the existence of consciousness during the course of the case, and that there was a certain delusion. He went on to refer to the hypnotic state and the analogies between that and catalepsy.

Dr. YELLOWLEES referred to a case of cataleptoid nature at present under his care. The man had a want of volitional power, and seemed unable to complete actions which he had begun. He would remain with a foot in the air, poised, until someone touched him, and he required to be stimulated similarly when at meals.

Dr. ROBERTSON replied briefly. At first the pricking of the skin in his case was not followed by bleeding, but afterwards such wounds bled freely. There was no doubt great torpidity of the circulation in the early stage of his malady, but he believed that it was caused by the nervous disorder. Notwithstanding the

* These papers will appear in the July number. –[EDS.]

application of heat and cold to the head had been followed by benefit. Dr. Robertson showed the original apparatus for this purpose he had devised and shown at a former meeting of the Association here some sixteen years ago.

Dr. DODDS read clinical notes on "A Case of Epilepsy."

Dr. WICKHAM said that he had tried everything that was recognized as a remedy in the treatment of epilepsy with very different results in different cases. He had found nitrite of amyl of service in one case, and in another it was a complete failure.

Dr. YELLOWLEES asked if anyone had tried the plan of bleeding during a succession of fits as advocated lately by Dr. Wallis?

Dr. URQUHART had bled a patient quite lately. He was admitted labouring under alcoholic insanity, with an enlarged liver and an engorged circulation. Shortly after his arrival he had a succession of epileptic fits, which were promptly stopped by venesection to six ounces. Unfortunately he developed double pneumonia some time after and died.

Dr. YELLOWLEES showed a skull-cap with very great and irregular thickening in its anterior half. The bony deposit occurred in rounded wavy protuberances, and the thickness of the cranial vault at two of these was $\frac{1}{8}$ths of an inch. A similar condition, though not so well marked, is figured in Dr. Clouston's book. Such thickening of the bone is usually regarded as compensatory for loss of brain substance, and it is supposed to occur only with prolonged dementia. In this case the patient was not demented, but exceptionally intelligent. She died from abdominal disease at the age of 57 in her second attack of melancholia, the previous attack having been climacteric. There was no paralysis of any kind, and although the convolutions were flattened by the bony growths, there was no disintegration or manifest wasting of brain substance.

The members dined together at the Bath Hotel after the meeting.

The next business-meeting of Scottish Members will be held on the second Thursday of November.

THE LUNACY ACTS AMENDMENT BILL.

The following has been addressed by the Honorary Secretary of the Medico-Psychological Association on behalf of the Parliamentary Committee, to the Lord Chancellor:—

To the Right Honble. the Lord Chancellor.

MY LORD,—I am instructed by the Parliamentary Committee of the above Medico-Psychological Association respectfully to submit for your consideration their views with regard to some of the provisions in the Lunacy Acts Amendment Bill (1887).

The most important is the provision in Clause 3, s-s. 9 (p. 4, l. 7, *et seq.*), that notice of petition be given to the alleged lunatic by the magistrate, &c. This procedure the Committee is of opinion would be most inimical to the welfare of the insane, and would lead in some cases to the suicide of the patient, in others would induce homicidal assaults, and in many would enable the lunatic to escape from the jurisdiction of the magistrate.

The extent of the jurisdiction of the various magistrates, &c., and their power to control an alleged lunatic under petition, would appear to require definition, as well as the power of friends to exercise control over an alleged lunatic during the consideration of a petition.

This sub-section (Clause 3, s-s. 7) appears to the Committee to reduce the question of insanity to a legal prosecution, in which the relative or friend is the prosecutor, the sick man is the defendant or criminal, and the magistrate is the judge, in the place of being the guardian of the patient's interest.